ROGUE VALLEY COUNCIL OF GOVERNMENTS
Area Agency on Aging

Jackson and Josephine Counties, Oregon

(541) 664-6674 • FAX (541) 664-7927 • www.RVCOG.org

AREA PLAN

2025-2029

REVISED 5-2025

ROGUE VALLEY COUNCIL OF GOVERNMENTS
AREA AGENCY ON AGING
2025-2029 AREA PLAN

SECTION A - AREA AGENCY PLANNING AND PRIORITIES

A - 1 Introduction

The Rogue Valley Council of Governments (RVCOG) has been the designated Older Americans Act Area Agency on Aging (AAA) for Jackson and Josephine Counties since 1974. The RVCOG is a voluntary association of local governments including Jackson County, Josephine County, all thirteen municipalities located within the two-county area, and representatives from higher education and several special districts.

The RVCOG serves Jackson and Josephine Counties with a total population exceeding 312,000[1]. The region includes two Census-designated urbanized areas, one centered on the City of Medford and the other on the City of Grants Pass.

The Senior and Disability Services Department (SDS) and the Senior Nutrition Department's Food & Friends Meals on Wheels and Senior Meals Program (F&F), provide RVCOG's largest program offerings, with an annual combined budget of approximately $6 million and 38 full and part-time staff. Please note that for the purposes of this Area Plan, RVCOG or AAA will be used to refer to both the Senior & Disability Services and Senior Nutrition Departments unless otherwise noted.

RVCOG, under an Intergovernmental Agreement with the State, partners with the Medicaid Long-Term Care and Financial Assistance programs, which are directly provided by District 8 Aging and People with Disabilities (APD). District 8 APD services are delivered from three sites including a Senior Services site in Medford, a Disability Services site in Medford, and a site providing combined services in Grants Pass. Services include SNAP, medical coverage, medical supplies, Adult Foster Care licensing, Adult Protective Services, and eligibility and case

[1] U.S. Census Bureau, U.S. Department of Commerce, American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05, 2023

management for clients enrolled in Medicaid Long Term Services and Supports (LTSS). Launched in 2024, Oregon Project Independence – Medicaid (OPI-M) is jointly administered by RVCOG and APD.

RVCOG and APD's goal is to provide a seamless service system to older adults and adults with disabilities in the two-county area. Towards this goal, service descriptions for both RVCOG and APD are included in this plan. This four-year Area Plan describes APD Services as well as those provided by RVCOG to give a comprehensive understanding of services for older adults and adults with disabilities.

RVCOG is the certified Aging and Disability Resource Connection (ADRC) for the two-county area and provides Oregon Project Independence (OPI) services, a senior nutrition program (Food & Friends), family caregiver support, health promotion/prevention programs, behavioral health services, advocacy, and program coordination/development services.

This four-year plan has been developed to ensure that RVCOG has provided the opportunity for community input concerning senior and disability services in Jackson and Josephine Counties. Community input fulfills the critical need to provide a more complete understanding of community needs, enabling RVCOG to prioritize its services, based upon those needs deemed to be the most important by the community.

A copy of the 2025-2029 Four-Year Area Plan is available for public review at the Rogue Valley Council of Governments administrative office, 155 North 1st Street, Central Point, Oregon 97502; Phone (541) 664-6674; Fax (541) 664-7927; and on www.RVCOG.org.

A - 2 Mission, Vision, Values

Senior & Disability Services Mission Statement:

"Together we promote the dignity, quality of life, and self-determination of seniors and people with disabilities."

Food & Friends Mission Statement:

"Together, we strive to cultivate an equitable approach to improving the health, wellbeing and independence of older adults and adults with disabilities through nutrition services, meaningful social connections, and opportunities for education."

RVCOG AAA Vision and Values

- We support the dignity, quality of life and independence of people as they age or experience disabilities.
- We empower individuals and families to help themselves by providing information and resources to all, so that they have choices.
- We respect each person's uniqueness and understand that well-being encompasses physical, nutritional, social, financial, mental, and emotional health needs that can change and evolve.
- We empower caregivers to be knowledgeable and have the skills to provide quality care and thrive while providing care.
- We protect and intervene for people as they age and for people with disabilities so that they are free from emotional, physical, and financial abuse.
- We promote our communities' preparation for and support of long-term services and supports.

We believe all people have the right to be free from discrimination, particularly, of a sexual orientation, gender identity, gender expression, racial, ethnic, age, religious, or disability-related nature.

We provide a financially and programmatically sustainable service system.

This Area Plan reflects an outcome-based approach embraced by RVCOG. Service descriptions within this Area Plan are organized into the following general areas (see Section B – 3 AAA Services, Administration and Service Providers for more detail).

- **Administration, Program Coordination and Development** – Provide efficient and competent administration, program coordination and development.

- **Advocacy and Advisory Councils** – Serve as a voice for older adults and adults with disabilities in the Jackson and Josephine County areas.
- **Behavioral Health** – Provide resources and services that help provide a better quality of life.
- **Community Living** – Enable consumers to understand the range of home and community-based residential care options including information about financial assistance.
- **Emergency Preparedness** – Connect people with access and functional need to the Disaster Registry.
- **Family Caregiver Support and Training** – Provide access to a range of services to support family caregivers.
- **Federal Assistance Programs for Seniors and People with Disabilities** – Partner with the locally-available Medicaid Long-Term Care and Financial Assistance Programs, Aging and People with Disabilities (APD).
- **Health Promotion Programs** – Provide services that maintain or empower health including services for those with chronic conditions and diabetes.
- **Information and Expert Help** – Provide knowledge or resources for aging and disability challenges and available services.
- **Lifelong Housing Certification** – Provide information about RVCOG's Lifelong Housing Certification program, a voluntary certification process for evaluating the accessibility and/or adaptability of homes.
- **Nutrition** - Food & Friends Meals on Wheels and Senior Meals Program.
- **Safety and Rights** – Provide tools to protect aging individuals and individuals with disabilities from harm or abuse.

RVCOG CORE VALUES....

SERVICE COLLABORATION PROFESSIONALISM STEWARDSHIP INTEGRITY RESPECT

A - 3 Planning and Review Process

The agency recognizes there will be a continual increase in need for the services that RVCOG provides, both due to in-migration and a demographic of citizens who are progressively aging as well as an increased population of adults with disabilities.

The reasons for this growing demographic are multiple, but subjectively one can attribute the increase in the senior numbers to the aging of the Boomer generation combined with increased immigration due to the popularity of Southern Oregon as a retirement destination. Additionally, the number of younger people with disabilities is increasing, due to advances in medical technology that contribute to a higher survival rate of severely injured individuals and people with disabling chronic conditions. Finally, increasing life span is contributing to a greater frequency of age-related chronic conditions, many of which eventually lead to individuals requiring assistance with activities of daily living.

The Senior Advisory Council, in partnership with RVCOG staff, played a key role in the Four-Year Area Plan process. The following is a list of the 2025-2029 Four-Year Area Plan activities completed:

- SAC members and RVCOG staff jointly developed and implemented a survey of older adults and individuals with disabilities in Jackson and Josephine counties. The purpose of the survey was to better understand what services older adults need to ensure that those facing aging or disability issues, or those caring for persons with such issues, are able to live as independently as possible. The survey was presented in both English and Spanish. A total of 727 surveys were completed. The respondents completed the survey either on paper forms or by entering responses directly on the SurveyMonkey website. The survey period was January through March 2024. The data was collected to describe the demographic characteristics of the respondents, their current living conditions, the state

of their health, sources of health information and support, and needs for assistance and services.

- RVCOG staff, SAC members, and community partners participated in focus groups with key stakeholders. Focus groups included: Community Volunteer Network (CVN) Age Wise-Age Well, foster grandparents, and SHIBA program participants; Food & Friends meal site participants; SAC members; and DSAC members. Input from stakeholders was received on unmet needs for older adults and adults with disabilities, needed community improvements for this population, the importance of aging in place, resources for caregivers, and successes and challenges to health and well-being. The surveys did not reveal needs specific to demographic groups but rather showed that needs were spread widely over all demographic groups.
- From the gathered survey and stakeholder data, the agency identified the following list of needs (not prioritized):
    - Access, transportation, and accessible parking
    - Affordable housing and supports for the unhoused community
    - Financial barriers
    - Food security
    - Access to durable medical equipment
    - Opportunities for social connections – events and multigenerational
    - Single point of entry for resource assessments and navigation assistance
    - Caregiver consistency from homecare agencies
    - Training for caregivers
    - Family caregiver reimbursement
    - Safety – lighting, accessible entrances to businesses, medication reviews, environments that welcome all
    - Easy access to recreation and exercise
    - Understanding medical coverage and physicians not taking Medicare
    - Digital literacy – access, affordability, use of devices

- RVCOG conducted a public hearing on March 3, 2025, to review and gather public and Senior Advisory Council feedback on the Four-Year Area Plan.

A - 4 Prioritization of Discretionary Funding

OAA Title IIIB funds are the least restrictive of all Title III funds. Minimum expenditures are required in three categories, In Home (3%), Legal (3%), and Access Services (18%), totaling 24% of the total. For the four fiscal years covered by this Area Plan, July 2025 through June 2029, RVCOG will meet or exceed all minimums in these categories. After analyzing the results from the conducted needs assessment and current documented program needs RVCOG will focus its OAA Title IIIB discretionary funding on the following priorities:

- Administration;
- Program Coordination and Development, including promotion of the Lifelong Housing Certification program and Disaster Registry – new revenue development, Disaster Registry and Lifelong Housing activities, coordination with local groups, organizations, and service providers targeting LGBTQIA2S+, Native Americans, rural communities, non-native English speakers, people experiencing homeless, low-income, and at-risk older adults and adults with physical disabilities;
- Transportation, Assisted and Non-Assisted;
- Outreach and Public Outreach/Education for AAA programs;
- Health Promotion, Non-Evidence Based Mental Health Screening & Referral and Preventive Screening, Counseling & Referral;
- Health Promotion, Evidence Based Mental Health Screening & Referral, Chronic Disease Prevention/Management/Education;
- Person-Centered Options Counseling;
- Home repair and modification to address fall risks and enable clients to safely stay in their homes;
- Health, Medical and Technical Assistance Equipment;
- Nutrition Education; and
- Legal assistance and guardianship/conservatorship.

Though some AAA programs are open to all qualifying individuals, many require an assessment before delivery of services. While specific to each program, these assessments provide the mechanism to ensure that services to those in greatest economic and social need enter into services with priority and the lowest possible barriers. When waitlists are needed due to program/staff capacity and/or funding barriers, we use a risk assessment tool to identify highest risk/highest need participants to be considered first. Current high-need programs most at risk of waitlists are:

- Food & Friends Meals on Wheels – program capacity, volunteer, and funding challenges;
- Oregon Project Independence (OPI), all versions – staff capacity and funding challenges;
- Program to Encourage Active and Rewarding Lives (PEARLS) – staff capacity and funding challenges;
- Options for People to Address Loneliness (OPAL) – staff capacity and funding challenges; and
- Other Behavioral Health workshops and interventions – staff capacity and funding challenges.

As OAA ARPA IIIB funds will be exhausted before implementation of this Area Plan, funding challenges are increasing across the board for OAA Title III programs. Traditional methods to bridge funding gaps will continue to be used to the greatest extent possible, and include:

- Direct fundraising to support program services;
- Applications for additional State and aging network funding opportunities – ODHS, OHA, OWN;
- Grants to private foundations;
- Applications and funding requests to RVCOG member jurisdictions; and
- Trust distributions and donations from the estates of RVCOG AAA participants.

A - 5 Service Equity

RVCOG is committed to addressing the systemic oppression that impacts all protected classes. We recognize that Oregon's history of racial discrimination and other forms of social exclusion have created economic, political, health, and social disparities that continue to disproportionately impact communities of color, LGBTQIA2S+ populations, Oregon Tribal members, residents of rural areas, and other marginalized and underserved populations. To more equitably serve all populations we commit to:

- Actively engaging with all communities to build relationships so that our services and supports are assured to meet current and evolving needs;
- Learning from the diverse communities, people, and agencies that have historically served individuals who have not historically been or are currently not adequately served to promote AAA services and opportunities;
- Identifying, analyzing, and removing current barriers to services encountered by these groups; and
- Building trust and service equity into the design and delivery of our programs, supports, and services.

RVCOG welcomes people of all experiences, backgrounds, and identities with dignity, integrity, respect, and compassion. We are fully committed to diversity, equity, and inclusion in principle and in practice. Diversity, equity, and inclusion are central to the organization's current and future success in engaging all staff, clients, caregivers, advisory council members, and policy makers in promoting equitable and inclusive programs and resources for older adults and adults with disabilities.

There shall be no barriers to full participation in our programs on the basis of race, gender, gender identity, gender expression, sexual orientation, ethnicity, native or indigenous origin, age, generation, culture, religion, belief system, marital status, parental status, socioeconomic status, language, accent, ability status, mental health, educational level or background, geography, nationality,

work style, work experience, job role function, thinking style, personality type, physical appearance, political perspective or affiliation, and/or any other characteristic that can be identified as recognizing or illustrating diversity. We commit to promoting diverse, equitable, and inclusive programs, supports, and referral resources for older adults and adults with disabilities through fostering education, engaging with marginalized and underrepresented groups, and creating equitable outreach and services for our evolving community. As we engage in this work, we will be mindful of the complex, cumulative way in which the effects of multiple forms of discrimination, such as racism, ageism, ableism, and classism, combine, overlap, and intersect, especially in the experiences of marginalized individuals or groups. We commit to an annual internal review of service equity needs and gaps in our service area and to continually seek feedback, information, and education from our clients, community partners, and the larger community on how we can improve upon our delivery of diverse, equitable and inclusive programs, supports, and referral resources.

The RVCOG AAA strives to collaboratively build service equity into our everyday work of designing and delivering programs, services, and supports to older adults and adults with disabilities. This will be accomplished through intentional, culturally sensitive, person-centered care (outreach and input), collaboration with organizations, agencies, churches, and other community groups already trusted by those who have historically been or who currently are not adequately served, building staff capacity for language access and community outreach, and improving data collection to identify gaps and barriers to service.

Service Equity priority details are:

Priority 1: Committing to **foundational changes** to build Service Equity.

<u>Categories of work within this priority area:</u>

- Policies
- Trainings/Presentations
- Internal AAA Equity Work
- AAA Workforce Development
- Collaboration with APD Staff

Priority 2: Advancing the **framework** of Service Equity.

Categories of work within this priority area:

- Language Resources/Accessible Resources/Language Access
- Advocacy
- Community Engagement to Support Populations who are Underserved or not Adequately Served
- Welcoming Clients

Priority 3: Evolving into a **catalyst** for Older Adults and Adults with Disabilities with Service Equity at our Core.

Categories of work within this priority area (tied to key Older Americans Act Core Services):

- Nutrition Services
- Health Promotions Programs and Other Health Related Initiatives
- Elder Abuse
- Recruitment of Volunteers
- Broadband Access

Priority 4: Ensuring that our Service Equity Plan continues to reflect the ever-changing face of the Rogue Valley. (Continual reexamination)

SECTION B – PLANNING & SERVICE AREA PROFILE

B - 1 Population Profile

The 2023 population 5-year estimates indicate that the RVCOG Area Agency on Aging (AAA), which serves Jackson and Josephine Counties, has a total population of approximately 312,000.[2] The vast majority of the population lives within the Rogue Valley statistical metropolitan area, which includes the cities of Medford, Ashland, Talent, Phoenix, Central Point, Eagle Point, and Jacksonville, and in the Middle Rogue statistical metropolitan area, which includes the cities of Grants Pass, Rogue River, and Gold Hill.

[2] U.S. Census Bureau, U.S. Department of Commerce, American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05, 2023

Approximately 15.8 percent of area residents identify as a race other than white, with 10 percent identifying as two or more races.[3] Hispanic or Latino residents of any race make up 12.5 percent of the population of Jackson and Josephine Counties.[4] There are 0.65 percent of residents identifying as Native Americans living within the two-county area.[5]

In Josephine County, it is estimated that 5 percent of people speak a language other than English at home, while for Jackson County that estimate is 9.7 percent.[6] Of those in Josephine County, approximately 1.4 percent and in Jackson County 1.7 percent, speak English less than "very well".[7]

It is estimated that 15.8 percent of people in Josephine County and 12.4 percent of people in Jackson County live below the poverty level. [8] This highlights the economically disadvantaged in Josephine County.[9] Both counties have higher rates of poverty than the State of Oregon as a whole, which reports 11.9 percent of people live below the poverty level. [10]

People aged 60 and older

There are an estimated 96,832 people aged 60 years or older across the two counties[11], equating to an estimated 31.1 percent of the population. Therefore, the two-county area features a higher proportion of older residents than the rest

[3]U.S. Census Bureau, U.S. Department of Commerce, American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05, 2023

[4] Ibid., table DP05, 2023

[5] Ibid., table DP05, 2023

[6] U.S. Census Bureau, U.S. Department of Commerce, American Community Survey, ACS 5-Year Estimates Subject Tables, Table S0102, 2023

[7] Ibid., table S0102, 2023

[8] Ibid., table S0102, 2023

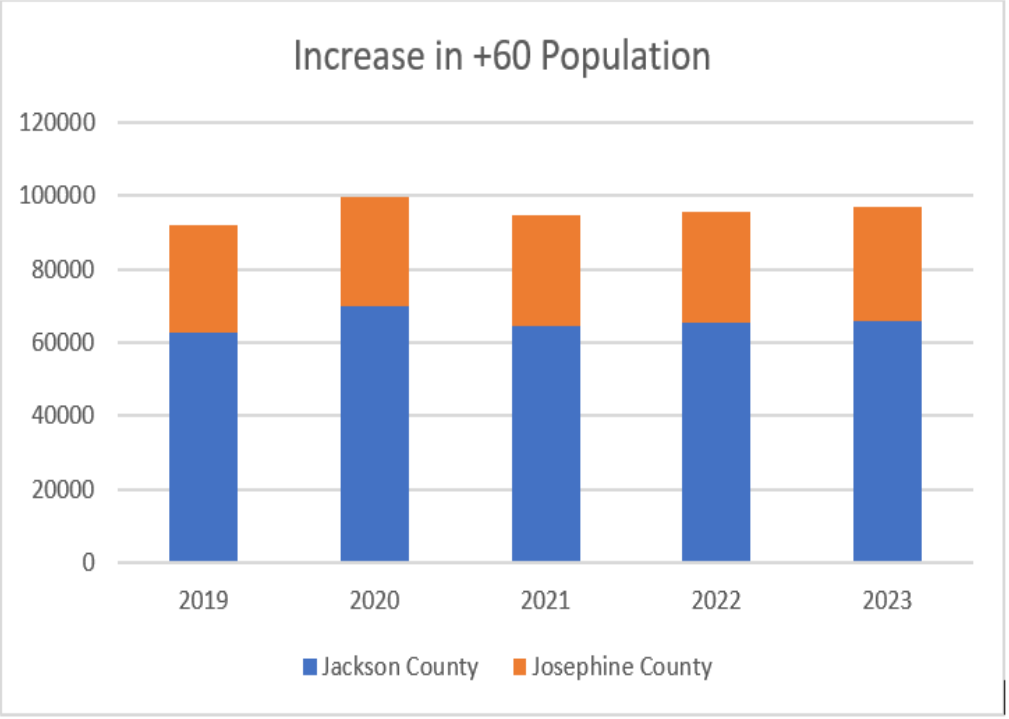
[9] Ibid., table S0102, 2023

[10] Ibid., table S0102, 2023

[11] Ibid., table S0102, 2023

of the State, which reports 25 percent.[12] The proportion of older residents is climbing, with the percentage of persons 60 and older increasing in both Jackson and Josephine Counties from 2019 to 2023[13] as depicted below.

The senior population in the area is less racially and ethnically diverse than the general population. As the area population ages, it is expected that the senior population will become more diverse racially, ethnically, and linguistically. Currently, 8.8 percent of area residents aged 60 and older identify as a race other than white. Additionally, 5.4 percent who are 60 or older identify as two or more races.[14] Hispanic or Latinx residents of any race make up 4.5 percent of the 60+ population of Jackson and Josephine Counties.[15] There are 0.5 percent Native American elders residing within the two-county area.[16]



[12] Ibid., table S0102, 2023
[13] Ibid., table S0102, 2023
[14] Ibid., table S0102, 2023
[15] Ibid., table S0102, 2023
[16] Ibid., table S0102, 2023

In Josephine and Jackson Counties, an estimated 4.2 percent of people aged 60 or older speak a language other than English.[17] Among those residents, 1.5 percent report that they speak English less than "very well".[18]

Economically, older adults are, on average, doing better than the general regional population. However, all ages are below the state averages. In our region there are an estimated 11.4 percent of people 60 and over who are below the poverty level and 10 percent of people 60 and over who are at or below 149 percent of the poverty level.[19] Statewide, 10.2 percent of people aged 60 and older are below the poverty level and 7.6 percent are at or below 149 percent of the poverty level.[20]

People with disabilities

In Jackson and Josephine Counties, there are an estimated 32 percent of people aged 60 and older who are living with disabilities.[21] Jackson and Josephine Counties have a higher percent of people aged 60 and older who are living with disabilities than the State of Oregon, in which 15.1 percent of the population report having a disability.[22]

In addition, the number of people with a disability in all six self-reported categories of difficulties (see table below) is higher in Jackson and Josephine Counties than in the State of Oregon.[23]

[17] Ibid., table S0102, 2023

[18] Ibid., table S0102, 2023

[19] Ibid., table S0102, 2023

[20] Ibid., table S0102, 2023

[21] Ibid., table S0102, 2023

[22] Ibid., table S0102, 2023

[23] U.S. Census Bureau, American Community Survey, ACS 1-Year Estimates Subject Tables, S1810, 2023

People with Self-Reported Difficulties[24]	Jackson County	Josephine County	Oregon
Persons with Self-Reported Hearing Difficulties	4.5%	5.2%	4.5%
Persons with Self-Reported Vision Difficulties	2.5%	2.8%	2.4%
Persons with Self-Reported Cognitive Difficulties	7.7%	8.8%	6.8%
Persons with Self-Reported Ambulatory Difficulties	7.3%	8.5%	6.8%
Persons with Self-Reported Self-Care Difficulties	2.5%	4.6%	2.8%
Persons with Self-Reported Independent Living Difficulties (ages 18+)	6.8%	8.8%	6.9%

Summary Table of Population Statistics

Characteristic	**Jackson County**		**Josephine County**	
	Total	**60 years and over**	**Total**	**60 years and over**
Population				
All	222,563	65,996	88,069	30,836
Rural [25]	45,981		38,004	
Male	49.1%	46.0%	48.7%	46.4%
Female	50.9%	54.0%	51.3%	53.6%
Low income				
Below poverty level	12.4%	10.6%	15.8%	13.3%
At or below 149%	9.2%	9.0%	13.2%	12.0%
Race/Ethnicity/Language				
Minority	10.8%	9.0%	12.7%	8.4%
Native American	0.7%	0.6%	0.6%	0.3%
Hispanic	14.2%	4.8%	8.4%	3.9%

[24] Ibid., table S1810, 2023

[25] County-level Urban and Rural information for the 2020 Census (Updated September 2023)

Language other than English spoken at home	9.7%	4.5%	5.0%	3.6%
Limited English Proficiency	2.7%	1.9%	1.4%	0.9%
Person with disability				
	16.4%	30.0%	20.7%	35.3%
Source: US Census Bureau, 2020 American Community Survey 5 Year Estimates, table S0102.				

With the steady increase in the 60+ population and the expectation that the senior population will become more diverse racially, ethnically, and linguistically, RVCOG has focused on creating more outreach efforts to the bilingual community. With an increase in distribution of our material in Spanish and the hiring of a bilingual Community Outreach Coordinator, RVCOG significantly increased outreach efforts towards the LatinX community. As more information becomes available, RVCOG is prepared to adjust staffing to accommodate the needs of the community. Through our ADRC program we can distribute emergency funds for immediate needs to low-income older adults if they qualify.

B - 2 Target Populations

RVCOG is committed to provide high quality services to individuals with the greatest economic and social needs, including low-income minority older individuals, individuals living in rural areas, individuals with limited English proficiency, older individuals at risk for institutional placement, older Native American individuals, LGBTQIA2S+ individuals, and older adults with disabilities. Based on the analysis of population trends in the area in combination with our needs assessment survey and requested services through our ADRC program, RVCOG is able to identify and provide services to targeted populations in our PSA. Available funds are distributed with a priority set to impact the greatest economic and social needs first. Service assessment tools not only rate economic and functional needs but also availability of natural supports to ensure that those at the highest risk and highest need are prioritized for services. Targeted outreach to

priority populations and organizations serving these individuals aids in identification of priority individuals and their entry into available services.

1. **Rural, Low Income:** The agency operates 10 congregate/home-delivered meal sites (Ashland, Cave Junction, Central Point, Eagle Point, Grants Pass, Jacksonville, Medford, Merlin, Rogue River, and Wolf Creek) and 5 home-delivered staging sites (Gold Hill, Phoenix, Shady Cove, Talent, and White City) in the two-county area from which home-delivered and/or congregate meals are served. Nearly all of these meal sites serve areas that feature low household median income.[26]
2. **Rural, Low Income:** We make a special effort to recruit Senior & Disability Services Advisory Council members from low-income, rural, and limited English-speaking communities.
3. **Low Income:** RVCOG cooperates with local APD offices that can provide access to SNAP, medical insurance, assistance with medical supplies, and Medicaid-funded long-term care support for eligible residents. All offices provide staff visits to older adults in response to referrals from self, family, agencies, and other interested parties. They assess needs and provide assistance as required. The Aging and Disability Resource Connection (ADRC) is available toll-free to anyone regardless of income.
4. **Low Income, Minorities, Limited English:** Latinx individuals are the predominant minority population in the two-county area. The RVCOG and its contractors are all listed in locally available resource guides including The Silver Pages, Senior Resources Directory, and Retirement Connection. These publications are distributed broadly throughout the two-county area including medical offices, hospitals, home health and hospice agencies, home medical agencies, senior meal sites, and businesses where older adults congregate. The agency is also listed in local newspapers. A bilingual

[26] US Census, 2010

Community Outreach Coordinator position was created to address communication barriers, a translation service is available for phone services, and many outreach materials are available in Spanish.

5. **Low Income, Minority, Limited English:** The agency actively participates on the Jackson County Continuum of Care Board and Homeless Task Force, including implementation of the Jackson County 10-Year Plan to End Homelessness, Josephine County Homeless Task Force, Jackson County Community Services Consortium, the Hispanic Interagency Committee, and the Multi-Disciplinary Adult Protective Services teams (MDTs) in Jackson and Josephine Counties.
6. **Limited English:** Bilingual staff members, fluent in Spanish and German, are employed in the administration office. Language Line translation services are available during phone communications. Spanish brochures for the ADRC, Food & Friends, and other programs are available in each of RVCOG's offices, contractor offices (including legal aid offices) and at all meal sites. They are also distributed throughout the two-county area to churches, medical offices, hospitals, home health and hospice agencies, and home medical agencies. A wallet-sized bilingual emergency resources for older adults and people with disabilities guide is widely distributed.

7. **Native Americans:** RVCOG is participating in Regional AAA and Tribal meetings coordinated by Community Services and Supports Unit (CSSU). These meetings provide RVCOG staff with the opportunity to build relationships with the tribes who have members living in the Jackson and Josephine County Areas. The focus is on increasing outreach to educate the tribal elders about services and resources.

8. **Lesbian, Gay, Bisexual, and Transgender (LGBTQIA2S+):** In Oregon, 7.8%[27]of the population identifies as LGBTQIA2S+. RVCOG continues to reach out to the LGBTQIA2S+ community at any available events to educate about services and resources. RVCOG achieved SAGECare Platinum status in 2023.

[27] Howard, Jerry (April 19, 2024). *Kotek's approved spending includes funds for LGBTQIA2S+ research*. kdrv.com/news. https://www.kdrv.com/news/top-stories/koteks-approved-spending-includes-funds-for-lgbtqia2s-research/article_f3466250-fe9c-11ee-95dd-97605cbbf924.html

B - 3 AAA Services, Administration, and Service Providers

Directly Provided and Contracted Services

RVCOG provides some services directly and contracts with local agencies for others. Direct services are provided from a central administrative office, located in Central Point, and three APD Field Offices: two in Jackson County (Senior Services and Disability Services) and the APD Office in Josephine County. More information regarding all RVCOG programs is available at www.rvcog.org.

With the changing demographic and changing needs, RVCOG is continuously trying to identify new service providers and/or available programs in the area. Regular presentations during the Senior Advisory Council meetings from community partners and invited speakers at staff meetings aid in being fully informed on relevant and available programs in our service area. Additionally, RVCOG follows Oregon Public Contracting regulations and uses the OregonBuys eProcurement System for applicable contracted services.

All services provided, either directly by Area Agency staff or through contractors, are subject to RVCOG's conflict of interest policies. Please see Appendix G - Conflict of Interest Policy.

The following sections describe provided services and activities:

Administration, Program Coordination and Development – Provide efficient and competent administration, program coordination, and development. Under its Intergovernmental Agreement (IGA) with the State of Oregon, RVCOG is responsible for:

- Developing and annually updating a Four-Year Area Plan, now including the Service Equity Plan;

- Implementing the planned services;
- Maintaining required records;
- Fulfilling the requirements of Federal regulations, State rules, and State Unit Policies and Procedures;
- Supporting the Advisory Councils and their subcommittees;
- Contract administration and monitoring; and
- Financial accounting and quality assurance.

Under the IGA, the State also contracts with RVCOG to partner with the Medicaid Long-Term Care and Financial Assistance programs which are directly provided by District 8 Aging and People with Disabilities (APD). RVCOG and APD's goal is to provide a seamless service system to older adults and people with disabilities in the two-county area.

RVCOG is a regional consortium of local governments that is the federally designated Area Agency on Aging (AAA) for Oregon District 8 Planning and Services Area (PSA) and encompasses the entirety of Jackson and Josephine Counties. RVCOG is also a certified Aging and Disability and Resource Connection (ADRC) for the two-county area.

RVCOG's AAA Management Team

The Nutrition Program Director manages all aspects of the Meals on Wheels and Senior Meals Program and is supported by the Food & Friends Team:

- Nutrition Program Coordinator – Provides advanced analytical and administrative support, including a variety of complex clerical functions, for the Nutrition Program. Works with the Nutrition Program Director to develop and implement program policies, procedures, and systems to ensure the long-term viability of the program. Assists in fundraising and grant writing efforts at levels sufficient to meet the demand for service.

Aids in the development and monitoring of the Nutrition Program budget. Develops, monitors, and processes renewals for Nutrition Program contracts and agreements. Assists the Nutrition Program Director in ensuring compliance with all applicable required standards and policies.

- Nutrition Program Administrative Specialist/Home Delivery Coordinator – Provides general oversight of meal sites and Meal Site Coordinators. Assures prompt and accurate delivery of hot and frozen meals to qualified participants in accordance with program requirements. Coordinates home delivery activities, including training and coordination of meal site staff, volunteers, and community partners. Maintains appropriate records and prepares accurate reports related to the program, including daily meal counts, monthly transaction records, volunteer hours, and other program-related reporting.
- Nutrition Program Volunteer Coordinator – Performs outreach and recruitment activities to ensure an adequate number of home delivery and meal site volunteers. Provides onboarding and continuing training for program volunteers.
- Administrative staff

The SDS Program Director manages all aspects of the Senior & Disability Services program and is supported by the SDS Team:

- SDS Program Supervisor – Provides direction, supervision, coordination, organization, and/or delivery of direct service programs, including, but not limited to Oregon Project Independence, Family Caregiver, Veterans Directed Care, Aging and Disability Resource Connection, and Health Promotion programs. Plans, develops, and manages programs, resources, and new initiatives in collaboration with various local community and regional partners, state and federal collaborators, and all stakeholders.
- Program and Advocacy Coordinator – Provides oversight for the Disaster Registry program, assists the SDS Program Director with advocacy activities,

and serves as resource staff to the Senior Advisory Council and its Committees. Engages with community partners and consumers to strengthen services for older adults, people with disabilities, and their unpaid caregivers. Plays a key role in increasing community awareness of SDS programs and services through educational events, trainings, media outreach, and marketing, promotes access to SDS programs, and heightens community awareness of the problems and issues confronting older adults, people with disabilities, and their unpaid caregivers in the local community, including dementia, mental health issues, behavioral health issues, and common diseases or chronic conditions associated with aging.

- Community Outreach Coordinator – Performs equitable and inclusive community outreach for AAA programs and services. Provides information in both English and Spanish in a wide variety of venues to ensure including of underserved populations. Creates and fosters relationships with community partner agencies to coordinate service delivery to older adults and adults with disabilities. Promotes collaboration at local, state, and federal levels for AAA programs.
- Administrative Staff

Program Coordination & Development - The RVCOG AAA Program Directors and staff connect with other agencies and organizations serving older adults, work to develop services, and mobilize non-OAA funds to enhance delivery of services to older adults. These activities have a direct and positive impact on the enhancement of services.

Other

- Southern Oregon Center for Community Partnerships
  AAA Directors participate in the Southern Oregon Center for Community Partnerships (SOCCP) Board meetings to represent AAA programs and fundraising opportunities. SOCCP is a 501(c)(3) non-profit intended to raise public and private funds through fund raising, donations, and endowments

to benefit the existing and future clients of the Rogue Valley Council of Government's AAA programs. As appropriate, the non-profit may also engage in activities that encourage communication, consultation, and cooperation across southern Oregon.

- Oregon Wellness Network

  RVCOG is a Partner with the Oregon Wellness Network (OWN), a division of the Oregon Association of Area Agencies on Aging & Disabilities (O4AD). OWN is a network hub that provides administrative services to all of the AAAs in Oregon. These administrative services include a central referral system, data collection, training and quality assurance, and a billing and revenue management system.

  Through this partnership, OWN establishes contractual relationships with different payers to include, but not limited to Medicare, Medicare Advantage companies, waivered Medicaid organizations (called Coordinated Care Organizations (CCO) in Oregon), and private insurance companies with consumers across the state.

- Role of AAA in National and State Planning Efforts
  - Mental Health Access Improvement Act – For ten years, the RVCOG Joint SAC/DSAC Advocacy Committee assumed a major role in educating Area Agencies on Aging and NAMI (National Alliance for Mental Illness) Chapters around the country about both federal Senate and House versions of the Mental Health Access Improvement Act. In December 2022, the Mental Health Access Improvement Act was passed, and expanded coverage will begin on January 1, 2024. Prior to the passage, under Medicare, mental health services could only be paid for if they were provided by a licensed clinical social worker or a "higher level" provider. Marriage and family therapists and licensed counselors were not covered by Medicare. That left large, mostly rural, swaths of residents who

received Medicare benefits without mental health coverage which impacted both older adults and adults with disabilities. Implemented on January 1, 2024, the Mental Health Access Improvement Act has expanded the provider network to include marriage and family therapists and licensed counselors, although **access to qualified mental health resources is still problematic in our region**.

- Accessible Housing – RVCOG's Lifelong Housing Certification program is the focal point of state and national efforts to increase the availability of accessible homes. The State is currently working on legislation that includes "accessible" housing. The Lifelong Housing Steering Committee continues to advocate for the adoption of the Lifelong Housing Program's definitions of visitable, adaptable, and accessible housing.
- LBGTQIA2S+ Rights - In 2023, the AAA leadership, the Senior Advisory Council, and the Joint SAC/DSAC Advocacy Committee, along with O4AD, worked ardently with Oregon State Senators and Representatives for the passage of SB99, "LGBTQIA2S+ Bill of Rights," which prohibits certain facilities that provide long-term care from taking specified actions based in whole or in part on resident's actual or perceived sexual orientation, gender identity, gender expression or human immunodeficiency virus status. This bill passed during the 2023 legislative session.

The following sections provide descriptions of services, either directly provided by or contracted by the RVCOG. Please refer to Attachment C Service Matrix and Delivery Method immediately following these descriptions.

Behavioral Health – Provide resources and services that help provide a better quality of life.

- Buried in Treasures – Training to learn the skills to de-clutter and stop acquiring so much "stuff." This 16-week course helps improve the participant's life and create more living space for them and their family. This group meets once per week for two hours and offers a judgement-free environment for people ready to make a change in their life.
- Program to Encourage Active and Rewarding Lives (PEARLS) - An evidence-based treatment program for older adults (and all-age adults with epilepsy) with minor depression. This brief intervention program is delivered in the home with eight visits and four follow-up calls over a period of six to eight months.
- Options for People to Address Loneliness (OPAL) - This evidence-informed program was developed by SDS Behavioral Health staff to address issues of social isolation and loneliness through Options Counseling support and behavior modification strategies based on the PEARLS program. This brief intervention program is delivered in-home or remotely in six sessions with two follow-up phone calls.
- Guided Autobiography Program (GAB) – GAB is an evidence-based program for older adults involving five weekly classes per session for a group of six to eight individuals. Each week, participants write a two-page life story based on different weekly themes. Each member reads their story out loud to the group to share memories, insights and increase integration of past events. The classes also provide a safe space for older adults to make connections with each other, both individually and as a group, in order to reduce a sense of loneliness and social isolation.

Community Living – Enable consumers to understand the range of home and community-based residential care options.

- In-Home Care Assistance to persons who are having difficulty with one or more of the following activities of daily living—bathing; eating; toileting; ambulation; dressing; and cognition. Additionally, tasks such as preparing meals; shopping for personal items; using the telephone; doing light housework may be included. This type of assistance may be secured through two programs.
    - Medicaid-funded In-Home Services - Caregivers help with bathing, eating, toileting, ambulation, dressing, cognition, housekeeping, meal preparation, medication management, and other personal needs to a Medicaid-eligible client living in their own home. An individual may directly employ a caregiver, or they may opt to have the Medicaid office suggest/assign a caregiving agency. This program is only available to persons whose income/resources fall within eligibility criteria and who exhibit a sufficient need for assistance in managing their Activities of Daily Living (ADLs). A Client Assessment and Planning System (CA/PS) and financial assessment are done for the individual to determine their eligibility.
    - Oregon Project Independence – Medicaid (OPI-M) – Launched in June of 2024 became available to the general public in March 2025. This program will utilize Medicaid funding, including financial eligibility and ADL assessments, to cover in-home services similar to the current two OPI programs.
    - Oregon Project Independence Classic (OPI-Classic) – Like the Medicaid in-home service, OPI provides in-home care to individuals who show a need for assistance in their ADLs and whose income/resources fall within eligibility criteria. OPI clients have a

little too much income to qualify for Medicaid but are at risk of institutional placement without help. Both financial and ADL assessments are done to determine eligibility and priority level for each individual. Case Managers provide support to each OPI client to ensure the care they receive is most appropriate for them and that any care transitions are supported. Like the Medicaid program, a person can choose to either directly employ the caregiver themselves or have RVCOG supply the caregiver through a contracted caregiving agency.

- Community Based Services - While in-home care provides the highest level of independence for a person needing care, there are several other options that also provide a higher level of independence than a Skilled Nursing Facility; including:
    - Adult Foster Care (AFH) - This provides an option that closely approximates the home environment. Adult Foster Care homes can serve up to five individuals. APD staff license and monitor the care of clients who live in adult foster care homes.
    - Residential Care Facilities (RCF) - This option provides care for individuals in a residential setting. An RCF has six or more individuals in private or shared rooms. APD Medicaid staff determine eligibility for this service and monitor the care of clients who live in Residential Care Facilities.

    - Assisted Living Facilities (ALF) - Clients have their own apartments with many shared services such as meal preparation. APD Medicaid staff determine eligibility for this service and monitor the care of clients who live in the ALF.

- Skilled Nursing Facilities (SNF) - For individuals in need of more intensive support on a 24-hour basis, APD Medicaid staff can provide access to people who meet financial and ADL eligibility criteria. The SNF is the least independent option but is one that meets the needs of many individuals.

Emergency Preparedness – Connect vulnerable people to the Disaster Registry.

With the help of volunteers, RVCOG maintains a Disaster Registry of older adults and adults with physical, cognitive, or severe mental disabilities who may need assistance during a disaster event. Individuals may request an application in person or online at www.rvcog.org. The Disaster Registry was created after a 1997 flood in Jackson County, an event that highlighted the need for first responders to be able to locate people with access and functional needs before and during a disaster.

Family Caregiver Support and Training – Provide access to a range of services to support family caregivers.

The Family Caregiver Support program is available to family caregivers who are caring for someone over the age of 60; who are caring for an individual and not receiving a wage or salary for providing that care; who are caring for an individual who is not receiving assistance through an acute care setting; who are 55 or older and caring for children age 18 and younger; or who are any age and caring for an individual with Alzheimer's or other related disorders with neurological and organic brain dysfunctions.

- Family Caregiver Resource Specialists assist family caregivers by providing a place to start and information and assistance to caregiver resources in our area. They also help to develop a plan for care.

- RVCOG provides Powerful Tools for Caregivers training in the two-county area. Powerful Tools focuses on the family caregiver rather than the disease process. It helps family caregivers take care of themselves while caring for an older adult, child with a disability, or person with Alzheimer's or related dementia. A number of RVCOG staff team up with other agency trainers and volunteers to teach classes.
- Dementia support programs designed to assist family caregivers navigate dementia are offered as staffing allows. STAR-C, a program that aims to decrease the symptoms of stress and/or depression that caregivers may experience will again be offered in the future.
- Family Caregiver funding is available to pay for respite, a brief period of rest and relief for eligible family members, guardians, or others who are regular caregivers. Eligibility as described above.

Federal Assistance Programs for Seniors and People with Disabilities – RVCOG partners with the locally-available Medicaid Long-Term Care and Financial Assistance Programs, Aging and People with Disabilities (APD). The following are available to eligible consumers through APD offices:

- Contract Registered Nurse
- Medical Supplies
- Transportation, both medical and non-medical, is available for clients through partnership with a local transportation brokerage through a contract with Oregon's Medicaid program.
- Medicare Part D Low-Income Subsidy Screenings/Referrals and Choice Counseling – APD staff screen Medicare beneficiaries for Medicare Part D Low-Income Subsidy (LIS) and offer Medicare Part D choice counseling for people who are already eligible for both Medicare and Medicaid.
- Oregon Health Plan (OHP) / Oregon Supplemental Income Program (OSIP) – This means-tested program is for those 65 and older or those under 65 who

have been determined disabled by Social Security Administration (SSA) criteria. Eligibility for OSIP qualifies the client for Medicaid. Medical benefits are provided through enrollment in a managed health care system or on a fee-for-service basis.

- Presumptive Medicaid Disability Determination Process—The State of Oregon is required to make Medicaid disability determinations within ninety (90) days for applicants alleging a disability that would meet the Social Security Administration (SSA) disability requirements for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and, for whom the SSA has not made a disability determination. The disability determination is one of the requirements an applicant must meet in order to establish eligibility for the Oregon Supplemental Income Program.
- State Plan Personal Care—Supportive services which enable a Medicaid financially-eligible person to move into or remain in their own home. Services are limited to 20 hours per month per client.
- Supplemental Nutrition Assistance Program (SNAP) – APD is the portal for older residents and persons with disabilities to access SNAP, formerly known as Food Stamps. The intent of the program is to improve the health and well-being of low-income individuals, older adults and people with disabilities, and other groups of people by providing a means to substantially meet their nutritional needs. SNAP benefits are issued via an electronic Oregon Trail Card.

Health Promotion Programs – Provide services that maintain or empower health including services for those with chronic conditions and diabetes.

- Chronic Disease Self-Management Education – RVCOG carries the license for CDSME programs and supports delivery of these programs in Spanish through our partnership with LaClinica, a system of clinics that provides

culturally appropriate, accessible healthcare for all, in Jackson County. RVCOG conducts classes throughout the two-county area.

- Diabetes Education - Diabetes Self-Management Program (DSMP) is an evidence-based diabetes education program. The DSMP program has been approved as part of recognized Diabetes Education Programs by the American Diabetes Association and the Association of Diabetes Care and Education Specialists. This 6-week program is designed for people with type 2 diabetes. SDS staff and volunteers have cross-trained to coach the DSMP program and classes will begin in 2025.

- Fall Prevention - "A Matter of Balance: Managing Concerns About Falls" program is an evidence-based program designed to help older adults reduce their fear of falling, thereby enhancing activity levels. RVCOG anticipates offering this program when staff are available for training.

Information and Expert Help – Provide knowledge or resources related to aging and disabilities.

Aging and Disabilities Resource Connection (ADRC) - The State of Oregon has developed a statewide ADRC program that provides older adults, people with disabilities, their loved ones, and the community with free unbiased information about services and available community resources. The ADRC provides a universal "No Wrong Door" model that emphasizes a person-centered approach designed to empower consumers to make decisions about their long-term care, plan for the future, spend their money wisely to delay or avoid using Medicaid funds, independently live at home longer, thrive

with chronic conditions such as Alzheimer's, and many more topics.

RVCOG is the certified ADRC of Jackson and Josephine Counties. ADRC staff members are certified by Inform USA as soon as testing qualifications are met. All staff have been trained in person-centered approaches to provide objective and trusted information about public services and community resources. ADRC staff aim to empower consumers to help make informed decisions about the consumer's self-identified needs and goals.

Core Services Offered by the ADRC:

- Information & Referral and Assistance - The ADRC serves as the one-stop for consumers, their friends and family members, and the community as they seek to find information about resources for those who are aging or have a disability. ADRC is designed to streamline access to information about available services, with referrals being made to programs and organizations that may meet the individual's specific needs. Assistance is provided in accessing services when needed or requested. ADRC's services are available on the phone and by email in both Jackson and Josephine Counties.
- Person-Centered Options Counseling - Trained professionals provide a more in-depth assessment of the consumer's situation and offer options for services and available community resources. Services are available over the phone, by email, or in person. Options Counselors aim to assist by putting the consumer's preferences and needs at the center of the planning process and by focusing on what is important to the consumer. Often times, Options Counselors enlist the support of the consumer's family, friends, and any other professionals chosen by the consumer to ensure that needs, preferences, and the consumer's choices are honored. With the consumer's consent, staff is also able to advocate on

behalf of consumers who are not able to do so on their own due to lack of resources, cognitive ability, rural location, and so on.

- Online Resource - The ADRC of Oregon offers a database of resources for older adults and people with disabilities. Resources available include state programs, private companies, nonprofit organizations, and religious organizations that serve older adults and people with disabilities and meet the ADRC's inclusion/exclusion policy. RVCOG has more than 340 listings in the database, which are updated quarterly to ensure that consumers are given the most accurate information possible. The website is available 24/7 to consumers at www.ADRCofOregon.org.

One of the main focuses of ADRC of Jackson/Josephine Counties has been to make services seamless for consumers between the Medicaid programs provided by Aging and People with Disabilities (APD) District 8 and the programs provided through the AAA. RVCOG and APD have formed a Team Enhancement Committee (TEC) which meets monthly to collaborate on enhancing the service delivery system between the AAA and APD. As its first major work product, the TEC developed a process for seamlessly sending referrals between the ADRC and all three APD offices. This process includes an on-going training for all current and new APD and AAA staff on services provided by both agencies. This referral process has been instrumental in the launch of the OPI-M program, allowing AAA and APD staff to communicate sensitive personal information in a safe and secure manner.

Lifelong Housing Certification

RVCOG has developed the first certification program in Oregon for Lifelong Housing. Before a home can be Lifelong Housing certified, a set of specific design and construction standards must be attained for the home. The

certificate assures a prospective home buyer or renter that the house will make aging an easier process in their home for many years to come.

Nutrition - Food & Friends Meals on Wheels and Senior Meals Program

RVCOG, through the Food & Friends program, provides approximately 1160 meals daily to adults 60 and older and adults with disabilities in the two-county area. Meals are prepared in a central kitchen located in Jackson County, then transported to five HDM-only distribution locations and ten combined congregate/home-delivered meal (HDM) sites where they are either packaged into home-delivered meals or served to congregate participants. Each meal complies with the Dietary Guidelines for Americans and provides a minimum of 33% of the current daily Recommended Dietary Reference Intake (DRI) established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences.

- Congregate Meals

  Food & Friends provides approximately 34,000 meals annually at ten congregate meal sites in the two-county area. Our congregate participation rates continue to grow, with an average of 340 participants a month.

- Home-Delivered Meals

  Approximately 450 volunteers pack and deliver more than 235,000 home-delivered meals along 60 routes to home-bound older adults in the two-county area, annually. In addition, volunteer drivers provide vital social interaction and perform regular safety checks on the participants to whom they deliver meals.

- Nutrition Education

  Food & Friends distributes an article quarterly to all meal participants. Each publication includes nutrition and health education tips. Food & Friends

meal site staff are educated regarding nutrition issues and supplied with approved educational materials to hand out and discuss with participants at meal sites as well as distribute and discuss with home-delivered meals participants. The articles are available on the website. In addition, Nutrition outreach staff also provide information to people in their homes as part of the home-delivered meals eligibility process.

Safety and Rights – Provide tools to protect aging individuals and individuals with disabilities from harm or abuse. A variety of services are available:

- Guardianship/Conservatorship - The RVCOG contracts with the Center for Nonprofit Legal Services to provide a guardianship/conservatorship program in Jackson County. The agency performs legal and financial transactions on behalf of a client based upon a legal transfer of responsibility (e.g., as part of protective services when appointed by court order), including establishing the guardianship/conservatorship.
- Legal Assistance - RVCOG contracts for legal assistance services with:
    - Center for Nonprofit Legal Services (CNPLS) - The agency is staffed by Oregon licensed attorneys who are organized into four specialty units: Housing/Consumer, Family, Public Benefits/Employment, and Individual Rights. Low-income persons and older adults with priority legal problems are accepted by the agency for direct legal representation. The senior case load is about 10-15% of the total workload. Services are provided based on priorities established by the Senior Advisory Council.
    - Oregon Law Center (OLC) - A senior law hotline service is provided by Oregon licensed attorneys. The hot line is staffed 3 hours per week. Older adults are not screened for income eligibility but are screened for conflicts with prior OLC clients as per the Oregon State Bar Disciplinary Rules. Additional free legal assistance is provided as

needed on a case-by-case basis. Free training is provided four times a year on relevant topics of interest to older adults. Services are provided based on priorities established by the Senior Advisory Council.

- Adult Protective Services/Elder Abuse/Patient Abuse – APD Medicaid staff provide Adult Protective Services (APS) to aged, blind, or individuals with disabilities 18 years of age or older. The intent of the program is to investigate and document allegations of abuse and provide protection and intervention on behalf of those adults who are unable to protect themselves from harm or neglect. The Title XIX APD District Manager oversees this program.
- Elder Abuse Prevention – RVCOG annually provides funding for an Emergency Fund for Adult Protective Services (APS) staff to pay for such things as emergency shelter, transportation, food, medications, and clothing for older adults 60 and older in protective service situations.

Attachment C

SERVICE MATRIX and DELIVERY METHOD

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

☐ **#5 Adult Day Care**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

☒ **#20-2 Advocacy**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#9 Assisted Transportation**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Contractor to be determined for 25-26 fiscal year. No current contractor.

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

1

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#30-5/30-5a Caregiver Respite**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☒ Self-provided (Respite reimbursement to caregivers)

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Addus Health Care, 1240 N Riverside Ave, Medford, OR 97501 (for profit)
New Horizons, 255 W Stewart Ave, Ste 101, Medford OR 97501 (for profit)

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

Funding Source: ☐ OAA ☐ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

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

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

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#70-9/70-9a Caregiver Training**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#6 Case Management**

Funding Source: ☒ OAA ☒ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☐ **#3 Chore** (by agency)

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

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

☒ **#7 Congregate Meals**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☒ Self-provided Meal production is contracted; meal service is self-provided.

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): RVCOG contracts withTrio Community Meals, PO Box 742992, Atlanta, GA 30374 (for profit) for production of meals and delivery to meal sites.)

☒ **#80-4 Consumable Services**

Funding Source: ☒ OAA ☐ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

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

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Center for NonProfit Legal Services, 225 W Main St, Medford, OR 97501 (Jackson County)

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

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

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

Funding Source: ☒ OAA ☐ OPI ☒ Other Cash Funds

☒ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Community Volunteer Network, One W Main St, Ste 303, Medford, OR 97501
LaClinica, 931 Chevy Lane, Medford, OR 97504

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

Funding Source: ☒ OAA ☐ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

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

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided Assistive Equipment purchased from retail suppliers and provided to consumers by RVCOG staff or direct ship.

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

☒ **#4 Home Delivered Meals**

Funding Source: ☒ OAA ☒ OPI ☒ Other Cash Funds

☒ Contracted ☒ Self-provided Meal production is contracted; meal service is self-provided.

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): RVCOG contracts withTrio Community Meals, PO Box 742992, Atlanta, GA 30374 (for profit) for production of meals and delivery to meal sites.)

☒ **#30-1 Home Repair/Modification**

Funding Source: ☒ OAA ☐ OPI ☒ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Rebuilding Together Rogue Valley, PO Box 1837, Jacksonville, OR 97530

☒ **#2 Homemaker** (by agency)

Funding Source: ☐ OAA ☒ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Addus Health Care, 1240 N Riverside Ave, Medford, OR 97501 (for profit)
New Horizons, 255 W Stewart Ave, Ste 101, Medford OR 97501 (for profit)

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

☒ **#13 Information & Assistance**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#60-5 Interpreting/Translation**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☒ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Languale Line Services, One Lower Ragsdake Dr, Bldg 2, Monterey, CA 93940 (for profit)

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Center for NonProfit Legal Services, 225 W Main St, Medford, OR 97501 (Jackson County)
Oregon Law Center, 424 NW 6th St, Ste 102, Grants Pass, OR 97528 (Josephine County)

☐ **#8 Nutrition Counseling**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

☒ **#12 Nutrition Education**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#70-2 Options Counseling**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

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

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

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

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

☐ **#901 Other (specify)**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#1 Personal Care** (by agency)

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

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Addus Health Care, 1240 N Riverside Ave, Medford, OR 97501 (for profit)
New Horizons, 255 W Stewart Ave, Ste 101, Medford OR 97501 (for profit)

☒ **#1a Personal Care** (by HCW)

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

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

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☒ **#60-3 Reassurance**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☒ Self-provided

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

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

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

☒ **#72 Self-Directed Care**

Funding Source: ☐ OAA ☐ OPI ☒ Other Cash Funds

☐ Contracted ☒ Self-provided

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

☐ **#80-1 Senior Center Assistance**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

☒ **#10 Transportation**

Funding Source: ☒ OAA ☐ OPI ☐ Other Cash Funds

☒ Contracted ☐ Self-provided

Contractor name and address (List all if multiple contractors and note if contractor is "for-profit" agency): Rogue Valley Transportation District, 239 W Barnett Rd, Medford, OR 97501 (Jackson County)
Josephine Community Transit, 300 NW 5th St, Grants Pass, OR 97526 (Josephine County)

☐ **#60-4 Volunteer Services**

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

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

Funding Source: ☐ OAA ☐ OPI ☐ Other Cash Funds

☐ Contracted ☐ Self-provided

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

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

There are many services in the Rogue Valley that older adults and people with disabilities frequently request that the AAA does not directly provide or contract to provide. Under each of the following services that are not provided by the agency, there is a list of key community providers that may help as well as indicating if no provider/service is available. This is not meant to be a complete list of resources. Also note that although service providers may exist, staff capacity and funding limitations may impact availability of services.

A comprehensive list of resources in both counties can be found on the ADRC of Oregon website (ADRCofOregon.org). Resources are updated quarterly to ensure accuracy for consumers. Resources are also listed in the Silver Pages, the Senior Resource Directory, and the Retirement Connection booklet.

In addition to listing key community providers for each service, the agency has included, as appropriate, information regarding planning, services necessity/gaps, and funding issues.

- Advocacy/Problem Solving/Dispute Resolution
    - Help Now! Advocacy Center
    - Center for Nonprofit Legal Services
    - Oregon Law Center - Grants Pass Office
- Alzheimer's or Other Dementia
    - Alzheimer's Association Oregon Chapter – Southern Oregon Regional Office
    - Power of the Heart Dementia Care Education and Behavior Coaching.

- Case Management (fee based or privately funded): Our belief is that a well-trained government and private case management/client consultant work force not only spreads the workload but also best meets the needs of older adults and people with disabilities in our area. To that end, RVCOG shares information regarding training opportunities and, when possible, provides training, for private geriatric care providers as it comes available.
    - National Association of Private Geriatric Care Managers
    - Senior Options, LLC - Jackson County.
    - Power of the Heart Dementia Care Education and Behavior Coaching
    - Georgie Gentry, Ground Spring Associates
    - Aging and People with Disabilities District 8 (for Medicaid-eligible people only)
- Community Action Programs
    - UCAN Community Action Program of Josephine County
    - ACCESS Community Action Program of Jackson County
- Community Healthy Aging
    - Oregon State University Extension Service
    - Southern Oregon University
    - Rebuilding Together, Rogue Valley - Fall Prevention/Home Modification Program
    - YMCA of Ashland, Medford and Grants Pass Senior Program
    - Jackson County Health and Human Services
    - Josephine County Health and Human Services
- Disability Services and Programs

    - HASL Center for Independent Living for Jackson and Josephine counties.
    - Jackson County Developmental Disability Services
    - Community Living Case Management of Josephine County
    - Southern Oregon Aspire
    - Creative Supports Brokerage
    - Southern Oregon Goodwill Industries
- Education and Counseling Programs
    - Consumer Credit Counseling Money Management Program (Jackson and Josephine Counties)
    - Medicaid Helpline 800-344-4354 (Jackson and Josephine Counties)
    - Community Volunteer Network - SHIBA Senior Health Insurance Benefits
    - UCAN - SHIBA Senior Health Insurance Benefits (Josephine County)
    - Southern Oregon University OLLI Program for Seniors
    - Age Wise Age Well peer mentoring program
    - Compass House peer mentoring program
- Elder Abuse Awareness and Prevention
    - Adult Protective Services, Aging and People with Disabilities District 8
- Emergency Response Systems
    - Asante Lifeline Emergency Response System
    - Connect America
- Employment Programs
    - Oregon Employment Department - WorkSource Oregon

    - Southern Oregon Goodwill Employment Program
    - Medford Employment Resource Center
    - Easter Seals of Oregon
    - OHRA Community Resource Center
- Financial Assistance
    - ACCESS, the Community Action Agency of Jackson County
    - UCAN, the Community Action Program of Josephine County
    - St. Vincent de Paul
    - The Salvation Army
    - Anna May Foundation (through RVCOG)
    - Jewel Brooks Charitable Trust (through RVCOG)
- Heating and Energy Assistance Programs
    - ACCESS, the Community Action Agency of Jackson County
    - UCAN, the Community Action Program of Josephine County
- Information and Referral/Assistance Programs (non-AAA funded)
    - 2-1-1 Info
    - HASL Center for Independent Living
- Legal Assistance
    - Center for Nonprofit Legal Services
    - Oregon Law Center
    - Help Now! Advocacy Center
- Low Health Literacy
    - No services yet identified

- Low Income and Emergency Housing
    - ACCESS Community Action Agency of Jackson County
    - Housing Authority of Jackson County
    - Josephine Housing Council
    - Medford Gospel Mission, Men's, Women and Children's Shelter
    - UCAN Community Action Program of Josephine County
    - St. Vincent de Paul
    - Rogue Retreat
    - Mobile Integrative Navigation Team (MINT), Josephine County
    - OHRA
- Medical Equipment
    - ACCESS Community Action Agency of Jackson County
    - HASL Center for Independent Living – Jackson and Josephine County
    - UCAN Community Action Program of Josephine County
- Mental Health
    - Jackson County Mental Health
    - Options for Southern Oregon
    - Compass House Peer Mentoring Program
    - La Clinica Behavioral Health
    - National Alliance on Mental Illness of Southern Oregon
    - Rogue Community Health
    - Columbia Care
- Minority Groups
    - BASE – Black Alliance and Social Empowerment Southern Oregon

    - Coquille Indian Tribe – Medford Office
    - Cow Creek Band of Umpqua Tribe of Indians – Medford Office
    - Families for Community (support network for parents of children with special needs and disabilities)
    - LINC – Latinx Interagency Network Committee– Jackson County
    - LINC – Latinx Interagency Network Committee– Josephine County
    - UNETE – Center for farmworker and immigrant advocacy
    - LGBTQIA2S+ Groups in the Rogue Valley
        - Southern Oregon Pride
        - Southern Oregon University – Queer Resource Center
        - TransOregon
- Money Management
    - Oregon Money Management Program - Consumer Credit Counseling of Southern Oregon
- Respite Care
    - ARC of Jackson County
    - Community Volunteer Network Respite Program
- Senior Centers
    - Ashland Senior Program (Focal Point)
    - Central Point Senior Resource Center (Focal Point)
    - Eagle Point Senior Center (Focal Point)
    - Grants Pass Community Center
    - Josephine County Senior Resource Center (Focal Point)
    - Jacksonville Community Center

    - Illinois Valley Senior Center
    - Medford Senior Center
    - Rogue River Community Center (Focal Point)
    - Upper Rogue Community Center
- Volunteer Program
    - Community Volunteer Network Retired and Senior Volunteer Program (RSVP)
    - UCAN Senior Companion Program of Josephine and Douglas County
    - Oregon Money Management Program – Consumer Credit Counseling of Southern Oregon
- Transportation: RVCOG will continue to work with Rogue Valley Transportation District and Josephine Community Transit to ensure the needs of older adults and those with disabilities are incorporated into their transportation plans / operations.
    - Josephine Community Transit
        - Dial-a-Ride Paratransit Program
        - Local Bus System
        - Rogue Valley Commuter Line (bus which connects Jackson and Josephine County)
    - Rogue Valley Transportation District
        - Valley Lift Paratransit Program
        - Local Bus System
    - Community Volunteer Network Call-a-Ride volunteer program
    - Veterans Administration
    - Rogue River Community Center Transportation Program

SECTION C - FOCUS AREAS, GOALS, AND OBJECTIVES

Our commitment is to outreach, to individualized person-centered services, and to agency partnerships.

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

Person-Directed Services and Supports:

RVCOG supports providing respectful and responsive services and supports that take into account individual preferences, needs, values, cultures and diverse backgrounds. Service delivery is completed under a person-centered, trauma-informed, and culturally sensitive approach. For example, when APD Case Managers, RVCOG SDS Case Managers, and ADRC Options Counselors assist consumers, they strive to keep decision making as close to the individual as possible and support individual choices. RVCOG staff provide each individual with accurate, objective information so that the individual can make informed decisions.

Service Equity:

RVCOG will continue to maintain a commitment to service equity by:

- Maintaining open dialogue and internal and external communication efforts that are centered on inclusion and outcomes – for example, RVCOG will continue to participate in key community meetings including: Jackson County Continuum of Care, Homeless Task Force, Human Service Consortium, United Way, UNETE, Latinx Interagency Network Committee, SOHealthy, Jackson Care Connect (CCO)/Aging and People with Disabilities Multi-Disciplinary Team, Mental Health Disability Advisory Committee, Public Safety Coordinating Council and the Suicide Coalition;
- Creating a seamless long-term service and support delivery system that is culturally and linguistically responsive – for example, continue monthly Team Enhancement Committee (TEC) meetings with a focus on strengthening communication and cooperation between AAA and APD and assuring service delivery is inclusive;

- Providing services at each consumer's specific need level with community needs informing and guiding services – for example, continue to deliver person-centered and trauma-informed ADRC services;
- Providing long-term services and support information in a variety of formats to meet the diverse linguistic, literacy and community needs – for example, provide alternative format access such as Braille, personalized reading, large print materials, interpreting services and a commitment to addressing individual needs of clients;
- Providing monitoring and evaluation of the quality and capacity of long-term services and supports – for example, assure that OPI Case Managers and ADRC staff deliver services in a consistent and effective way;
- Ensuring staff, volunteers, and advisory group members represent and can appropriately communicate and address the cultural diversity of the area's population – for example, continue to recruit SAC members from throughout the two-county area and through connections with individuals and organizations that have entry to culturally diverse groups such as the LINC, the Regional AAA/Tribal meetings, and LGBTQIA2S+ community, as well as participation in the Jackson County Continuum of Care Board to oversee services to the unhoused population;
- Allocating funds, developing and implementing contracts and policies that support underserved populations – for example, allocating funding to LGBTQIA2S+ activities;
- Maintaining an environment in all our dining locations so all older adults feel welcome, safe, and supported; and
- Incorporating culturally specific meals into our regular menu offerings.

RVCOG strives to take into account each individual's preferences, needs, values, cultures, and diverse background, and works to assure that each individual is free from discrimination. All of our Case Managers have completed Person-Centered

Options Counseling and Oregon Project Independence Case Management training and are well versed in the person-centered approach.

RVCOG staff and SAC members participated in SAGECare training to strengthen cultural competency to better serve LGBTQ+ residents in our service area. RVCOG received the platinum credential in LGBTQ+ cultural competency training from SAGE. AAA staff participate in additional SAGECare training on an annual basis. SAC members are invited to do the same.

RVCOG provides equal employment opportunities to all qualified persons without regard to race, color, gender, sexual orientation, religion, age, national origin, physical and mental disability, veteran status, or any status or activity protected under applicable law. It is an RVCOG policy that all employees perform their work with a concern for the well-being of their coworkers, clients, and the public. Under RVCOG's Core Values, staff and volunteers are expected to adhere to and adopt the Core Value of Respect – "We will respect our clients, partners, members of the public, fellow employees, volunteers, and ourselves by treating everyone with dignity, understanding, and compassion."

C – 1.1 Information and Referral Services and Aging and Disability Resource Connection (ADRC)

Provides knowledge or resources for older adults and people with disabilities.

All ADRC staff complete Person-Centered Options Counseling training and understand the need to take into account each individual's preferences, needs, values, cultures and diverse background. ADRC services include Information and Referral/Assistance and Options Counseling and are delivered free from discrimination and disparity. ADRC staff continually verify new resources to add to the database. Existing resources are verified quarterly to maintain fidelity of the data.

RVCOG funds ADRC activities with Older Americans Act and State General Fund No Wrong Door funding. Maximizing Medicaid Administrative Claiming is a challenge for our staffing model and has not yielded great success. To ensure adequate coverage and availability of backups, all full-time ADRC staff also

provide Case Management services for Oregon Project Independence, Veteran Directed Care, and Family Caregiver programs, so Random Moment Sampling yields a low rate of Medicaid-claimable activities. Advocacy and data-supported demonstration of the value of ADRC services are key to maintaining sustained funding for RVCOG's ADRC.

To ensure the ADRC meets quality assurance standards and service equity for all consumers, RVCOG will continue to monitor data entry completion rates, train all staff in REALD requirements, follow a developed program to shadow each ADRC staff annually, conduct a customer satisfaction survey, and provide Inform USA training and certification for new staff as they become eligible to take the examination.

RVCOG provides community outreach and education about the ADRC. The agency has developed a Referral Guide, ADRC business cards and Resource Folders which are used as outreach and education materials. This includes ADRC information, and materials in Spanish. The agency regularly distributes these materials at local events where older adults and people with disabilities congregate and at public meetings. Promotion of the ADRC services is also provided to community organizations that intersect with priority populations, including older adults in rural areas, LGBTQIA2S+ older adults, non-native English speakers, Tribal elders and older adults living with HIV/AIDS, to whom ADRC provides services for ongoing education. RVCOG strives to expand partnerships with organizations servicing these priority populations and expects the newly created bilingual Community Outreach Coordinator position to aid in this goal. RVCOG AAA staff will continue to make presentations to community organizations, including community health workers and Veteran Services providers, and tabling events to develop further partnerships to provide resources to priority populations.

The Referral Guide and ADRC brochures are available in the lobbies of all of the APD offices and the RVCOG central office. The level of referrals to ADRC from the APD and APS staff remains consistent. The Referral Guide is available at the meal sites, and home-delivered meals eligibility staff provide it to new Food & Friends

participants. The ADRC is posted in multiple places on the RVCOG website www.rvcog.org. All three local senior resource guides include thorough ADRC descriptions.

ADRC call volume - Month of July, year over year

	Unduplicated Consumers	Number of Calls
July 2014	136	193
July 2015	200	274
July 2016	193	272
July 2017	185	270
July 2018	173	255
July 2019	141	216
July 2020	155	197
July 2021	147	192
July 2022	170	229
July 2023	177	219
July 2024	181	221

Focus Area - Information and Referral Services and ADRC

Goal: *Provide information and assistance to older adults, adults with disabilities, and family members/caregivers to provide information and assistance to navigate service options in the region.*

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Maintain fully-functioning ADRC for Jackson and	a	Staff ADRC phone line Monday through Friday	SDS Program Supervisor, ADRC Lead	7/2025	6/2029

Josephine Counties		from 9 am to 4 pm, maintain ADRC database with new resources and quarterly verification of existing resources, and provide I&R/A services that leverage collected REALD data to ensure those in greatest economic and social need receive information and referrals to the maximum number of available services			
	Accomplishment or Update				
	b	Provide 25 units of service of Options Counseling per month, ensuring a focus on serving priority populations	SDS Program Supervisor, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				

	c	Provide Mental Health First Aid and Suicide Prevention training to ADRC and front-line staff – new hires and biennial refreshers	SDS Program Director, Program Supervisor, Behavioral Health Specialists	7/2025	6/2029
	Accomplishment or Update				
	d	Provide Inform USA training and certification when staff are eligible	SDS Program Supervisor, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				
	e	Continue and expand ADRC outreach and education activities to priority populations through culturally specific events and organizations – at least one	SDS Program Director, Program Supervisor, ADRC Lead, Advocacy & Program Coordinator, Community Outreach Coordinator	7/2025	6/2029

		activity per quarter			
	Accomplishment or Update				

Goal: *Continue to monitor and assess quality control for ADRC service delivery.*

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Perform monitoring of staff and quality control for ADRC services	a	Ensure proper data collection and recording during ADRC service delivery utilizing monthly report verification	SDS Program Supervisor, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				
	b	Utilize an annual customer satisfaction survey to assess quality of ADRC services	SDS Program Supervisor, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				

	c	Annually shadow ADRC staff to ensure compliance with Inform USA service delivery standards	SDS Program Supervisor, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				

C – 1.2 Nutrition Services

Food & Friends Mission Statement

Together, we strive to cultivate an equitable approach to improving the health, wellbeing and independence of older adults and adults with disabilities through nutrition services, meaningful social connections, and opportunities for education.

The Nutrition Department's Food & Friends program target population is adults 60 years or older and eligible adults with disabilities who are at a high risk of experiencing hunger. Food & Friends strives to consider each individual's preferences, needs, values, culture, and diverse background in our service delivery and works to assure that each individual is free from discrimination and disparity. Based on US Census population data from the American Community Survey DPO5 "ACS Demographics & Housing Estimates" for the 2023 reporting year, 31.3% of those living in Jackson County and 35.2% of those in Josephine

County are age 60 or older. This is notably higher than the state (25.9%) and national (24.2%) figures.

Based on US Census population data from the American Community Survey S1701 "Poverty Status in the Past 12 Months" for the 2023 reporting year, shows the population 60 years and over living below poverty level is 11.1% in Jackson County and 15.2% in Josephine County. The state average is 11.1% and the national average is 11.3%.

Approximately 2,300 people elect to participate in our program on an annual basis. Food & Friends surveys consistently demonstrate that, for many of the older adults the agency serves, the meal delivered is the only one they will eat that day (47%), and the volunteer who delivers the meal is often the only person they will see on a given day (61%). The regular visit to our home delivery participants provides a safety check, something that is not provided by any other service providers in our region.

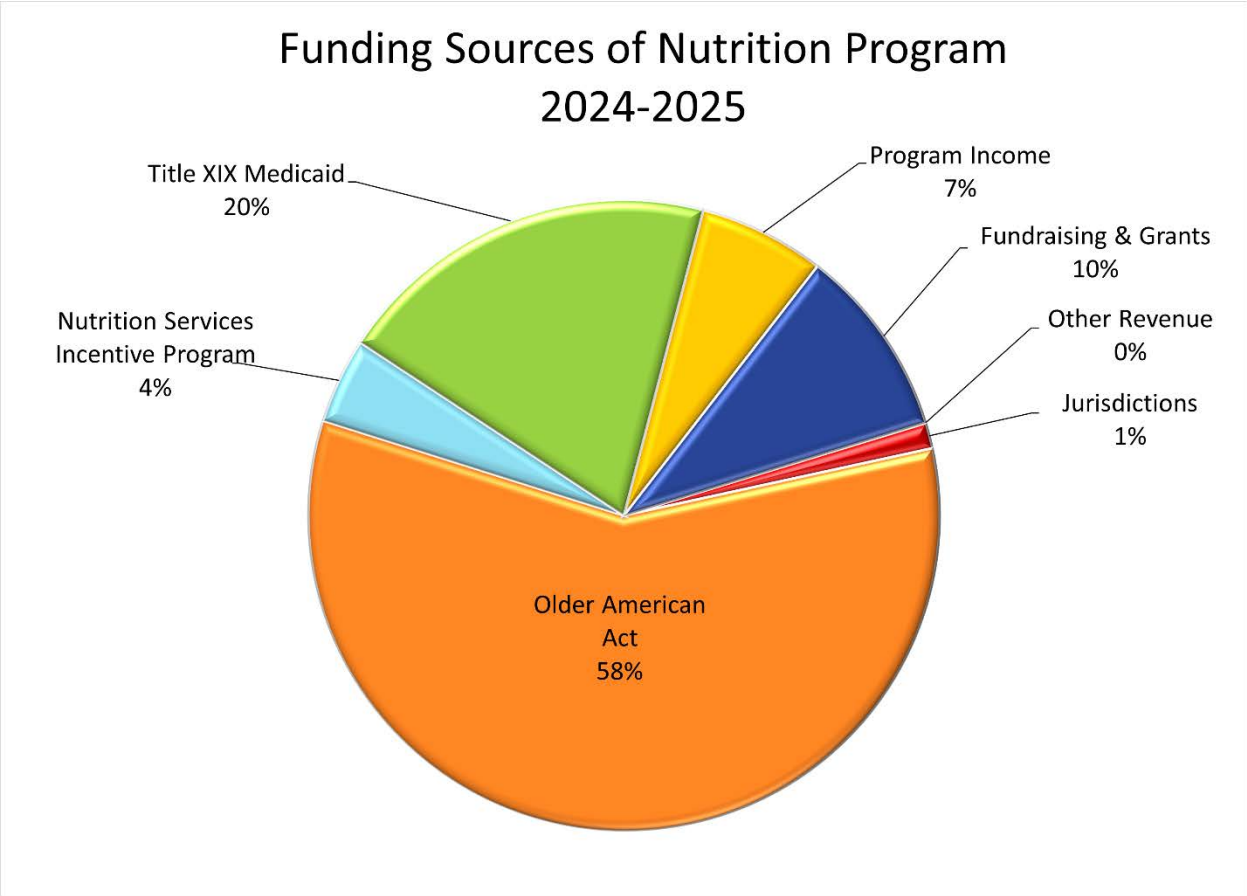
The Food & Friends survey also consistently demonstrates that our participants feel that they are benefiting from the service the agency provides. In our 2024 annual survey, 88% of respondents reported improved nutritional health, 94% report feeling safer and 94% indicated that the volunteer visit makes them feel less isolated. Our Congregate diners reported similar outcomes in the same survey, 75% responded that their nutritional health had improved, 81% reported that eating at the meal site has improved their quality of life, 92% agreed they enjoy the meals at the meal site, and 96% said they are satisfied to very satisfied with the Senior Meals Program.

How Title III C Funding will be used:

Title III-C Federal funding will be used to provide service to home delivery and congregate meal participants in both Jackson and Josephine Counties, which will include all administrative and production costs (meal preparation, packaging, transportation, staffing, and volunteers {includes mileage reimbursement, supplemental insurance, and training costs}, etc.). Food & Friends continues to

contract with our nutrition provider, TRIO Community Meals. TRIO provides a licensed Dietician specializing in nutrition for older adults to assist in recipe development and menu planning and staff to manage and operate our central kitchen.

The OAA funding remains unchanged and is not keeping up with the increased programmatic costs. Food & Friends depends on a variety of strategies to address this challenge, including fundraising (see the Funding Sources of Nutrition Program 2024-2025 chart below).



RVCOG/Food & Friends' partnerships with local community organizations and cities provides low-cost space for staging home-delivered meals and/or for congregate dining. These partnerships have been critical to allowing Food & Friends to continue to meet demand with limited use of waitlisting. Partnerships

with the following communities provide funding or free/low-cost space: Jackson County, City of Ashland, Ashland Senior Center, City of Central Point, City of Eagle Point, Eagle Point Senior Citizens Club, Gold Hill IOOF, Illinois Valley Senior Center, City of Jacksonville, Jacksonville IOOF Hall, City of Medford, Medford Lions Sight & Hearing Center, Merlin Community Center, City of Phoenix, Phoenix Presbyterian Church, City of Rogue River, Rogue River Community Center, St Martin's Episcopal Church in Shady Cove, Talent Community Center, and Wolf Creek Alliance Community Church.

Meal Sites/Distribution Points

Food & Friends - Jackson County					
Site	Location	Days of Service		Number of Days of Svc	Avg. Monthly Attendance Congregate Dining
		CONG	HDM		
Ashland	1699 Homes Ave, 97520	MON - FRI	MON - FRI	5	50
Central Point	123 N 2nd St, 97502	MON - FRI	MON - FRI	5	55
Eagle Point	121 Loto St, 97524	MON - FRI	MON - FRI	5	26
Gold Hill	483 4th Ave, 97525	n/a	MON & THU	2	HDM Distribution Point
Jacksonville	175 S. Oregon St, 97530	MON - FRI	MON - FRI	5	20
Medford	228 N. Holly St, 97501	MON - FRI	MON - FRI	5	6
Rogue River	132 Broadway, 97537	MON - FRI	MON - FRI	5	5
Shady Cove	95 Cleveland St, 97539	n/a	TUE & THU	2	HDM Distribution Point
Talent	104 E. Main St, 97540	n/a	MON - FRI	5	HDM Distribution Point
Phoenix	121 W. 2nd St, 97535	n/a	MON - FRI	5	HDM Distribution Point
White City	3131 Ave "C", 97503	n/a	MON - FRI	5	HDM Distribution Point
Food & Friends - Josephine County					
Site	Location	Days of Service		Number of Days of Svc	Avg. Monthly Attendance
		CONG	HDM		
Cave Junction	520 E River St, 97523	MON, WED, FRI	MON, WED, FRI	3	35
Grants Pass	1150 NE 9th St, 97526	MON - FRI	MON - FRI	5	115
Merlin	109 Acorn St, 97532	TUE & THU	TUE & THU	2	15
Wilderville	(Service from Grants Pass)	n/a	Wed	1	HDM Distribution Point
Williams	(Service from Grants Pass)	n/a	WED	1	HDM Distribution Point
Wolf Creek	130 Main St, 97497	TUE & THU Grab n' Go Only	TUE & THU	2	14

NOTES:

- Average attendance based on July-Sept. 2024.
- All congregate meal sites listed above act as HDM pick-up locations for those who qualify for HDMs using Title III C-2 funds but live outside our delivery area.
- All congregate locations listed above offer Grab-and-Go using Title III C-1 funds for those who prefer to take their meals to-go and for those on the waitlist for HDMs who are able to arrange for pick-up at the site.
- Our rural location in Wolf Creek only allows for the distribution of pick-up HDMs (Title III C-2) and the option of Grab n' Go congregate meals (Title III C-1). This site is not available for in-person dining.

Home delivered meals are provided five days a week from nine locations in Jackson County and from one location in Josephine County. In our seven remote

service areas in both counties, factors such as distance, expense and accessibility of volunteers directly affects the availability of service. Recipients of home delivered meals in areas with service of fewer than five days a week are offered frozen meals to cover the days Food & Friends is not able to deliver. For those individuals who qualify for home delivered meals using Title lll C-2 funds but live outside of our delivery area, arrangements are made for participants to pick up meals at the closest meal site.

Congregate meal sites are open up to five days a week in both counties from 11am to 1pm with lunch being served from 11:30am to 12:30pm. For those participants who prefer to Grab-and Go congregate meals for personal health reasons or for those living in far reaching rural communities without a congregate location, we continue to accommodate this request using Title lll C-1 funds (see request for proposal to use Title lll C-1 funds for Grab-and-Go flexibility below).

Request for Approval to Use Title lll C-1 Funding for Grab-and-Go Flexibility

Food & Friends is requesting approval for the continuation of Grab-and-Go Flexibility at our congregate meal site locations. See support for this request below:

1. *The proposed plan shows evidence, using participation projections based on existing data, that provision of such meals will enhance and not diminish the congregate meals program, and offers a commitment to monitor impact on congregate meals program participation.* When congregate meal sites were closed due the pandemic in 2020, congregate participation dropped 50.8% by the end of that FY (congregate supported 100% by Grab-and-Go flexibility during pandemic). As meal sites remained closed, participation decreased by an additional 20.2% by the end of the following FY. As meal sites were reopened for in-person dining, we saw a small increase in participation rates of 12% at end of FY22. By the end of the FY24, congregate participation had increased by 42.9% since reopening in 2022. This increase was supported by an influx of new in-person diners. As congregate participation grew, those living locally participating in the Grab-and-Go option were now choosing to participate in in-person dining. We

will commit to monitor the impact that Grab-and-Go meals have on congregate participation.

2. *The proposed plan provides a description of how provision of such meals will be targeted to reach those populations identified as in "greatest economic need" and "greatest social need."* This proposal targets low-income older adults in far-reaching rural communities of the Applegate, Illinois, Rogue and Sams Valleys located in Jackson and Josephine Counties. Many of the older adults in these regions are living on incomes below the poverty level in unincorporated communities lacking in accessible resources. The provision of such meals will allow for a person-centered approach to the congregate meals program when taking this subset of the population into consideration

3. *The proposed plan clearly identifies eligibility criteria for service provision.* Eligibility criteria will mirror that of that required for congregate meals site participation. However, special consideration for Grab-and-Go meals will be provided to those who do not qualify for HDMs living in rural communities located a great distance from their closest meal site, struggle economically, have concerns about transportation, housing issues and/or would otherwise have limited access to nutritious meals and services.

4. *The proposed plan offers evidence of consultation with nutrition and other direct services providers, other interested parties, and the general public regarding the need for and provision of such meals.* Throughout the reopening of our congregate dining locations, we discussed with our nutrition contractor's Nutritionist the importance of providing meals to go in tandem with nutrition education to those unable to participate in in-person dining, but not eligible for HDMs. We also discussed barriers preventing older adults from accessing healthy food options and/or nutritional needs in our focus groups. It was identified that costs/finances, transportation, and housing were top barriers to older adults accessing healthy food options. The Grab-and-Go flexibility will assist older adults

struggling with these and other barriers to access congregate meals in a way that works best for them, while keeping them connected with the community.

5. *The proposed plan provides a brief description of how provision of such meals will be coordinated with nutrition and other direct services providers and other interested parties.* With the continued flexibility of providing Grab-and-Go meals, our program will be able to continue to provide this much needed congregate nutrition service to members of our community. We will continue to provide nutrition education to these participants on the days they are able to come into the meal site. In addition, referrals to Senior & Disability Services, such the ADRC, PEARLS and OPAL programs, will be made as needed to include referrals to other community-based organizations and direct service providers. As we implement our focus areas laid out in this plan, we hope to introduce an older adult specific food pantry in each county we serve, allowing for the additional access of fresh produce and shelf-stable supplemental food items.

Changes in Meal Production and Delivery Systems (if necessary):

Food Packaging:

Our meal trays are made of compostable material, and we have discontinued the use of single-use plastic bags in compliance with the State of Oregon's 2020 ban. The program is considering more environmentally friendly packaging for our smaller salad and dessert containers; however, we found paper alternatives to leak or lose their form in transit and to be less cost effective. We continue to research alternative packaging that is more environmentally friendly and is in compliance with the Oregon Styrofoam ban in 2025 (Senate Bill 543).

Medically Tailored Meals:

Food & Friends has begun planning for the provision of Medically Tailored Meals. We have negotiated meal costs with our nutrition provider, TRIO, and have amended our current 24/25 FY contract to specify the provision of these meals.

We will continue to study program needs, capacity building and logistics within the 4 years of this Area Plan with the goal of introducing these meals within that time frame.

Funding:

Funding remains a concern as the OAA funding streams do not keep up with the demand for service and the rising costs associated with running and maintaining the program at appropriate levels. This shortcoming in Federal revenue makes it difficult to continue to close the funding gap through our fundraising efforts. The program does have a plan to help address increases in demand coupled with possible lower revenues, which would involve some, or all of the following:

- Non-essential food items such as dessert and/or milk may be eliminated.
- Delivery frequency may be reduced with the option of providing one hot meal with a frozen for the next day.
- Moving to frozen meals only.
- Lower risk clients (as determined by our initial eligibility screening, NAPIS evaluation, and the Meals Service database) would be the first to be placed on the waiting list, giving the priority for service to high-risk clients.

Partnerships:

Food & Friends has developed a large base of partner agencies who share our objective of providing critical services and assistance to our participants. They include: OSU Extension registered dietitian (nutrition education), ACCESS Inc. (e.g. additional outreach, supplemental food items, energy assistance), Jackson County Health & Human Services (information or health services for clients), Community Volunteer Network (volunteer recruitment), Oregon Department of Human Services (criminal background checks for volunteers), regional hospital discharge planners, Medicaid case managers (referrals) and AllCare and Jackson Care Connect Coordinated Care Organizations.

In emergencies, Food & Friends notifies family members or case managers, and if necessary, emergency services or Adult Protective Services. The program will continue to explore any partnership that provides additional benefits to those receiving our services.

During the last 23 years, the program has established an effective fundraising strategy that includes two mailer campaigns each year, one to established donors and the other as an acquisition. The program has set in place a recognition protocol for our donors that has been successful in generating larger donations from them in subsequent years. An endowment has been established to benefit the nutrition program and the program has a very successful track record in writing successful grant applications – based on the local community and many charitable foundations' faith in our ability to carry out our mission.

Nutrition Education:

- Quarterly nutrition education instruction is conducted at the meal sites using approved nutrition education training materials. Following these education sessions, the congregate sites will return a list of participants in attendance with a copy of the education topic covered for tracking and reporting purposes.

- All HDM new starts and reassessment participants will receive nutrition education via our Outreach Coordinators. The Outreach Coordinators record a Nutrition Education unit of service in Oregon Access each time an education topic is covered. Additional Nutrition Education materials are sent out to our HDM participants throughout the year (i.e. Food Hero for Older Adults, available in English and Spanish).

- Staff are required to present education to congregate meal clients no less than on a quarterly basis. Site Coordinators are trained on how to present these materials through practice sessions at regular staff meetings.

- Per the ODHS Congregate and Home-Delivered Nutrition Program Standards – Older Americans Act and OPI, Nutrition Education, Item 15 – "Nutrition Counseling may be provided to participants where appropriate." Food & Friends has chosen not to provide nutrition counseling due to funding constraints and the lack of qualified dieticians and nutritionists in our region.

- The Food & Friends website has links on the "Resources" page for those clients and family members interested in more education topics. Links to topics in Spanish are also provided.

- Food & Friends has a partnership with OSU Extension to distribute their nutrition and health publication to supplement our nutrition education efforts.

- In partnership with our nutrition contractor, TRIO Community Meals, the back of our monthly menu provides nutrition education developed by TRIO's Older Adult Nutritionist.

Link between the Nutrition Program and Other Applicable AAA Services.

Some of the ways in which the Food & Friends program ensures that it is employing best practices in benefitting the older adults and adults with disabilities in the region, are as follows:

- Interacting closely with other AAA services.
- The Food & Friends staff regularly make referrals to the ADRC to assist callers in finding solutions for their issues.
- Based on funding availability, Food & Friends will continue to provide meals to OPI clients as a component of their service plan. OPI clients have long benefitted from the nutrition program regardless of availability of OPI funding to cover the cost.

- Food & Friends will provide additional HDM services in compliance with the coming nutrition services offered under OPI-M.
- Food & Friends is taking under consideration the provision of HDM meals for Community Care Organizations under the 1115 waiver.
- Food & Friends regularly distributes information to its clients on the availability of Powerful Tools for Caregivers, PEARLS, OPAL, and other health promotion programs, including Vaccination Clinics.

Food & Friends provides a connecting point, through the congregate sites and home delivered meal delivery, the means by which various SDS programs can reach some of the region's at-risk older adults.

Consumer Protection handouts are periodically distributed to clients as an additional source of information.

Focus Area – Nutrition Services

Goal: *Reduce hunger and food insecurity for older adults and adults with disabilities with increased accessible options for nutrition supplementation and the increased availability of culturally specific meals.*

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Increase variables in choice for older adults, adults with disabilities	a	To offer 100% of over yield meal components (not full meals)	Meal Site Coordinators	7/1/2025	6/30/2029

and their caregivers living on low incomes in rural and economically depressed communities optional services to help meet expressed needs for supplemental food items.		such as salads, vegetables and carbohydrates as supplemental food items for older adults attending the congregate meal site in the rural area of Cave Junction.			
	Accomplishment or Update				
	b	Establish new or maintain a minimum of one (1) current partnership in each county with local food retailers and growers to supplement participants' diets with donated fruit, vegetables, bread, or protein foods.	Nutrition Program Director	7/1/2025	6/30/2029
	Accomplishment or Update				

	c	Establish relationships with county food banks to set up mobile food pantries for older adults at the Josephine County Senior Resource Center and Central Point Senior Resource Center to meet the expressed needs of participants accessing services at these locations. Measurable objective to add one (1) food bank location in each county for a total of two (2).	Nutrition Program Director	7/1/2025	6/30/2027
	Accomplishment or Update				

	d	Incorporate more culturally specific meals into our menus through the “Around the World” (ATW) meals program, adding one (1) new ATW meal the first Friday of every month and integrate a minimum of one (1) previous ATW meal into each remaining week of the month. This would result in one (1) culturally specific meal every week of the year.	Nutrition Program Director, Nutrition Program Coordinator	7/1/2025	6/30/2026
	Accomplishment or Update				

Goal: Community engagement with an equitable approach to volunteer recruitment that reflects the population of our service area in a variety of methods.

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2025-2029

				(by Month & Year)	
				Start Date	End Date
~~*Increase volunteer recruitment*~~ Increase volunteer recruitment program wide to include targeted efforts to engage with those living in rural communities and minority populations including those who identify as BIPOC and/or LGBTQ+ members of our communities to foster trust and a sense of belonging.	a	Utilize Facebook to increase awareness by creating recruitment posts at a minimum of 1x/month to reach those who prefer communicating via social media, targeting local multicultural, rural and LGBTQ+ Facebook groups.	Nutrition Program Director, Volunteer Coordinators	7/1/2025	6/30/2026
	Accomplishment or Update				
	b	Continue to use MOWA social media and recruitment materials/tools at a minimum of 1x/quarterly.	Nutrition Program Director, Volunteer Coordinators	7/1/2025	6/30/2029

	Accomplishment or Update				
	d	Recruit among underserved populations and rural committees for all volunteer activities to include the BIPOC and/or LGBTQ+ community members. We will sponsor and attend up to four (4) rural and/or culturally specific community events each year to help establish program recognition and foster trust in service delivery and our volunteer opportunities.	Nutrition Program Director, Volunteer Coordinators	7/1/2025	6/30/2029

	Accomplishment or Update

Goal: *Identify and develop new partnerships assisting those in distress or living with HIV/AIDS*

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Establish new partnerships with community organizations targeted at providing services for older adults, adults with disabilities, their families and/or caregivers in times of emergency, disaster, and/or pandemic and those	a	Establish a relationship and MOU with the Red Cross of Jackson County to coordinate meal service delivery to older adults and adults with disabilities in times of disaster/emergency.	Nutrition Program Director, Nutrition Program Coordinator	7/1/2025	6/30/2026
	Accomplishment or Update				
	b	Meet with, at a minimum once a year, to collaborate and establish a partnership with HIV	Nutrition Program Director	7/1/2025	6/30/2029

living with HIV/AIDS.		Alliance to build program recognition, foster trust in program services and engage older adults and adults with disabilities living with HIV/AIDS.			
	Accomplishment or Update				
	d			7/1/2025	6/30/2029

Goal: *Increase access to additional nutrition education.*

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Provide opportunities for access to additional nutrition education in various	a	Partnership with OSU Extension to provide in-person nutrition education that	Nutrition Program Director	7/1/2025	6/30/2029

formats to help meet older adults and adults with disabilities where they are at and in their preferred method of learning.		is applicable to older adults 2x/year at the Josephine County Senior Resource Center.			
	Accomplishment or Update				
	b	Distribute OSU “Food Hero for Older Adults” newsletter once monthly in both English and Spanish to all meal sites and make it available to HDM participants via our website and on social media.	Outreach Coordinators & Meal Site Coordinators	7/1/2025	6/30/2029
	Accomplishment or Update				

	c	Explore adding opportunities for online or internet-based Nutrition Education through our Nutrition contractor, TRIO Community Meals, to be made available via our website. New Nutrition Education videos to become accessible once every month.	Nutrition Program Director	7/1/2025	6/30/2026
	Accomplishment or Update				

C – 1.3 Health Promotion

Provide services that maintain or empower health including services for those with chronic conditions and diabetes.

RVCOG is licensed under the Oregon Wellness Network (OWN) to deliver health promotion programs, and under the umbrella of this license, La Clinica, a system of clinics that provides culturally appropriate, accessible healthcare for all in Jackson County, delivers Spanish CDSME. Additionally, SDS supports La Clinica by providing materials, training support, and reporting to the Oregon Wellness Network.

In August 2023 RVCOG SDS, along with partner La Clinica, held an in-person Chronic Disease Self-Management (CDSMP) class in Medford, and in 2024 held a CDSMP class in Cave Junction, rural Josephine County, at the Illinois Valley Senior

Center. In 2025 RVCOG SDS will conduct Diabetes Self-Management Program (DSMP) classes in Jackson and Josephine Counties.

All of these programs are grounded in a person-centered approach that supports each individual's preferences and choices related to the program goal. SDS works with our local CCOs, hospitals, and other partner agencies to provide information about these programs, to which they can refer their most at-risk populations. ADRC staff are made aware of each program and referral process for seamless referrals to meet presenting needs of ADRC callers.

Promotional materials are distributed at a variety of venues including health fairs, senior and community centers, hospitals, and other community events focused on older adults. Advertising has also been done in print, radio, and television formats to promote the programs that RVCOG offers in order to reach at-risk and vulnerable populations. RVCOG is and will continue to partner with initiatives that support the health and wellness of LGBTQIA2S+ older adults. This work is also carried out through the SAC Advocacy Committee.

The long-term success of our communities will be greatly determined by the health of our residents. Efforts to achieve a sustainable health care and long-term support system will have to place much more emphasis on health promotion. To that end, the RVCOG will strive to further develop contracts with local CCOs, as well as a system for billing CMS, in order to support our current programs.

Problems/Needs:
Health promotion programs address the social determinants of health, an understanding which is gaining broader support from the Centers for Medicare and Medicaid (CMS) and Coordinated Care Organizations (CCOs). Only recently have providers embraced the clearly demonstrated outcomes of self-management and other health promotion programs. RVCOG entered into an agreement with OWN which provides the ability to bill CMS for CDSME and PEARLS services.

Focus Area – Health Promotion

Goal: *Improve health outcomes by offering person-centered Health Promotions programming to meet the needs of the most at-risk populations in our service area.*

Measurable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Conduct CDSME (CDSMP & DSMP) classes	a	Recruit participants for CDSMP & DSMP classes, focusing on priority populations with a goal of contacting at least 20 potential participants per quarter	SDS Program Director, Program & Advocacy Coordinator	7/2025	6/2029
	Accomplishment or Update				
	b	Work with local CCOs, hospitals, and other agencies to establish referral procedures for at-risk populations.	SDS Program Director, Program & Advocacy Coordinator	7/2025	6/2029
	Accomplishment or Update				
	c	Continue to expand CMS billing capacity through agreements	SDS Program Director, Program & Advocacy Coordinator	7/2025	6/2029

		with OWN to support health promotion programs.			
	Accomplishment or Update				

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Continue and expand availability of CDSME classes to priority populations, including older adults in rural areas, those who speak languages other than English, LBGTQIA2S+ older adults, Tribal elders, and older adults living with HIV/AIDS, by engaging with community partners who	a	Expand health promotion program outreach to Spanish-speaking community through community partners, including providing training to new Community Outreach Coordinator to facilitate CDSME classes in Spanish. At least one class per year to be provided in Spanish.	SDS Program Director, Community Outreach Coordinator	7/2025	06/2029
	Accomplishment or Update:				
	b	Continue to provide training, supportive materials, and	SDS Program Director, Program and Advocacy Coordinator	7/2025	06/2029

specifically serve these populations		reporting for all CDSME classes delivered, ensuring leader training is made available to individuals and organizations serving priority populations			
	Accomplishment or Update:				
	c	Seek to expand community partners for health promotion service delivery so that at least two classes are held per year with a focus on serving members of priority populations	SDS Program Director, Program and Advocacy Coordinator	7/2025	06/2029
	Accomplishment or Update:				

C – 1.4 Family and Unpaid Caregiver Support

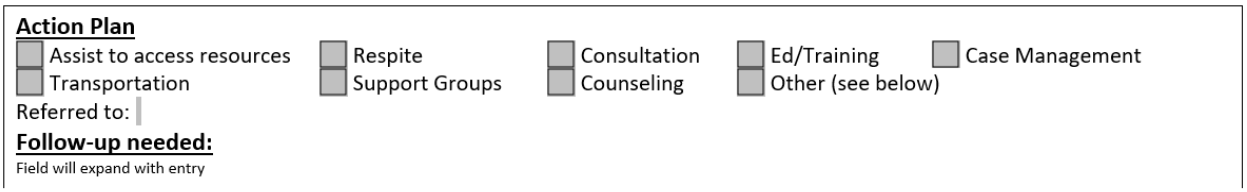
Family Caregiver Support and Training – Provide access to a range of services to support family caregivers.

RVCOG's Family Caregiver Services focus on:

1. Education/training
2. General population awareness
3. Provide respite/day care
4. Provide workplace education
5. Do advocacy to increase funding/capacity
6. Provide home modifications
7. Provide support groups

Current Family Caregiver services, subject to available funding, include Information Services, Access Services, Counseling, Training, Support Groups, Respite Care, and Supplemental Services. Within the Family Caregiver program, we also offer the Relatives as Parents Program (RAPP). This program offers similar services for grandparents and other relatives, if qualifying, to take on the responsibilities of parenting in the absence of the parents. This program is currently not heavily utilized in our service area. Targeted outreach and collaboration with other agencies will be used to promote this program. Service gaps and limits are largely related to available funding barriers which have the biggest impact on respite care reimbursements. Some family caregivers quickly exhaust their annual respite reimbursement allotments.

Utilizing the Family Caregiver Intake Form and one-on-one discussions with the caregiver, we capture vital information that helps to identify specific needs such as cultural preferences or barriers, current access to services and supports, income limits, living situation, and health status or concerns. The intake Form also includes an action plan that is driven by the caregiver:



The Oregon Caregiver Assessment Risk Scale tool is used to gather information that allows us to ensure services are prioritized to those at greatest need for caregivers who are caring for individuals determined to be functionally impaired:

Oregon Caregiver Assessment Risk Scale

The Oregon Caregiver Assessment Risk Scale enables you to understand the risk stage to the Caregiver's well-being in order of protocol. The red * asterisk within the assessment is an indicator created to track the Caregiver's priority of need for services. Compare your answers within the assessment to the point system below to determine the Caregiver's level of need.

Questions	Score
Caregiver Information Question #3 How many people do you provide care for in your household? 1(0 pts) 2(1pt) 3(2pts) 4 (3pts)	Up to 3
Question #4 Do you provide unpaid care for someone outside the home? [1] yes [ ] If yes, how many [ ] No	1 pt
Question #5 How much ADL/IADL do you usually provide for your care recipient each day? (For multiple care recipients, add ALL hours of care provided) Full Assist (4pts) Substantial Assist(3pts) Minimal(2pts) Occassional(1pt) Independent (0pts)	Up to 4
Question #6 Is the Care Recipient unable to perform at least two activities of daily living without substantial assistance, including verbal reminding, physical cueing, or supervision? [1] Yes [ ] No	1 pt

Question #7 Can the care recipient be left alone at home? [ ]Yes [1]No	1 pt
Question #8 Is the Care Recipient determined to be functionally impaired? [1] Yes [ ] No	1 pt
Question #9 What is your employment status? Full/part-time work (2pts) Long/Short Term Disability (3pts) Leave of Absence (1pt) Retired/Unemployed (0 pt)	Up to 3
Question # 10 Are you (the Caregiver) a veteran? Yes (1 pt) No (0 pt)	up to 1 pt
Question # 11(a) According to the Federal Poverty Guidelines, are you- At or below 100% FPL (1pt) Above 100% FPL (0 pt)	Up to 1 pt
Informal Support Question # 13 How satisfied are you with the support of your family/friends/others to assist you at home with your	Up to 2

Caregiver responsibilities? Very dissatisfied (2 pts) Dissatisfied (1 pt) Satisfied (0 pt) Very Satisfied (0 pt)	
Question # 15 If nobody helps you provide care, are there others who could assist you in the future? Yes (0 pt) No (1 pt) Not applicable	Up to 1 pt
Question # 16 Choose one of the following to define your physical health? Good (0 pt) Fair (1 pt) Poor (2 pts)	Up to 2 pts
Question # 19 How would you describe your stress level? Very little (0 pt) Moderate stress (1 pt) High (2 pts) Maximum stress (3 pts)	Up to 3
Care Recipient Information Question # 21 Which of the following existing concerns does the care	Up to 15

recipient experience? i. Alzheimer's disease and/or related disorder/ Neurological or brain dysfunction (3 pts) ii. Behavioral Challenges (1 pt) iii. Emotional Challenges (1 pt) iv. Geographic Isolation (2 points) v. Intellectual/Developmental Disability (1 Point) vi. LGBTQIA2S+ (1pt) vii. Limited English proficiency (1 point) viii. Native Hawaiian/American Indian/Native American (1 pt) ix. Other minority or marginalized community(1pt) x. Physical Disabilities (1 points) xi. Social Isolation (2 points)	
	Total pts 39

Total prioritized points indicator below:

0 - 10 - Mild/Limited

11-19 - Moderate level

20 -28 - High Level

29 - 39 – Maximum Level

*To be eligible for **respite care or supplemental services**, families of adults aged 60 and older or of individuals of any age with Alzheimer's disease or a related disorder, the individual for whom they are caring must be determined to be functionally impaired because the individual is unable to perform at least two activities of daily living without substantial assistance, including verbal reminding, physical cueing, or supervision.*

In addition, we perform quarterly contacts with all enrolled family caregivers and provide one-on-one counselling and information assistance as needed during each call. To continuously assess our services, we utilize a Caregiver Support Satisfaction Survey that is sent out every 6-months in addition to the quarterly contacts.

To further support family caregivers, the workshop Powerful Tools for Caregivers is focused on selfcare being a caregiver to a family member. We encourage the participants of these workshops to attend our support groups afterwards to meet with other caregivers and share their experiences. A separate support group for participants in the RAPP program is available in Josephine County.

SDS strives to provide inclusive and equitable programming that addresses the wide variety of family systems and populations in the community, including related family, domestic partnerships, those not related by blood or marriage, LGBTQIAS2S+ families, and other types of unpaid caregivers. This programming is designed to address the following situations:

Limited English-speaking and ethnic caregivers, including Native American caregivers: RVCOG employees have access to the language line to assist with simultaneous translation services for family caregivers who are non-native English speakers. RVCOG is also making targeted outreach attempts to Native American caregivers including being available to distribute information at the Annual Native Caregiving Conference held each year.

Caregivers in the Greatest Economic and Social Need: Though RVCOG does not screen based on income, consumers are asked if they are able to hire an outside caregiver. In general, most report they do not have the resources to make such a hire, and therefore have to depend on relatives to provide the service. Unfortunately, a significant number of family caregivers receiving support also have physical and developmental/intellectual disabilities.

Caregivers Providing Care to Persons at Risk for Institutionalization: Often family caregivers are what stand between a consumer staying in the home and placement in an institutional care setting. The one-on-one support

family caregivers receive either through Caregiver Counseling (short term) or from Case Managers (ongoing Access to Caregiver Support) can make all the difference in preventing or delaying a loved one's placement in a facility. Having the ability to talk with an Options Counselor or Case Manager who has the training, experience, and knowledge helps the family caregiver know how to care for oneself, manage their loved one's care needs and behaviors, and to be able to problem solve and plan for the future.

Non-traditional Family Caregivers (Lesbian, Gay, Bisexual and Transgender): RVCOG continues to reach out to the LGBTQIA2S+ community to provide information about services and resources.

Grandparents/Relatives Raising Children: There is a support group in Grants Pass called "Grandparents as Parents," which has been meeting weekly for over 15 years. A partnership with Boys and Girls Club allows for the space and free child care during these group meetings. Although this group is located in Grants Pass, grandparents from Jackson County have been invited to attend. RVCOG provides resource materials to the support group. Though RVCOG is not directly involved in running this support group, it provides resource materials, refers grandparents to the group, and recruits support group members to participate in the Powerful Tools for Caregivers workshops and encourages members to take advantage of other RVCOG AAA services.

Older individuals caring for people with disabilities, including developmental disabilities: RVCOG partners with HASL, the Center for Independent Living.

Focus Area – Family and Unpaid Caregiver Support
Goal: *Increase support options for Family Caregivers*

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2025 - 2029 (by Month & Year)

Ensure staff are trained to deliver Powerful Tools for Caregivers and set regular schedule for classes				Start Date	End Date
	a	Ensure adequate staff and volunteers are trained in the Powerful Tools for Caregivers program – at least two available at all times	SDS Program Supervisor	7/2025	06/2029
	Accomplishment or Update				
	b	Regularly schedule classes in both counties – at least one in each county per year; perform outreach to ensure unpaid caregivers are aware of the opportunities with specific focus on priority populations	SDS Program Supervisor, ADRC Lead, Case Managers	7/2025	6/2029
	Accomplishment or Update				
	c	Offer virtual Powerful Tools for Caregivers classes, as desired by participants to overcome barriers if located in rural areas or have transportation barriers	SDS Program Supervisor, ADRC Lead, Case Managers	7/2025	6/2029
	Accomplishment or Update				
Measurable Objectives *Maintain Case Management for Family Caregiver Clients*		Key Tasks	Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
	a	Maintain case management assignments to ensure person-centered, trauma-informed, and	SDS Program Supervisor, ADRC Lead	7/2025	6/2029

		culturally sensitive services as well as the shortest wait list possible			
	Accomplishment or Update				
	b	Engage in active case management to ensure family caregivers are aware of and supported by program offerings, including quarterly contacts with all clients	SDS Program Supervisor, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				
	c	Develop and continue caregiver support group sessions for all participants	SDS Program Supervisor, ADRC Lead, Case Managers	7/2025	6/2029
	Accomplishment or Update				
	d	Perform FCG Satisfaction Survey biennially and use results to improve services and identify gaps	SDS Program Supervisor, ADRC Lead, Case Managers	7/2025	6/2029
	Accomplishment or Update				

Goal: *Greater Outreach and Education to support diverse family caregivers.*

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Communicate with key community partners about ongoing supports for	a	Continue to provide outreach and printed program materials to community partners with a focus on organizations serving priority	All SDS Staff	7/2025	6/2029

Family Caregivers		populations, including those serving Spanish speaking, rural/low income, and LGBTQIA2S+ caregivers.			
	Accomplishment or Update				
	b	Develop deeper relationships with CCOs regarding family caregiver support programs, including workshops and respite; perform outreach at least twice per year to each CCO.	SDS Program Supervisor, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				
	c	Continue to provide presentations and printed program materials at community events in English and Spanish; attend at least four events per year.	All SDS Staff	7/2025	6/2029
	Accomplishment or Update				

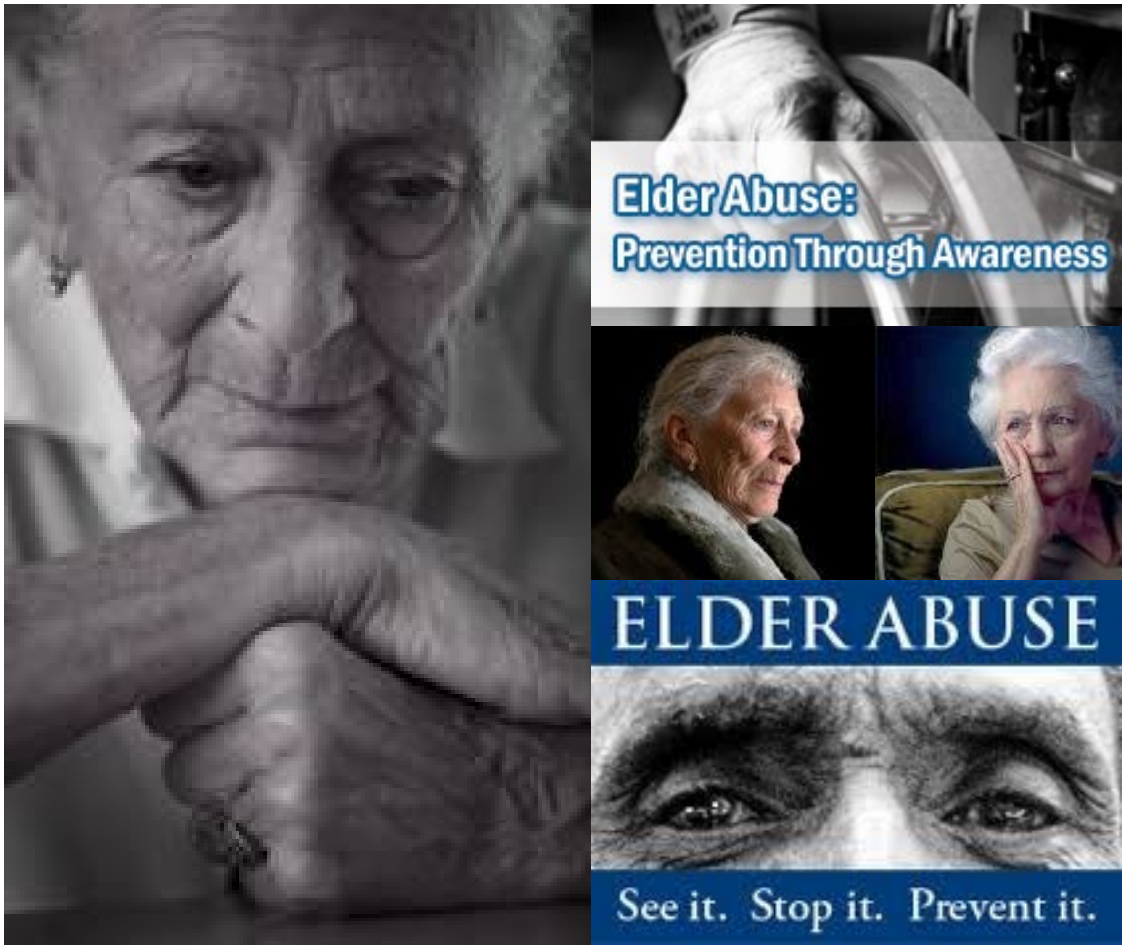
Goal: *Promote service equity when Family Caregiver programs have waitlists.*

Measurable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Continue to ensure that waitlist criteria prioritize underserved populations.	a	Maintain current waitlist procedure that prioritizes underserved, highest need, and highest risk participants	SDS Program Supervisor, ADRC Lead	7/2025	6/2029

		– see Oregon Caregiver Assessment Risk Scale tool.			
	Accomplishment or Update				
	b	Reassess participants who have been on the waitlist for more than 90 days to confirm risk levels have not changed over time.	SDS Program Supervisor, ADRC Lead	7/2025	6/2029

C – 1.5 Legal Assistance and Elder Rights Protection Activities

Safety and Rights – Provide tools to protect aging individuals and individuals with disabilities from harm or abuse.



RVCOG currently provides an Adult Protective Services (APS) Emergency Fund to pay for such things as emergency shelter, transportation, food, medications, and clothing for older adults 60 and older in protective service situations. The agency

also sponsors an annual educational initiative for both professionals and the community regarding elder rights, abuse, and legal assistance.

All employees and volunteers of RVCOG, as well as sub-contractor employees, volunteers, and direct care providers for RVCOG clients are informed that they are mandatory reporters under ORS 124.050 through 124.095 and OAR Chapter 411, Division 20. When a consumer is believed to be at risk of abuse or neglect, mandatory reporters refer the consumer to APS by filling out the APS Screening form (sample follows this section) and sending a secure email to the APS office. RVCOG Case Managers and Behavioral Health staff are available to participate on adult abuse multi-disciplinary teams when requested; however, there are currently no scheduled meetings.

When appropriate for long-term care facility residents, clients and/or their representatives are referred to the Long-Term Care Ombudsman office. If clients are experiencing a barrier to making a connection to the LTCO office, RVCOG staff may assist with making a report.

As mandatory reporters, elder rights protections are at the forefront of RVCOG's service delivery model. Any suspected abuse, physical, financial, or self-neglect, is immediately reported to APS. Additionally, individuals with suspected abuse that may have legal ramifications, including guardianship/conservatorship issues, are referred to one of our legal service providers.

There are currently two legal services agencies in Southern Oregon with whom RVCOG contracts to provide services to the older adult and disabled populations. The Center for Non-Profit Legal Services (CNPLS) is located in Medford and provides legal assistance on a variety of issues including guardianship, housing, and elder abuse protections. The Oregon Law Center (OLC) operates in Josephine County and offers a free phone line for legal questions from older adults in the

area. Contract language ensures that each agency abides by equity guidelines and also seeks to connect with target populations of at risk or underserved individuals. Contracts also incorporate and include as an exhibit the Oregon Legal Assistance Program Standards Under the Older Americans Act provided by ODHS APD.

Service gaps for legal assistance and elder rights protection activities are identified through ADRC services including Information & Assistance/Referral and Options Counseling, Family Caregiver assistance and counseling, and referrals back from legal services agencies. Efforts are made to connect individuals with all available resources; however, there is a general lack of Representative Payee service availability.

APS SCREENING FORM

Select Date		**Time**		**Log#**		**Investigator**	Select
Case Type:	**Select**			Allegation #1	**Select**	**Triage**	**Select**
Access	Select	**Prime**		Allegation #2	Select	**Screener**	Select
Last Case		**CM or Licensor**				**Time & Date In**	
Facility: **Self Report** ☐		**Facility Name:**		**Facility failed to:**	Choose an item.		

CO	Name:		Phone:		Relation to Victim:
	Address:		Email:		
RV	Name:		Phone:		Relation to Victim: RV
	Address:		DOB:		
RP	Name:		Phone:		Relation to Victim:
	Address:		DOB:		
W1	Name:		Phone:		Relation to Victim:
	Address:		DOB:		
W2	Name:		Phone:		Relation to Victim:
	Address:		DOB:		

Please fill out all highlighted fields if applicable. List any additional participants and their relationship to the **VICTIM** here. Type **NARRATIVE** in this field and provide as much detail as possible. Email this form to APDD8.APS@state.or.us

Screened out by:	**Select**	Date:	
Peer Review by:	**Select**	Date:	

Luisa Waites 02-2018

Focus Area - Legal Assistance and Elder Rights Protection Activities

Goal: *To provide a person/family the tools to protect themselves or their loved ones from any kind of harm, abuse, or catastrophe.*

Measurable Objectives	Key Tasks		Lead Position & Entity	Timeframe for 2021-2024 (by Month & Year)	
				Start Date	End Date
Provide an annual educational initiative for professionals and the community regarding elder rights and legal assistance.	a	Produce an annual educational event in collaboration with community partners and agencies from other regions.	SDS Program Director, Program and Advocacy Coordinator	7/2025	6/2029
	Accomplishment or Update				
	b	Provide outreach materials for each event in both English and Spanish and to organizations specifically serving priority populations	SDS Program Director, Program and Advocacy Coordinator, Community Outreach Coordinator	7/2025	6/2029
	Accomplishment or Update				

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2021-2024 (by Month & Year)

				Start Date	End Date
Continue efforts to protect elders from abuse and fraud, specifically focusing on priority populations	a	Maintain knowledge and training of mandatory reporting practices for staff and volunteers with both new hire training and annual refreshers; training to include person-centered, trauma-informed, and culturally sensitive service delivery methods	All AAA Staff and volunteers	7/2025	6/2029
	Accomplishment or Update				
	b	Maintain annual contracts with CNPLS and OLC to ensure objectives are being met and consumers continue to get the help they need; ensure contract language references OAA 102(a)(23) &	SDS Program Director	7/2025	6/2029

		(24) definitions of economic and social needs			
	Accomplishment or Update				
	c	Perform outreach and education activities for elder rights protection and legal services for priority populations, include Spanish speakers, through culturally specific events and organizations – at least one activity biennially	SDS Program Director, Program Supervisor, Program and Advocacy Coordinator, Community Outreach Coordinator, ADRC Lead	7/2025	6/2029
	Accomplishment or Update				

C – 1.6 Older Native Americans

To ensure inclusivity, RVCOG reaches out to all populations with the goal of removing any cultural and or language barriers that may exist.

Jackson and Josephine counties are served by the Cow Creek Band of Umpqua Tribe Indians and by the Coquille Indian Tribe. Although there are about 1,000 elder Native Americans in the area, the majority belong to tribes from other parts of the state and nation. RVCOG, through its participation on the Regional AAA/Tribal Gathering meetings, continues to explore ways to make our services more responsive and attractive to Native Americans and to better coordinate

services between the tribes and the AAA. Although there are few tribal members from any one group in our two-county area, RVCOG continues to find value in attending these joint meetings and collaborating with neighboring AAAs and Tribes.

We recognize there is a service gap in our area including but not limited to the lack of an established reservation in Jackson and Josphine Counties. We receive low numbers of interactions with those that identify as Native American and only received 23 information and referral callers that identified as American Indian/Alaska Native in the last 12 months. We hope to improve outreach and the ability to provide program referrals directly to individuals in need by forming closer partnerships with tribal navigators and local organizations serving the Native American population. Through collaboration with tribal navigators, a referral system will be further developed to ensure older Native Americans and family caregivers are aware of services for which there are eligible.

Outreach and services are provided in a culturally appropriate and trauma-informed manner with training assistance of tribal navigators. AAA staff seek out opportunities to engage with Tribal elders and family caregivers at local events and presentations. Opportunities to serve on the Senior Advisory Council and subcommittees are shared with tribal navigators.

Although we have a robust Disaster Registry program, we recognize there is a need to connect with Tribal partners to see if emergency management is an area we can collaborate on as appropriate.

Focus Area – Older Native Americans

Goal: *To ensure inclusivity, focus on outreach to all populations and remove any cultural and or language barriers that may exist.*

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2025-2029

Continue intentional outreach to the Native American population in the area				(by Month & Year)	
				Start Date	End Date
	a	Continue to build relationships with Native American organizations in the area. Establish a primary contact with both the Cow Creek and Coquille tribes and initiate goal setting for our two counties. Including but not limited to seeking participation of a local tribal representative on one of our advisory councils. Seek to use this opportunity to develop the best way to refer individuals between Title III and Title VI programs.	SDS Program Director, Program Supervisor	7/2025	6/2026
	Accomplishment or Update				
	b	Continue to provide information to Native American organizations about AAA services through presentations, brochures, and/or electronic outreach efforts. With information from primary contacts at Cow Creek and Coquille	SDS Program Director, Program Supervisor	7/2025	6/2029

		tribes, identify native American specific events at which we can provide information and perform outreach activities at least twice per year.			
	Accomplishment or Update				
	c	Continue to attend AAA/Tribal gatherings and other events. Continue to gain information and training to stay culturally and linguistically responsive by attending the Tribal/AAA gatherings and seek information on tools used in other areas that have been successful. Also, provide opportunities for participation in events and service planning and share program information.	SDS Program Director, Program Supervisor,	7/2025	6/2029
	Accomplishment or Update				
	d	Continue to research Native American resources to include in the ADRC resource database, following plain	SDS Program Director, Program Supervisor, ADRC staff	7/2025	6/2029

		language policy (www.plainlanguage.gov) to foster service equity. Through information gained from contacts and relations add appropriate Native American resources to our ADRC database. Develop a Native American specific needs survey that will be used throughout the year to capture gaps in services and better serve those in our region.			
	Accomplishment or Update				
	e	Work with tribal navigators to ensure staff receive biennial training to deliver services to consumers and family caregivers in a person-centered, trauma-informed, and culturally sensitive manner	SDS Program Supervisor	7/2025	6/2029
	Accomplishment or Update				
	f	Perform outreach to organizations and tribal contacts with a focus on identifying those in greatest economic and	SDS Program Director, Program Supervisor, Community	7/2025	6/2029

		social need; personally engage with identified tribal members to develop methods to connect with hard to reach groups to provide services. Outreach efforts to occur at least quarterly.	Outreach Coordinator		
	Accomplishment or Update				

C – 1.7 Behavioral Health

Behavioral health is the promotion of mental health and well-being, the treatment of mental and substance use disorders, and the support of those who experience and/or are in recovery from these conditions.

As our population ages, there is a greater need for behavioral health services, especially in Southern Oregon where older adults make up a higher percentage of our population than is the case in the rest of the state. Although most older adults rely on Medicare to cover their healthcare needs, both Medicare behavioral health coverage and Medicare behavioral health providers are severely limited.

Recognizing this need, RVCOG has developed and implemented several behavioral health programs to address the issues of depression, social isolation, and other behavioral health challenges facing older adults in our area.

- Program to Encourage Active and Rewarding Lives (PEARLS) is an evidence-based brief depression management, in-home treatment program for older adults and adults with epilepsy. In addition to screening and intake visits, the program provides six to eight in-home behavior activation and problem-solving sessions.
- Options for People to Address Loneliness (OPAL) is an evidence-informed program developed by RVCOG behavioral health staff in response to the increase in social isolation during the pandemic. OPAL is a brief in-home behavioral health program designed to reduce levels of loneliness and isolation experienced by older adults and adults with disabilities. In addition to screening and intake visits, the program provides six behavior activation, mini goals/action plans, and resource coordination sessions.
- Buried in Treasures (BIT) is a 16-week workshop based on harm-reduction and strength-based practices for people who struggle with hoarding disorder. BIT provides a safe peer and educational environment to encourage participants to change their thinking, change their acquiring and discarding lifestyle, and change their home environments to result in a safe place to live.
- Star-C is an evidence-based program designed to help family caregivers who are caring for someone with Alzheimer's disease or a related dementia. Participants who are unpaid family caregivers, live with the person who has dementia, spend at least four hours a day with the person, and plan to keep a stable housing situation for the next six months receive four one-hour in-home visits and two 15-to-30-minute phones calls over a six-week period, followed by four follow-up phone calls and a caregiver

feedback survey. Clinical tests proved this program lowers depression in caregivers and decreases problem behaviors in persons with dementia.

- Guided Autobiography (GAB) is an evidence-based structured approach that involves delving into one's life story with the guidance of a trained facilitator. It offers individuals an opportunity to deeply reflect on and chronicle significant life experiences, enabling them the gain valuable insight, perspective, and a richer understanding of their personal journey. Each session revolves round a specific life theme guiding participants to engage with a series of thought-provoking questions tailored to elicit memories and encourage the writing of approximately two pages of their life story during each session. GAB participants show improvements in self-acceptance, reduced anxiety, increased energy, a more positive outlook, and enhanced connections with others.

The necessity for behavioral health crisis and complex case intervention services continues to increase at an exponential level. Behavioral Health Specialists provide coordination of community mental health and behavioral health services, participate in educational activities, and consult with partner agencies including home health social workers, hospice workers, and Older Adult Behavioral Health Specialists.

Focus Area - **Behavioral Health**

Goal: *Reduce the levels of social isolation and loneliness among older adults and adults with disabilities by providing various evidence-based and evidence-informed behavioral health support programs.*

Measurable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Secure trained behavioral health staff to provide programs; collect data to measure the effectiveness of each program at reducing levels of social isolation and loneliness.	a	Provide trained staff for BH programs. (Three-year timeframe to indicate that all programs to be offered have unique training requirements.)	SDS Program Director, Behavioral Health Specialists	7/2025	6/2028
	Accomplishment or Update				
	b	Develop data collection process to measure program impact on social isolation and loneliness.	SDS Program Director, Behavioral Health Specialists	7/2025	6/2026
	Accomplishment or Update				

	c	Develop and implement post-program completion support group sessions for BH program participants	SDS Program Director, Program Supervisor, Behavioral Health Specialists, Case Managers	7/2026	6/2029
	Accomplishment or Update				
	d	Outreach to community partners to ensure awareness of BH programs	SDS Program Director, Behavioral Health Specialists, ADRC staff	7/2025	6/2029
	Accomplishment or Update				
	e	Advocate for BH services for Medicare recipients – coverage and availability are extremely lacking in our region	SDS Program Director, Program Supervisor, Program and Advocacy Coordinator, Behavioral Health Specialists	7/2025	6/2029
	Accomplishment or Update				

Goal: *Increase capacity to provide behavioral health crisis and complex case intervention.*

Measurable Objectives		Key Tasks	Lead Position & Entity	Timeframe for 2025-2029 (by Month & Year)	
				Start Date	End Date
Address growing need to provide BH crisis and complex case intervention, educational activities, and coordination with partner agencies.	a	Ensure staff capacity (and funding) to address urgent mental health crisis services.	SDS Program Director, Behavioral Health Specialists	7/2025	6/2029
	Accomplishment or Update				
	b	Maintain relationships with partner agencies, including home health and hospice social workers, Older Adult Behavioral Health Specialists	All SDS Program staff	7/2025	6/2029
	Accomplishment or Update				
	c	Provide ongoing trainings for both	Behavioral Health staff	7/2025	6/2029

		internal staff and external partners on behavioral health programs and best practices.			
	Accomplishment or Update				

SECTION D - OPI SERVICES AND METHOD OF SERVICE DELIVERY

Administration of Oregon Project Independence Classic (OPI-C)

Types and Amounts of Authorized Services

The following services are offered in OPI-C, formerly two separate programs OPI 60+ and OPI 19-59, based on the best mix of services to meet the Consumer's needs: Home Care, Personal Care, Case Management, Home Delivered Meals, Chore Service, Assistive Technology, Adult Day Services, Evidence-Based Health Promotion programs, Options Counseling, and Assisted Transportation. Amounts of authorized services are determined by local priorities (see section "Prioritizing OPI Service Delivery" below), safety of care plan, best mix of services to meet Consumer need, and the most cost-effective service options, including natural supports. The maximum hours of Home and Personal Care that can be assigned to an OPI-C Consumer is 6 hours per week. Exceptions to the maximum can be approved for short-term situations and require consultation and approval from the SDS Program Supervisor. Other services may be authorized by the assigned Case Manager in consultation with the SDS Program Supervisor, depending on Consumer need and available funds.

Cost of Authorized Services per Unit

***Unit cost per service is as follows, as of July 1,* 2024**

Home Care—Contracted:	$32.92/hour (Addus); $34.07hour (New Horizons)
Personal Care—Contracted:	$32.92/hour (Addus); $34.07/hour (New Horizons)
Home Care Worker:	$24.83 through $30.09, depending on training and length of service

Home Delivered Meals:	$12.25/meal
Assistive Technology:	Variable, depending on item needed
Case Management / Options Counseling:	$60.63 through $78.96

Timely Response to Inquiries for Service

The following Priorities for OPI-C have been established for RVCOG, and staff will schedule work to be completed based on these priorities. The SDS Program Supervisor periodically monitors for compliance.

- **Priority 1: Intake and Annual Paperwork**
  Intake paperwork of eligible consumers will be scheduled within five to seven days of consumer coming up on the waitlist according to Service Priority Level (SPL). Paperwork includes:
  - OPI Service Agreement (SE287L), including signatures of consumer and Case Manager, updated annually
  - OPI Fee Determination (SE287K), updated annually
  - Authorization for Disclosure, Sharing, and Use of Individual Information (ME3010), updated annually
  - Home Care Worker Compensation Agreement, SE354, at intake or as needed
  - Representative Choice (SE737) annually
  - HCW/In-Home Agency Service Authorization (546N), annually
  - Task List (598N) completed and mailed to consumer/employer representative if using an HCW, or to home care agency annually or as needed
  - Home Care Worker Notice of Authorized Hours and Services (4105) completed and mailed to HCW, annually or as needed

Establishment of services will begin as soon as possible after timely completion of intake paperwork including signatures of the consumer and/or the Consumer Representative.

- **Priority 2: Maintain Waitlist**

  In the event that funding or staffing levels do not allow addition of new Consumers, a Waitlist will be maintained in the following way:
  - Designated Case Manager will contact consumer or Authorized Representative within 3 business days of referral to complete a new Electronic Waitlist Tool (MSC2549B)
  - Consumer information and outcome of Waitlist Tool is recorded in SDS file and OACCESS if already in the system, within 3 days of Waitlist Tool assessment
  - Consumers will be prioritized according to highest need, as shown by Waitlist Tool, and for those with equal score, will be prioritized according to first-come-first-served. Considerations will be made for high-risk individuals whose needs are not captured by the Electronic Waitlist Tool and are at risk for institutionalization and/or hospitalization
  - Waitlisted OPI Consumers will be offered Options Counseling to address their current needs

- **Priority 3: Ongoing OPI-C Consumer Services and Program Management**
  - Reviews of Consumer will be completed annually on or before due date or as requested/required
  - Narration of any activity will be completed within three business days
  - Monthly OPI unit meetings will be held to staff issues, share information and education
  - OPI core curriculum/training will be completed by all Case Managers as soon as possible after hiring
  - Urgent OPI Consumer calls will be returned within the same business day if possible

- Non-urgent OPI Consumer calls will be returned within 3 business days. If Case Manager is out for 3 days, a backup worker will be assigned to triage non-urgent phone calls
- Non-OPI-specific problems or concerns will be addressed by assigned Case Manager through Options Counseling and/or referral to community partners or services

Initial and Ongoing Periodic Screening

When a possible Consumer calls the Aging and Disability Resource Connection (ADRC) or Aging and People with Disabilities (APD) Branch Office and requests OPI services, they submit a referral to the designated OPI Case Manager. Designated Case Manager will contact Consumer or Authorized Representative within three business days of the referral to complete an Electronic Waitlist Tool (EWT). The EWT will provide information on whether a consumer is eligible to be placed on the OPI waitlist according to the EWT score. If the OPI-C waitlist is closed at the time of referral, the client is advised and offered Person Centered Options Counseling, if needed, to explore other options to meet their needs, including referral for OPI-M. If the consumer wishes to apply for OPI-M they are given the contact information and location of the appropriate ODHS APD local office.

Because OPI-C is not intended to replace the resources available to an individual from their own financial assets and natural support systems, the OPI Case Manager makes every effort to assist applicants in utilizing other resources before bringing them onto OPI-C. Persons appearing to be eligible for Medicaid, including the new Oregon Project Independence – Medicaid (OPI-M) program, are so counseled and encouraged to apply. OPI Case Managers may approve OPI-C for persons eligible for Medicaid who do not wish to enroll, subject to available funding for OPI-C. People who are eligible for SNAP, Qualified Medicare Beneficiary, or Supplemental Low Income Medicare Beneficiary Program may also qualify for OPI.

During the annual review visit or when there is need or request for a new assessment, the OPI Case Manager reassesses Consumer needs and resources and makes referrals as appropriate, including to Medicaid.

The OPI Case Manager narrates in the Consumer's electronic Oregon Access case file their exploration or discussion regarding other resources, including Medicaid.

Eligibility

In order to qualify for OPI-C services, each consumer must meet the Eligibility Requirements in Oregon Administrative Rules (OAR) 411-032-000. People who qualify for and receive OSIPM and/or SSI are not eligible for OPI-C and may be referred to State Plan Personal Care. To assess eligibility, the assigned OPI Case Manager meets with the applicant to complete an assessment, including assessing the individual's needs, resources, natural supports, and eligibility for the program. OPI Case Managers use the Oregon Access (OACCESS) Consumer Assessment/Planning System (CA/PS) assessment tool to determine Consumer's Service Priority Level (SPL). Consumers who are at or below SPL 18 are eligible for OPI as long as they meet SPL requirements, qualifying income and living arrangements. (See section *Prioritizing Service Delivery*, below.)

Service Provision

Home Care and Personal Care services are provided either through the use of a State Home Care Worker (HCW) or through a contracted in-home agency. Currently RVCOG is contracted with Addus Healthcare, Inc., and New Horizons Homecare. The Consumer is responsible for choosing to use an agency or a HCW, with support and information from the Case Manager.

If needed, home-delivered meals are provided by the Food & Friends Meals on Wheels Program. Options Counseling and Case Management are provided by RVCOG Case Managers. Assistive Technology is purchased, as needed, on a

limited basis through a variety of vendors depending on the item, consumer choice, and price.

Prioritizing Service Delivery

An AAA may establish local priorities for OPI authorized services, although the AAA's local priorities cannot conflict with OAR 411, Division 32. In the event of a grievance, the OAR takes precedence over local priorities. The current priorities of RVCOG are as follows:

1. **Maintaining Current Consumers**: Maintaining Consumers already receiving authorized service as long as their condition indicates they qualify for the program (with a Service Priority Level between 1 and 18). Prioritized services are Personal Care, Home Care, Case Management, and Home Delivered Meals. Other services may be approved if the budget allows by authorization from the SDS Program Supervisor. These may include Chore Service, Assistive Technology, Adult Day Services, Evidence-Based Health Promotion programs, Options Counseling, and Assisted Transportation. The Consumer has the primary responsibility (with OPI Case Manager's guidance) for choosing and whenever possible developing the most cost-effective service options. The Maximum units of in-home services per eligible OPI-C individual is up to 6 hours per week for both Home Care and Personal Care combined, whether it is delivered via contract or by State Home Care Worker, within District Eight budget limitations. If the reduction of hours puts the consumer at risk of an unsafe care plan, an exploration of natural supports and other resources will be completed and a consultation with the SDS Program Supervisor will be conducted to determine if exception hours can be authorized. If budget circumstances change, the monthly maximum hours may be reconsidered. This does not mean that every Consumer will be authorized the maximum units of service. Hours are assigned after consideration of need, natural and other supports. Exceptions to the maximum will be staffed by the OPI

Case Manager and the SDS Program Supervisor who will determine whether to approve or not. Approval of exception hours will be limited in duration and require review to ensure the consumer is either no longer in need of the extra hours or has developed a long-term plan to safely meet their care needs. Examples of short-term situations include being discharged from the hospital, acute illness, transition to another program with a higher level of care, etc.

2. **Maintaining and prioritizing a Waitlist**: When adequate funding to bring on new Consumers to OPI-C services is not available, the OPI Case Manager will continue to accept applicants for OPI service and will complete the Electronic Waitlist Tool for each referral. However, the waitlist is capped at 100 individuals and is closed if the cap is reached. They will inform the Consumer of the lack of OPI funds at this time and inform them that they will be notified by the OPI Case Manager when their name has come up on the waitlist and there is funding to provide services to them. The minimum information needed for the waitlist is the Consumer's full name, EWT score, prime number if they have one, phone number, screening date and date of birth. Individuals are placed on the waitlist with those having the highest EWT score at the top of the list, descending to those with the lowest EWT score (see OAR 411-015-0010). If two or more people score the same on the priority scale, priority will be given on a first-come-first-served basis. Considerations will be made for high-risk individuals whose needs are not captured by the Electronic Waitlist Tool and are at risk for institutionalization and/or hospitalization. The OPI Case Manager will offer Information and Referral services or Options Counseling for individuals who are placed on the waitlist but need immediate assistance.

Services may be authorized on an exception basis when lack of services will present imminent risk to health or safety of the individual or no other funds/resources are available to provide services. These cases will be

staffed with the SDS Program Supervisor for approving services. The OPI Case Manager will document the exception justification in Oregon Access.

The OPI Case Manager will continue to stress the need to pay service providers privately where income/resources indicate the Consumer is financially able to do so or apply for other public funded programs. A referral is made to the Aging and Disability Resource Connection (ADRC) for resource needs and Options Counseling if needed.

Denial, Reduction, or Termination of Services

In some instances, a Consumer will be denied or terminated from OPI services, or have their services reduced.

Denial of services for a new applicant will be based on whether they qualify for OPI according to the CA/PS assessment and other eligibility requirements. If they do not qualify for services, they will be informed of this in writing. Denial of a requested service for a current Consumer will be based on the CA/PS assessment, the Care Plan or living environment is unsafe, refusal to participate in program requirements or lack of available funds.

A current Consumer may have their services reduced if their annual or other reassessment indicates a reduced need for services. A current Consumer in the OPI program may have services terminated in the following instances:

1. **Unsafe Care Plan:** If the maximum number of allowable hours of Home and Personal Care, along with other authorized support services, result in an unsafe Care Plan, the Consumer will be counseled by the OPI Case Manager and strongly encouraged to utilize other services in the community. The OPI Case Manager will thoroughly narrate in the Consumer's electronic file in Oregon Access their discussion regarding the unsafe Care Plan. If the Care Plan remains unsafe, Case Manager will staff the case with SDS Program Supervisor, and make any additional relevant referrals (APS, APD offices,

mental health, etc.). If situation cannot be made safe with available OPI services, local resources, and natural supports and a resolution cannot be found, the SDS Supervisor will staff the case with OPI policy and determine the best course of action including but not limited to the dismissal of the consumer from the program.

2. **Unsafe Working Conditions:** If the Case Manager determines that the service setting has dangerous conditions that jeopardize the health or safety of the individual or Service Provider and necessary safeguards cannot be taken to improve the setting, or services cannot be provided safely or adequately by the service provider based on the choices or preferences of the eligible individual or the individual's representative, the Case Manager will staff the situation with the SDS Program Supervisor. If a resolution cannot be found, the SDS Program Supervisor will staff the case with OPI policy and determine the best course of action including but not limited to the dismissal of the Consumer from the program. .

3. **No Longer Qualifies:** If the annual or other reassessment indicates that the Consumer no longer qualifies for the program based on the CA/PS assessment or other criteria, the Consumer will be terminated from the program.

A Consumer may have their services reduced if their reassessment, whether annual or for a change in circumstances, indicates a safe care plan with reduced services based on the CA/PS assessment.

NOTE: During an Emergency Declaration time period, there may be restrictions on reducing or termination of services. RVCOG will follow APD policy in the event this occurs.

Notice to Applicant or Consumer of Decision to Deny, Reduce, or Terminate OPI Service

When an OPI Case Manager determines that an applicant or consumer of OPI services will not be provided a requested service, or service will be reduced or terminated, the OPI Case Manager shall provide to the applicant, by mail, a written notice within ten days of this decision. This notice shall state the specific reason(s) for this decision and shall describe the applicant's appeal rights (see below), including the deadline for submitting an appeal and the form for filing such an appeal. Change in service level or termination from services will not be effective until ten business days after the notification is sent, except in the instance of Unsafe Work Environment, in which case services may be reduced or terminated immediately.

All written notices to Deny, Reduce, or Terminate OPI Service should include information listing possible alternative services or referrals that could assist the Consumer, including Options Counseling services to assist with transition planning.

Copies of all written correspondence to the Consumer should be placed in the physical file and narrated in OACCESS.

Appeals and Grievance Process

This procedure is designed to address and resolve Consumer concerns related to the provision, denial, reduction, or termination of OPI services by RVCOG.

1. **Guidelines and Definitions:**
    a. Appeal: filed by a Consumer who wishes to appeal RVCOG decisions which result in a reduction, termination, or denial of OPI services.

b. Grievance: filed formally or informally to resolve a difference in opinion between a Consumer and RVCOG, for example, a process concern or customer service complaint.

c. Representation: The Consumer may be represented at any stage in the appeal process by a representative of the Consumer's choosing, including legal counsel. All costs related to representation shall be at the Consumer's expense. (Free legal counsel may be available from: Oregon Public Benefits Hotline – 1-800-520-5292; Center for Non-Profit Legal Services, 225 W. Main Street, Medford, OR 97501, 541-779-7292 or Oregon Law Center, 424 NW 6th Street, #102, Grants Pass, OR 97526, 541-476-1058.)

d. Written Decision: A decision, rendered at any level, shall be in writing, setting forth the decision and the reason for it. The decision shall be promptly mailed to the Consumer or representative.

e. Time Limits: It is important that an appeal be processed as rapidly as possible. Specified time limits may, however, be extended by mutual agreement between the person who is filing the appeal/grievance and RVCOG. If documentation is not submitted by the Consumer or their representative within the time limit established by this procedure, the appeal shall become void. If RVCOG fails to respond to a procedural step within the established timeline, the Consumer or their representative may proceed to the next step of the process within the specified timeline for it.

f. Definition of the term "day": A "day" shall mean a business day. If a due date falls on a weekend or an RVCOG holiday (list follows), the due date shall be the next business day. When an RVCOG holiday falls on a Saturday, it will be observed on the preceding Friday. When an RVCOG holiday falls on a Sunday, it will be observed on the

following Monday.

New Year's Day
Martin Luther King Jr. Day
President's Day
Memorial Day
Juneteenth
Independence Day
Labor Day
Veteran's Day
Thanksgiving Day
Day following Thanksgiving
Christmas Eve
Christmas Day

2. Filing a Grievance:

a. Ideally, differences of opinion between a Consumer and RVCOG should be resolved informally, at the lowest level possible. A suggested first step is for a Consumer or representative to share their concern in writing or verbally to the OPI Case Manager. Case Managers should schedule a meeting to attempt to resolve such concern within five business days.

b. If the Consumer or their representative do not find a suitable resolution after requesting a meeting with their OPI Case Manager, or if they wish to forgo this first step, they should file a Grievance with the SDS Program Supervisor. A grievance can be filed formally using the provided form or can be done informally by contacting the SDS Program Supervisor by phone at 541.423.1361.

c. Upon receiving either an informal or formally submitted Grievance, SDS Program Supervisor will review the complaint, interview the involved SDS staff, contact the Consumer, and conduct any other

necessary steps to determine a potential resolution. Upon receipt of a grievance, a response will be written and mailed to the Consumer and/or representative within five business days for an informal grievance or ten business days for a formal grievance.

3. Filing an Appeal for denial, reduction, or termination of services:

The Consumer or their representative must file a written notice of appeal with RVCOG at the address below within ten days of the mailing of the notice of contemplated action which is the subject of the appeal.

RVCOG
Attn: SDS Program Director
155 North First Street
PO Box 3275
Central Point, OR 97502

a. If a Consumer files an appeal with RVCOG, their benefits will continue during the appeal process, except in the case of termination for Unsafe Working Conditions, in which case program service will end immediately upon verbal notification.

b. Upon the receipt of a written notice of appeal, RVCOG shall schedule an appeal review meeting. This meeting shall be scheduled within ten days of the receipt of the appeal. The Consumer and their representative (if any) shall be notified by mail of the date, time and location of the meeting. This notice shall contain the following additional information:

    i. The name and phone number of the RVCOG staff member to contact for additional information about the contents of the notification letter.

ii. Notification of the Consumer right to continue receiving OPI service while they are awaiting the outcome of RVCOG appeal review.
iii. Information on the Consumer rights at the appeal review, including the right to representation and the right to have witnesses testify on their behalf.
iv. Information on the Consumer right to seek an administrative review by ODHS of the outcome of RVCOG appeal review.

c. The appeal review meeting shall be held at the date, time and location specified in the appeal meeting notification letter. To encourage impartiality, the review shall be conducted by the SDS Program Supervisor.

d. Within five days of the conclusion of this meeting, the SDS Program Supervisor shall inform the Consumer or representative, as appropriate, of a decision in writing regarding this matter. Upon notification, services could be terminated immediately.

e. Within five days of receipt of the decision, the Consumer or their representative may contact the SDS Program Director to request a review of the decision. The SDS Program Director will complete their review and make a final decision within five days of the request. During this review, terminated services will not be reinstated. The SDS Program Director will review the written documentation and may contact the eligible individual or their representative for additional clarification. The SDS Program Director's decision shall be binding unless the aggrieved Consumer or their representative wishes to pursue this matter with the Oregon Department of Human Services.

f. The Consumer or their representative who wishes to request an administrative review with ODHS may do so following the conclusion

of RVCOG's appeal review process. The administrative review request should be sent in writing to: OPI Policy, Community Services and Support Unit, 500 Summer Street NE E12, Salem, Oregon, 97301-1015. The OPI Policy Analyst should also be notified if the consumer chooses to request an administrative review. In the event ODHS decides against RVCOG as a result of their review, the Consumer will be eligible for reinstatement of service at the time of ODHS's decision.

Fees for Services

At the time of intake or review, the OPI Case Manager completes an OPI Fee Determination Form 287k. The Case Manager asks the applicant how much of their monthly household income is from Social Security, pension, interest on savings, investments, property rentals, or other income sources and enters this information on the 287K form. The OPI Case Manager then asks the Consumer what their medical expenses are on a monthly basis. This information is categorized under medicines, medical supplies, medical equipment, doctor and/or hospital bills, monthly cost of supplemental health insurance, and other medical expenses. This is also documented on the 287K. The total amount of monthly medical expenses is subtracted from the monthly income amount and entered on the form. The balance or "Net Monthly Income" is used to determine the Consumer's OPI fee for services. The Case Manager determines the fee by using the OPI Fee Schedule and taking into consideration whether the Consumer is living in a single-person up to a six-person household. The fee amount including "0" is recorded on the 287K which the Consumer signs and on the SDS 546N. A copy of the SDS 546N is sent to RVCOG's NAPIS Office Specialist who sets up and posts units of service in OACCESS from the monthly In-Home Service Provider billing, Homecare Worker report, and Food & Friends Report.

Minimum One-time Fee

A $25.00 one-time minimum fee is applied to all individuals receiving OPI services who have adjusted income levels at or below the federal poverty level (everyone who does not pay a fee for service). The fee is due at the time eligibility for OPI service is determined.

RVCOG is opting to apply the $25.00 fee to Case Management services.

At the time of initial assessment, the OPI Case Manager will inform the Consumer, as appropriate, that they will be assessed a $25.00 fee and that a statement will be sent along with an envelope within the next 30 days. When the OPI Case Manager gives the Consumer the OPI Service Agreement 287L, it explains the $25.00 and documents that services have been authorized. The OPI Case Manager sends the form to the NAPIS Office Specialist. The NAPIS Office Specialist prepares and mails a letter/invoice to the Consumer along with a return envelope requesting a check. A follow-up letter/invoice is not mailed if the Consumer does not pay. A Consumer does not lose service if they do not pay the minimum one-time fee.

The NAPIS Office Specialist maintains billing and payment information on a separate spreadsheet (not in the NAPIS billing system), bills consumers monthly, and reports any income billed and collected to the RVCOG Finance Office for inclusion on the monthly Form 148 Cumulative Financial and Services Reports.

Non-Payment of Monthly Fees

Each month the NAPIS Office Specialist sends OPI Case Managers copies of the billing letters that have been sent to the Consumer. The OPI Case Managers review the letters to check on each Consumer's payment status. In addition, the NAPIS Office Specialist contacts the OPI Case Manager when they notice that a Consumer is 60 days past due. The OPI Case Managers are responsible for contacting Consumers who are more than sixty days in arrears in payment of fees

or owe more than $20 in fees. If payment is not received within thirty days, the Case Manager staffs the case with the SDS Program Supervisor to determine what action may be needed. If it is determined that the consumer is unable to pay because of financial hardship or other challenges, or if the consumer has left the program, the fees will be waived. The OPI Case Manager will notify the NAPIS Office Specialist in writing and the balance due is reduced to zero.

Monitoring and Evaluation

Case Managers at least annually review a sample of cases to determine if service eligibility, determination of services and fees for services are being determined appropriately. A monthly report of service expenditures is reviewed by the SDS Program Director and SDS Program Supervisor as well as the OPI Case Managers for their use in staying within budget. At least once during the current In-Home contract solicitation cycle, the provider is monitored to assure they are meeting contractual requirements. The SDS Program Supervisor maintains daily contact with OPI Case Managers to problem solve and assure Consumer needs are being met. The SDS Program Director and SDS Program Supervisor meet regularly to address status of expenditures and budget.

Conflict of Interest Policy

RVCOG's Conflict of Interest Policies apply to OPI service delivery. Please see Appendix G for further information.

Service Equity

There shall be no barriers to full participation in OPI on the basis of race, gender, gender identity, gender expression, sexual orientation, ethnicity, native or indigenous origin, age, generation, culture, religion, belief system, marital status, parental status, socioeconomic status, language, accent, ability status, mental health, educational level or background, geography, nationality, work style, work experience, job role function, thinking style, personality type, physical

appearance, political perspective or affiliation, and/or any other characteristic that can be identified as recognizing or illustrating diversity.

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

Oregon Project Independence – Medicaid (OPI-M) became available to the public on March 1, 2025. Eligibility for OPI-M is different than traditional Medicaid with higher income and asset limits. OPI-M also does not include estate recovery like traditional Medicaid. OPI-M is administered through a close partnership between RVCOG SDS and ODHS APD District 8. Referrals to OPI-M can come either through RVCOG's ADRC line or directly to APD offices. Like traditional Medicaid, OPI-M requires asset and income verification. Like OPI-C, a CA/PS assessment is also required to determine an individual's SPL. Eligibility for OPI-M may take up to 45 days, and individuals approved for OPI-M services transition back to RVCOG for service planning and case management. OPI-M individuals who are also approved for medical coverage may stay with APD for service planning and case management. Services provided by RVCOG Case Managers will largely follow OPI-C processes with some programmatic differences.

Eligibility

To qualify for OPI-M, an individual must be age 18 or older, have income at or below 400% of the Federal Poverty Level, have limited resources that do not exceed the cost of six months in a nursing facility, and need help with personal care tasks. Qualifying individuals are eligible for up to 20 hours per week of in-home care services.

Service Fees

There is no fee for services received through OPI-M, and there is no estate recovery.

Available Services

- In-home care services such as help with bathing, toileting, and walking
- Home delivered meals, up to 2 meals per day
- Adult day services, provided in place of in-home care services
- Emergency response systems
- Long term care community nursing – evaluation and identification of supports that help an individual maintain maximum functioning and minimize health risks while promoting the individual's autonomy and self-management of healthcare
- Ancillary services:
    - Chore services – assistance with things such as heavy housework, yard work, or sidewalk maintenance provided on an intermittent or one-time basis to assure health and safety
    - Home modifications – changes made to adapt living spaces to meet specific services needs of eligible individuals with physical limitations to maintain their health, safety, and independence
    - Assistive technology – equipment or technology that is used to achieve, maintain, or improve the functional capabilities of an individual, replaces the need for human interventioins, or enables an individual to self-direct their care and maximize their independence
    - Special medical equipment – durable medical equipment that is used to achieve, increase, maintain, or improve the functional capabilities of an individual and can withstand repeated use
    - Medical supplies – single-use items that help individuals care for themselves

SECTION E – AREA PLAN BUDGET

SEE AREA PLAN BUDGET WORKBOOK ATTACHED

APPENDICES

Appendix A – Organizational Chart

Appendix B – Advisory Councils and Governing Body

Appendix C – Public Process

Appendix D – Final Updates on Accomplishments of 2021-2025 Area Plan

Appendix E – Final Updates on Service Equity Plan Accomplishments

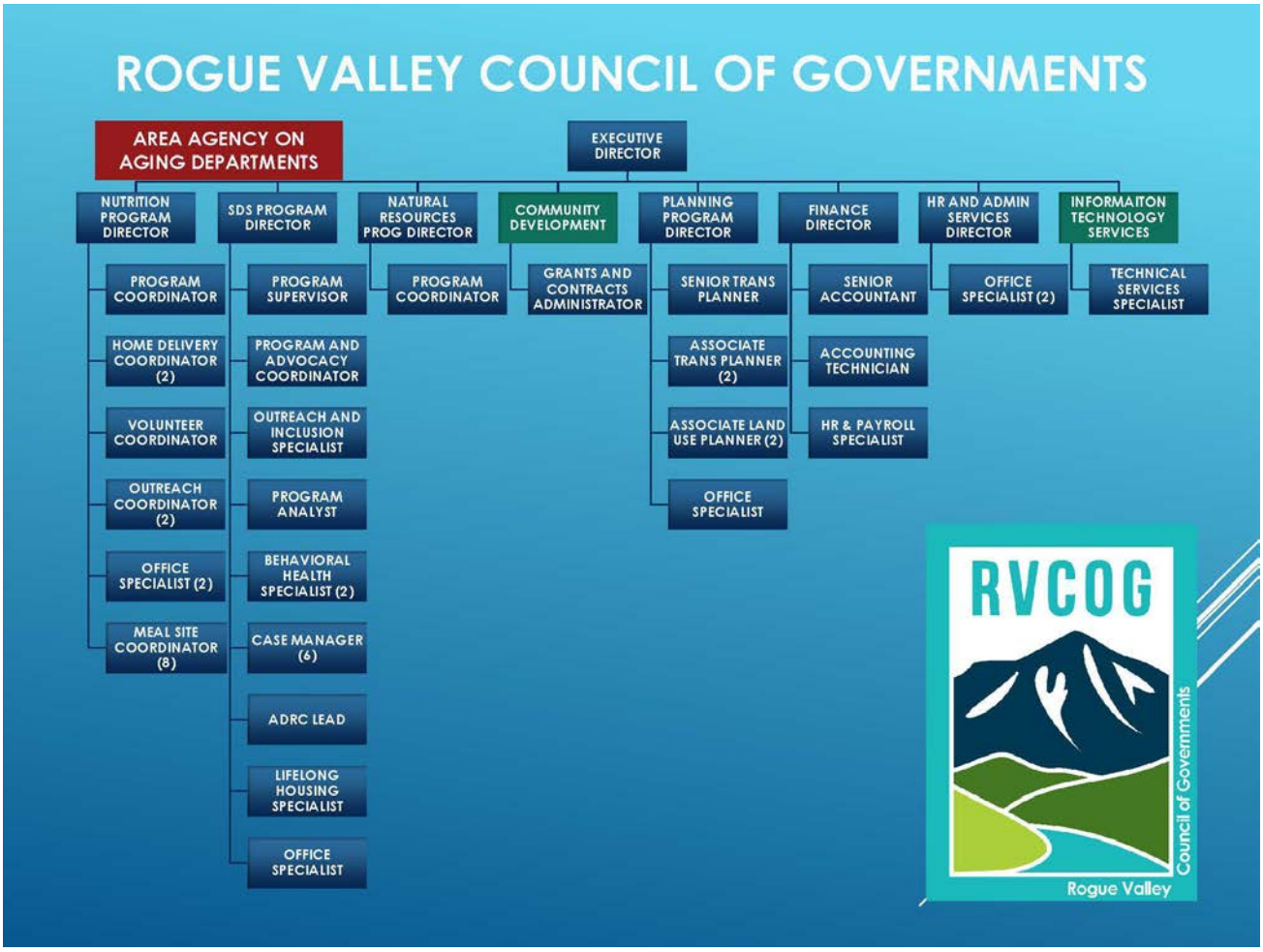
Appendix F – Emergency Preparedness Plan

Appendix G – Conflict of Interest Policy

Appendix H – Partner Memorandums of Understanding

Appendix I – Statement of Assurances and Verification of Intent

Appendix A – Organizational Chart



Appendix B – Advisory Councils and Governing Body

Senior Advisory Council

The purpose of the Council is to advise, provide guidance and support, and assist the RVCOG in administration of AAA Services. As described and mandated by the Older Americans Act and the Oregon Revised Statutes, the purpose of the council is to provide citizen involvement, whose members provide a link between older adults and the Area Agency on Aging (RVCOG) to help ensure that programs and service delivery meet the needs of local older adults and people with disabilities.

The Senior Advisory Council Executive Committee consists of the Council Chair, the Vice Chair, and the chair or designated alternate from each standing committee. The Executive Committee provides advisement and assistance to AAA staff in a variety of ways, including the preparation and revision of long-range plans, recommendations on the allocation of funds, and in the preparation and implementation of the administrative budget.

SENIOR ADVISORY COUNCIL		
NAME	**REPRESENTING**	**DATE TERM EXPIRES**
Colleen Roberts	Jackson County Commissioner	N/A
Vacant	Josephine County Commissioner	N/A
Natalie Mettler (Chair)	Jackson County	June 30, 2027
Leah Swanson (Vice-Chair)	Josephine County	June 30, 2025
Paul Golding	Jackson County	June 30, 2025
Liz James	Jackson County	June 30, 2025
Noriko Toyokawa	Jackson County	June 30, 2025
Jennine Greenwell	Jackson County	June 30, 2026
Cherie Linnemeyer	Josephine County	June 30, 2026
Eleanor Ponomareff	Jackson County	June 30, 2026
Sherrill Boots	Josephine County	June 30, 2027

Total number age 60 or over = 5
Total number minority = 3
Total number rural = 5
Total number self-indicating having a disability = 1

Disability Services Advisory Council

The purpose of the Disability Services Advisory Council is to advise the Oregon Department of Human Services Aging and People with Disabilities and Rogue Valley Council of Governments Area Agency on Aging on basic policy guidelines for those clients receiving services, reviewing and evaluating the effectiveness of the services provided by APD, advocate for appropriate services, and address other related topics, such as accessibility and transportation issues.

DISABILITY SERVICES ADVISORY COUNCIL		
NAME	**REPRESENTING**	**DATE TERM EXPIRES**
James Naegle (Chair)	Jackson County	June 30, 2026
George Adams (Vice Chair)	Jackson County	June 30, 2026
Denyce Gavin	Jackson County	June 30, 2027
Katie Callies	Josephine County	June 30, 2025
Cody Guinn	Jackson County	June 30, 2027
Kerrie Walters	Josephine County	June 30, 2027
Bonnie Huard	Jackson County	June 30, 2027
Leslie McIntyre	Jackson County	June 30, 2025

Total number age 60 or over = 4
Total number self-indicating having a disability = 7

Rogue Valley Council of Governments Board of Directors

EXECUTIVE COMMITTEE	
NAME	**REPRESENTING**
Jody Hathaway (President)	Emergency Communications of Southern Oregon
John Quinn (1st Vice President)	Rogue Valley Sewer Services
Pam VanArsdale (2nd Vice President)	City of Rogue River
Kelley Johnson	City of Central Point
Bill Mansfield	Rogue Valley Transportation District
Kathy Nuckles	City of Shady Cove

BOARD MEMBERS	
NAME	**REPRESENTING**
Colleen Roberts	Jackson County
Vacant	Josephine County
Eric Hansen	City of Ashland
Trish Callahan	Town of Butte Falls
Meadow Martell	City of Cave Junction
Kathy Sell	City of Eagle Point
Ronald Palmer	City of Gold Hill
Victoria Marshall	City of Grants Pass
Andrea Thompson	City of Jacksonville
Zac Smith	City of Medford
Al Muelhoefer	City of Phoenix
Darby Ayers-Flood	City of Talent
Marta Tarantsey	Jackson County Library District
Mike Hussey	Jackson County Fire District 3
Jill Smedstad	Jackson Soil & Water Conservation District
Jonah Liden	Rogue Community College
Tom Fischer	Southern Oregon Regional Economic Development Inc
Marc Overbeck	Southern Oregon University

Appendix C – Public Process

The following is a list of the 2025-2029 Four-Year Area Plan public involvement activities that have been completed:

- SAC members and RVCOG staff jointly developed and implemented a survey of older adults and individuals with disabilities in Jackson and Josephine counties. The purpose of the survey was to better understand what services older adults need to ensure that those facing aging or disability issues, or those caring for persons with such issues, are able to live as independently as possible. The survey was presented in both English and Spanish. A total of 727 survey forms were completed. The respondents completed the survey either on paper forms or by entering responses directly on the SurveyMonkey website. The survey period was January to March 2024. The data was collected to describe the demographic characteristics of the respondents, their current living conditions, the state of their health, sources of health information and support, and needs for assistance and services.
- RVCOG staff, SAC members, and community partners participated in focus groups with key stakeholders. Focus groups included: Community Volunteer Network (CVN) Age Wise-Age Well, foster grandparents, and SHIBA program participants; Food & Friends meal site participants; SAC members; and DSAC members. We had input from 113 stakeholders provided input on unmet needs for older adults and adults with disabilities, needed community improvements for this population, the importance of aging in place, resources for caregivers, and successes and challenges to health and well-being.
- RVCOG conducted a public hearing on March 3, 2025, to review and gather public and Senior Advisory Council feedback on the Four-Year Area Plan. This hearing was advertised in the Rogue Valley Times and the Grants Pass Courier.
- *The RVCOG Board of Directors met on March 26, 2025, and approved the Area plan for submission to the State.*

PUBLIC ANNOUNCEMENT

The Rogue Valley Council of Governments (RVCOG) Area Agency on Aging is seeking public feedback or recommendations on the 2025-2029 Area Plan. The public comment period will be open from 02/08/2025 until 03/10/2025. A copy of the draft version of the 2025-2029 Area Plan may be obtained at RVCOG's office by request or by visiting www.RVCOG.org. Please send any comments via email to lturnbull@rvcog.org or via mail to:

Rogue Valley Council of Governments
155 N. First Street
Central Point, Oregon 97502

NOTICE OF PUBLIC HEARING
March 3, 2025
1:00 pm to 2:00 pm

During a public meeting of the Senior Advisory Council of the Rogue Valley Council of Governments (RVCOG), the Senior Advisory Council will conduct an online public hearing to introduce the 2025-2029 Area Plan and receive public feedback and recommendations. To receive an access link to participate, provide your email at: 541-664-6674 or email lturnbull@rvcog.org.

Public comments for consideration by the Senior Advisory Council may also be emailed prior to the meeting to lturnbull@rvcog.org. A copy of the draft version of the 2025-2029 Area Plan may be obtained at RVCOG's office by request or by visiting www.RVCOG.org.

LEGAL NOTICE

PUBLIC ANNOUNCEMENT

The Rogue Valley Council of Governments (RVCOG) Area Agency on Aging is seeking public feedback or recommendations on the 2025-2029 Area Plan. The public comment period will be open from 02/08/2025 until 03/10/2025. A copy of the draft version of the 2025-2029 Area Plan may be obtained at RVCOG's office by request or by visiting www.RVCOG.org. Please send any comments via email to lturnbull@rvcog.org or via mail to:

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Central Point, Oregon 97502

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No. 00513302 - February 12, 2025

Appendix D – Final Update on Accomplishments of 2021 – 2025 Area Plan

1. Focus Area – Information and Assistance Services and Aging & Disability Resource Connection (ADRC)

A. Goal 1: <u>ADRC system for older adults and people with disabilities that provides information and assistance to individuals seeking information on local resources, professionals seeking assistance for their clients, and individuals planning for their present and future long-term care needs.</u>

Measurable Objectives – Maintain fully-functioning ADRC for Jackson and Josephine Counties:

a. Staff ADRC I&R/A – The ADRC phone line continues to be staffed Monday through Friday from 9 am to 4 pm. After hours and overflow calls are returned within 24 hours.
b. Staff ADRC Options Counseling – Case Managers continue to provide Person-Centered Options Counseling to consumers. Higher needs consumers are served by Behavioral Health Specialists.
c. Staff ADRC Database Maintenance – New resources are added to the ADRC database as they become known. All resources are verified and updated on a quarterly basis.
d. Participate in Statewide ADRC Meetings – The ADRC Lead attends these monthly meetings.
e. Staff ADRC Core Partners' Meetings – The SDS Program Supervisor and ADRC Lead attend these quarterly meetings.
f. Staff ADRC Advisory Committee Meetings – The SDS Program Supervisor and ADRC Lead attend these quarterly meetings.
g. Develop training plan for all ADRC specialists which includes person-centered and service equity training – All ADRC specialists are placed on a training plan which includes shadowing experienced staff on the phone line,

gaining certification through Inform USA when eligible to take the exam, and person-centered options counseling.

B. Goal 2: <u>Increase monitoring and quality control for ADRC service delivery to improve and expand services.</u>

Measurable Objectives – Evaluate, assess, and modify, as necessary, current ADRC service delivery:

a. Maintain accurate and concise record keeping of consumers who contact the ADRC, including demographic information to ensure services and outreach are being provided to the underserved populations in Jackson and Josephine Counties – A process for quality assurance checks is in place and provides and effective training and performance recognition tool for staff.
b. Annually shadow each ADRC staff person to ensure Inform USA service delivery standards are met – Shadowing is the start of training for new hires and continues at least annually for all staff.
c. Develop consumer satisfaction survey for ADRC consumers – This Key Task remains as an opportunity for the 2025 – 2029 Area Plan.
d. Utilize representatives from Senior Advisory Council, TEC, ADRC Advisory Committee, and staff to review results from tasks a, b, and c above, as well as, to offer input on service provision – ADRC call statistics are reviewed by RVCOG staff and the TEC, an AAA/APD joint committee, on a monthly basis, and the SAC ADRC Advisory Committee quarterly.
e. Implement any changes necessary to better serve and reach consumers – ADRC staff engage in continual training and learning in order to provide the best service and reach to consumers.
f. Provide time and resources for new staff to prepare for and take the Inform USA certification exam – All staff are

provided time to study for and take the certification exam as soon as they are eligible to do so.

2. Nutrition Services

A. Goal 1: Reduce older adult hunger and food insecurity.
Measurable Objectives – Increase meal output to at-risk seniors:

a. Continue to offer over-yield as an additional meal for those seniors attending congregate meal sites, especially in rural areas – We continue to offer over yield as additional meals in all congregate service areas. Additional over yield meals are often distributed to clients in the Cave Junction service area to help participants in this rural community.
b. Establish partnerships with local food retailers to augment clients' diets with donated fruit, vegetables, bread, and/or protein foods – Partnerships continue with ACCESS, Harry and David, and others. Efforts to develop new partnerships are ongoing.
c. Expand the availability of HDM service in the cities of Cave Junction, Grants Pass, and Medford through the development of new routes and increased volunteer recruitment – Expansion efforts are continual but have been hampered by increasing difficulty in volunteer recruitment.

B. Goal 2: Increase volunteer recruitment.
Measurable Objectives:

a. Utilize Facebook to increase awareness – Since last reported, our page "Likes" have increased by 4% from 589 to 612. Our page "Followers" have increased by 6% from 541 to 681. Facebook continues to be an excellent resource for volunteer recruitment and program awareness.
b. Continue to use MOWA social media and recruitment materials/tools – MOWA social media and recruitment tools continue to be an asset to the program. We have successfully incorporated their "#SAVELUNCH" campaign and are currently

receiving the tool kits for the 2025 “March for Meals” and “End the Wait” campaigns.

c. Continue to use various tools to outreach for volunteer recruitment and education – Although volunteer recruitment continues to be a challenge, we have managed to reduce the need for HDM drivers in Josephine County by 33% and in Jackson County by 92%. We continue to use various methods of outreach (TV, radio, print, social media, etc.) Our program uses an equitable approach to volunteer recruitment that is inclusive for all those eligible to volunteer.
d. Senior Advisory Council will continue meeting – The Nutrition Program Director has increased participation in the SAC meetings to bolster the presence of the Nutrition Department.

C. Goal 3: <u>Increase access to additional nutrition education.</u>
Measurable Objectives – Provide opportunities for access to additional nutrition education:
   a. Partnership with OSU Extension to provide nutrition education that is applicable to seniors – A partnership with OSU Extension continues with in-person sessions offered at the Josephine County and Central Point Senior Resource Centers.
   b. Distribute OSU “Food Hero” newsletter and senior-appropriate nutrition education publications – We continue to distribute OSU’s “Food Hero for Older Adults” monthly in both English and Spanish. We also send out their special addition “Food Hero for Older Adults” which contains healthy senior-friendly recipes.
   c. Explore adding opportunities for online or internet-based nutrition education – Promotion of online educational opportunities continues.

D. Goal 4: <u>Assure Nutrition Program staff & volunteers are trained.</u>
Measurable Objectives:
   a. Regular bi-monthly meetings for Nutrition Program staff – Bi-monthly staff meetings continue and cover topics including new policies, protocols, guidelines, and methods of nutrition education and DEIB.

b. Volunteer orientations – Volunteer orientations are conducted and include OLVR training and coaching volunteers on the practice of observe, listen, validate, and respond.
c. MOWA webinars to provide training for administrative staff – MOWA online training opportunities continue with administrative staff.

E. Goal 5: Improvements to Service Equity

Measurable Objectives – Make available program materials for Spanish speaking individuals and increase frequency of culturally-specific meals:

a. The translation, production, and distribution of program materials in Spanish; including program brochure, client information sheets and agreement form - Our participant Information & Agreement form has been translated and printed in Spanish.
b. Incorporate more culturally specific meals into our menus - Our "Around the World" meal program continues into its fourth year with great success. Participants have been noting that they enjoy the new menu items being introduced.

F. Goal 6: Redevelop service areas devasted by fires.

Measurable Objectives – Provide outreach and improve availability of service to seniors returning to areas affected by the Almeda fire:

a. Area-specific outreach activities in the cities of Talent and Phoenix such as mobile home park canvasing and advertisements in local papers and newsletters to increase HDM services – Outreach efforts in Talent and Phoenix continue and have shown a successful growth rate.
b. Provide outreach services to inform former and potential new clients of the congregate meal site in the city of Talent upon reopening – Unfortunately, a meal site in the city of Talent has yet to reopen. Currently, Talent residents are referred to the Ashland meal site. Plans are in the works for a new Community Center in Talent which may provide an opportunity for congregate meal services.

3. **Health Promotion**

A. Goal 1: <u>Improve health outcomes by offering person-centered health promotions programming to meet the needs of the most vulnerable populations in our service area.</u>

Measurable Objectives – Continue to offer CDSME class annually:

a. Recruit participants for CDSME classes – We have trained one new staff and volunteer to be CDSME class leaders. In August 2023 RVCOG SDS, along with partner La Clinica, held an in-person Chronic Disease Self-Management (CDSMP) class in Medford, and in 2024 held a CDSMP class in Cave Junction, rural Josephine County, at the Illinois Valley Senior Center. In March of 2025 RVCOG SDS will conduct a DSMP class in rural Jackson County.
b. Work with local CCOs, hospitals, and other agencies to establish referral procedure for vulnerable and at-risk populations – RVCOG continues to participate in UniteUs and receives valuable referrals from community partners.
c. Continue to work with the Oregon Wellness Network to establish CMS billing procedures and develop agreements with local CCOs to provide health promotion programs – A contract with OWN is currently in place.

Measurable Objectives – Continue to partner with LaClinica to offer Spanish CDSME classes:

a. Ensure LaClinica staff and volunteer leaders maintain active leader status with the program – LaClinica continues to offer CDSME classes in Spanish.
b. Continue to provide training, supportive materials, and reporting for all CDSME classes delivered – RVCOG continues to provide materials for Spanish classes.

Measurable Objectives – Promote accessible housing for older adults and adults with disabilities through the LifeLong Housing initiative and advocacy for accessible housing:

a. Maintain SDS staff to advocate for the LifeLong Housing Certification Program – A 0.2 FTE employee has been retained to further knowledge of and advocate for RVCOG's LifeLong Housing Program.
b. Coordinate with local groups, organizations, and services providers who target LGBTQIA2S+, Native Americans, persons experiencing homelessness, persons of low-income, and at-risk elders and adults with physical disabilities to advocate for accessible housing bills in the Oregon Legislature for two legislative sessions – This remains an ongoing effort with some success seen in recent accessible housing legislation.
c. Introduce bills for accessible housing and locate bill sponsors for two legislative sessions – This remains an ongoing effort with success in HB 3309.

4. Family Caregivers

A. Goal 1: <u>Increase support options for Family Caregivers.</u>

Measurable Objectives – Re-start the delivery of in-person Powerful Tools for Caregivers:

a. Train staff in the Powerful Tools for Caregivers program – RVCOG maintains at least two staff members who are trained to deliver this program.
b. Promote the program with current and new community partners when in-person classes become possible – In-person classes are now offered and promoted region-wide.
c. Deliver at least two Powerful Tools classes per year – This goal remains and is being achieved. Classes alternate between Jackson and Josephine Counties so that there is one class in each county per year.

Measurable Objectives – Develop and deliver remote classes via Zoom:

c. Deliver remote Powerful Tools classes as needed – Classes continue to be offered remotely as needed; however, most participants prefer in-person classes.

Measurable Objectives – Initiate and support creation of a more general Family Caregiver Support Group (i.e., not focused on a particular need group):

a. Refer FCG consumers to support group – This is an ongoing goal and carries over to the new Area Plan.

B. Goal 2: <u>Greater Outreach and Education to support diverse Family Caregivers.</u>

Measurable Objectives – Communicate with at least six key community partners about ongoing supports for Family Caregivers:

a. Provide RVCOG printed program materials, including Family Caregiver Respite pamphlets, to community partners – This Key Task an ongoing, regular task.
b. Keep ADRC staff up to date on all available supports, including Teepa Snow (PAC) and STAR-C counseling, and respite – ADRC staff is continually informed of and trained on a variety of FCG supports available. Teepa Snow Positive Approach to Care will no longer be offer due to training costs; however, STAR-C will be reimplemented when staff are available for training.
c. Offer community presentations at churches and other local groups – Community presentations are ongoing in a variety of settings as opportunities are presented.

C. Goal 3: <u>Sustain ongoing respite opportunities for Family Caregivers, including for underserved populations.</u>

Measurable Objectives – Continue to assist family caregivers in arranging for respite through self-selected caregiver or agency caregiver, with the aim of increasing the percentage of underserved populations (underserved populations include: LGBTQIA2S+, caregivers of color, and limited English proficiency):

a. Maintain contracts with local in-home care providers to provide respite services for family caregivers – Contracts are in place with two local in-home care agencies.
b. Continue to distribute updated printed materials that explain the program, including in Spanish – Outreach efforts have

grown beyond pre-pandemic levels and include events focusing on underserved populations.

5. Legal Assistance and Elder Rights Protection Activities

A. Goal 1: <u>To provide a person/family the tools to protect themselves or their loved ones from any kind of harm, abuse, or catastrophe.</u>
Measurable Objectives – Provide at least one educational initiative annually for both professionals and the community regarding elder rights and legal assistance:
   a. Work with SAC, APD APS staff, and MDT on an annual basis to identify potential educational initiatives and implement – This work is ongoing with large biennial events and smaller events in the other years.
   b. Determine target audiences for the training, with emphasis on underserved and at-risk populations (Spanish speaking communities, LGBTQ) – Outreach list includes UNETE, BASE, United Way listserve, LINC, Tribal Governments, APD, AAAs, and AARP contacts.

6. Older Native Americans

A. Goal 1: <u>To ensure inclusivity, RVCOG AAA must reach out to all populations and remove any cultural and/or language barriers that may exist.</u>
Measurable Objectives – Continue intentional outreach to the Native American population in the area:
   a. Continue relationships with Native American organizations in the area – RVCOG AAA continues to participate in opportunities to engage with Native American organizations, including participation in AAA/Tribal Gathering meetings.
   b. Provide information to Native American organizations about RVCOG AAA services through presentations, brochures, and/or electronic outreach efforts – These activities are continuing.
   c. Attend any Tribal/AAA gathering or event in other counties – In 2024 and 2025, RVCOG AAA representatives have attended

AAA/Tribal Gathering meetings in Canyonville, Klamath Falls, and Florence.

d. Research and add Native American resources to ADRC, following plain language policy (www.plainlanguage.gov) to foster service equity – As in prior years, this remains an ongoing initiative.

7. Behavioral Health

A. Goal 1: <u>Reduce gaps and barriers for older adults to receive behavioral health treatment.</u>

Measurable Objectives – Identify gaps and barriers to behavioral health treatment for older adults including increased access to needed medical care:

a. Continue work with Providence and Asante Hospitals to provide competent behavioral health care in the medical setting – This partnership continues with both entities.
b. Continue work on addressing Medicare coverage gap with community partners – Although legislation to include additional types of mental health professionals in Medicare coverage has passed, there continues to be a shortage of available mental health practitioners in the region.
c. Increase access for older adults and people with disabilities with behavioral health and medical challenges – Outreach and collaboration with medical partners in the region continues, but the shortage of mental health resources remains.
d. Increasing access to home health care for older adults and people with disabilities also experiencing behavioral, cognitive, and health challenges – Partnerships with service delivery partners and on Interdisciplinary Team Conferences continue.
e. Increase access to behavioral health, medical and community services through increased professional networks – RVCOG Behavioral Health Specialists continue to partner with OABHI staff and other mental health professionals locally and statewide.

Appendix E – Final Updates on Service Equity Plan Accomplishments

Actions – Policies

- Review and edit of the SAC Bylaws with a service equity lens was completed and approved by the RVCOG Board in August 2024.
- Creating and implementing a Diversity, Equity, and Inclusion (DEI) Plan was completed and approved by the RVCOG Board of Directors in December 2021.
- Review and update of local OPI policies to include service equity is an ongoing process with the addition of the OPI-M program.
- Annual review of the Four-Year Area Plan with a service equity lens has been implemented.

Actions – Trainings/Presentations

- AAA staff completed Service Equity training Parts 1 and 2 in 2021.
- AAA staff participate in monthly trainings on service equity topics to increase cultural competency.
- DEI-related videos are shown at each SAC meeting and are well received.
- DSAC members continue to be invited to participate in SAC meetings. A joint SAC/DSAC orientation was held in January 2025 which included DEI training.

Actions – Welcoming Clients

- RVCOG staff includes pronouns in virtual meetings and email signature blocks.
- RVCOG provides a welcoming environment in all offices including the display of inclusive posters and marketing materials.
- A contract with Language Line for translation services is ongoing and staff are trained in its use.

- AAA program materials are provided in both English and Spanish and have been updated to be more inclusive in wording and graphic display.
- Jackson Care Connect, a local CCO, provided the RVCOG main office with hearing loop technology for front office staff, the lobby, and the large conference room.
- Pocket-size resource guides in both English and Spanish were created and are distributed to community partners and at tabling events.
- Review and development of program documents through the lens of "plain language" continues.
- RVCOG participates in events centered around non-native English speakers, Native Americans, and other underserved population groups.

Actions – Elder Abuse

- Annual Elder Abuse Prevention activities focus on underserved populations, including rural, Latinx, LGBTQIA2S+, and Tribal Members.
- Abuse-related materials are shared digitally via email blasts and social media.

Actions – Advocacy

- Advocacy with legislators and their staff continues to provide information on inequities and barriers that may exist with our system.

Actions – Internal AAA Equity Work

- The original RVCOG AAA Service Equity Work Group no longer meets as a separate entity. Rather than a stand-alone separate activity, service equity principles have been incorporated into the everyday work that we do. Service equity, like our RVCOG Core Values, has become ingrained in our way of thinking and is represented in all that we do.

Actions – AAA Workforce Development

- RVCOG as a whole is committed to a workplace culture that recognizes and celebrates diversity, requires inclusivity, promotes accessibility, and rewards empathetic behaviors.

Actions – Community Engagement to Support Underserved Populations

- RVCOG continues to build meaningful partnerships with community organizations that serve rural residents, communities of color, non-native English speakers, the LGBTQIA2S+ community, Native Americans, and people with disabilities, to promote collaborative work, foster understanding, and gain trust in AAA programs and resources.

Appendix F – Emergency Preparedness Plan

ROGUE VALLEY COUNCIL OF GOVERNMENTS (RVCOG)
EMERGENCY PREPAREDNESS, RESPONSE AND RECOVERY PLAN

Purpose of Plan and Office locations

This plan outlines the actions to be taken by RVCOG staff in the event of a disaster that threatens the safety of employees and/or consumers and that impacts the agency's ability to carry out its day-to-day business. The plan covers RVCOG 's Administration Office in Central Point and is a subset of the Rogue Valley Council of Government's overall Emergency Plan. The RVCOG plan relates to the plans of the three Oregon Department of Human Services/Adults and Persons with Disabilities (ODHS APD) field offices, as well as Food & Friends Senior Meals Program's plan.

- Administration Office is located at the Rogue Valley Council of Governments, 155 N. 1st St., Central Point, Oregon 97502.
- Case Managers for SDS programs as well as Food & Friends are out stationed in two of the three APD Field Offices of Department of Human Services (ODHS) Aging and People with Disability (APD): the Medford Senior Services Office and the Grants Pass Senior and Disability Services Office. Each of these offices has both a response and a continuity of operations plan, as directed by the State of Oregon APD. RVCOG staff are expected to follow the immediate safety plans of those offices while present in the offices, and to follow the RVCOG plan for their work assignments during and after the event.
    - Grants Pass Senior and Disability Services Office, 2102 NW Hawthorne St., Grants Pass, Oregon, 97526
    - Medford Disability Services Office, 28 W. 6th St., Medford, Oregon 97501 and
    - Medford Senior Services Office, 2860 State St., Medford, Oregon 97504.
- RVCOG interests also include the safety of Food & Friends Meal Sites and Home Delivered Meals staff, volunteers and consumers. The locations and contact information for the 15 Meal Sites are included in the Phone List as part of the Procedures document attached to this plan.

Assessment of Potential Hazards

RVCOG leadership is aware of the Jackson and Josephine County Emergency Operations Plans, which contains thorough information and assessment of potential local hazards, including natural disasters (such as earthquake, flooding, high winds, excessive snow, and wildland fires) and other non-natural events such as hazardous materials incidents and pandemics. All of these incidents could impact RVCOG consumers. For detailed information regarding potential hazards in Jackson and Josephine Counties and general plans for community response, refer to these documents.

RVCOG employees, consumers, and visitors are at risk from various emergencies and/or hazards. The following list identifies those that would pose the greatest need for response:

- Medical emergencies
- Structural fire
- Wildland fires
- Other natural disasters, such as flooding, winter storms, periods of severe heat, extended periods of smoke
- Hazardous spills
- Violent or Criminal Behavior
- Pandemics

PREPAREDNESS PHASE

Disaster Registry: RVCOG SDS maintains the Disaster Registry for Jackson and Josephine Counties. Adults with access and functional needs who cannot evacuate themselves, nor stay in their own homes alone for three days, may register by completing an application which is entered into a database, mapped by GIS, and distributed to the local 911 Center and other emergency response agencies. Disaster Registry phone volunteers contact everyone in the Registry twice a year to make sure information is current. The registry also includes State licensed Assisted Living facilities, Residential Care facilitates, Adult Foster Homes, Skilled Nursing Facilities,

Intellectual & Developmental Disability facilities, Mental Health residential facilities, and Childcare facilities.

Review and Exercise of Plan, Participation in Community-wide Exercises: RVCOG Management Team shall review and exercise the plan once a year through table top exercise. If the RVCOAD or either County Emergency Managers plan a county- or region-wide exercise, RVCOG and, in particular, Disaster Registry staff will participate on behalf of the at-risk populations they represent and the organization.

RESPONSE PHASE

Notification

RVCOG staff will receive notification of impending events through normal broadcast and social media as the general public receives it or other informal methods. However, Disaster Registry staff may receive specific notification through one or both County Emergency Managers. When notification is received through any medium, it should be relayed immediately to the RVCOG Executive Director or SDS Program Director or designee, who will verify the information and activate the RVCOG Emergency Plan. A current list of RVCOG staff may be found in Appendix i.

Chain of Command

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

- RVCOG Executive Director
    - RVCOG staff, all departments
- SDS Program Director and Nutrition Program Director
    - SDS and Nutrition Management Staff
        - SDS and Nutrition Staff
        - Meal Site Coordinators, Volunteers
- APD District Manager (State Employees)
    - APD Field Office Mangers
        - APD Staff

A Standing RVCOG Response Team will be created, with active defined roles. (See Appendix i.) In addition, a current list of contact names, office numbers and cell phone numbers will be attached to this plan and updated twice a year. (For current list, see Appendix i.)

The SDS Program Director has been designated as the Incident Commander on-site at the Central Point Office. They shall be the ranking SDS Program officer on site at any given time and shall be responsible for the initiation and coordination of SDS response during an emergency situation. If the SDS Program Director is not available, SDS Program Supervisor will perform this role. The RVCOG Executive Director or their designee will assign this duty.

As part of their duties, the Incident Commander shall perform or delegate:

- Assess and triage the incident
- Ensure an accurate accounting of RVCOG personnel on the scene
- Activate a Response Team
- Determine the activities of the Response Team
- Assign duties
- Ensure constant communication with the Response Team and RVCOG employees
- Activate the Disaster Registry
- Plan for the next phase of the response
- Plan for and authorize the deactivation of the response
- Serve as the Public Information Officer while at the scene, being the only person who shall provide statements to media personnel (all other RVCOG employees shall not provide any information or should say “no comment.”)
- Coordinate with the RVCOG Executive Director and other RVCOG staff housed at the RVCOG main office (155 N. 1st, Central Pont, OR)
- Defer to the RVCOG SDS Program Director for any of these duties, should the RVCOG Executive Director so order

The APD District Manager is the main contact for all Field Offices. All Field Office Managers will back each other up. Salem contact is APD Field Office Manager in APD Field Service Office.

Communications Plan

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

- Identify key audiences. Determine who needs to be informed of the situation, and in what order (both on- and off-site)
- Communicate with staff at the RVCOG main office, satellite offices and other locations, as needed
- Case Managers phone consumers identified as especially vulnerable to check their status.

When the Incident Command Team has developed a plan for response to the event, Managers will communicate the plan and assignments to their staff through phone trees or other appropriate communication method, given the urgency of the need for action.

Continuity of Operations Plan and Local Partner Coordination

RVCOG has developed, and will continue to develop, working relationships with local emergency management personnel and agencies. RVCOG will continue to be involved with Rogue Valley Community Organizations Active in Disaster (COAD) through email and meetings to advocate for our consumers and have awareness of the plan in the event of an emergency. RVCOG's role will be to ensure that emergency groups know about our populations with access and functional needs in the community and to identify resources that might be available to our clients during and after an event. The ability of RVCOG to successfully continue to provide services during an emergency will depend to a large degree on the ability of RVCOG consumers and long-term care facilities to continue their own operations.

The three APD Field Offices provide case management, SNAP, medical & information assistance. It is essential that the services they provide be available to clients as soon

as feasible after an event (continuity of operations). Each Field Office has its own emergency plan, as mandated by the State. In an emergency, where one or more location is closed, the other locations may provide service coverage. In the event all three offices and the main RVCOG office are non-operational, RVCOG will coordinate with State level ODHS/APD department officials, other Area Agencies on Aging and local partners such as the ODHS Self-Sufficiency office, County offices, and community centers for service and business continuation.

SDS Case Managers will maintain a list of names and addresses of the highest risk and clients with access and functional needs that receive in-home long-term care services based on their care plan. This list will be updated twice a year. At the time of an event, Case Managers will phone their vulnerable clients for a status check. If the safety of any client is in question, the information will be conveyed to Emergency Management or First Responders via RVCOG Chain of Command.

Food & Friends Senior Meals Program

See full Food & Friends Plan in Appendix iii. Generally: The Food & Friends Meals Program will close congregate sites when it is unsafe for participants to attend. Home Delivered Meals service will be maintained for vulnerable consumers if at all possible. The decision to close facilities will be made by the Food & Friends Program Director in coordination with the RVCOG Executive Director depending on site location and local conditions. The plan will be communicated to the Contracted Kitchen Manager and Food & Friends staff as laid out in the program emergency phone tree.

Emergency alternate plans will be communicated to meals recipients (dependent on the level of the emergency) by TV or radio stations, community chalkboards or PSA's. In extreme emergency situations Food & Friends will comply with and where requested, aid Jackson and Josephine Counties emergency plans first responders to determine the level of need for our most vulnerable and dependent clients. The determination will be made through the priority scoring available through our Meal Service client database. The Contractor is required to have a separate Disaster Plan in place to ensure the continued supply of meals for our clients.

Additionally:

- Congregate Meal Sites: each emergency is different and may affect the various meal sites in a different manner or in varying levels of severity as they are spread throughout a wide geographic area. The Meal Site will be closed as determined by the Food & Friends Program Director. Each site will have on hand additional frozen meals to distribute to congregate clients in the event of forecasted adverse weather conditions.
- Home Delivered Meals: emergency frozen meals will be distributed to every Home Delivered Meals client three times between November and February. These frozen meals will be labeled (clearly visible) with instructions to save for use when the volunteers are unable to deliver. Sites will receive sufficient meals to supply clients who start service between November and February.

Beyond these plans for meals, RVCOG consumers will be served by the disaster assistance provided by local entities and nutrition service as coordinated with state, local and volunteer organizations.

Disaster Registry Activation

The Disaster Registry is activated by RVCOG SDS staff as soon as a disaster is announced by Emergency Management. If the event is localized, SDS staff will implement contact procedures for individuals and facilities in the impacted area. If the event is an earthquake or other event that impacts all of Jackson and Josephine Counties, Disaster Registry phone volunteers will be contacted and requested to check in on everyone in their books.

The primary purpose of contacting registrants is to see if they are aware of the event and have assistance to shelter in place or to evacuate as instructed by emergency responders. If the individual or facility has been given orders to evacuate but is unable to do so because they need assistance, the caller contacts the Disaster Registry Coordinator or designate who then notifies the appropriate County Emergency Manager.

RECOVERY PHASE

RVCOG will resume operations—in a phased in manner, if necessary—as dictated by the type and severity of damage to facilities and impact on community resources available

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APPENDICES

i. RVCOG SDS Contact Information
ii. APD Management Contact Information
iii. RVCOG Food & Friends Emergency Plan and Contact Information

Appendix G – Conflict of Interest Policy

RVCOG, a Special Government Body as defined in ORS 174.117, requires that all contractors receiving public funds, staff, volunteers, board members, and advisory council members abide by the regulations of ORS 244 – Government Ethics. Pursuant to ORS 244.120, the nature of all potential and actual conflicts of interest must be publicly disclosed prior to any discussion or action by the individual, board, or council. For all actual conflicts of interest, individuals must refrain from participating in any discussion or debate on the issue out of which the actual conflict arises or from voting on the issue, unless the vote is necessary to meet the minimum required number of votes to take official action. All questions regarding conflicts of interest should be referred to the RVCOG Executive Director. The RVCOG Board of Directors shall hold final responsibility for disposal instructions of any unresolved conflicts of interest. RVCOG contract and employee handbook policy examples follow.

RVCOG Professional Services Contracts

The following section is an excerpt from our professional services contracts with all contractors providing case management services.

Exhibit D – Special Provisions

1. **Conflict Free Case Management.** Case management services shall be conflict free in accordance with federal rules noted in the ODHS APD Firewall Policy for Conflict Free Case Management. In situations where the only willing and qualified provider does both case management and direct services, the following firewalls must be in place to ensure a separation of functions within the organization. Direct services are services provided by the AAA yet paid for through contracts/agreements with partners (ex: hospitals, Medicare, Coordinated Care Organizations, and Medicaid Home Delivered Meals).
    a. Administrative: There must be administrative separation between assessments, service planning, and those delivering direct services.
    b. Case Management and Direct Services: Case Management and Direct Services must be separate.

c. Person-Centered Plan: Direct Services/Providers shall not develop an individual's person-centered plan.

When the AAA is aware of any conflict of interest, the AAA should refer to the ODHS APD Firewall Policy for Conflict Free Case Management and submit identified actions to ODHS APD. Identified actions shall be reviewed initially and are subject to ongoing monitoring to ensure all firewalls remain in place and any conflict is mitigated.

The following section is an excerpt from our professional services contracts with all other contractors providing services to RVCOG.

Conflict of Interest

The CONTRACTOR shall comply with all applicable federal, state and local conflict of interest laws and regulations. The CONTRACTOR agrees to avoid all conflicts of interest and to immediately disclose to RVCOG any personal, professional, or financial interest that may influence, or appear to influence, CONTRACTOR's ability to perform the services objectively and in the best interest of RVCOG.

The CONTRACTOR shall not engage in any business or professional activities, accept any obligation, or enter into any relationship that would create an actual or perceived conflict with their duties under this Agreement without prior written consent from RVCOG.

If a potential conflict arises, the CONTRACTOR must promptly disclose the matter in writing to RVCOG, which shall have the sole authority to determine whether such conflict is permissible or requires termination of the relationship or mitigation steps.

Failure to disclose a conflict of interest or engaging in activities that create a conflict may be considered a material breach of this Agreement and may result in termination for cause.

RVCOG Employee Handbook Policy

The proper operation of RVCOG and fulfillment of its mission requires employees to be independent, impartial, and responsible to the people they serve. It also requires that decisions and policy be made through the proper channels of the RVCOG structure, that RVCOG not be used for personal gain, and that the public have confidence in its integrity. Therefore, employees are prohibited from engaging in any business or transaction or from having a financial or other personal interest, direct or indirect, which is incompatible with the proper discharge of their official duties or that would tend to impair their independence of judgment or action in the performance of their official duties.

Examples of the types of conflicts of interest that would violate this policy appear below. If employees are faced with a situation that is not covered by these examples, they must seek guidance and approval from their supervisor first and then the Human Resources Director or the Executive Director before taking any action that could violate this policy. Violations of this policy will result in discipline up to and including termination of employment.

Gratuities, Gifts and Loans: Employees are not permitted to accept gifts of cash or merchandise from clients or from organizations that are currently doing business with RVCOG or are reasonably anticipated to do so. As a very limited exception, employees may be permitted to accept incidental gifts of nominal value (less than $50) such as a thank-you basket. Employees are also prohibited from selling any goods or services to any current clients or vulnerable persons outside of the normal working relationship and RVCOG procedures. In addition, employees may not loan or borrow money from current clients or otherwise involve current clients in business deals or contracts of any kind outside of the normal working relationship and RVCOG approved procedures.

Interest in Appointments: Canvassing of members of RVCOG, directly or indirectly, in order to obtain preferential consideration in connection with any appointment to staff is prohibited and may disqualify the candidate for appointment and expose them to disciplinary action.

Preferential Treatment or Use of Confidential Information: Granting any special consideration, treatment, or advantage to any citizen beyond that which is available to every other citizen, unless required by law, is not permitted. Also not permitted is using confidential or other information obtained through employment with RVCOG to advance the financial or other private interest of an employee or an employee's friends, business associates, or family members.

Incompatible Treatment: Engaging in or accepting private employment or rendering services for private interests when such employment or service is incompatible with the proper discharge of the employee's duties or when it would tend to impair their independence of judgment or action in the performance of their official duties is not permitted. For more information on employee obligations with regard to outside employment activities, please see "Outside Employment" in Section 13.13 of the Employee Handbook.

Representing Private Interests Before RVCOG or Courts: RVCOG employees are prohibited from appearing on behalf of private interests before any RVCOG committee or board, or committees or boards staffed by RVCOG. An employee may appear before RVCOG and its committees on behalf of constituents in the course of their duties as a representative of RVCOG or in the performance of their obligations. However, employees are prohibited from accepting a retainer or compensation that is contingent upon a specific action by RVCOG or its affiliated organizations.

Interest in Contract with RVCOG: Employees are prohibited from holding any interest in or accruing any benefits from any contract issued by RVCOG. Limited exceptions may be granted only if RVCOG determines the contract benefits—in its majority—RVCOG or its clients, and the employee receives advance written approval of the Executive Director.

Disclosure of General Conflict of Interest: An employee of RVCOG who has a financial or other private interest in any project or program being considered by RVCOG must notify RVCOG in writing of the nature and extent of such interest. Should an employee in that situation have decision-making authority, they must disqualify themself from exercising that authority.

Public Employee Ethical Obligations

Because RVCOG employees are part of the public sector, they must comply with the public employee code of ethics as required by Oregon law (ORS 244). All employees are required to complete a Government Ethics training course that outlines the requirements of Oregon Government Ethics Law, including the definition of “public official,” proper use of office, gift stipulations, and the disclosure of conflicts of interest. Violation of the public employee code of ethics will result in discipline up to and including discharge. Employees may also be subjected to individual civil fines and penalties under the law if they are found to have violated the code of ethics.

Employees who have questions about their obligations under Oregon Government Ethics Law should contact the Human Resources Director.

Appendix H – Partner Memorandums of Understanding

Senior and Disability Services
(541) 664-6674 • FAX (541) 664-7927 • www.rvcog.org

Memorandum of Understanding

Between the

The ADRC
(of RVCOG Senior & Disability Services)
And
Jackson County

I. **Purpose**

The following Memorandum of Understanding is between the Aging and Disability Resource Connection of RVCOG SDS and Jackson County (JC).

The purpose for this Memorandum of Understanding (MOU) is to recognize the interconnected and complementary nature of the services provided by the Aging and Disability Resource Center (ADRC) and JC and to define the roles, responsibilities and procedures for collaboration between ADRC and JC.

The period of this agreement begins on July 1, 2013 and continues until amended or terminated.

II. **Roles and Responsibilities**

Referrals for Service

JC will strive to refer clients to the ADRC for services such as:

- Information and assistance where ADRC services can complement or augment those provided by JCMH and/or JCDD services;
- Disability and aging benefits counseling;
- Assistance in accessing publicly funded long term care;
- Care Transition services;
- Health Promotion programs for the aging/people with disabilities;
- Any other ADRC service that may benefit the consumer.

The ADRC will strive to refer clients to JC to:

- Determine if they have an existing DD or MH service coordinator.

- Determine eligibility for Developmental Disabilities or Mental Health services.
- Provide Options Counseling for people who are likely eligible for services from JCMH or JCDD Services as needed.

Quality Assurance

- JC will strive to ensure that intake staff providing Options Counseling will have appropriate Options Counseling training.
- JC will strive to ensure the client will have the same Options Counselor through the entire Options Counseling process.

Information Sharing

- The ADRC and JC will participate in the ADRC Steering Committee on a regular basis to provide information about their respective services and philosophies as well as problem-solving on ADRC operational issues.
- JC will assist in providing information regarding the opportunity for clients to join the ADRC Operations Council- a consumer driven Council that will provide input to the ADRC Steering Committee.
- JC and the ADRC will share information regarding other services, providers and resources to assist in maintaining and updating their respective resource databases.
- JC and the ADRC will provide each other with information regarding unmet needs of people with mental illness and/or Developmental Disabilities who are aging or with disabilities.
- The ADRC and JC will share information about staff and consumer training opportunities, as well as participate in cross-training opportunities when resources allow.

Nonbinding

- This MOU creates no right, benefit, or trust responsibility, substantive or procedural, enforceable at law or equity by either party or by any third party. The parties shall manage their respective resources and activities in a separate manner to meet the purposes of this MOU. Nothing in this MOU authorizes any of the parties to obligate or transfer funds. Specific projects or activities that involve the transfer of funds, services, or property among the parties require execution of separate agreements and are contingent upon the availability of appropriated funds. These activities must be independently authorized by statute. This MOU does not provide that authority. Negotiation, execution, and administration of these agreements must comply with all applicable law. Nothing in this MOU is intended to alter, limit, or expand the agencies' statutory and regulatory authority.

This MOU is effective upon signature by both parties and shall terminate upon the notice by one party to the either party. This MOU may be revised upon the mutual concurrence of both parties.

ROGUE VALLEY COUNCIL

Senior and Disability Services
(541) 664-6674 • FAX (541) 664-7927 • www.rvcog.org

Memorandum of Agreement

Between the

The ADRC
(of RVCOG Senior & Disability Services)
And
Options for Southern Oregon

I. Purpose

The following is an agreement between the Aging and Disability Resource Connection of RVCOG SDS and Options for Southern Oregon (Options).

The purpose for this Memorandum of Agreement (MOA) is to recognize the interconnected and complementary nature of the services provided by the Aging and Disability Resource Center (ADRC) and Options and to define the roles, responsibilities and procedures for collaboration between ADRC and Options.

The period of this agreement begins on July 1, 2013 and continues until amended or terminated.

Roles and Responsibilities

Referrals for Service

Options will refer clients to the ADRC for services such as:

- Information and assistance where ADRC services can complement or augment those provided by Options;
- Disability and aging benefits counseling;
- Assistance in accessing publicly funded long term care;
- Care Transition services;
- Health Promotion programs for the aging/people with disabilities;
- Any other ADRC service that may benefit the consumer.

The ADRC will refer clients to Options for service such as:

- Clients that may be eligible for mental health services, Options Counseling (OC) for people who are currently receiving services from Options or are likely to be eligible for such services.
- Information and assistance where mental health services can complement or augment those provided by ADRC;
- Care Transition services where appropriate for mental health.

Quality Assurance

- Options staff providing Options Counseling will have appropriate Options Counseling training.
- Options staff trained in Options Counseling will provide services that meets ADRC Options Counseling standards
- When appropriate, Options will strive to ensure the client will have the same Options Counselor through the entire Options Counseling process

Information Sharing

- The ADRC and Options will participate in the ADRC Steering Committee on a regular basis to provide information about their respective services and philosophies as well as problem-solving on ADRC operational issues.
- Options will assist in recruitment of clients to join the ADRC Operations Council- a consumer driven Council that will provide input to the ADRC Steering Committee.
- Options and the ADRC will share information regarding other services, providers and resources to assist in maintaining and updating their respective resource databases.
- Options and the ADRC will provide each other with information regarding unmet needs of people with mental illness who are aging or with disabilities.
- The ADRC and Options will share information about staff and consumer training opportunities, as well as participate in cross-training opportunities when resources allow.

This agreement is effective until terminated by either party and may be revised upon the mutual concurrence of both parties.

Dave Toler, Director RVCOG SDS ADRC — Date: 6/3/13

Shelly Uhrig, COO Options for Southern Oregon — Date: 6/3/13

CCO-LTSS Partnerships MOU Template:

MOU Period: January. 1, 2025 through December. 31, 2028___

Please submit your CCO's CCO-LTSS MOU(s) by March 31, 2025 through the CCO portal at via the Contract Deliverables portal located at https://oha-cco.powerappsportals.us/. This report content is subject to public posting and redaction. It will be shared without redaction with the Centers for Medicare and Medicaid Services (CMS) and with the Oregon Department of Human Services. Final MOUs will be posted at https://www.oregon.gov/oha/hsd/ohp/pages/cco-ltss.aspx

CCO Name _____AllCare CCO, Inc_____ OHA Contract #_____161755-9_____

Partner AAA/APD District (s) Names/Locations ___Rogue Valley Council of Governments and Aging and People with Disability District 8_____

If more than one AAA/APD office in your CCO Geographic Region Please Circle or X Whichever Applies: Single Combined MOU___ Multiple MOUs_X__

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
CCO will clearly articulate in this section: AllCare CCO will clearly articulate: Medicaid-funded long-term care (LTC) services are legislatively excluded from the budgets of Care Coordination Organizations (CCO) by law. These services will continue to be directly funded by the Oregon Department of Human Services (ODHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. To reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system must coordinate care and share accountability for individuals receiving Medicaid- funded LTC services. Care Coordinators will involve members, and/or their authorized representatives, APD/AAA case managers, and any member of the members interdisciplinary care team. In developing the individualized care plan (ICP). Additionally, Care Coordinators will inform members and/or their authorized representatives about the Interdisciplinary Team (IDT) meetings and invite/engage them as appropriate. This is a non-binding agreement between AllCare CCO (Medicaid, Medicare Advantage and DSNP), Rogue Valley Council of Governments and Aging People with Disabilities District 8. The mutual goal of the proposed agreement is to improve person-centered care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system.	**AAA/APD will clearly articulate in this section:** The regional Area Agency on Aging is Rogue Valley Council of Governments (RVCOG) for District 8 (Jackson and Josephine Counties) and is located within Rogue Valley Council of Governments (RVCOG) in Central Point, Oregon. Two advisory councils assist with this advocacy. The Senior Advisory Council (SAC) is made up of up to 21 community members, appointed by the RVCOG Board of Directors, and is mandated under the federal Older Americans Act to advise the Area Agency on Aging Program Directors. The Council provides advice and assistance with new program development and service implementation to meet the needs of seniors and people with disabilities, are advocates and sources on information to the community, and advise on key issues and emerging trends. The Disability Services Advisory Council (DSAC) is made up of up to 11 members of the community and meets monthly to advise local Aging and People with Disabilities (APD) offices on program policy and the effectiveness of services provided (such as Medicaid and SNAP) to both seniors and younger people (18-64) living with disabilities.

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

MOU Service Area:				
Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success**	**Annual Report on Specific Statewide Measures of Success (provide data points*) —monthly & annual [REQUIRED data points at minimum]**
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members	AllCare CCO utilizes a data dashboard that incorporates 834 enrollment data and other care coordination data points. This data dashboard identifies Long Term Service and Support (LTSS) members, through the utilization of filters, we can determine if members have a case open, if members have an assigned care coordinator, the date of their most recent Health Risk	APD/AAA will provide AllCare Health bimonthly reports and the access to identify members with high health care needs; this includes relevant data on all CCO members receiving Medicaid funded long-term care services, a change in care provider and Medicare plans. APD/AAA will communicate key health related information, including risk	AllCare CCO's Information Technology team has enhanced the Care Management System record to better include care plan interventions, tasks, and reports that capture data exchange, referrals and assessments. See referenced documents: Domain_1_834Report_ Domain_1a_LTSS-MOU_Staff_Training_ Guide_ Domain _1b_APD_Referral_ Domain_1c_APD_Communication_ Domain_1d_Incoming_Referral_APDAAA_ Domain_1e_Community_Partner_LTSS_Referral_pdf_ Domain_1f_Tableau_Dashboard_	# of members with LTSS that prioritization data was shared during each month/year Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]—calculated by OHA from data submitted. # of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs). # of APD/AAA referrals to CCO for care

	Assessment and if a member is identified as having Special Health Care Needs (SHCN). This information allows us to quickly identify members who need outreach and engagement into care coordination. The initial outreach is essential for coordinating targeted care based on each member's individual needs, assessing potential additional unmet needs, and collaborating with the member and the member's care team. Newly enrolled members are opened for care coordination, if a member has been enrolled into AllCare and is	assessments created by LTC providers and local Medicaid APD/AAA offices. This can be done during scheduled IDT's, or through case consultations between AAA/APD case managers and AllCare Staff. There will also be collaborative efforts in developing, reporting and meeting metric requirements for the following: linking supportive resources, health promotion and prevention, plus safeguards for members.		coordination review # of completed referrals for care coordination review [Monthly/Year Total]

	newly LTSS, they are easily identified, and a care coordinator is assigned. The member is outreached for an initial Health Risk Assessment (HRA), and care coordinators work to identify the members Interdisciplinary care team (ICT) to create a comprehensive person-centered care plan. If a member is not LTSS but their HRA or conditions indicate that they may be eligible for LTSS services, the member is referred to APD/AAA through the LTSS Community Partner LTSS Referral Process to connect members to APD/AAA			

	services.			
			DOMAIN 2: Interdisciplinary care teams	
DOMAIN 2 Goals: Interdisciplinary care teams	AllCare CCO (Medicaid, Medicare Advantage and DSNP), conducts Interdisciplinary Team Meetings (IDT) every other week, and/or more frequently as needed. IDT meetings ensure member needs are met, and care gaps are closed. For example, transitions of care barriers are identified, as well as additional services and supports to ensure safe transitions for members. This includes those in acute care settings and skilled nursing facilities who are facing increased complexities in the transfer process, as well as members transitioning from a home setting to a higher level of care.	APD/AAA shall support and participate in AllCare CCO Interdisciplinary Team Meetings (IDT) if needed to coordinate planned care for CCO members. This shall include CCO members who are in the acute care setting and skilled nursing facilities and are experiencing increased complexities in the transfer process. The following information to be shared at each meeting as needed: provider information, care	IDT meetings are documented using several methods to accurately capture collaboration, participation, and progress on care plans. Each IDT meeting is recorded in a member's Care Management System. Additionally, meetings are tracked through a sign-in sheet and an IDT case presentation form. See referenced documents: Domain_2_IDT_Meeting_Template_ Domain_2a_ Individualized_Care_Plans_with_Updates_ Domain_2b_IDT_Form_Template_ Domain_2c_IDT_Meeting_Definations_	# of members with LTSS that are addressed/staffed via IDT meetings monthly. % of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month. total annual IDT meetings completed by CCO-APD/AAA teams. % of times consumers participate/attend the care conference (IDT) by month/year. % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by

	These IDT meetings are scheduled with APD/AAA through the end of the year and held through a secure online meeting. Members and their Interdisciplinary Care Team (ICT) are invited to attend and participate in IDT meetings. This includes, but is not limited to, the member, the attending medical provider, and other medical professionals caring for the member, case managers from APD/AAA or other collaborative agencies and/or participants who the member identifies. Members identified for IDT meeting agenda is determined by active unmet needs, or barriers to support, care or goals, (Domain 1).	supports in place, Medicare plans, assessments, treatment and care plans, care transitions, discharge follow-up care, referrals, case worker contact information and any other necessary information to assist in the coordination of care for the CCO member such as legal guardian information.		CCO).

DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	AllCare CCO Care Coordination works with all providers, including community and social support providers, and with the member to create a patient-centered care plan. Care plan development includes the member, family and/or other individuals identified by the member, medical providers and community agencies which is documented and recorded in the AllCare CCO Care Management System and shared with the member's ICT upon completion and upon any changes. Care Planning is initiated upon enrollment. Care Coordination telephonically or in person, engages with the member, attempts to complete the HRA to	The following care plan information shall be coordinated between agencies to support individualized member care and ensure there is no duplication of services initially and on an ongoing basis. Care plans to include evidence-based practices with the member, family and/or other individuals involved in care plan creation and completion, medical providers and community agencies which is documented and recorded. Other information to be shared pertinent in care planning shall be:	Supervisors conduct regular case audits verifying completion of state timelines. Reports are also generated as needed from the Care Management System for reporting purposes. See referenced documents: Domain_3_Chart_Audit_Tool_ Domain_3a_Individualized_Shared_ Case_File_ Domain_3b_AllCare_Nondiscrimination_and_Language_Access_OHA_pdf_ Domain_3c_Achhc_Faq_Interpreter_Services-pq_.pdf_ Domain_3c_DEI_COO_006_Meaningful_Language_Access_Policy.pdf_ Domain_3d_Health_Promotion_Prevention_and_Education_Policy.pdf	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals. % of CCO person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties.

	identify special health care needs, and care coordinators work collaboratively on the creation of the Individualized Care Plan (ICP). If a member declines completing an HRA, the care coordinator will develop an ICP with the member based on the members identified needs. If a member needs end-of-life care planning, medication reconciliation, these services are engaged through Care Coordination efforts, and AllCare CCOs Benefit Management team. If a member needs language / disability services AllCare CCO utilizes our language access teams to assist and provide linguistically appropriate support. Collaboration with the ICT is to support the members ICP and ensure a reduction of	member living situation preference and cost, most cost effective option to meet the member's care need, APD case worker information, LTC contact information and any other supportive individual involved in the member's care. Additionally, risk assessments generated by the LTC providers shall be integrated into the care plans shared.		

	duplicated services as well as understanding APD/AAA service plan for the member to support member's goals with other care teams. AllCare CCO (Medicaid, Medicare Advantage and DSNP), goal for care plan creation is to ensure member centric and holistic care, coordinated between agencies and medical professionals caring for the member, this will ensure services are not duplicated. See optional domain A for process to link community resources to care plans. See optional domain A for process to link community resources to care plans. APD/AAA and AllCare CCO engage in IDT meetings every 2 weeks or sooner based on member's			

	needs. These are held through a secure online meeting. Care plans are shared during IDT meetings or through secure email or fax. (Domain 1) Each care plan is reviewed at least every 90 days or more frequently and after every IDT meeting, allowing for care plan amendments to meet the needs and care of all members. Care Plans are shared with the members ICT upon completion, when changes occur, and are also available electronically to members on the AllCare secure member portal.			
DOMAIN 4: Transitional care practices/Care Setting Transitions				
DOMAIN 4: Transitional care practices Goals	AllCare CCO has processes written into various policies and procedures outlining specific transitions of care for members.	For CCO members in residential, inpatient, long-term care, home to a higher level of care, or other	AllCare CCO's Care Management System automates system triggers for all TOC cases to contact agencies involved in the member's care. The system triggers specific tasks to coordinate medication, DME, transportation and other TOC needs as identified by the Centers for Medicare and Medicaid Services (CMS) Transitions of Care. All completed actions are reportable and shall be submitted upon request.	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition?

	These policies provide state guidelines and specific timelines while working with members. Through PointClickCare, AllCare CCO Care Coordinators monitor member hospitalizations, emergency department usage, and skilled nursing facility discharge events in real time. These events may prompt updates to care planning, referrals to APD/AAA, or other necessary support and engagement. AllCare CCO has interdepartmental systematic guidelines to map the coordination and care for members transitioning between care settings. This	similarly licensed care facility, APD will support and participate in discharge meetings as follows: • The transition meeting must be held 30 days prior to the member entering the CCO's service area; and/or • If applicable to another facility or program or as soon as possible if CCO is notified of impending discharge with less than 30 days of notice of discharge. This information	See referenced documents: Domain_4_Pop_Health_Audit_Tool_ Domain_4a_Transition_of_Care_Program_Policy_.pdf_ Domain_4b_Transitions_of_ Care_ Case_ File_ Example.docx_ Domain_4c_Point_Click_Care_Medical_Cohorts_Including_SNF_and_Daily_Hospital.pdf__	% transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge? % CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)? # of Debrief meetings held quarterly to post-conference transitions where transitions wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4].

	provides decision-making processes for clinical and non-clinical staff reviewing behavioral, physical, and oral health service requests. Upon identification of a member with special healthcare needs or LTSS (long-term services and supports), various qualified staff are available to assist in the transition, this includes resources needed for Social Determinants of Health (SDOH). Such qualified staff may include, but is not limited to, Health Related Services, Non Emergent Medical Transportation (NEMT) Liaison, Register Nurses, Licensed Practical Nurses, Behavioral Health Specialists, Respiratory	may be informational only if care coordination is needed or outlined in current CCO-LTSS state guideline requirements.		

	Therapists, Intensive Care Coordinators, Maternal Child Advocates, Traditional Health Workers and Pharmacists. AllCare CCO also has a dedicated team that focuses on Transitions of Care within Care Coordination, the Behavioral Health team and the Benefit Management team. Staff attend in-person facility meetings and meet with members face-to-face. Dedicated Transitions of Care staff work to ensure key post discharge planning begins at the time of admission, ensuring follow-up appointments are made, as well as supporting DME, medications, home health services, and the entirety of			

	discharge orders follow the member from one care setting to another or to home. This includes additional benefits such as face-to-face interactions, home meal delivery and remote patient monitoring.			
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	When an AllCare CCO member is identified for a referral to APD/AAA, AllCare CCO will utilize the Community Partner LTSS referral Process to initiate this referral. (Domain 1) AllCare CCO has various reporting mechanisms in place notifying multiple internal departments of hospital events and services obtained by	Both entities will continue to expand, improve and utilize communication resources available. APD/AAA shall continue to receive CCO referral requests which include request for assessment of services. AllCare CCO's communication between entities shall be documented	AllCare CCO's Care Management Software allows all completed actions within a member's case to be reportable and shall be submitted upon request. AllCare also utilizes external HIE platforms to produce HEN reports. Additionally, claim data reports are utilized for monitoring, potential referrals, collaboration of care and care coordination as needed. See referenced documents: Domain_5_Point_Click_Care_Medical_Cohorts_Including_SNF_and_Daily_Hospital.pdf_ Domain_5a_Community_Parnter_LTSS_Referral_ Domain_5b_Transitions_of_Care_Case_File_Example_	# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments. # of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments.

	members. This includes claims review by the AllCare CCO Benefit Management team. Through the use of PointClickCare, AllCare CCO Care Coordinators can monitor, in real time, member hospitalization, emergency department utilization and SNF discharge events. These events can trigger care planning updates, referrals to APD/AAA or other supports/engagement as needed. AllCare CCO Staff also utilize Health Information Exchange (HIE) platforms to obtain further information that results in the need to collaborate with agency partners such as	and supplied to OHA reporting requirements.		MOU includes written process documents (prioritization, IDT, care planning, transitions) that clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).

	APD/AAA. The HIE can also provide additional information regarding members care team. AllCare CCO will review with the APD/AAA team our unique and varied utilization of community-based tools, like the HIE and PointClickCare, to increase collaboration and share workflows that improve quality of care.			
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	AllCare CCO continues to collaborate with medical care teams and community partners in implementing a CIE (Unite Us) platform for resource utilization. This closed-loop referral system will be	RVCOG AAA currently participates in the Unite Us platform and may send or receive referrals from AllCare CCO and community partners.	All entities will have independent reporting access for various data elements to meet individual metric outcomes, state requirements or other information needed for reporting.	

	made available to multiple entities without cost or fees.	Participation in the Unite Us CIE allows for a more comprehensive referral system needed for assessment requests, social service support and other needs. This system provides a closed loop referral resource, and allows for tracking of referrals, and coordinated efforts between all involved in the member's care. Linking to Support Services: AAA programs may include: • PEARLS: Program to Encourage Active and Rewarding Lives for Seniors • OPAL: Options for People to Address Loneliness • Powerful Tools for Caregivers classes		

		• Aging and Disability Resource Connection (ADRC) is available to assist any consumer, family member, or friend of senior or person with disability. ADRC will refer to other health promotion and prevention programs such as (but not limited to) those named above. APD is actively exploring the utilization of the CIE and are engaging with community partners in this process. These services are available through individual referral or through specific contract with AllCare CCO to support its	

		membership.		
OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Health Promotion and Prevention	AllCare CCO care coordination staff complete the LTSS community referral training upon hire, and at least annually or upon identified changes. AllCare CCO will continue collaborating with the Health and Wellness team to support members on their wellness journeys. Appropriate referrals will be initiated to the Health and Wellness team for the following programs: • Tobacco Cessation • Preventative Wellness Program • Lose It AllCare CCO supports members with Advance Directives, including providing community-based education, provider network	APD attends AllCare Population Health Staff meetings at least annually or more often to provide education regarding APD programs. AAA will additionally attend Population Health Staff meetings to provide education to our team regarding health promotion and prevention services. AAA office will additionally provide tangible or electronic flyers for community sharing regarding workshops offered. APD / AAA offices support AllCare participants in ensuring they have access to Advance Directive benefits.	AllCare CCO will have an identified liaison communicating with APD/AAA's liaison to evaluate processes and safeguards while evaluating necessary changes needed to meet a member's goal. Communication will be a combination of electronic and face-to-face collaboration at least quarterly.	

	training, as well as community provider support in assisting members with Advance Directive education and support with completion of their Advance Directives. AllCare provides referrals to the AAA programming that is outlined in section A. Crisis protocols will remain in effect, and ongoing collaboration will continue with AllCare CCO's Behavioral Health (BH) team, Medical Directors, Quality and Compliance departments, and any other relevant internal policies or departments to ensure the safety and well-being of members, in line with AllCare CCO obligations. Additionally, AllCare CCO collaborates with	AAA offices offer supportive education and classes as outlined in section A.		

	state entities, such as the Oregon Health Authority (OHA) Ombuds Program.			
OPTIONAL DOMAIN C: Cross System Learning Goals				
OPTIONAL DOMAIN C: Cross-System Learning Goals	AllCare CCO, when requested, provide CCO education and presentations to APD/AAA outlining the following: • CCO Capabilities • Processes • Language and terminology • Limitations within each required domain • Prioritization of high needs members • Interdisciplinary team meetings (IDT) • Development and sharing of individualized care plans • Transitional care practices • Collaborative Communication Tools and Processes • Phone / email contact lists of care coordinators	APD/AAA will, when requested, provide agency education and presentations to AllCare CCO outlining the following: • APD/AAA capabilities • Program availability • APD/AAA processes • Language and Terminology • Limitations within each required domain • Interdisciplinary Care teams • Development and sharing of individualized care plans • Transitional care practices	Both entities agree to keep records of education documentation and attendance for all training sessions. Training will be conducted at least annually to assist in employee turnover, program changes, and or other potential barriers that may prevent members from achieving their care plan goals.	

SIGNATURES: Include Name, Job Title, Agency, Signature, Date

Signatures of All MOU parties (APD/AAA and CCO) should be included and signed prior to March 31, 2025. OHA/DHS review will occur after CCO submits the MOU. Neither OHA or DHS will require review or co-signature to the MOU.

CCO Authorized Signature. Name. Job Title. CCO Name, Date

Max Janasik
max.janasik@allcarehealth.com Max Janasik, CEO, AllCare CCO, Inc. 03/04/2025

APD Field Office Authorized Signature. Name, Job Title, APD Field Office Name, Date

Jeremy Wolf
jeremy.i.wolf@odhs.oregon.gov Jeremy Wolf, APD District Manager, District 8 Jackson and Josephine Counties, 03/07/2025

AAA Office Authorized Signature. Name. Job Title, AAA Office Name, Date

Ann Marie Alfrey
amalfrey@rvcog.org Ann Marie Alfrey, Executive Director, Central Point Rouge Valley Council of Governments (RVCOG), 03/13/2025

Appendix I – Statement of Assurances and Verification of Intent

For the period of July 1, 2025, through June 30, 2029, the Rogue Valley Council of Governments (RVCOG) Area Agency on Aging accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) as amended in 2020 (P.L. 116-131) and related state law and policy. Through the Area Plan, RVCOG shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. The RVCOG assures that it will:

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

OAA Section 306, Area Plans

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural

areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;
(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible, regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence- based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;
(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and
(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—
(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—
(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and
(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on

those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

Section 306 (e)
An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

The Rogue Valley Council of Governments further assures that it will:
With respect to legal assistance —

(A)

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) assure that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.
(C) give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

With respect to services for the prevention of abuse of older individuals—

(A) when carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent abuse of older individuals;

(ii) active participation of older individuals participating in programs under the OAA through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iii) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

If a substantial number of the older individuals residing in the planning and service area are of limited English-speaking ability, the area agency on aging for each such planning and service area is required—

(A) to utilize in the delivery of outreach services under OAA section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under the OAA; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

Conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to OAA section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

Have policies and procedures regarding conflicts of interest and inform the State agency if any conflicts occur which impact service delivery. These policies and procedures must safeguard against conflicts of interest on the part of the area agency, area agency employees, governing board and advisory council members, and awardees who have responsibilities relating to the area agency's grants and contracts.

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a 30-calendar day or greater time period for public review and comment on the Area Plan and a public hearing prior to submission of the Area Plan to ODHS. The Rogue Valley Council of Governments shall publicize the hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

March 18, 2025
Date

Advisory Council Chair

March 18, 2025
Date

Ann Marie Alfrey
RVCOG Executive Director

3-26-25
Date

RVCOG Board President