Department for the Aging

Naturally Occurring Retirement Community Supportive Service Programs (NORC SSP)

Standards of Operation and Scope of Services

Based on standards set by the New York City Department for the Aging and the New York State Office for the Aging.

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Introduction

Naturally Occurring Retirement Communities **Supportive Services Programs (NORCs)** support the aging-in-place of older residents of a community or neighborhood. Operated as partnerships among the housing entity, older NORC residents, a health care provider and a provider of social services, NORC programs are located on-site (unless granted a waiver by NYC Aging) at public housing and other large-scale residential buildings. In addition to providing services and activities for older residents, programs work to: (1) adjust the physical environment for age-friendliness, accessibility, and safety; (2) facilitate residents' access to, and utilization of, community services; (3) ensure availability of work, volunteer, and educational opportunities for older residents; and (4) encourage older residents to participate in the civic, cultural, social and recreational life of the community.

NORCs provide the required core services of: **Case Management**, **Case Assistance**, **Healthcare Management**, **Healthcare Assistance**, and **Health Promotion** and conduct **Health Indicator Surveys** that inform health programming. They also provide other optional services proposed in their response to NYC Aging's Request for Proposals (RFP), including Education and Recreation, Transportation, Friendly Visiting, Shopping Assistance, Housekeeping, Personal Care/Home Health Care, Telephone Reassurance, and Meal Services. If meal services are offered as a supplemental service, all related food safety, nutrition, and nutrition education requirements apply and providers must adhere to the OAC Standards of Operation published on the Contractor Tools page of the NYC Aging website: https://www.nyc.gov/site/dfta/community-partners/contractor-tools.page.

These Standards are applicable to all NYC Aging-funded NORCs. NORCs are also required to comply with NYC Aging's General Program Standards of Operation published on the Contractor Tools page of the NYC Aging website: https://www.nyc.gov/site/dfta/community-partners/contractor-tools.page. These NORC SSP Standards highlight specific sections of the NYC Aging General Program Standards, but NORC programs are responsible for ensuring their compliance with the entirety of the NYC Aging General Program Standards of Operation.

Section A. NORC Eligibility and Target Population

Standard 1: Eligibility

The NORC program serves eligible individuals living within the defined NORC housing community.

Compliance 1.1. Eligible Individuals. The program serves any person 60 years and older living within the NORC housing community.

Note:

- *Older adults from outside the NORC housing community may be deemed eligible for some group services, as determined by the NORC partnership.*
- *Services should be provided to all eligible individuals, unless funding is not available, the NORC SSP is unable to meet needs, or the participant's needs can be more appropriately met by other services or provider.*

Standard 2: Target Population

The program serves its priority and target population. (Please refer to NYC Aging General Program Standards, Section 1)

Compliance 2.1. Target Population. The program targets persons 60 years and older living in the NORC who are:

- Minorities – Persons of Black, Hispanic, Asian, Native American (American Indian), Alaska Native, Native Hawaiian or Other Pacific Islander origins. Persons who identify as two or more races or who identify as other than White may be included.
- Low-Income – Incomes at or below 150% of the Federal Poverty Level (FPL).
- Frail – Persons who have one or more functional deficits in physical or mental functions.
- Vulnerable – Socially or linguistically isolated, or affected by other conditions including the following:
    - Limited English Proficiency (LEP);
    - Persons with disabilities;
    - At risk of institutionalization;

- Lesbian, gay, bisexual, transgender (LGBT) older adults;
- Low literacy;
- Homebound;
- Isolated and hard-to-reach;
- Part of a non-traditional family;
- Caring for age 60+ individuals living in the NORC; and/or
- Have Alzheimer's or other dementia.

Standard 3: Outreach
The program conducts targeted outreach to residents.

Compliance 3.1. Outreach to Residents. The program conducts outreach to residents by achieving at least four (4) of the following annually:

- Regularly holds Outreach Events, at least two of which are designed to attract one or more underserved groups within the NORC community– for example, a younger older adult population than the program's current participants, or persons from a specific cultural/ethnic group that is a minority in the program or in the NORC community.
- Organizes targeted or mass mailing/distribution of information about its services on at least an annual basis.
- Makes a specific and demonstrable effort to attract older persons with special needs (e.g., vision or hearing impaired; frail older persons; developmentally disabled over 60; etc.).
- Makes specific, demonstrable, and regular efforts to attract an underserved population within the NORC community.
- The program has and makes publicly available a current, accurate brochure about the program.
- The program regularly posts program information, distributes flyers and/or other promotional materials to varied locations in the NORC housing development(s) and the larger community.

In addition to the above, the program achieves at least two (2) of the following annually:

- The program conducts NORC-wide, language-appropriate survey(s).
- The program conducts resident focus groups.
- The program systematically solicits input from other sources (e.g., housing management, community-based service providers that serve NORC residents, NORC resident organizations, etc.).
- The program makes specific, demonstrable, and regular efforts to bring homebound older adults to the program location for activities, meetings, special events, etc.

Section B. NORC Scope of Services and Administration

Standard 4: Hours of Operation
The program is open, and services are provided during budgeted hours of operation. (Please refer to NYC Aging General Program Standards, Section 4)

Standard 5: Informed Consent
The program obtains informed consent from each participant. (Please refer to NYC Aging General Program Standards, Section 2)

Standard 6: Language Access and Cultural Competence
The program has a language access plan that is linguistically and culturally competent. (Please refer to NYC Aging General Program Standards, Section 3)

Standard 7: Feedback and Survey Procedures

The program maintains a process for soliciting feedback from participants. (Please refer to NYC Aging General Program Standards, Section 4)

Standard 8: Complaints and Grievance Procedures

The program has a written Complaints and Grievance Procedure. (Please refer to NYC Aging General Program Standards, Section 4)

Standard 9: Incident and Accident Reporting and Recording

The program has written procedures for incident and accident recording and reporting. (Please refer to NYC Aging General Program Standards, Section 6)

Compliance 9.1. The program documents all incidents and accidents on NYC Aging's Incident/Accident Report Form found at (http://dftantiis04/prism/Home/Index) and uploads the completed form to PRISM within three (3) business days from the date of the incident.

Standard 10: Emergency Preparedness and Response

The program maintains emergency procedures. (Please refer to NYC Aging General Program Standards, Section 6)

Compliance 10.1. The program has comprehensive accident and emergency procedures, which include fire/other evacuation emergency procedures.

Compliance 10.2. The program requests and maintains emergency contact information for all participants.

Standard 11: Documentation and Recordkeeping

The program utilizes the NYC Aging participant data system to record all required data elements, services, and service units.

Compliance 11.1. All required information in the social demographic section of the participant data system must be fully completed for each participant.

Compliance 11.2. Staff update participant information in the NYC Aging participant data system annually, or in line with specific requirements put forth by NYC Aging.

Staffing

Standard 12: Staffing Levels and Qualifications

The required level of staffing is secured, and staff have the required level of education and training to provide the contracted services. (Please refer to NYC Aging General Program Standards, Section 5)

Compliance 12.1. The program screens all potential employees and volunteers to verify credentials, experience, and skills, and obtains at least two (2) references which are verified by the program.

Compliance 12.2. All program staff receive required training, which is documented by the program, including but not limited to training required by NYC Aging.

Compliance 12.3. Director. The program has a full-time NORC SSP Director. The Director would preferably have a master's degree in social work or in a related field with at least one year of relevant experience or a bachelor's degree in the field of social work or in a related field with at least 3 years of relevant experience. The Director would demonstrate strong leadership qualities and skills in community organizing, team building, interdisciplinary casework, and serving heterogeneous groups of older adults.

Compliance 12.4. Healthcare Worker. The program has an experienced healthcare worker on-site a minimum of fourteen (14) hours per week (which includes being on site at minimum two (2) days per week), and whose professional qualifications are commensurate with healthcare programming. The healthcare worker can be a community health worker, nurse with a bachelor's degree, RN, or LPN, a nurse practitioner, a physician's assistant, or related titles.

Health Indicators Surveys

Standard 13: Health Indicators Surveys

The program administers health indicators surveys and utilizes data from the surveys in programming and/or assisting individual NORC participants.

Compliance 13.1. Implementation. The program can demonstrate that it has conducted a valid Health Indictors Survey of older NORC residents within the first year of the contract and then every three (3) years thereafter.

Compliance 13.2. Survey Follow-up. The program can demonstrate that it:

- Follows up through healthcare management service or healthcare assistance service with individuals identified by the survey to be at risk of a chronic condition(s).
- Is tracking information on outcomes of its interventions with specific participants.
- Is providing programming and group activities (health promotion) targeted to specific health conditions identified through the survey as being prevalent in the NORC.
- Is tracking whether the methods and activities are having a positive impact on aggregate health data.

Partnerships and Linkages

Standard 14: Core & Community Partnerships

The program establishes a partnership comprising of both Core (Social Service Provider, Health Care Partner, NORC Resident Representatives from the Advisory Council, and Housing Management) and Community partners to develop cultural and other opportunities for NORC participants.

Compliance 14.1. Mission Statement. The program and its core partners collaboratively develop a mission statement for the partnership. The partners review the mission statement and revise it as needed. This is reflected in partnership/advisory meeting minutes.

Compliance 14.2. Partnership Network. The program has a Partnership Network, which consists of the partners identified in the RFP (Social Service Provider, Health Care Partner, NORC Resident Representative and Housing Management).

Compliance 14.3. Memorandum of Understanding. The program and its Partnership Network create a Memorandum of Understanding (MOU) that clearly specify roles, responsibilities, and accountability for each of the core partners, and establishes lines of communication among the partners.

Compliance 14.4. Partnership Meetings. Partnership meetings are held either in person or telephonically at a minimum of four (4) times per year with core partners, and other stakeholders as appropriate, at which time the core partners plan, review, and assess ongoing programs, services, and performance.

- Other collaborators, such as NYC Aging-funded case management and home delivered meals providers, and other community stakeholders are invited to attend partnership meetings at least annually.

- Meetings have attendance sheet, agenda, and minutes which include follow up plans and a review of the status of previous follow up plans.

Compliance 14.5. Programs Located in a Public Housing NORC. If the program is located in a public housing NORC, the program also adheres to New York City Housing Authority (NYCHA) guidelines regarding advisory councils.

Compliance 14.6. Lead Agency. The program serves as the lead agency for the partnership. As the lead agency, the program will convene the partners, foster collaboration, and coordinate the contributions of the core partners and other stakeholders.

Compliance 14.7. Healthcare Partners. Where the Healthcare partner is not the Program Sponsor/Contractor, the program maintains an effective and collaborative relationship with the healthcare provider. The healthcare provider plays a key role in determining the overall health of the NORC community, identifying its health risks, and maximizing the health and wellness of the community.

- The program and the healthcare provider create a program document, such as a MOU or other agreement that specifies the role and function of the healthcare partner.
- There is an operating protocol that guides the daily interface between social work and healthcare services.
- The healthcare partner focuses on the overall health and well-being of the older adult population and identifies healthcare trends and issues within the NORC community.
- In collaboration with the other NORC-SSP partners, the healthcare partner can demonstrate how health-related needs of the NORC community were determined, how the steps/interventions to address these needs were developed, what resources were marshaled, and what has been accomplished.
- The nurse receives clinical supervision from the healthcare provider.
- Healthcare providers must comply with all appropriate federal, state and city laws and regulations pertaining to the services they provide. For example, the healthcare provider respects a participant's right to choose which Certified Home Health Agency, vendor, etc. they want to be referred to.
- Healthcare providers must disclose potential conflicts of interest to residents. For example, if a resident is opting for services of the sponsoring health care agency, the healthcare provider must disclose this information to the participant who needs those services.

Compliance 14.8. Housing Partners. Where the housing partner is not the program sponsor/contractor, the program maintains an effective and collaborative relationship with the housing partner. The housing partner plays a key role as host, promoting the program in the community, responding to residential issues, and supporting the NORC SSP.

- The program and housing entity create a program document, such as a MOU or other agreement that specifies the role and function of the housing partner.
- The housing partner provides appropriate space(s) for program operations.
- The housing partner provides the appropriate match required by the contract, if applicable.
- When available, the housing partner provides relevant data regarding the resident composition of the housing development.
- The program provides relevant training for housing management and/or housing staff. (e.g., signs and symptoms of an older person in trouble, how to make referrals to the program, etc.)
- Program staff understand the different components of the housing entity (housing boards, management, security, maintenance, committees), and how the program interacts and communicates with these components.
- The program can demonstrate that when there are complex-wide issues, the NORC-SSP and housing entity work together to timely respond to residents that might be impacted by these issues.
- A document is created that specifies the criteria for identifying and referring residents to housing management, as well as a protocol for the housing entity to refer residents to the program.
- Housing management notifies the program when there are complex-wide issues so the program can timely respond to residents that might be impacted by these changes.
- Housing management works in conjunction with the program concerning emergency plans and safety requirements.

Compliance 14.9. Resident Partners. The residents of the NORC are full partners in the NORC-SSP, and play a meaningful part in the planning, designing and maintenance of the program. The program maintains an effective and collaborative relationship with the NORC residents. They have a key role in assuring that the program reflects the needs, preferences, and aspirations of the NORC residents on an on-going basis.

- A document is created and periodically reviewed in collaboration with resident representatives that specifies the roles and function of the resident partners.

- The program maintains an effective and collaborative relationship with the NORC residents.
- The program seeks to maximize the involvement of older adult residents through all mechanisms available, both formal and informal.

Compliance 14.10. Interdisciplinary Team. The program has an interdisciplinary team, which includes nursing/healthcare and case management. There is an interdisciplinary intake process, and the team can demonstrate shared care planning and coordination for cases in common.

- A program document is created that specifies the intake process.
- The nurse and case manager participate in staff meetings/team meetings.
- New intakes are reviewed by the interdisciplinary team in a case conference/team meeting.
- The program has established procedures and mechanisms in place for coordinating and sharing cases across disciplines.
- The interdisciplinary team guides the team plan through formal and informal case conferences.

Standard 15: Advisory Council

The program establishes and maintains an Advisory Council.

Compliance 15.1. Advisory Council. The program has a functioning Advisory Council. The Advisory Council holds a minimum of two (2) meetings per year to promote the social and civic engagement of older residents. Members are NORC participants elected through regularly scheduled elections open to the entire NORC community. The Council has a publicized meeting schedule. The Director or their delegate attends meetings. The program is responsible for creating an Advisory Council that is representative of NORC participants, with members elected by the membership and responsible to both the members and the program. Each Advisory Council should develop its own written by-laws which set forth its roles and responsibilities and formalize its method of operation. These by-laws will vary from NORC to NORC. They should be approved by the membership and NORC program sponsor. The Advisory Council does not have the authority to determine policy or make final decisions about operations of the NORC.

Standard 16: Volunteers

The program establishes and maintains an active corps of volunteers.

Compliance 16.1. A key component of a successful NORC-SSP is an active corps of volunteers, especially among older adult residents. The program's role and responsibilities regarding volunteers:

- The program creates an environment that fosters and inspires volunteerism.
- A program document is created that specifies the role and function of the volunteer.
- The program makes a demonstrable effort to recruit active older adults, who have a stake in the program, to become a volunteer.
- Volunteers represent the cultural, ethnic and racial diversity of the NORC.
- The program tracks volunteer hours and activities.
- Volunteers are always treated with respect, and their input is encouraged.
- There is a designated staff person who recruits, trains and supervises volunteers.
- The program obtains the following from volunteers:
    - A signed confidentiality agreement
    - Forms that indicate their emergency contact information
    - Permission of a Parent or Guardian is obtained for volunteers who are minors
- The program enforces procedures regarding participant rights to confidentiality.
- Volunteers are provided with an orientation kit, which includes:
    - The mission of the NORC-SSP
    - Program policies and procedures
    - Written job description
    - Specific standards for service provided
- Volunteers receive an orientation, which includes:
    - Specific volunteer roles and responsibilities
    - Information on identified staff person who will supervise volunteer
    - Participants' rights, including confidentiality, consideration, respect, and individual choice
    - Emergency procedures

- Profile of specific NORC community
- Specific program components

Standard 17: Linkages

The program establishes linkages with the greater community surrounding the NORC and with NYC Aging-funded programs.

Compliance 17.1. Linkages with the Greater Community Surrounding the NORC. The program can demonstrate effective linkages with the greater community surrounding the NORC.

- The program identifies, develops, and maintains relationships with key civic and representative offices serving the community.
- The program identifies, develops, and maintains relationships with multiple community organizations, including NYC Aging funded agencies.
- The program has developed a formal referral system with other organizations and community providers to accept and refer participants.
- The program works with other providers to maintain and update a Resource Directory.
- Members of community and business organizations, especially those serving older adults, serve on the program's Partnership Network.
- The program can demonstrate linkages in the surrounding community by achieving at least two (2) of the following annually:
  - The program encourages community and local businesses to participate in NORC events and programs. Their special skills are utilized for functions such as grant writing, fundraising, press coverage, community outreach and training.
  - The program participates in any of the following; interagency councils, task forces or committees of government agencies, and/or community planning bodies and this participation relates back to the program.
  - The NORC Director regularly attends and participates in meetings/events with other NORC programs.
  - The program coordinates funding proposals with other human services providers in addition to the programs of the sponsoring agency.

Compliance 17.2. Linkages with NYC Aging-Funded Programs. The program maintains linkages with NYC Aging-funded programs.

- A protocol is established for referrals to NYC Aging-funded programs.
- A protocol is developed to identify participants who are served in common.
- Coordination of services and sharing of resources with other NYC Aging funded programs is encouraged, as this contributes to stronger community linkages and reduces duplication of services.
- On a semi-annual basis, NORC shall host a convening of program staff from NYC Aging-funded programs, including case management, home delivered meal providers, and older adult centers, to coordinate efforts to meet the needs of the NORC older adults.
- On an annual basis, NORC shall host a partnership meeting of NYC Aging-funded case management and home delivered meal programs to coordinate efforts to meet the needs of the NORC older adults .

Compliance 17.3. Outcome of Linkage. The program can demonstrate that it has leveraged support from the surrounding community by achieving at least one of the following annually:

- The program receives additional financial and/or in-kind services and resources, including but not limited to government entities.

- The program can demonstrate support and input from the larger community: community service organizations, community institutions, community businesses, community planning bodies, or government agencies with a presence in the community.
- Organizations, institutions or businesses in the surrounding community provide any of the following types of assistance:
  - Marketing
  - Fundraising
  - Training for staff or older adults
  - Use of space or facilities
  - Equipment or materials
  - Grant monies

Knowledge of NORC Residents, Community Resources, and Assets

Standard 18: Knowledge of the Community

The program has an in-depth understanding of the community it serves.

Compliance 18.1. NORC Residents. The program demonstrates its knowledge of the NORC residents.

- The program provides descriptive information to NYC Aging on an annual basis, if requested, pertaining to NORC demographics, and the older adults served by the NORC program. This information includes, at a minimum: gender, age ranges, living situation, ethnicity, race, number in household, and income range. This may be in addition to data entered into the NYC Aging participant data system.
- The program can demonstrate efforts to cultivate relationships with key resident leaders, older adult residents and their caregivers, in the NORC.

Compliance 18.2. NORC Housing Community. The program demonstrates its knowledge of the NORC housing community.

- The program maintains an accurate count of the number of residents and number of older adults in the NORC, and this count is updated at least every year. *Note: If housing management cannot provide this information to the program, utilization of alternative sources of information must be reviewed by NYC Aging.*
- The program maintains an up-to-date list of the organizational structure of the housing entity, including housing manager, board of directors, tenant's association/resident or building councils list of officers.
- The program maintains a list of the meeting dates for the board of directors, tenant's association/resident or building councils.

Standard 19: Knowledge of Community Assets

The program demonstrates knowledge of the community assets.

Compliance 19.1. Knowledge of Community Assets. The program:

- Creates and maintains a description of the physical/geographic/social landscape of the community.
- Maintains and updates relevant information on community resources, including:
  - Key businesses serving the residents of the community.
  - Cultural, religious and educational institutions in the community.
  - Key healthcare providers (public and voluntary), including hospitals, ambulatory care clinics, community health centers, nursing homes, etc., serving the community.
  - Service providers (including all NYC Aging-funded programs) serving the community.

Standard 20: Elder Abuse Educational Sessions

The program provides education to raise awareness of elder abuse and preventive measures.

Compliance 20.1. Elder Abuse Prevention and Awareness. The program conducts two (2) Elder Abuse Prevention and Awareness sessions annually. Each session must address the definition of elder abuse, the various types of abuse, signs and indicators of abuse, and how to detect and report suspected abuse. Elder abuse is defined as a knowing, intentional, or negligent act by a caregiver or other person in a trusting relationship with a vulnerable older adult that causes harm or creates a serious risk of harm. The various types of abuse include physical, emotional/psychological, sexual, financial exploitation, neglect, abandonment, and confinement.

- The required number of elder abuse sessions are held within one (1) year after the contract start date, and annually thereafter.
- Elder abuse sessions must comprehensively address elder abuse prevention and awareness. Presentations focused solely on scams or stranger-perpetrated crimes as part of broader education do not satisfy the requirement. However, presentations on scams are valuable for older adults.
- The program posts signage in a prominent common area within the program site that directs those who need information regarding elder abuse detection, reporting, counseling, and services to contact 311, Adult Protective Services, NYC Aging's Aging Connect 212-AGING-NYC (212-244-6469) or Crime Prevention and Support Services (C-PASS) .

- The program maintains documentation for each session, including the date session was conducted, attendance sheets, and materials presented.

Section C. NORC Case Assistance

Introduction

Case Assistance assists older residents to obtain appropriate services, benefits/entitlement and other resources to address an identified need(s). The service is delivered on an individual basis and includes: assisting the older adults in defining concerns, needs and capacities; providing direction or guidance relative to identified needs; and assisting with referrals and linkages to appropriate services and opportunities. Where a referral has been initiated, the service includes follow-up to determine whether the service/benefit has been, or is being, provided.

Case assistance addresses a specific issue(s) and usually results in a specific outcome – e.g., application for an entitlement; receipt of a service; linkage to a program; translation of a document. Case assistance is usually a short-term or time-limited service.

Unit of Service: One Unit = One contact of service to or on behalf of a participant.
Note: Contact with a family member/emergency contact regarding participant's safety/welfare may be counted as a Case Assistance unit.

Standard 1: Case Assistance as a Core Service.
The program provides comprehensive case assistance as a core service.

Compliance 1.1. Assisted referral and/or linkages. The program assists older adults who need referrals to appropriate resources in the community.

- When needed, the referral involves contact with the resource provider to ascertain that the participant can be served and to facilitate the linkage – e.g., by making an appointment, arranging for the service, sending participant information (with the participant's consent), etc.
- Referrals are timely.
- After making an assisted referral to a resource (with participant's consent), the program follows up with the resource provider within one (1) month to determine outcome/status. Follow-up is monthly thereafter if outcome is pending.
  - Each follow-up contact is documented in the participant's record.
  - Outcome of the referral is documented in the participant's record.

Note: In instances where follow-up with the participant is more appropriate, the program follows up with the participant until an outcome can be documented.

Compliance 1.2. Benefits and Entitlements Assistance. The program makes a concerted effort to screen all new members for benefits/entitlements eligibility and offers periodic screening for benefits/entitlements assistance to all members. Older adults with benefits/entitlements needs are assisted as needed through one or more of the following activities:

- Screening to determine the person's eligibility for benefits and entitlements, using Access NYC, BenefitsCheckUp and/or other electronic programs where possible.
- Counseling when the participant is reluctant to apply.
- Assistance filling out forms, completing paperwork and/or collecting documentation.
- Submitting forms on the participant's behalf.
- Accompanying the participant who cannot manage on their own to the office that administers the benefit or to other locations in connection with application.
- Advocacy on behalf of the participant if a benefit/entitlement has been denied.
- Follow-up to ascertain whether the participant is receiving/will receive the benefit.
- Assisting the participant in timely recertification for the benefit/entitlement.

Compliance 1.3. The program completes the benefits and entitlement form in the NYC Aging participant data system.

Compliance 1.4. Immigrant Assistance. The program helps older immigrants adjust to new customs, systems and institutions, acquire benefits and entitlements, and develop support networks.

- The program provides assistance in the language of the immigrant requesting services, using interpretation services where necessary.

- Activities include but are not limited to: advocacy; assisted referral to immigrant assistance organizations and coordination to the extent necessary with other organizations providing assistance; translation of documents; linkages to culture-specific social service agencies; English as a Second Language linkages; interventions to address social isolation.

Compliance 1.5. Supportive contact. The program provides supportive contact to help individuals address problems of daily living, such as managing mail; making and remembering appointments; organizing daily activities; coping with specific personal or family problems.

- Support is provided only where there is an identified problem/need/issue.
- Assistance involves such activities as reassurance, clarification, advice giving, filling out papers or forms. *Note: Referral for mental health counseling should be considered when the participant's emotional or personal needs exceed the scope of this type of case assistance.*
- Each interaction to provide supportive contact is documented in case notes, with an explanation of the issue(s) addressed.

Compliance 1.6. Advocacy. The program helps participants who require personal representation or other types of advocacy to obtain an entitlement or needed service which has been denied (or which is in jeopardy of being denied); to prevent or forestall an action against the participant (e.g. eviction; service cut-off); to assist with housing problems; or to initiate a formal appeals process; etc.

Standard 2: Time-Limited Interventions

The program provides the service to participants who have a specific need, problem and/or issue appropriate for short-term or time-limited interventions.

Compliance 2.1. A determination is made during the initial participant interview that the participant has a specific need/problem/issue that can be addressed through specific activities of the worker over a period of time. *Note: Older adults with needs that the program cannot address are referred to a more appropriate provider, wherever possible.*

Standard 3: Intake Interview

The program completes an Intake Interview with each case assistance participant and enters pertinent information in NYC Aging's participant data system.

Compliance 3.1. Intake. An intake interview is conducted with each participant found to be appropriate for case assistance to learn more about their request. The participant's presenting problem, plan of action and follow-up schedule are to be documented in an initial Case Assistance note for the participant in NYC Aging's participant data system.

Compliance 3.2. Participant interviews are conducted in privacy in a location where participant confidentiality can be maintained.

Standard 4: Case Assistance Documentation

The program documents in case notes the appropriateness of the service provided to the participant based on their needs/issues/concerns.

Compliance 4.1. All worker activities related to each case assistance participant (i.e., type of activity, intake, case notes, consents, time spent, service termination, outcome, etc.) are entered into NYC Aging's participant data system.

Compliance 4.2. A case note is required in order to claim a Case Assistance unit. Case notes should clearly reflect the purpose of the contact, a summary of the service provided, actions taken, outcome or follow-up required, and whether the activity involved joint case review or subsequent independent follow-up. Documentation should clearly distinguish between joint case review activities and separate follow-up contacts.

- Entries include the date, name of person with whom there was contact, a brief summary of the reason for the contact, actions to be taken and who will be responsible for taking those actions.

Compliance 4.3. Case notes are written within four (4) business days of the actions taken and/or worker/participant contact.

Compliance 4.4. Case notes should be reviewed and marked as final by a supervisor within ten (10) business days of the date of the case note.

Standard 5: Resource Information
The program maintains comprehensive and up-to-date resource information.

Compliance 5.1. The program's information about eligibility and application requirements for benefits and entitlements needed by older adults is current and comprehensive. This may be in the form of paper resource files or electronic programs such as ACCESS NYC and BenefitsCheckUp.

Compliance 5.2. The program's information about resources and services available in its service area is current and comprehensive. It includes but is not limited to information about: NYC Aging-funded programs and other community resources such as mental health programs and legal assistance; social security office; tax preparation assistance; continuing education programs for older adults; low or no-cost health maintenance facilities; local hospitals and clinics; houses of worship; fraternal organizations; sources of immigrant assistance; culture-specific societies; food pantries; sources of free transportation; free holiday meals.

Compliance 5.3. The program's information on each resource includes the provider organization's name (including common name or acronym, if applicable), address, offices, telephone number, days and hours when open, eligibility requirements, fees and other crucial facts.

Standard 6: Promotion of Case Assistance Services
The program promotes utilization of case assistance service.

Compliance 6.1. The program's literature and other public materials include statements in each of the languages spoken by more than 30% of community residents that: (1) the program can assist with information about services, benefits and resources for older persons and with benefits/entitlements application; and (2) the program can provide this assistance in the primary language of the older adult requesting assistance.

- Program literature includes the service phone number if different from the program's main telephone number.

Compliance 6.2. The program publicizes hours when the service is available if these are at specific times of the day. When case assistance is available only during certain hours, notice of available dates and times is visibly posted in the languages spoken by more than 30% of members.

Level of Service

Standard 7: Budgeted Units
The program provides its budgeted annual units.

Compliance 7.1. The program provides the number of units specified in its contract.

Standard 8: Unit Definition
The program uses the correct definition in documenting service provision.

Compliance 8.1. The program reports units for each direct participant service (assistance to or on behalf of a participant). The unit also includes:

- Collateral contacts on behalf of the participant.
- Case review with supervisor. *Note: Time spent by the supervisor and the worker discussing or reviewing the case together can only be claimed by the worker **or** the supervisor, not both. If both do separate follow-up on the case, each records their own time spent separately.*
- Documenting participant information.

*Note: The unit does not include professional development such as training. Case assistance is a one-on-one service requested by the participant; units of case assistance do not include the provision of public information. Public information refers to **group informational activities** designed to inform participants or potential participants of available services and/or interventions initiated by the program for the purpose of identifying potential participants and encouraging their use of available services and benefits.*

Case Assistance Staffing

Standard 9: Staffing Levels and Qualifications

The required level of staff is secured, and staff have the required level of education and training to provide the service.

Compliance 9.1. As appropriate to the tasks they perform, all casework staff (including MSW-interns who are properly supervised) demonstrate the following skills and knowledge:

- Cultural sensitivity/competence in recognizing and addressing the special needs and challenges of diverse populations in the program's service area, including different socio-economic, racial and ethnic older populations as well as population with different cultural preferences and lifestyles and new immigrant populations.
- Knowledge of types of entitlements/benefits for older people and eligibility and application requirements.
- Knowledge of local and citywide resources for older persons.
- Ability to accurately prepare entitlement applications and to assist participants in gathering documentation and completing applications.
- Interviewing/assessment skills.
- Ability to make appropriate referrals and follow-up in a timely manner.
- Ability to write clear, professional case notes.
- Ability to work with participants empathically and respectfully.

Section D. NORC Healthcare Assistance

Introduction

NORC Healthcare Assistance is provided to older adults with specific health-related issues or needs that are short-term, non-urgent, or require only routine monitoring.

Unit of Service: One Unit = One contact of service to or on behalf of a participant.

Standard 1: Healthcare Assistance as a Core Service

The program provides Healthcare Assistance to NORC participants as a core service.

Compliance 1.1. Healthcare Assistance. Healthcare assistance may include the following:

- Health-related consultation;
- Short-term assistance dealing with specific health-related issues/needs or chronic conditions;
- Coordination/advocacy with healthcare providers;
- Health screenings;
- Monitoring of a specific condition for a limited period of time, such as blood pressure and other health indicators for residents who have been identified to be at risk;
- Help with medication management.

Compliance 1.2. Healthcare Assistance Provision and Staff Qualification. Healthcare assistance may be provided to individuals either by the program's healthcare worker or casework staff, depending on the nature of the assistance.

- Health screenings such as blood pressure monitoring and individual participant health consultations are conducted by a healthcare worker.
- Casework staff may help participants with scheduling appointments and contacting pharmacies.
- Healthcare assistance provided to participants is documented in the participant's case notes.

Standard 2: Documentation of Healthcare Assistance

The program documents Healthcare Assistance in NYC Aging's participant data system.

Compliance 2.1. A case file in the NYC Aging participant data system is opened for each NORC Healthcare Assistance participant, where contacts, service plans, and outcomes are documented in a timely manner.

Section E. NORC Case Management

Introduction

NORC Case Management is an independent and on-going process of identifying the needs and strengths of the older resident, developing a plan to address needs and build on identified strengths and capacities, and arranging and coordinating services and resources on their behalf. The goal of this service is to help residents maintain their independence to the extent possible and improve their current and future quality of life.

Unit of Service: One Unit = One hour of service to or on behalf of a participant including travel time.

Standard 1: Case Management as a Core Service

The program provides Case Management to NORC participants as a core service.

Compliance 1.1. Initial Assessment. The program conducts a comprehensive initial assessment, and annual (at minimum) reassessments thereafter, of each participant requiring NORC case management due to long-term needs or complex issues. In conducting an assessment/reassessment, the case manager uses the skills of observation, deduction, exploration and inquiry to obtain in-depth information about the participant's current strengths, resources (including formal and informal support systems), problems, needs, and quality-of-life goals. The purpose of the assessment is to evaluate all aspects of the participant's current functioning and situation in order to develop a comprehensive care plan.

Compliance 1.2. Assessment/Reassessment for NORC Case Management. The program conducts a comprehensive assessment using the NYC Aging approved NORC assessment tool in the participant data system. The case manager conducting the assessment obtains in-depth information about the participant's current strengths, resources (including formal and informal support systems), problems, needs, and quality-of-life goals. The purpose of the assessment is to evaluate all aspects of the participant's current functioning and situation to develop a comprehensive care plan.

- At minimum, participants are reassessed for NORC case management services annually when there have been no changes to the participant's living status or well-being.
- Participants receive an event-based reassessment after an acute medical event or if there is a major change in functional capacity, financial situation, social or physical environment, or a change to the formal/informal support system.

Compliance 1.3. Assessment Tool. The program completes (or updates at reassessment) all sections of the NYC Aging NORC Assessment in NYC Aging's participant data system within thirty (30) days of initial contact.

- The program's healthcare worker, if available, participates in the assessment with the case manager when the participant appears to have healthcare needs.
- The case manager and/or the healthcare worker seeks information relevant to the participant's presenting problems, recent care issues, and input from informal supports and others involved in the participant's care.
- With written permission from the participant, formal and/or informal caregivers are involved in the assessment process to the greatest extent possible.
- **Assessment Summary.** The program's written Assessment Summary includes a detailed description of any participant safety issues and describes the issues that need attention. The Assessment Summary additionally includes:
    - Participant's strengths, current formal and informal supports and resources;
    - Factors that impact the participant's everyday functioning and well-being;
    - Participant's current level of engagement in personal and community interests;
    - Participant goals and how the case manager will help the participant attain them.

Compliance 1.4. Assessment/Reassessment Sign-off. The case manager signs off on the initial assessment and subsequent reassessments. For example, the statement, "The case manager completed the Assessment on this date" is written at the end of the Assessment Summary in the case notes section.

Standard 2: Care Plan
A Care Plan is developed for participants.

Compliance 2.1. Care Plan. The case manager develops a comprehensive care plan based on the assessment. When participants have healthcare management and case management needs, the case manager coordinates with the healthcare worker in developing, implementing, and monitoring the care plan.

Compliance 2.2. Information and Counseling. Information and counseling are provided when discussing goals and presenting service options. The case manager promotes and respects participant autonomy in deciding which services best meet their needs.

Compliance 2.3. Care Plan Content. The care plan addresses all the participant's assessed needs and specified preferences through direct services and/or referrals to other programs. The care plan specifies:

- Services the NORC program will provide and the frequency of the services;
- Steps to engage the participant through personal interests with life in the community when disengagement is an issue;
- Types of care provided by caregivers and interventions to strengthen and support those caregivers;
- Coordination and referral to NY Connects when counseling and assistance with long-term care planning is needed;
- Referrals to other NYC Aging-funded services such as case management for home care and/or home delivered meals, elder justice services, transportation, legal assistance, etc.;
- Linkages to non-NYC Aging funded medical, non-medical, and other community services.

Compliance 2.4. Interventions. Interventions specified in the participant's care plan are implemented.

- The case manager makes all planned authorizations, linkages, and arrangements and carries out planned social work interventions.
- The case manager encourages and supports the participant in completing any actions that are the participant's responsibility.
- The healthcare worker carries out all planned interventions involving health care services and/or linkages.
- The healthcare worker specifies in the participant's care plan how the participant's health management needs will be met.
- The care plan is reviewed and updated at least annually, based on the reassessment.

Compliance 2.5. Care Plan Monitoring. The case manager or a staff person, under the case manager's direction, monitors the participant's care plan via phone or home visit as needed. Participant contact is made at least every sixty (60) days. Monitoring involves active inquiry, coordination, and follow-up to ensure that:

- Services are being implemented as authorized;
- Progress is being made to reach the participant's goals;
- Participant's needs are being addressed and new issues/needs come to the case manager's attention; and
- Problems with the care plan are identified and resolved.

Standard 3: Case Management Staff Qualification
Persons who provide case management have appropriate qualifications.

Compliance 3.1. Case Management staff are either trained professionals (hold a minimum of a Bachelor of Social Work degree OR a high school diploma AND four years or more of casework experience in a community social service or social action program) or are under the supervision of trained professionals.

Compliance 3.2. All casework staff demonstrate strong intake and assessment skills, cultural sensitivity and competence, knowledge of entitlement/benefits for older adult participants, local and citywide resources, the ability to prepare applications and assist participants in gathering documentation, and the ability to make appropriate referrals**.**

Section F. NORC Healthcare Management

Introduction

NORC Healthcare Management targets individuals who have immediate and on-going healthcare needs but may also focus on the overall health and well-being of the older population, identifying healthcare trends and issues within the NORC community. Healthcare Management is provided to participants who have received a NORC Case Management assessment and were found to need healthcare support and/or monitoring. NORC Healthcare Management has a similar overall goal as NORC Case Management but is provided by a qualified healthcare worker. The healthcare worker, as a member of an interdisciplinary team, provides individual healthcare consultation and coordination, and helps identified NORC residents live with and manage chronic conditions, respond to acute episodes, and get the care they need from the healthcare system.

Unit of Service: One Unit = One hour of service including travel time.

Standard 1: Healthcare Management as a Core Service

The program provides Healthcare Management as a core service.

Compliance 1.1. The program's healthcare worker provides healthcare management to individual participants by a qualified healthcare worker who serves as a member of an interdisciplinary team.

Compliance 1.2. Healthcare management staff must be on site a minimum of fourteen (14) hours per week. This schedule must include healthcare staff who are on site for two (2) days per week. For example: two full days or one full day and two half-days are both acceptable schedules.

Compliance 1.3. NORC Healthcare Management Provision. Healthcare workers:

- Provide individual health care consultation, coordination with doctors, and follow-ups;
- Help participants live with and manage chronic health conditions;
- Assist participants with accessing the healthcare system for proper care, and respond to acute episodes;
- Implement the health management interventions specified in the participant's care plan;
- Reassess the participant at least annually for new or ongoing healthcare needs;
- Conduct an event-based reassessment when there is an acute healthcare event; and
- Identify healthcare trends and issues within the NORC community.

Standard 2: Assessment/Reassessment

The program conducts a comprehensive assessment of the individual's needs.

Compliance 2.1. Assessment/Reassessment. This service is provided to individual participants who have been assessed using the NYC Aging NORC Assessment tool and Health and Wellness Status tool and who have been found to need immediate and/or ongoing healthcare support and/or monitoring.

- The participant is reassessed at least annually for new or ongoing healthcare needs.

Compliance 2.2. The assessment/reassessment is conducted in a private space where participant confidentiality can be maintained**.**

Standard 3: Care Plan

The program develops a care plan for the participant.

Compliance 3.1. Care Plan. The healthcare worker specifies in the participant's care plan how the participant's health management needs will be met.

- The participant's healthcare worker and case manager collaborate on development of the care plan when participant has both social service and healthcare needs.
- The care plan is reviewed/renewed or re-developed at least annually, based on the reassessment.

Compliance 3.2. The healthcare worker implements the health management interventions specified in the care plan.

Standard 4: Participant Monitoring
The program monitors participants' healthcare management.

Compliance 4.1. Participant Monitoring. The healthcare worker monitors the participant's healthcare management through follow-up and monitoring calls at least every sixty (60 days). (Follow-up calls may also be conducted by NORC case worker and reported back to healthcare worker.)

Standard 5: Documentation of Healthcare Management
The program documents Healthcare Management in NYC Aging's participant data system.

Compliance 5.1. A case file in the participant data system is opened for each NORC Healthcare Management participant, where contacts, service plans, and outcomes are documented in a timely manner.

Section G. NORC Health Promotion

Introduction

Health Promotion Services are provided in a group setting to promote physical and mental health, aid in the prevention of conditions that negatively impact health and facilitate older adult's ability to manage their own health. They help participants improve or maintain their quality of life and increase their awareness and understanding of healthy lifestyles. Programming can be offered directly by the program (using staff, volunteers, or consultants) or through linkages with community partners.

Unit of Service: One Unit = Each participant or attendee of a group session, class, or event. *Note: Each group session, class or event is at least 45 minutes in duration.*

Health Promotion services include but are not limited to:

- Physical fitness. Examples include but are not limited to group exercise classes, walking clubs, virtual bowling, dance, and movement classes.

- Health management programs. Examples include but are not limited to: blood pressure monitoring; weight management and other support groups; brain exercise/memory enhancement workshops; smoking cessation programs; routine screenings which may include (not limited to) hypertension, glaucoma, cholesterol, vision, hearing, diabetes, bone density, depression and nutrition screening to detect health and mental health problems; flu shots; medications review and management to prevent incorrect medication usage; educational workshops and presentations.

Examples showing how to calculate service units:

- 100 participants receive flu shots at an NORC = 100 units
- A health fair for older adults where 150 receive vision screening = 150 units
- A weekly walking program with 5 participants a week = 260 units (52 weeks x 5)
- One diabetes screening event that screened 72 older adults = 72 units
- Screened medications for 90 participants at a medication review event led by local pharmacists = 90 units
- 25 participants attended a "Know Your Numbers" presentation = 25 units

Note: The following are generally prohibited: Diagnostic tests that involve sedatives; invasive procedures that penetrate or break the skin or enter an internal body cavity; medication prescriptions; eye glass prescriptions (See "Invasive Procedures" in the Reference Section for exceptions to this policy.)

NORC Health Promotion Procedures and Methods

Standard 1: Health Promotion as a Core Service

The program provides physical fitness and mental/physical health management activities to promote participants' health as a core service.

Compliance 1.1. NORC Programming. Each week the program offers the number of weekly sessions as contracted.

- Sessions include fitness activities and physical/mental health management programs.
- NYC Aging encourages a mix of evidence based and non-evidence-based activities.

Compliance 1.2. Additional programming includes:

- Sessions/activities offered in collaboration with health care, academic, or other institutions in the community/City;
- Opportunities for center members to participate in off-site activities that promote health (e.g., gyms, libraries, recreation facilities, etc.);
- Enhancements to its nutrition program through linkages/opportunities for members to participate in communal gardening, food co-ops, farmer's markets, etc.;
- Activities targeted to health conditions prevalent among participants, as ascertained by the program through surveys, focus groups, or other types of investigation;

- Sessions/activities that encourage collaboration with or participation by neighborhood NORCs and older adult centers.
    - Examples: by opening activities to members of neighborhood NORCs and providing transportation to and from its site; offering joint activities with neighborhood NORCs; or providing sessions at the NORCs.

Compliance 1.3. If the program provides evidence-based fitness programs, they are guided by the EB-1 programs listed on the National Council on Aging (NCOA) website at: https://ncoa.org/evidence-based-programs.

Standard 2: Service Agreements

The program has signed Agreements with organizations that provide health screening or vaccination services to participants.

Compliance 2.1. Article 28 or 31 providers. If the provider of screening services is an Article 28 or Article 31 provider (see Reference Section) with a Certificate naming the program as an "extension site" the signed agreement stipulates:

- That the parties are independent contractors with respect to the services to be performed. Each of the parties will be responsible for their own acts and omissions.
- That neither party to the agreement will assume any liability or obligation of the other.
- That the medical service provider will maintain sufficient insurance coverage to cover all liabilities that may be incurred during the term of the agreement.
- That the medical service provider will hold harmless the City of New York, the Department for the Aging and the NYC Aging-funded program against all claims, actions or proceedings arising from the performance of the agreement.

Compliance 2.2. Non-Article 28 or 31 providers (external). If the provider of screening services is not an Article 28 or Article 31 provider with a Certificate naming the program as an "extension site", the provider and the program have a signed Health Screening or Vaccination Agreement (form will be provided by NYC Aging). Key provisions of the Agreement include:

- Services are provided free of charge.
- Participants will be informed (either in writing or through lecture) about the nature of the problem(s) the test detects, meaning of results, need to follow-up with their physician if problems are detected, preventive measures where applicable and other pertinent data.
- Participants will be informed individually of their test results when any problem has been detected. Participants may voluntarily elect to reveal to the screening organization their names and addresses to facilitate receiving screening reports in the privacy of their homes. Test results may also be mailed in sealed envelopes to each individual in care of the program.
- Participants in need of follow-up will be referred to their own physician or presented with a list of at least three (3) locally qualified providers of the needed services. The list may include the name of the screening organization.
- Medicare, Medicaid, or personal insurance information may be requested only for administration of vaccinations.

Standard 3: Disclaimer for Health Screening Participants

Health screening participants sign Disclaimer Forms utilizing the NYC Aging approved forms.

Compliance 3.1. Disclaimers. Each participant in a health screening or vaccination activity conducted by a health services provider signs a Consent and Disclaimer Form (form will be provided by NYC Aging) holding harmless the program and the City from all claims or actions resulting from the performance of health screening activities. Participants may sign once for a series of the same screening.

Standard 4: Participant Confidentiality

Participant confidentiality is maintained.

Compliance 4.1. The program does not disclose participants' Medicare/Medicaid or personal insurance identification numbers and/or social security numbers to any persons or organizations making presentations or providing screening services.

- Participants are advised that if they are asked for insurance information by the provider performing the screening or activity, they may provide the minimum information necessary to allow the provider to be paid (e.g., name, address, date of birth and Medicare number). They should not be asked for telephone numbers or other personal information.

Compliance 4.2. Providers of screening/examination service comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Standard 5: Service Provision
Service provision is non-commercial, non-coercive and free of charge.

Compliance 5.1. The program does not sell, allow to be sold, or endorse, either verbally or in writing, any product or health care service/provider.

- Staff are not permitted to accept any gifts or gratuities from presenters.

Compliance 5.2. Discretion is exercised in choosing which groups or vendors are permitted to make presentations at the program. Education for the benefit of older adult consumers is the reason for scheduling any presentation. Permission is refused to organizations that appear to be seeking to exploit a captive older adult audience.

Compliance 5.3. When presentations on new insurance options and health/safety or other products are scheduled to assist older adults in making informed decisions, the program encourages competitors to present on their services/products as well.

Compliance 5.4. Screening service is provided to participants regardless of whether they wish to provide their Medicare numbers or other identifying information to the screening provider.

Service Levels

Standard 6: Contracted Units
The program provides the number of contracted annual service units.

Compliance 6.1. The program provides the number of units specified in its contract.

Health Promotion Staff Appropriateness and Continuity

Standard 7: Staff Qualifications
Persons who provide health promotion services have appropriate qualifications.

Compliance 7.1. Health promotion services (education, fitness activities, support groups, screenings, blood pressure monitoring, medications review, etc.) are provided only by persons in the following categories:

- Staff or paid consultants (resumes indicating suitable qualifications are on file, and, where applicable, licensure or certification, references, and contracts).
- NYC Aging-trained volunteers.
- Student nurses, medical technicians or others in a New York State approved health sciences training program that supervises activities performed by their trainees.
- Employees of health care organizations that designate the program as a site where they provide community service.
- Professional health care consultants who provide free community service to the program (resumes listing qualifications are on file, including licensure where applicable).
- Employees of government agencies in the performance of their public health responsibilities.
- Employees of organizations or institutions with which NYC Aging has an agreement.

Standard 8: Supervision

All providers of health promotion services are appropriately supervised.

Compliance 8.1. The program's health promotion services are overseen by the program director or a person who has at minimum a Bachelor of Social Work degree, or a bachelor's degree and one year experience in health or social service provision, or an Associate's degree and two years health or social service experience, or four years of direct health or social service experience.

Compliance 8.2. Persons providing screening/testing or other health-related procedures are directly supervised by NORC staff or by staff of the institution they represent.

Physical Environment

Standard 9: Physical Environment

Health Promotion services are provided only in an appropriate setting. (Please refer to NYC Aging General Program Standards, Section 8)

Compliance 9.1. Health screening tests are conducted in spaces that:

- Are sanitary.
- Ensure privacy.
- Can accommodate the scope of the activity – e.g., screeners, participants, equipment, and a waiting area if necessary.

Compliance 9.2. The program has a properly functioning Automated External Defibrillator (AED) on site.

- The AED(s) is/are correctly assembled and properly functioning at all times.
- The program has the necessary up to date supplies and equipment on site. This includes:
    - AED pads and batteries that are current (not past expiration date)
    - A Fast Response Kit with refreshed supplies
- The program monitors the AED(s) and maintains a weekly log indicating the date the device was checked.
- The program has trained staff certified to operate an AED on site at all times that older adults are present.
- Signage
    - There is signage near the main entrance to the site that clearly indicates where the AED is stored and maintained.
    - Signs are posted near the AED with the names of the staff members certified to operate the AED and their contact information.
    - A copy of Site-specific and Maintenance Plan (see AED NYC Aging Manual) is available on site.

Health Promotion Documentation

Standard 10: Documentation

The program maintains required documentation.

Compliance 10.1. Health Screening Documentation:

- Signed Agreements with providers of screening services who are not employed by the provider.
- Signed Disclaimer Forms.
- Record of persons referred to a health care provider as the result of screening test administered by a staff person or an outside agency, including confirmation that counseling and referral of participants with abnormal or problematic results occurred.

Reference

Invasive Procedures

An invasive procedure is one that penetrates the skin or enters an internal body cavity. The following are exceptions to NYC Aging's prohibition against invasive procedures:

- Puncture of a finger by an RN, medical technician, or other qualified health professional to obtain a sample for blood glucose and other diagnostic tests.
- Administration of flu, pneumonia, COVID or Shingles vaccines by the Department of Health or qualified health care providers or registered pharmacists.
- Other procedures when:
    - The provider has prior written approval from NYC Aging to provide the services.
    - The program is listed as an "extension site" on the certificate of an Article 28 or Article 31 medical provider.
    - The provider has received a permit from the New York State Department of Health to run a one-time "health fair."
    - The provider has registered with the NY State Department of Health as a "limited testing site."

Examples of non-invasive procedures include: checking blood pressure; hearing and vision checks; mammograms; mental health screening; glaucoma screening; bone density screening; skin cancer screening; body fat analysis; foot examinations.

Disclaimer Form

A Disclaimer Form holds the program and the City harmless from all claims or actions resulting from the performance of a health screening activity by a non-City agency. Every participant in a health screening activity must sign a Disclaimer Form specific to each screening or series of screenings (e.g., Keep on Track blood pressure monitoring involves a series of screenings).

Extension Site of an Article 28 and Article 31 Provider

Medical institutions or clinics licensed by the State of New York to provide services may operate "extension sites" at NYC Aging-funded programs. The program site must be incorporated into and named in the clinic's Article 28 or Article 31 Certificate, which specifies the "extension sites" where the institution or clinic is licensed to provide services.

Extension program operated as Article 31 sites are monitored and regulated by the New York State Office of Mental Health. Article 28 sites are monitored and regulated by the New York State Department of Health.

Health Screening or Vaccination Agreement

The Health Screening or Vaccination Agreement (form will be provided by NYC Aging) is required of health screening services providers that do not have an Article 31 or Article 28 Certificate covering the NYC Aging-funded program where screening services will be performed.

Evidence-Based Health Programming (EB Programming)

These programs, approved by the Administration on Community Living, are based on scientifically designed research, where there is extensive data analysis and testing in the field to ensure efficacy and ease of replication in various settings. EB programming translates these tested program models and interventions into practical, effective community programs that can provide proven health benefits to participants. For a list of approved EB programs, visit: https://ncoa.org/evidence-based-programs

Section H. Education and Recreation

Introduction

Education/Recreation consists of scheduled and organized activities designed to foster the well-being of older persons through: (1) satisfying use of leisure time; (2) social interaction; (3) development/enjoyment of interests, skills, talents, creative expression; and (4) participant leadership.

Unit of Service: One Unit = One session of a group scheduled activity.

Education and Recreation Scope

Standard 1: Varied and Diverse Programming

The program offers varied and diverse programming in the areas of arts and culture, technology, and non-health related education/recreation.

Compliance 1.1. The program provides activities in each of these three categories: (1) arts and culture, (2) technology, and (3) non-health related education/recreation. Activities may take the form of organized and scheduled workshops, classes, discussion groups, trips, rehearsals, performances, games, sports, studio sessions and other types of session. Program makes an effort to offer activities as virtual programming in order to include homebound older adults.

Compliance 1.2. The program offers the number of sessions as contracted.

Compliance 1.3. The program includes technology within its Education/Recreation offerings, which may consist of training and education in the use of technology. Program establishes linkages with technology programs/providers in the community. Individual and group technology services are offered.

- Individual technology services would include one-on-one technical support related to the use of computers, tablets, and/or phones.
- Group technology services would include age-appropriate, group technology training classes that would encourage older adults to engage with technology, connect to other people, and research information on health and other meaningful topics of concern.

Standard 2: Planned Activities

Activities are planned, structured, and organized.

Compliance 2.1. Each activity has a planned beginning and ending time.

Compliance 2.2. The program posts and/distributes a calendar or schedule listing each activity, with its name and start time at least one (1) day before the activity is scheduled to occur.

Compliance 2.3. The posted calendar or schedule is current.

Compliance 2.4. Each group activity has a leader (staff, volunteer, or consultant) that teaches or leads the activity.

Compliance 2.5. All congregate activities must have a minimum of five (5) older adult participants in attendance at the time the activity is conducted to be considered claimable as a service unit.

Compliance 2.6. NORC members have leadership roles in planning activities.

Compliance 2.7. Each group activity is at least 30 minutes in duration.

Compliance 2.8. Group activities must be held on-site at the NORC location, unless this is not feasible. If not feasible, the activity can be held in a community space that is within a half (1/2) mile of the NORC, such as community centers, libraries, or older adult centers (If using OAC space, there must be a clear delineation of NORC and OAC roles, responsibilities, and allocation of services and units).

Compliance 2.9. Co-located OACs/NORCs may not invoice or be reimbursed for duplicative services. OACs/NORCs with different sponsors shall have an agreement or Memorandum of Understanding (MOU) delineating responsibilities for programming/services to ensure programs will not invoice or be reimbursed for duplicative programming or services.

Standard 3: Program Appeal to Older New Yorkers
Activities are designed to appeal to both current and prospective NORC members.

Compliance 3.1. The program has an annual (or more frequent) process for gauging interests among older persons in the community (participants and those who do not attend the program).

- The program can demonstrate that it responds to emerging interests and trends through new education/recreation offerings.

Standard 4: Participation
Activities are open to any member who wishes to participate.

Compliance 4.1. Eligible persons may participate in any activity on the program's schedule within the limits of space (e.g., room limitation), or specific proficiency requirements.

Standard 5: Publicizing Activities
The program publicizes its education/recreation activities in the community.

Compliance 5.1. The program's promotional activities in the community include information about the types of educational/recreational programs and activities it offers.

Compliance 5.2. At least one (1) special event or activity session during the year draws older adults from the community who are not members of the program at the time.

Level of Service

Standard 6: Budgeted Units
The program provides the number of budgeted units yearly.

Compliance 6.1. The program provides the number of units specified in its contract.

Standard 7: Unit Definition
The correct unit definition is used in reporting the level of education/recreation service.

Compliance 7.1. Units are reported only for scheduled education and recreation sessions that are planned, structured, and organized.

Compliance 7.2. Activities reported as education/recreation are not also reported as another service – for example, activities are not reported as both education and recreation and health promotion.

Compliance 7.3. The program indicates in NYC Aging's participant data system whether the session was conducted virtually, in-person, or hybrid (combination of virtual and in-person).

Compliance 7.4. Free Bingo. Pursuant to the NYS General Municipal Law, free bingo games cannot be conducted on more than one day per week and not more than thirty (30) times during any calendar year. The program must comply with all laws, rules, codes, ordinances, and licensing requirements that are applicable to the operation of bingo.

Education/Recreation Staffing

Standard 8: Staffing Levels and Qualifications
Instructors/leaders are appropriately qualified.

Compliance 8.1. Appropriate documentation is on file for each consultant or volunteer instructing or leading education/recreation sessions. This includes:

- Resume or application indicating that person is qualified (e.g., appropriate education, training).
- Contracts or written agreements specifying rates and number of sessions for individuals who are paid consultants.

Note: This does not apply for continuous play (games) education/recreation activities.

Education/Recreation Documentation

Standard 9: Documentation of Attendance
Each participant's attendance at an education/recreation activity is documented.

Compliance 9.1. The program documents each participant's attendance at an education/recreation activity in their record in NYC Aging's participant data system. *Note: Sign-in sheets are maintained as back-up.*

Section I. Transportation Services

Introduction

Transportation Services are intended to complement existing transportation services available to older adults in New York City. The program provides Individual and Group transportation.

NORC programs are responsible for ensuring their compliance with the entirety of the NYC Aging General Program Standards of Operation. All NORCs providing transportation must adhere to applicable requirements in the NYC Aging General Program Standards and the Transportation Services Standards published on the Contractor Tools page of the NYC Aging website: https://www.nyc.gov/site/dfta/community-partners/contractor-tools.page.

Unit of Service: One Unit = Trip (each one-way trip per person).

Standard 1: Eligibility

The program serves eligible individuals in its catchment area.

Compliance 1.1. The program serves participants 60 years or older who meet the eligibility criteria below:

For individual transportation:

- Reside in the NORC program's catchment area.
- Have been assessed and have a documented need for the service.
- Are unable to make a trip because it is beyond their walking or driving ability.
- Have a permanent or temporary physical, cognitive, sensory, or mobility limitation that prevents utilization of public transportation.
- Terminals for public transportation are situated beyond their walking ability.
- Trip by public transportation requires transfers beyond their ability.

For group transportation:

- NORC residents are transported to fixed destinations (e.g., recreational, cultural, educational, and social activities) to promote socialization and community involvement.
- Participants must be registered in the NYC Aging participant data system as a NORC member.

Note:

- Participants who do not meet the eligibility criteria are assisted with referral to other programs if possible, and the referral service is documented in the NYC Aging participant data system.
- The program does not provide medical transport to Medicaid participants. Medicaid participants requesting individual transportation to or from medical services are referred to Medicaid transportation.
- Transportation to non-medical appointments can be provided to Medicaid participants.
- The program does not assess participants for insurance eligibility.
- The program does not request medical insurance information from participants, including proof of insurance coverage.
- The program does not deny rides to participants based on their insurance status.
- The program may provide transportation to social and medical adult day care participants only in the event the participant is not Medicaid eligible or cannot get this service through their Medicaid Managed Care Plan. This is documented in the participant's file in the NYC Aging participant data system.
- NYC Aging funds must not be used for trips to casinos.

Standard 2: Informed Consent

The program obtains informed consent from each participant seeking transportation services. (Please refer to NYC Aging General Program Standards, Section 2)

Compliance 2.1. Consent to Refer and Share Personal Information. The program obtains signed consent to refer and share personal information form before any information is shared for referral to an NYC Aging-funded transportation service provider or other purposes.

Standard 3: Service Provision

The program provides the transportation services in its contract.

Compliance 3.1. The program provides services outlined in its contract.

- Trips may include, but are not limited to, medical appointments, social service appointments, stores, banks, paid or volunteer jobs, recreational activities, and places of worship.
- If capacity permits, and with NYC Aging's approval, trips may be provided to older adults who reside outside of the program's catchment area. These trips are authorized in writing (with reason for providing the trip explained) by the program director or transportation coordinator.
- With NYC Aging approval, limited trips may be provided to locations outside the boundaries of the five boroughs of NYC. Requests for approval must be submitted to NYC Aging at least one week prior to the trip.
- Trips must be pre-authorized in writing by NYC Aging. For both individual and group rides, maximum mileage does not exceed 40 miles outside of New York, unless prior approval is obtained from NYC Aging.
- Round trips must originate in the program's catchment area.
- Group trip must originate within the program's catchment area.
- Services cannot be exclusively offered to participants and programs within the program's organization.
- The program accepts referrals from hospitals, case management agencies and other social service providers.

Compliance 3.2. When feasible, drivers should be rotated among routes.

Standard 4: Persons with Disabilities

The program accommodates older persons with disabilities. (Please refer to NYC Aging Transportation Services Standards)

Standard 5: Accommodating Participants

The program accommodates as many participants as possible or facilitates their access to other transportation services. (Please refer to NYC Aging Transportation Services Standards)

Standard 6: Voluntary Contributions

The program has a written policy for soliciting, collecting, safeguarding, and accounting for voluntary contributions from transportation participants. (Please refer to NYC Aging Transportation Services Standards)

Standard 7: Budgeted Units and Rides

The program provides the number of budgeted transportation units and (rides) annually.

Compliance 7.1. The total number of units and (rides) delivered for transportation services is as contracted.

Compliance 7.2. The number of units reported to NYC Aging for transportation service matches the number of one-way trips participants received, as documented in NYC Aging's participant data system. (i.e., Service levels reported on invoices match levels recorded in NYC Aging's participant data system.)

Compliance 7.3. Each group trip must have a minimum monthly average of at least five (5) passengers each direction.

Compliance 7.4. The program must not exceed the approved budgeted monthly planned units without prior approval from NYC Aging.

Standard 8: Unit Definition

The program uses the correct unit definition in documenting the provision of services.

Compliance 8.1. The unit of service for an individual ride is each one-way trip per older adult. When budgeting and invoicing, providers will be reimbursed on the number of one-way rides per vehicle.

> Example: The NORC program organizes a trip to the local shopping center. Participants had the opportunity to purchase groceries and household items. Twenty-six (26) older individuals sign up and are brought to and from the shopping center. This is an example of group transportation. It is reported as fifty-two (52) units of transportation service (twenty-six individuals travel round trip).

Standard 9: Staffing Level

The program has sufficient staff to provide the transportation service. (Please refer to NYC Aging Transportation Services Standards)

Standard 10: Staff Qualification

The program ensures that transportation staff is appropriately qualified. (Please refer to NYC Aging Transportation Services Standards)

Standard 11: Staff Training and Supervision

The program ensures that transportation service staff are appropriately trained and supervised. (Please refer to NYC Aging Transportation Services Standards)

Standard 12: Quality of Service

The program ensures that service is safe, efficient, timely and reliable. (Please refer to NYC Aging Transportation Services Standards)

Standard 13: Monitor Costs

The program monitors costs charged by providers of car/taxi services to the program. (Please refer to NYC Aging Transportation Services Standards)

Standard 14: Vehicle Safety

The program ensures that vehicles are in safe operating condition. (Please refer to NYC Aging Transportation Services Standards)

Standard 15: Vehicle Maintenance

Vehicles are maintained in good condition. (Please refer to NYC Aging Transportation Services Standards)

Standard 16: Vehicle Insurance

The program ensures that vehicles are appropriately insured. (Please refer to NYC Aging Transportation Services Standards)

Standard 17: Emergency Preparedness and Procedures

The program has current plan and procedures for responding to emergencies. (Please refer to NYC Aging General Program Standards, Section 6)

Compliance 17.1. The program engages in emergency preparedness planning and exercises and works with NYC Aging to ensure the provision of services and continuity of care as directed by NYC Aging in an emergency and/or crisis.

Compliance 17.2. The program submits its emergency plan to NYC Aging's Office of Emergency Preparedness & Response ("OEPR").

Compliance 17.3. The program collaborates closely with OEPR to facilitate preparedness actions, training activities, and exercises.

Compliance 17.4. The program should be prepared to assist NYC Aging and NYC Emergency Management in the event of a local or citywide emergency. When requested, the program develops and submits to NYC Aging written emergency plans that list available vehicles for an emergency.

Compliance 17.5. The program has a written plan to deal with emergencies that occur on trips, such as accidents and medical emergencies. (See Compliance 27.3)

Compliance 17.6. In the event of a public health emergency, the program adheres to any additional guidance issued by NYC Aging.

Standard 18: Data Entry and Data Management

The program implements regular and appropriate data management and monitoring methods. (Please refer to NYC Aging Transportation Services Standards)

Standard 19: Documents and Records

Records and documentation are properly maintained. (Please refer to NYC Aging Transportation Services Standards, Section 2)

Section J. Friendly Visiting

Introduction

Friendly Visiting is a scheduled visiting service provided on a regular basis to older persons in their homes or virtually to (1) help reduce isolation, and (2) monitor the older person's safety, well-being and need for additional services. Friendly Visiting is not a one-time service.

Unit of Service: One Unit = Each contact with a participant with documented need for this service.

Standard 1: Eligibility
The program serves eligible older persons who need Friendly Visiting service.

Compliance 1.1. The program provides Friendly Visiting service to persons who meet the following criteria:
- Are 60 years of age or older.
- Have limited ability to leave home due to frailty, disability, or other health issues.
- Have few or no informal supports or opportunities for socialization (isolated or at risk for social isolation).

Standard 2: Adherence to Target Population
The program conducts outreach to the target population.

Compliance 2.1. The program does outreach to non-members in the NORC.
- The program can demonstrate referrals from the community (e.g., from social service agencies, hospitals, case management agencies, neighbors, friends, and families).
- The program conducts outreach specifically for this service if is not reaching its target population.

Procedures and Methods

Standard 3: Screening
The program provides the service only to participants with documented need for in-home assistance.

Compliance 3.1. A worker screens the request for friendly visiting service to make a preliminary decision about eligibility (i.e., need for in-home support due to frailty, disability, or other health issues and risk of social isolation). The interview takes place in the participant's home.

Compliance 3.2. If the participant needs additional services, the program refers the participant to a provider within two (2) weeks and follows up with the provider to confirm linkage has been made.
Note: Participants who do not meet in-home eligibility criteria are assisted with referral to the extent possible, and a "service ticket" is completed in NYC Aging's participant data system.

Standard 4: Visiting Schedule and Service Time Period
The program develops a visiting schedule with the participant and an effective end date for service provision.

Compliance 4.1. The worker establishes a visiting schedule with the participant but visiting occurs no less frequently than once every two (2) weeks.
- The schedule specifies the effective end date for the time period (number of weeks or months) during which service will be provided. *Note: The time period cannot be longer than one year without re-evaluation.*
- The schedule specifies the assigned visitor(s).
- Schedule and time period for service provision are documented in the participant's record.

Standard 5: Re-evaluation of Service Needs

The program re-evaluates the participant's need for the service at the conclusion of the time period specified on the visiting schedule.

Compliance 5.1. The participant's need for the service is re-evaluated at the conclusion of the time period indicated on the visiting schedule.

Compliance 5.2. Continued need is documented, or the service is terminated if need no longer exists.

Standard 6: Service Delivery

Visitors provide companionship and engage in conversation and activities with their assigned participants.

Compliance 6.1. The program makes every effort to ensure visitors and participants are compatible.

Compliance 6.2. The program provides each visitor with information about the participant's needs, circumstances, and interests before the first visit.

Compliance 6.3. The program lets the participant (or participant's emergency contact) know the name of the visitor before the first scheduled visit.

Compliance 6.4. The program ensures that visitors converse with their participants and regularly bring items such as crafts, games, books, etc., into the home and/or provide limited services such as letter writing, sewing or escort.

Standard 7: Monitoring Participant Safety

Visitors monitor participants' safety and welfare.

Compliance 7.1. Visitors document and report their participants' unmet needs, health problems and other problem situations to their supervisor.

Compliance 7.2. The supervisor follows up as necessary on all reported problems (for example, case management referral; additional services; phone calls to family members; benefits/entitlement assistance).

Compliance 7.3. Participant emergencies and other urgent situations are handled immediately and reported to NYC Aging within proscribed incident report timelines.

Staff Appropriateness and Continuity

Standard 8: Staffing

Staffing is appropriate to and adequate for the service.

Compliance 8.1. The number of full and/or part-time personnel (including volunteers) providing this service is sufficient to meet contracted service level.

Compliance 8.2. Volunteers. Visitors who provide the service:

- Are consistently available.
- Have been screened and interviewed to establish reliability and interest, by the staff person with oversight responsibility for the service.
- Have two references which have been checked.
- Have a visiting schedule on file.

- Have been assigned a supervisor.

Compliance 8.3. The service is overseen by a staff person who has at minimum a Bachelor of Social Work degree, or a Bachelor's degree and one year experience in social services provision, or an Associate's degree and two years social service experience or four years of direct social service experience.

Standard 9: Training and Supervision
The program trains and supervises visitors.

Compliance 9.1. All new visitors receive documented orientation on topics pertinent to the service they will be providing. Examples include but are not limited to: roles and responsibilities; relationship-building; limit-setting; services and activities that can be performed by the visitor; situations that should be reported to staff; how to "read" clues to a participant's needs; confidentiality; response to urgent situations; record keeping.

Compliance 9.2. Visitors communicate with their supervisors at least monthly to discuss their assigned participants.

Standard 10: Information Sharing
The program facilitates information sharing among visitors.

Compliance 10.1. There are demonstrable procedures and communication channels for communicating information about the participant to their visitors.
- Procedures protect the participant's confidentiality while maximizing the ability of each visitor to be helpful.

Service Levels and Reported Units

Standard 11: Budgeted Units
The program provides the number of budgeted units annually.

Compliance 11.1. The program provides the number of units specified in its contract.

Standard 12: Unit Definition
The correct unit definition is used in documenting service provided to the participant.

Compliance 12.1. Units are counted only for completed visit contacts with participants whose need for in-home support is documented in NYC Aging's participant data system and who have a visiting schedule. Completed collateral contact with a family member/emergency contact or other concerned individual regarding the participant's safety/welfare may be claimed as a unit of case assistance.

Note: One-time or occasional visits by members (e.g., sunshine, or other goodwill clubs) do not count as Friendly Visiting contacts unless an Intake has already been conducted and the visit(s) is(are) scheduled, or unless the visit results in an Intake and a schedule for visiting.
- Units may be counted for members who are temporarily homebound or hospitalized as long as they result in an Intake and regular schedule.

Compliance 12.2. Units reported as friendly visiting are not also reported as another service such as, education/recreation.

Recordkeeping

Standard 13: Recordkeeping

The program maintains required records.

Compliance 13.1. Participant records include:

- Intake information (eligibility for in-home support) in participant data system.
- Participant's visiting schedule, including estimated timeframe for service provision.
- Date of Service Start.
- Friendly Visiting contacts provided.
- Date(s) of service re-evaluation and documentation of continued need.
- Date of Service termination if participant is no longer receiving the service and reason for termination.
- Case notes documenting contacts with program, reports on participant needs from visitors, etc.

Compliance 13.2. Visitor records include:

- Name, address, contact information and family and emergency contact(s).
- Record of screening interview and references (particularly for volunteers).
- Record of supervisory contacts.

Section K. Housekeeping and Personal Care (Home Health Care)

Introduction

NORC Housekeeping and Personal Care services are provided to participants who need assistance with activities of daily living and/or instrumental activities of daily living. The main goal of Housekeeping and Personal Care is to assist older adults in their efforts to age in place by providing services that support the functioning of older adults in their homes.

Unit of Service: One Unit = Each hour of service.

Standard 1: Eligibility

The program serves individuals who meet the eligibility criteria for housekeeping and personal care services.

Compliance 1.1. All individuals authorized for NORC Housekeeping or Personal Care must meet the following requirements:

- be 60 years of age or older;
- have unmet needs for assistance with ADLs and/or IADLs based on assessment by the NORC program.
- be able to live safely in the home if support is provided; and
- there are no other resources available to assist the participant; and

Scope

Standard 2: Licensing

The program ensures the Home Care Agency is appropriately licensed.

Compliance 2.1. The program ensures the Home Care Aency (HCA) has a current license from the New York State Department of Health (NYSDOH). The NYSDOH licenses home care agencies to assure care is provided within health and safety standards established by statute and rule.

Standard 3: Employment Screening

The program ensures the Home Care Agency follows guidelines to screen staff and ensure workers who have direct in-person contact with participants complete required medical screenings prior to employment.

Standard 4: Housekeeping

The program provides assistance with housekeeping support tasks.

Compliance 4.1. The program provides some or total assistance to participants with the following housekeeping support tasks:

- Making and changing bed;
- Dusting and vacuuming living areas used by participant;
- Light cleaning of kitchen, bathroom and bedroom;
- Dishwashing;
- Listing needed supplies

Standard 5: Personal Care (Home Health Care)

The program provides assistance with personal care tasks.

Compliance 5.1. The program provides some or total assistance with personal care tasks. The program considers some assistance to mean that some tasks or functions are performed and completed by the participant with assistance from another individual. Total assistance means that all personal care tasks or functions are performed and completed for the participant.

- Bathing - sponge bath in the bed, tub or shower;
- Personal Hygiene - Grooming, including care of hair, shaving and ordinary care of nails, soaking, cleaning or filing nails, (Do not cut nails) cleaning teeth and mouth;
- Dressing - Assistance with putting on or taking off clothing including shoes;
- Mobility - Walking within and outside the home;
- Transferring - Transferring from bed to chair and/or to wheelchair;
- Toileting - including assisting participant on and off bedpan, commode, or toilet;
- Preparation of Meals in accordance with modified diets, including low sugar, low fat, low salt and low residue;
- Eating - Feeding; cutting foods and feeding to a participant directly;
- Self-administration of medication, including prompting participant of time, identifying the medication for the participant, bringing the medication and any necessary supplies or equipment to the participant, opening the container for the participant, positioning the participant for medication administration, disposing of used supplies and materials and storing the medication properly;
- Routine skin care;
- Changing simple dressings;
- Assisting participants with making phone calls.

Standard 6: Care Planning
The program develops a Care Plan for each participant.

Compliance 6.1. The program develops each participant's care plan, including service schedule, in consultation with the participant.

Compliance 6.2. The care plan includes:

- The day(s) and time(s) when participant should expect to receive services.
- The specific tasks with which the participant will receive assistance.
- The name of the worker assigned to the participant.
- Preferences of the participant regarding how tasks should be performed should be considered to the fullest extent possible.

Section L. Shopping Assistance

Introduction

Shopping Assistance provides help with shopping needs to older persons who can be safely maintained in their homes with fewer than four (4) hours a week of this service, alone or in combination with other services.

Unit of Service: Unit = One Contact.

Standard 1: Eligibility

The program serves eligible older persons who need shopping assistance.

Compliance 1.1. The program provides the service to persons who meet the following criteria:

- 60 years of age or older.
- Limited ability to leave home due to frailty, disability, or other health issues.
- Few or no informal supports (isolated or at risk for social isolation).

Compliance 1.2. The program does outreach to non-members in the NORC.

- The program can demonstrate referrals from the community - for example, from social service agencies, hospitals, case management agencies, neighbors, friends and families.
- The program conducts outreach specifically for this service if it is not reaching its target population.

Standard 2: Type of Participant

The program provides the service only to participants with documented need for in-home assistance.

Compliance 2.1. The program conducts an in-person interview with the participant to screen for eligibility and to obtain intake information.

Compliance 2.2. The program determines that the participant is eligible for in-home support (limited ability to leave home due to frailty, disability or other health issues and unavailability of informal supports to assist with needs).
Note: The program may accept referrals from hospitals, case management agencies or other social service agencies as indicating participant meets eligibility criteria. Participants who do not meet eligibility criteria are assisted with referral needs to the extent possible.

Compliance 2.3. The program opens a case record on each participant found to be appropriate for shopping assistance. *Note: The program may need to first register the participant in the NYC Aging participant data system if the participant has not been previously registered.*

Compliance 2.4. If the participant needs additional services, the program refers the participant to a provider within two (2) weeks and follows up with the provider to confirm linkage has been made.

Service Provision

Standard 3: Service Provision

The program provides shopping assistance service as contracted.

Compliance 3.1. The program provides shopping assistance as stated in its contract or current budget.

Compliance 3.2. When providing shopping assistance:

- The program has a written policy on whether Shoppers shop for or with participants, or both.
- The program provides Shoppers with carfare if needed for the shopping trip. The program does not pay Shoppers' travel costs to and from work.

Compliance 3.3. The program provides assistance with the following activities, as needed by the participant (and as pertinent to whether shopping for or with the participant):

- Making or reviewing shopping list (items needed) with the participant before going to the store.
- Collecting money, check or food stamps from the participant in order to make purchase (in accordance with program's policies).
- Shopping with the participant (or for the participant) for food, medicines or other necessities (program may limit grocery shopping to one store).
- Paying for purchases with the participant's money, in accordance with the program's policy.
- Returning items bought, change, and receipts to the participant.
- Reviewing purchased items with the participant.
- Assisting with unpacking and putting items away, if necessary.
- Accompanying the older person on the shopping trip.
- Helping to select items while shopping.
- Carrying packages.
- Helping the older person dress in outerwear such as coat, sweater or hat for the trip.
- Helping the older person lock and unlock their residence.

Note: The Shopper shall obtain receipts and submit these to the participant after reviewing the total costs with the participant.

Standard 4: Service Schedule

The program develops a service schedule with the participant with an effective end date.

Compliance 4.1. The program establishes a service schedule with the participant and specifies the time period during which the service will be provided (effective end date). *Note: The time period cannot be longer than one year without re-evaluation.*

- Schedule and time period for service provision are documented in the participant's record.

Standard 5: Re-evaluating Participant Need

The program re-evaluates the participant's need for the service at the effective end date of the service schedule.

Compliance 5.1. The participant's need for the service is re-evaluated at the conclusion of the time period specified on the service schedule (effective end date).

Compliance 5.2. Continued need is documented, and a new effective end date established, or the service is terminated if need no longer exists.

Standard 6: Safety and Follow-up

Shoppers monitor participants' safety and welfare.

Compliance 6.1. Shoppers document and report their participants' unmet needs, health problems and other problem situations to their supervisor.

Compliance 6.2. The supervisor follows up as necessary on all reported problems (for example, referral to a case management agency for additional services; entitlements/benefits assistance; phone calls to family members).

Compliance 6.3. Participant emergencies and other urgent situations are handled immediately and reported to NYC Aging within proscribed incident report timelines.

Level of Service

Standard 7: Budgeted Units
The program provides the number of budgeted units annually.

Compliance 7.1. The program provides the number of units specified in its contract.

Standard 8: Unit Definition
The correct unit definition is used in documenting service provided to the participant.

Compliance 8.1. Units are counted only for completed shopping contacts with participants whose need for in-home support is documented in NYC Aging's participant data system and who have a service schedule.

Note: In instances where a participant is unable to provide the necessary shopping need(s) to the Shopper, the program may communicate with a family member or emergency contact (i.e., a collateral contact) in order to determine the information needed for the Shopper to complete the Shopping Assistance.

Shopping Assistance Staffing

Standard 9: Staffing Levels and Qualifications
Staffing is appropriate to and adequate for the service.

Compliance 9.1. The number of full and/or part-time personnel (including volunteers) providing this service is sufficient to meet contracted service level.

Compliance 9.2. Volunteers. Program designates staff who is/are responsible for overseeing volunteer Shoppers, which includes:

- Screening and interviewing each Shopper to establish reliability and interest. Screening includes contacting at least two (2) references for the volunteer, which is documented.
- Provide supervision that ensures Shoppers are reliable/consistently available throughout the duration of their volunteer commitment.
- Providing Shoppers with their volunteer schedule and maintaining a copy in program records.

Compliance 9.3. The service is overseen by a staff person who has at minimum a Bachelor's of Social Work degree, or a Bachelor's degree and one year experience in social services provision, or an Associate's degree and two years social service experience or four years of direct social service experience.

Standard 10: Supervision
Staffing is appropriate to and adequate for the service.

Compliance 10.1. All new Shoppers receive documented orientation on topics pertinent to the service they will be providing. Examples include but are not limited to: program policies; roles and responsibilities; relationship-building; limit-setting; money management; services and activities that can be performed by the Shopper; situations that should be reported to staff; how to "read" clues to a participant's needs; confidentiality; response to urgent situations; record keeping.

Compliance 10.2. Shoppers communicate with their supervisors at least monthly to discuss their assigned participants.

Recordkeeping

Standard 11: Participant and Staff Records

The program maintains required records.

Compliance 11.1. Participant records include:

- Intake information (eligibility for in-home support) in participant data system.
- Participant's service schedule, including estimated time period in effect.
- Date of service start.
- Shopping contacts provided.
- Date(s) of service re-evaluation and documentation of continued need.
- Date of service termination if participant is no longer receiving the service and reason for termination.
- Case notes documenting contacts with program, reports on participant needs from visitors, etc.

Compliance 11.2. Staff records include:

- Name; address; contact information; and family and emergency contact(s).
- Record of screening interview and references (particularly for volunteers).
- Record of supervisory contacts.

Section M. Telephone Reassurance

Introduction

Telephone Reassurance is a scheduled calling service provided on a regular basis to older persons in their homes to (1) help reduce isolation, and (2) monitor the older person's safety, well-being and need for additional services. Telephone Reassurance is not a one-time service.

Unit of Service: One Unit = Each contact with a participant with documented need for this service.
Note: Voicemails do not count as contact with a participant and cannot be reported as a unit.

Standard 1: Eligibility

The program serves eligible older persons who need telephone reassurance.

Compliance 1.1. The program provides the service to persons who meet the following criteria:

- 60 years of age or older.
- Limited ability to leave home due to frailty, disability, or other health issues, which may be temporary.
- Few or no informal supports or opportunities for socialization (i.e., isolated or at risk for social isolation).

Standard 2: Adherence to Target Population and Target Areas

The program conducts outreach to the target population.

Compliance 2.1. The program does outreach to non-members in the NORC.

- The program can demonstrate referrals from the community - for example, from social service agencies, hospitals, case management agencies, neighbors, friends, and families.
- The program conducts outreach specifically for this service if it is not reaching its target population.

Telephone Reassurance Procedures and Methods

Standard 3: Screening

The program provides the service only to participants with documented need for in-home assistance.

Compliance 3.1. The program conducts a phone or in-person interview with the participant to screen for eligibility and to obtain Intake information.

Compliance 3.2. The program determines that the participant is eligible for in-home support in the form of Telephone Reassurance (limited ability to leave home due to frailty, disability or other health issues, and risk of social isolation). *Note: The program may accept referrals from hospitals, case management agencies and other social service agencies as indication that the participant meets eligibility criteria.*

Compliance 3.3. The program opens a case record in NYC Aging's participant data system on each participant who has been found to be appropriate for telephone reassurance. *Note: The program may need to first register the participant in NYC Aging's participant data system if the participant has not been previously registered.*

Compliance 3.4. The program collects information about the participant's interests, concerns and needs to facilitate the participant's interactions with the Caller (documented in case notes). If the participant needs additional services, the program refers the participant to a provider within two (2) weeks and follows up with the provider to confirm linkage has been made.

Standard 4: Calling Schedule

The program develops a calling schedule with the participant and an effective end date for service provision.

Compliance 4.1. The program establishes a calling schedule with the participant, but no less frequently than once every two (2) weeks.

- The schedule specifies the end date of the time period (number of weeks or months) during which service will be needed. *Note: The time period cannot be longer than one year without re-evaluation.*
- The schedule specifies the assigned Caller(s) and time of day when calls will be made.
- Schedule and time period for service provision are documented in the participant's record.

Standard 5: Re-evaluation of Service Needs

The program re-evaluates the participant's need for the service at the conclusion of the time period specified on the calling schedule.

Compliance 5.1. The participant's need for the service is re-evaluated at the conclusion of the time period specified on the calling schedule.

Compliance 5.2. Continued need is documented, or the service is terminated if need no longer exists.

Standard 6: Service Delivery

Callers provide reassurance and support to their assigned participants.

Compliance 6.1. The program makes every effort to ensure callers and participants are compatible.

Compliance 6.2. The program provides each caller with information about the participant's needs, circumstances, and interests before the service starts.

Compliance 6.3. The program lets the participant (or participant's emergency contact) know the name of the Caller before service starts.

Compliance 6.4. Callers inquire about and follow up on participant concerns and interests.

Standard 7: Monitoring Participant Safety

Callers monitor participants' safety and welfare.

Compliance 7.1. Callers document their participants' reported needs, health problems or other problem situations for review with their supervisor(s).

Compliance 7.2. The supervisor follows up expeditiously on all reported problems (for example, case management referral; additional services need; phone calls to family members).

Compliance 7.3. Participant emergencies and other urgent situations are reported and handled immediately and reported to NYC Aging within proscribed incident report timelines.

Telephone Reassurance Staff Appropriateness and Continuity

Standard 8: Staffing

Staffing is appropriate to and adequate for the service.

Compliance 8.1. The program is sufficiently staffed (including volunteers) to provide contracted program levels.

Compliance 8.2. Volunteers. Program designates staff who is/are responsible for overseeing volunteer Callers, which includes:

- Screening and interviewing each Caller to establish reliability and interest. Screening includes contacting at least two references for the volunteer, which is documented.

- Providing supervision that ensures Callers are reliable/consistently available throughout the duration of the volunteer commitment.
- Providing Callers with their volunteer schedule and maintaining a copy in program records.

Compliance 8.3. The service is overseen by a staff person who has at minimum a Bachelor's of Social Work degree, or a Bachelor's degree and one year experience in social services provision, or an Associate's degree and two years social service experience or four years of direct social service experience.

Standard 9. Training and Supervision
The program trains and supervises callers.

Compliance 9.1. All new callers receive documented orientation on topics pertinent to the service they will be providing. Examples include but are not limited to: roles and responsibilities; relationship-building; limit-setting; services and activities that can be performed by the caller; response to urgent situations; record keeping.

Compliance 9.2. Callers communicate with their supervisors at least monthly to discuss their assigned participants.

Standard 10: Information Sharing
The program facilitates information sharing among callers.

Compliance 10.1. There are demonstrable procedures and communication channels for communicating information about the participant to their callers.
- Procedures protect the participant's confidentiality while maximizing the ability of each Caller to be helpful.

Service Levels and Reported Units

Standard 11: Budgeted Units
The program provides the number of budgeted units annually.

Compliance 11.1. The program provides the number of units specified in its contract.

Standard 12: Unit Definition
The program uses the correct unit definition in documenting service provided to the participant.

Compliance 12.1. Units are counted only for:
- Completed telephone contacts with participants whose need for in-home support is documented in NYC Aging's participant data system and who have a calling schedule.
    - Exception: Units may also be counted for one-time/occasional contacts with members whose absence has caused concern (e.g., frail usual attendee who needs monitoring; absence of more than one week by someone who attends regularly; member who is recovering from a serious illness). The program enters a "need for service" note in participant's record in NYC Aging's participant data system.

Note: Units reported as telephone reassurance may not be reported as another service, such as education/recreation, case assistance, etc.

Recordkeeping

Standard 13: Records

The program maintains required records.

Compliance 13.1. Participant records include:

- Intake information (eligibility for in-home support) in participant data system.
- Participant's calling schedule, including estimated timeframe for service provision.
- Date of service start.
- Telephone Reassurance contacts provided.
- Date(s) of service re-evaluation and documentation of continued need.
- Date of service termination if participant is no longer receiving the service and reason for termination.
- Documentation of any contacts between participant and supervisor/coordinator.

Compliance 13.2. Caller records include:

- Name, address, contact information and family and emergency contact(s).
- Record of screening interview and reference checks (particularly for volunteers).
- Record of supervisory contacts.