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.

Updated January 2025

Table of Contents

Introduction

NORC Supportive Services Programs (NORCs) support the aging-in-place of older residents of Naturally Occurring Retirement Communities (NORCs). Operated as partnerships among the housing entity, older NORC residents, a health care provider and a provider of social services, 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 core required services of: **Case Management**, **Case Assistance**, **Health Care Management**, **Health Care Assistance**, **Group Health Promotion** and conducting **Health Indicator Surveys** that inform health programming. They also provide other optional NORC services proposed in their response to NYC Aging's Request for Proposal (RFP), including Education and Recreation, Transportation, Escort /Assisted Transportation, Friendly Visiting, Shopping Assistance, Housekeeping, Chore, and Telephone Reassurance.

These Standards are applicable to all NYC Aging-funded NORCs. NORCs are also required to comply with applicable requirements in NYC Aging's General Standards of Operation (https://www.nyc.gov/assets/dfta/downloads/pdf/community/General-Program-Standards-v02-01-2023.pdf).

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.

Notes:

- *Older adults from the outside NORC housing community may be deemed eligible for some group services, as determined by the NORC partnership.*

- *Service denial to eligible individuals may occur under these circumstances:*
  - *Reasons stated in service-specific standards.*
  - *Another provider can more appropriately serve the individual (the individual may be referred to that provider).*
  - *In accordance with program policies and procedures when the individual's behavior causes physical or mental harm to other.*

***Note**: Services should be provided to all eligible individuals, unless funding is not available, the NORC SSP is unable to meet needs, or the client's needs can be more appropriately met by other services or provider.*

Standard 2. Target Population

The program serves its priority and target population.

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 2 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 – has 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 underserved residents.

Compliance 3.1. Outreach to Underserved Residents. The Program conducts outreach to residents perceived as underserved 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 under-served groups within the NORC community.
- Organizes a 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 – 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.
- The program has 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.

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.).
- Makes specific, demonstrable, and regular efforts to bring homebound older adults to the program location for activities, meetings, special events, etc.

Administration

Standard 4. Hours of Operation

The program is open, and services are provided during budgeted hours of operation.

Compliance 4.1. The program is open 249 days annually (250 during a leap year).

Compliance 4.2. The NORC program's director or her/his appropriate delegate is present at the program during hours of operation (e.g., 8:00a.m to 4:00pm, or 9:00am to 5:00pm).

Compliance 4.3. Hours of operation are posted at point of entrance.

Compliance 4.4. The program responds to telephone calls during business hours in a timely manner.

Compliance 4.5. The program has at least one dedicated phone line during its hours of operation

Compliance 4.6. If the program needs to close due to an emergency or as mandated by State or City authorities, such as DOHMH or NYPD, the program notifies NYC Aging immediately and follows approved emergency procedures.

Standard 5. Informed Consent

The program obtains informed consent from each client. (See also NYC Aging General Program Standards, Section 2)

Compliance 5.1. Consent to Collect Personal Information. The program obtains consent to collect and record data from clients before any personal identifying information is entered into the NYC Aging client data system.

Compliance 5.2. Consent to Refer and Share Personal Information. The program obtains signed consent to refer and share personal information from the client before any information is shared for referral or other purposes.

Compliance 5.3. Revocation of Consent. Clients wishing to revoke consent are provided with an Informed Consent Revocation Form. Consent remains in effect until the client revokes it.

Compliance 5.4. Documentation of Consent. The program utilizes the NYC Aging approved consent forms. The program uploads all signed consent forms in the client's record in the client data system.

Compliance 5.5. Consent for non-English Speakers. Consent documents are available to clients in the language understandable to them.

- If necessary, the program uses a certified interpreter to aid in the consent process. (See NYC Aging General Program Standards, Standard 9 for more on Language Access requirements.)

Standard 6. Language Access and Cultural Competence

The program is linguistically and culturally competent. (See also NYC Aging General Standards of Operation, Standard 9)

Compliance 6.1. Language Access. The program provides language assistance free of charge to persons with limited English proficiency (LEP). At minimum, the program has a telephonic interpretation service contract or similar community arrangement with a language interpretation services provider to assist LEP individuals.

Compliance 6.2. Cultural Competence. Services are provided with respect for cultural differences, preferences, and styles of communication, and with skill in assisting individuals in overcoming cultural and linguistic barriers.

Standard 7. Complaints and Grievance Procedures

The program has written Complaints and Grievance Procedures. (See also NYC Aging General Program Standards, Standard 12)

Compliance 7.1. Complaints. The program has a written complaint policy and procedure that covers the following categories of complaints:

- Complaints about service denial.
- Complaints about satisfaction issues (e.g., program services or staff).
- Complaints about other NORC clients.

Compliance 7.2. Grievances. The program has a written grievance policy and procedures that includes:.

- Methods for notifying clients or service applicants of their right to file a grievance.
- The steps to be followed in filing a grievance.
- Reasonable timeframes for filing a grievance, investigating the grievance, reaching a decision, and having that decision communicated in writing to the grievant.
- An opportunity for the grievant to present her/his grievance, along with any pertinent information or documents relating to the issues, to a clearly identified individual or group of individuals that has the authority to make a binding decision.
- The criteria to be used for making a decision on the grievance.
- A process by which a client may appeal an initial decision made by the program.

Compliance 7.3. The program advises clients that assistance is available, upon request, to help with filing grievances; e.g., drafting a written grievance for those who are unable to or have difficulty doing so.

Compliance 7.4. The program ensures that the entire grievance process, including any written materials, is treated in a confidential manner.

Compliance 7.5. If large groups (more than 30%) do not speak English, the grievance procedures are written in their languages.

Compliance 7.6. The grievance procedure is posted in a visible location.

Compliance 7.7 The program maintains all relevant documents and records related to grievances on file for a minimum of six (6) years.

Standard 8. Incident and Accident Reporting and Recording
The program has written procedures for incident and accident recording and reporting.

Compliance 8.1. The program documents all incidents and accidents on NYC Aging's Incident/Accident Report Form found at (link to form in PRISM).

Compliance 8.2. Upon request, the program provides additional details about information in the report.

Compliance 8.3. Incidents and/accidents involving serious injury or death of a participant are reported immediately to NYC Aging and to appropriate authorities.

Compliance 8.4. The program provides requested information (including phone numbers, data, reports, etc.) to NYC Aging related to an ongoing emergency situation preferably by the Close of Business, but no later than 10:00 a.m. EST the following morning.

Standard 9. Emergency Preparedness and Response
The program maintains emergency procedures. (See also General Program Standards, Standard 27)

Compliance 9.1. The program has comprehensive accident and emergency procedures, which includes fire/other evacuation emergency procedures.

Compliance 9.2. The program requests and maintains emergency contact information for all clients.

Staffing

Standard 10. Staffing Levels and Qualifications
The required level of staffing is secured, and staff has the required level of education and training to provide the contracted services.

Compliance 10.1. The program screens all potential employees and volunteers to verify credentials, experience, and skills, and obtains at least two (2) references.

Compliance 10.2. Director. The program has a full-time NORC SSP Director. The Director has a master's degree in social work or in a related field with significant relevant experience, or a bachelor's degree with significant experience**.**

Compliance 10.3. Healthcare Professional. The program has an experienced healthcare professional on-site commensurate with healthcare programming. The Healthcare Professional 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 11. Health Indicators Surveys

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

Compliance 11.1. Implementation. The program can demonstrate that it has conducted a valid Health Indictors Survey of older NORC residents within the timeframe directed by NYC Aging.

Compliance 11.2. Survey Follow-up. The program can demonstrate that it:

- Follows up through health care management service or health care 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 clients.
- 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.

Compliance 11.3. Frequency of Survey. The program conducts at least one (1) Health Indicator Survey within the contract period.

Partnerships and Linkages

Standard 12. Core Partners

The program operates a successful partnership with its "Core Partners" - a social service provider, a healthcare provider, the NORC residents, and the NORC housing/residential entity.

Compliance 12.1. 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 12.2. Memorandum of Understanding. The program and its core partners create a Memorandum of Understanding that clearly specify roles, responsibilities, and accountability for each of the core partners, and lines of communication among the partners.

Compliance 12.3. Partnership Meetings. Partnership meetings are held either in person or telephonically at minimum four (4) times per year with core partners, and other stakeholders as appropriate, at which time the 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 12.4. 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, which require that two older adult residents from the housing development are on the Board, as well as the on-site housing manager.

Compliance 12.5. 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 12.6. Health Care Partners. Where the Health Care Partner is not the Program Sponsor/Contractor, the program maintains an effective and collaborative relationship with the health partner. The health partner 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.

- A program document, such as a Memo of Understanding, (MOU) or other agreement is created that specifies the role and function of the health care partner.

- There is an operating protocol that guides the daily interface between social work and healthcare services.
- The Health Care 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 health care 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 health care provider.
- Health care providers must comply with all appropriate federal, state and city laws and regulations pertaining to the services they provide. For example, the health care provider respects a clients' right to choose which Certified Home Health Agency, vendor, etc. they want to be referred to. 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 health care provider must disclose this information to the client who needs those services.

Compliance 12.7. 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.

- A program document, such as a Memo of Understanding (MOU) or other agreement, is created 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. (For example, signs and symptoms of an older person in trouble, how to make referrals to the program, etc.)
- Program staff understands 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 community wide issues, the NORC-SSP and housing work together in responding in a timely way 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 housing to refer residents to the program.
- Housing management notifies the program when there are complex wide issues so the program can respond in a timely way to residents that might be impacted by these changes.
- Management works in conjunction with the program concerning emergency plans and safety requirements.

Compliance 12.8. Resident Partners. The residents of the NORC are a full partner 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 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 12.9. Inter-Disciplinary 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 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.

Compliance 12.10. Volunteers. A key component of a successful NORC-SSP is an active corps of volunteers, especially among older adult residents.

Role and Responsibilities of the NORC Program.

- 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 a signed confidentiality agreement from each volunteer.
- The program enforces procedures regarding client rights to confidentiality.
- Volunteers are provided with and orientation kit, which includes:
    - The mission of the NORC-SSP
    - Program policies and procedures
    - Written job description
    - Specific standards for service performed.
- Volunteers receive an orientation, which includes:
    - Specific volunteer roles and responsibilities
    - Information on identified staff person who will supervise volunteer.
    - Clients' rights including confidentiality, consideration, respect, and individual choice
    - Emergency procedures
    - Profile of specific NORC community
    - Specific program components

Roles and Responsibilities of Volunteers

- Volunteers complete forms that indicate their emergency contact information.
- Permission of a Parent or Guardian is obtained for volunteers who are minors.
- Volunteers sign a confidentiality agreement and abide by procedures governing client confidential information.
- Volunteers can demonstrate that they have an understanding of the mission and goals of the program.
- Volunteers have an understanding of emergency procedures.

Standard 13. Partnership Board and Advisory Board

The program establishes and maintains an active Partnership Board,[1] and a Community Advisory Board [2] or a combination thereof [3].

Compliance 13.1. Partnership Board. The program has a Partnership Board, which consists of the partners identified in the RFP (Social Service Provider, Health Care Partner, NORC Resident Representative and Housing Management). Representatives of the Partnership Board and representatives of the NORC residents (optional) meet either in person or telephonically at minimum four (4) times per year**.**

Compliance 13.2. Community Advisory Board. The program has a Community Advisory Board, whose members include the Social Service Provider, older adult residents, community service organizations, community institutions, local businesses and / or government agencies with a presence in the community. The Community Advisory Board holds a minimum of two meetings yearly to promote the social and civic engagement of older residents. If the program is located in a public housing NORC, the program also adheres to NYCHA guidelines regarding advisory councils, which require that two older adult residents from the housing development are on the Board, as well as the on-site housing manager.

Standard 14. Linkages

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

Compliance 14.1. Linkages with the Greater Community Surrounding the NORC. The Program can demonstrate effective linkages with the greater community surrounding the NORC.

[1] Partnership Board is the governing board consisting of representatives from each of the core partners.
[2] Community Advisory Board consists of representatives from the core partners as well as other stakeholders from the larger community.
[3] The NORC SSP and its partners have flexibility in how governing and advisory boards are structured.

- 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 clients.
- 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 Community Advisory/ Partnership Board.
- The Program fosters and nurtures an environment of volunteerism and engages formal and informal volunteers in the community.
- 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 and 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 14.2. 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 clients 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, program staff from NYC Aging funded programs including case management, home delivered meal providers, and older adult centers are invited to meet to coordinate efforts to meet the needs of the NORC older adults served in common through case review.
- On an annual basis, NYC Aging funded case management and home delivered meal programs are invited to partnership meetings that include broader community of stakeholders.

Compliance 14.3. Outcome of Linkage. The program can demonstrate that it has leveraged support from the surrounding community by achieving at least one of following annually:

- The Program receives additional financial and 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 15. Knowledge of the Community

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

Compliance 15.1. NORC Residents. The program demonstrates its knowledge of the NORC residents.

- The program provides descriptive information to NYC Aging on an annual basis on the NORC demographics, and on the older adults served by the NORC Program. This information includes, at a minimum, gender, age ranges, living status, ethnicity, race, number in household, and income range.
- The program can demonstrate relationships with key resident leaders, older adults and non- older adults, in the NORC.

Compliance 15.2. 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 16. Knowledge of Community Assets

The program demonstrates knowledge of the community assets.

Compliance 16.1. Knowledge of Community Assets. The program:

- Provides a description of the physical/geographic/social landscape of the community on a yearly basis.
- Maintains and updates relevant information on community resources, including:
    - Key businesses serving the residents of the community.
    - Cultural, religious and education institutions in the community.
    - Key health care 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.

NORC Case Assistance

Introduction

Case Assistance service assists older consumers 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 client.

Case Assistance Services

Standard 1. Service Provision

The program provides comprehensive case assistance.

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

Note: In instances where follow-up with the client is more appropriate, the program follows up with the client 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, Benefits Check-up and/or other electronic programs where possible.
- Counseling when the client is reluctant to apply.
- Assistance filling out forms, completing paperwork and/or collecting documentation.
- Submission of forms on the client's behalf.
- Accompanying the client who cannot manage on her/his own to the office that administers the benefit or to other locations in connection with application.
- Advocacy on behalf of the client if a benefit/entitlement has been denied.
- Follow-up to ascertain whether the client is receiving/will receive the benefit.
- Assisting the client in timely recertification for the benefit/entitlement.

Compliance 1.3. The program completes the benefits and entitlement form in the NYC Aging client 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; ESL 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 client'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 clients 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 client (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 clients 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 client interview that the client 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 client and enters pertinent information in NYC Aging's client data system.

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

Compliance 3.2. Client interviews are conducted in privacy in a location where client confidentiality can be maintained.

Standard 4. Documentation

The program documents in case notes the appropriateness of the service provided to the client's needs/issues/concerns.

Compliance 4.1. Case notes reflect complete and appropriate actions taken, client issues, and other pertinent matters.

- 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 4.2. Case notes are written within four business days of the actions taken and/or worker/client contact.

Compliance 4.3. Case notes should be marked as final 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 ACCESSNY and Benefits Check-UP.

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; 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.
- See also General Program Standards, Standard 9: Language and Cultural Competency.

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. Service Definitions

The program uses the correct definition in documenting service provision.

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

- Collateral contacts on behalf of the client.
- 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 her/his own time spent separately.*
- Documenting client information.

*Note: The unit does not include professional development such as training. Case assistance is a one-on-one service requested by the client; units of case assistance do not include the provision of public information. As per NYSOFA's definition, Public Information refers to **group informational activities** designed to inform clients or potential clients of available services and/or interventions initiated by the program for the purpose of identifying potential clients 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 students) 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 clients in gathering documentation, completing applications.
- Interviewing skills.
- Ability to make appropriate referrals and follow-up in a timely manner.
- Ability to write clear, professional case notes.
- Ability to work with clients empathically and respectfully.

Standard 10. Training and Supervision

Staff receive appropriate training and supervision.
(Also see General Program Standards.)

Compliance 10.1. Each casework staff has a designated supervisor who reviews the worker's intakes, referrals, application assistance, follow-up, case notes and case closings with the worker on a regular schedule determined by the program.

Target Populations

Standard 11. Serving Older New Yorkers

Within funding limits, the program provides case assistance to any resident age 60+ who seeks out these services.

Compliance 11.1. The program can demonstrate that it serves persons who live in the NORC.

Compliance 11.2. The program makes targeted efforts to reach the most vulnerable older adult populations in its service area, including low-income and minority older adults, older adults with Limited English Proficiency (LEP), and other under-served older adults.

Recordkeeping

Standard 12. Documentation of Clients and Services

The program maintains required documentation of client and service information.

Compliance 12.1. All worker activities related to each case assistance client (type of activity, intake, case notes, consents, time spent, service termination, etc.) are entered into NYC Aging's client data system in the appropriate module.

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.

Standard 1. Healthcare Assistance as Core Service

The program provides Healthcare Assistance to NORC clients 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. Healthcare assistance may be provided to individuals either by the program's health care professional or casework staff, depending on the nature of the assistance.

- Health screenings such as blood pressure monitoring and individual client health consultations are conducted by a health care professional.
- Casework staff may help clients with scheduling appointments and contacts with pharmacies.
- Healthcare assistance provided to clients is documented in the client's case notes.

Standard 2. Documentation of Health Care Assistance

The program documents Health Care Assistance in NYC Aging's client data system.

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

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: One hour of service to or on behalf of a client.

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

Procedures and Methods

Standard 1. Case Management as a Core Service

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

Compliance 1.1. Initial Assessment. The program conducts a comprehensive initial assessment, and annual (at minimum) reassessments thereafter, of each client 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 client'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 client'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 client data system. The case manager conducting the assessment obtains in-depth information about the client'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 client's current functioning and situation to develop a comprehensive care plan.

- At minimum, clients are reassessed for NORC case management services annually when there have been no changes to the client's living status or well-being.
- Clients 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 client data system within 30 days of initial contact.

- The program's health care professional, if available, participates in the assessment with the case manager when the client appears to have health care needs.
- The case manager and/or the health care professional seeks information relevant to the client's presenting problems, recent care issues, and input from informal supports and others involved in the client's care.
- With written permission from the client, formal and/or informal caregivers are involved in the assessment process to the greatest extent possible.

Compliance 1.4. Assessment Summary. The Summary includes a detailed description of any client safety issues and describes the issues that need attention. The Assessment Summary includes:

- Client's strengths, current formal and informal supports and resources;
- Factors that impact the client's everyday functioning and well-being;
- Client's current level of engagement in personal and community interests;
- Client goals and how the case manager will help the client attain them.

Compliance 1.5. Assessment/Reassessment Sign-off. The case manager signs off on the initial assessment and subsequent reassessments. For example, "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 clients.

Compliance 2.1. Care Plan. The case manager develops a comprehensive care plan based on the assessment. When clients have health care management and case management needs, the case manager coordinates with the health care professional in developing the care plan, implementing the care plan, and monitoring of 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 client autonomy in deciding which services best meet their needs.

Compliance 2.3. Care Plan Content. The care plan addresses all the client'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 client 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 abuse services, transportation, etc.;
- Linkages to non-NYC Aging funded medical, non-medical, and other community services.

Compliance 2.4. Interventions. Interventions specified in the client'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 client in completing any actions that are the client's responsibility.
- The health care professional carries out all planned interventions involving health care services and/or linkages.
- The health care professional specifies in the client's care plan how the client'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 client's care plan via phone or home visit as needed. Client contact is made at least every two (2) months (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 client's goals;
- Client'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.

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 clients 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 professional. The healthcare professional, 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.

Procedures and Methods

Standard 1. Health Care Management as a Core Service.

The program provides Health Care Management as a core service.

Compliance 1.1. The program's health care professional provides health care management to individual clients by a qualified healthcare professional who serves as a member of an interdisciplinary team.

Compliance 1.2. NORC Healthcare Management Provision. Healthcare professionals:

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

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

Standard 3. Care Plan

The program develops a care plan for the client.

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

- The client's health care professional and case manager collaborate on development of the care plan when client 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 health care professional implements the health management interventions specified in the care plan.

Standard 4. Client Monitoring

The program monitors clients' health care management.

Compliance 4.1. Client Monitoring. The health care professional monitors the client's health care management through follow-up and monitoring calls at least every two months. (Follow up calls may also be conducted by NORC case worker and reported back to health care professional.)

Standard 5. Documentation of Health Care Management

The program documents Health Care Management in NYC Aging's client data system.

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

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. 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. *One Unit = each participant or attendee of a group session, class, or event.*

- 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.

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.) One Unit = each participant or attendee of a group session, class, or event.

Procedures and Methods

Standard 1. Programming

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

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);
- 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 or other types of investigation.
- Sessions/activities that encourage collaboration with or participation by neighborhood NORCs and older adult centers, for example 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 center provides evidence based fitness programs, they are guided by the EB-1 programs listed on the 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 its 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 insurance coverage sufficient 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 (NYC Aging Form). 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 envelope 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 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 (see Forms) 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 adult in making informed decisions, the program encourages competitors to present on their services/products as well.

Compliance 5.4. Participants who wish to participate in a screening service but do not wish to give their Medicare numbers or other identifying information to the screening provider receive the same service as older adults who divulge the requested information.

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.

Standard 7: Unit Definition

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

Compliance 7.1. The unit of service for health promotion is each participant (unduplicated) or attendee of a group session, class, or event.
Examples:

- *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*

Health Promotion Staff Appropriateness and Continuity

Standard 8: Staff Qualifications

Persons who provide health promotion services have appropriate qualifications.

Compliance 8.1. 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 9: Supervision

All providers of health promotion services are appropriately supervised.

Compliance 9.1. The program's health promotion services are overseen by the program director or a person who has at minimum a BSW degree, or a bachelor's degree and one year experience in health or social service provision, or an AA degree and two years health or social service experience, or four years of direct health or social service experience.

Compliance 9.2. 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 10: Physical Environment

Services are provided only in an appropriate setting.

Compliance 10.1. 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 10.2. Defibrillator:

- 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 (AED NYC Aging Manual) is available on site.

Documentation

Standard 11: Documentation

The program maintains required documentation.

Compliance 11.1. 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 (See Service Definitions);
  - 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 (NYC Aging form) 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, click on: *www.ncoa.org/resources/highest-tier-evidence-based-health-promotiondisease-prevention-programs.*

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: Each session of a group scheduled activity. An education/recreation unit of service is one session.

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.

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

Compliance 1.3. At least two sessions each year are on elder abuse prevention and awareness, with instructions on how to detect and report instances of elder abuse.

- The required number of elder abuse sessions are held within one year after contract start date, and annually subsequently.
- 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 call either 311 or the NYC Aging's Elderly Crime Victims Resource Center.

Compliance 1.4. The program includes technology within its Education/Recreation offerings, which may consist of training and education in the use of technology, virtual programming to include homebound older adults, and/or linkages with technology programs/providers in the community.

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 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 activities have a minimum monthly average of at least five individuals per session.

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

Compliance 2.7. Each group activity is at least 45 minutes in duration.

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.

Compliance 3.2. All sessions have an annual average of at least five individuals.

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. *(See also General Program Standards.)*

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 Definitions

The correct unit definition is used in reporting the level of education/recreation service.

Compliance 7.1. Units are reported only for scheduled education/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/recreation and health promotion.

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

Compliance 7.4. Per the NYS Gaming Commission – Bingo games cannot be conducted on more than fifteen (15) days during any calendar year. Provider may report no more than 15 units of Bingo during any contract year.

Education and 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.

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 his/her client data system record. *Note: Sign-in sheets are maintained as back-up.*

Escort (Assisted Transportation)

Introduction

Escort Service is a form of assisted transportation provided to an older person who needs personal accompaniment to a destination in the community, including medical or other appointments. It involves personal accompaniment throughout the outing or trip. Persons accompanied by escorts have mobility, vision, or cognitive impairments.
Unit of Service: Each one-way trip provided to a person with documented need for the service. All NORCs must adhere to requirements in the NYC Aging Transportation Standards.

Eligibility

Standard 1: Eligibility

The program serves eligible older persons who need escort services.

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

- 60 years of age or older.
- Unable to travel independently to and from destinations in the community due to mobility problems, cognitive problems, sight or hearing problems, or other types of disability.
- Unavailability of informal supports to meet their escort needs.

Note: The program conducts outreach specifically for this service if is not reaching its target population.

Standard 2: Escort Assistance

The program provides escort assistance.

Compliance 2.1. Service activities include the following:

- Helping the older person dress in outerwear such as coat, sweater, or hat for the trip.
- Helping the older person lock and unlock his/her residence.
- Accompanying the person while she/he uses public or private transportation or walks to her/his destination.
- Remaining with the older person throughout the duration of the visit and accompanying him/her home.

Compliance 2.2. The program provides escort workers with carfare when needed for the escorted trip. The program does not pay workers' travel costs to and from work.

Standard 3: Escort Services

The program provides escort only to clients with documented need for assisted transportation (escort).

Compliance 3.1. A worker conducts a face-to-face interview with each individual requesting escort service prior to service provision to screen for eligibility and to obtain intake information. Note: The program may accept referrals from hospitals, case management agencies and other social service agencies as indicating client meets eligibility criteria. Clients who do not meet eligibility criteria are assisted with referral to other programs if possible, and a "service ticket" is completed in NYC Aging's client data system. Exception**:** When the client has an emergency need for an escort, the interview (and Intake) may be completed after the first time service is provided.

Compliance 3.2. The worker opens a case record on each client found to be appropriate for Escort service and documents the client's need for the service in the client record. Note: The program may need to first register the client in the system if the client has not been previously registered.

Standard 4: Service Schedules

The program develops a service schedule with the client when service is needed regularly.

Compliance 4.1. When service is needed regularly, the program establishes a schedule with the client. Note: The effective date for the schedule cannot be longer than one year without re-evaluation.

- Schedule (day, time, service destination and whether a return trip will be provided) and time period during which schedule will be in effect are documented in the client's record.

Standard 5: Evaluating Client Needs

The program re-evaluates the client's need for recurring service at the end of the time frame for the service schedule.

Compliance 5.1. The program re-evaluates the client's need for the service at the conclusion of the time frame indicated on the client's service schedule.

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

Standard 6: Safety and Follow-up

Escorts monitor clients' safety and welfare.

Compliance 6.1. Escorts document their clients' reported unmet needs, health problems and other problem situations for review with their supervisor.

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

Compliance 6.3. Client emergencies and other urgent situations are reported and handled appropriately.

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 Definitions

The correct unit definition is used in documenting service provided to the client.

Compliance 8.1. Units are counted only for one-way trips that meet the service definition. Escort service is not assisting a client to the ladies' room at the program site. It is not the assistance offered by a van driver in operating a wheelchair lift or walking with an older person from the van to his/her front door. The driver is simply being helpful to the older person as part of regular transportation activities.

Compliance 8.2. Units reported as escort service are not also reported as another service – e.g., shopping assistance, case assistance, transportation. (If a client receives an escort and transportation service, that service is counted only under escort. A unit of escort and a unit of transportation cannot both be claimed.)

Escort (Assisted Transportation) 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 the contracted service level.

Compliance 9.2. Volunteers. Volunteers who provide the service:

- Are consistently available.
- Unless known to the program, have been screened and interviewed to establish reliability and suitability by the staff person with oversight responsibility for the service.
- Unless known to the program, have provided at least two references.
- Have been assigned a supervisor.

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

Standard 10: Staffing Levels and Qualifications

The program trains and supervises visitors.

Compliance 10.1. All new escorts (staff and volunteers) 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 escort; situations that should be reported to staff; confidentiality; response to urgent situations; record keeping.

Compliance 10.2. Escorts meet with their supervisor alone or in a group at least monthly.

Recordkeeping

Standard 11: Attendance

The program maintains required records.

Compliance 11.1. Client records

- Intake information (need for service) in client data system.
- Client's escort schedule if service is provided regularly, including time period schedule will be in effect.
- Date of Service Start.
- One-way trips provided.
- Date(s) of service re-evaluation and documentation of continued need.
- Date of Service termination if client is no longer receiving the service and reason for termination.
- Case notes on contacts with client, reported incident, need, etc.
- Consent forms.

Compliance 11.2. Escort Records

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

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: Each contact with a client 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 - for example, 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 clients 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 (need for in-home support due to frailty, disability, or other health issues and risk of social isolation).

Compliance 3.2. If the client needs additional services, the program refers the client to a provider within two weeks and follows up to confirm linkage has been made.
Note: Clients 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 client data system.

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

Compliance 4.1. The worker establishes a visiting schedule with the client but visiting occurs no less frequently than once every two 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 client's record.

Standard 5: Re-evaluation of Service Needs

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

Compliance 5.1. The client'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 clients.

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

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

Compliance 6.3. The program lets the client (or client'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 clients 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 Client Safety

Visitors monitor clients' safety and welfare.

Compliance 7.1. Visitors document and report their clients' 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. Client emergencies and other urgent situations are reported and handled immediately.

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. Volunteers who provide the service:

- Are consistently available.
- Unless known to the program, have been screened and interviewed to establish reliability and interest by the staff person with oversight responsibility for the service.
- Unless known to the program, have provided at least two references.
- 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 BSW degree, or a bachelor's degree and one year experience in social services provision, or an AA 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 client's needs; confidentiality; response to urgent situations; record keeping.

Compliance 9.2. Visitors have contact with their supervisors at least monthly to discuss their assigned clients.

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 client to her/his visitors.

- Procedures protect the client'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: Definition of Unit
The correct unit definition is used in documenting service provided to the client.

Compliance 12.1. Units are counted only for completed visit contacts with clients whose need for in-home support is documented in NYC Aging's client data system and who have a visiting schedule. Completed collateral contact with a family member/emergency contact or other concerned individual regarding the client'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 – e.g., education/recreation, escort service, etc.

Recordkeeping

Standard 13: Recordkeeping
The program maintains required records.

Compliance 13.1. Client records include:

- Intake information (eligibility for in-home support) in client data system.
- Client'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 client is no longer receiving the service and reason for termination.
- Case notes documenting contacts with program, reports on client 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.

Personal Care - Level I (Housekeeping/Chore) and Level II (Home Care)

Introduction

Personal Care Level I (Housekeeping/Chore) service includes some or total assistance with tasks on behalf of, or to assist a person commensurate with the person's limitations in Instrumental Activities of Daily Living (**IADLs**). **Personal Care Level II (Home Care)** includes assistance with the tasks on behalf of or to assist a client commensurate with the person's limitations in Activities of Daily Living (**ADLs**) or limitations in both ADLs and IADLs:

Standard 1: Personal Care Level 1 (Housekeeping/Chore)

The program provides assistance with housekeeping support tasks.

Compliance 1.1. The program provides some or total assistance to clients with the following housekeeping support tasks:

- Making and changing bed;
- Dusting and vacuuming living areas used by client;
- Light cleaning of kitchen, bathroom and bedroom;
- Dishwashing;
- Listing needed supplies;
- Shopping;
- Running essential errands like dropping off and picking up prescriptions at the pharmacy;
- Doing laundry, including ironing and mending;
- Preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue, as prescribed;
- Escorting clients to medical appointments, social service appointments, etc.

Standard 2: Personal Care Level II (Home Care)

The program provides assistance with home care tasks.

Compliance 1.2. The program provides some or total assistance with home care tasks. NYC Aging considers some assistance to mean that some tasks or functions are performed and completed by the client with assistance from another individual. Total assistance means that all homemaking or personal care tasks or functions are performed and completed for the client.

- 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 client 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 client directly;
- Self-administration of medication, including prompting client of time, identifying the medication for the client, bringing the medication and any necessary supplies or equipment to the client, opening the container for the client, positioning the client for medication administration, disposing of used supplies and materials and storing the medication properly;
- Routine skin care;
- Changing simple dressings;
- Assisting clients with making phone calls.

Shopping Assistance

Introduction

Shopping Assistance/Chore Service provides help with shopping needs and/or household chores to older persons who can be safely maintained in their homes with fewer than four hours a week of this service, alone or in combination with other services. Shopping Assistance/Chore Service Unit: each contact with a client for the purpose of providing the service.

Eligibility

Standard 1: Eligibility

The program serves eligible older persons who need shopping assistance and/or chore service.

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 is not reaching its target population.

Standard 2: Type of Client

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

Compliance 2.1. A worker conducts an in-person or telephone interview with the client to screen for eligibility and to obtain Intake information.

Compliance 2.2. The worker:

- Determines that the client 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 client meets eligibility criteria. Clients who do not meet eligibility criteria are assisted with referral needs to the extent possible.*

- Gives or sends the client a copy of the program's complaint procedure.

Compliance 2.3. The worker opens a case record on each client found to be appropriate for shopping assistance or chore service. *Note: The worker may need to first register the client in the client data system if the client has not been previously registered.*

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

Service Provision

Standard 3: Service Provision

The program provides shopping assistance and/or chore services as contracted.

Compliance 3.1. The program provides shopping assistance and/or chore service in its contract or current budget, and in accordance with the following activities.

Compliance 3.2. If providing chore service, the program provides assistance with the following activities, as needed by the client:

- Laundry, light cleaning, dusting, dishwashing, vacuuming and other household tasks.
- Light yard work.
- Running errands.

Compliance 3.3. If providing shopping assistance:

- The program has a written policy on whether shoppers shop for or with clients, 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 3.4. If providing shopping assistance, the program provides assistance with the following activities, as needed by the client (and as pertinent to whether shopping for or with the client):

- Making or reviewing shopping list (items needed) with the client before going to the store.
- Collecting money, check or food stamps from the client in order to make purchase (in accordance with program's policies).
- Shopping with the client (or for the client) for food, medicines or other necessities (program may limit grocery shopping to one store).
- Paying for purchases with the client's money.
- Returning items bought, change, and receipts to the client.
- Reviewing purchased items with the client.
- 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 his/her residence.

Standard 4: Service Schedule

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

Compliance 4.1. The worker establishes a service schedule with the client 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 client's record.

Standard 5: Re-evaluating Client Need

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

Compliance 5.1. The client'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

Workers monitor clients' safety and welfare.

Compliance 6.1. Workers document and report their clients' 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. Client emergencies and other urgent situations are reported and handled immediately.

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 Definitions

The correct unit definition is used in documenting service provided to the client.

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

- Completed collateral contact with a family member/emergency contact or other concerned individual regarding the client's safety/welfare may also be counted as a unit.

Note: *A one-time visit by a member (e.g., members of sunshine or other goodwill clubs) to assist a fellow member who is temporarily unable to shop or do chores does not count as a unit. Occasional visits do not count unless the client's eligibility for the service (in-home support need due to limited ability to shop or do chores, informal supports are not available to provide the service as needed, and a service schedule is noted in the client's record.*

Compliance 8.2. Units reported as shopping assistance/chore are not also reported as another service – e.g., housekeeping/chore, escort service, etc.

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. Volunteers who provide the service:

- Are consistently available.
- Unless known to the program, have been screened and interviewed to establish reliability and interest by the staff person with oversight responsibility for the service.
- Unless known to the program, have provided at least two references.
- Have a visiting schedule on file.
- Have been assigned a supervisor.

Compliance 9.3. The service is overseen by a staff person who has at minimum a BSW degree, or a Bachelor's degree and one year experience in social services provision or an AA 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 workers 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 worker; situations that should be reported to staff; how to "read" clues to a client's needs; confidentiality; response to urgent situations; record keeping.

Compliance 10.2. Staff have contact with their supervisors at least monthly to discuss their assigned clients.

Recordkeeping

Standard 11: Client and Staff Records

The program maintains required records.

Compliance 11.1. Client record

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

Compliance 11.2. Staff Records

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

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: Each contact with a client with documented need for this service. A unit can only be counted if contact is made with the client. (Voicemails do not count)

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. Note: inability may be temporary.
- Few or no informal supports or opportunities for socialization (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 is not reaching its target population.

Procedures and Methods

Standard 3: Screening

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

Compliance 3.1. A worker conducts a phone or in-person interview with the client to screen for eligibility and to obtain Intake information.

Compliance 3.2. The worker:

- Determines that the client 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 client meets eligibility criteria).
- Collects information about the client's interests, concerns and needs to facilitate the client's interactions with the caller (documented in case notes).
- Gives/sends the client a copy of the program's complaint procedure.

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

Compliance 3.4. If the client needs additional services, the program refers the client to a provider within two weeks and follows up to confirm linkage has been made.

Standard 4: Calling Schedule

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

Compliance 4.1. The worker establishes a calling schedule with the client, but no less frequently than once every two 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 client's record.

Standard 5: Re-evaluation of Service Needs

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

Compliance 5.1. The client'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 clients.

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

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

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

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

Standard 7: Monitoring Client Safety

Callers monitor clients' safety and welfare.

Compliance 7.1. Callers document their clients' 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. Client emergencies and other urgent situations are reported and handled immediately.

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. Volunteers who provide the service:

- Are consistently available.
- Unless known to the program, have been screened and interviewed to establish reliability and interest by the staff person with oversight responsibility for the service.
- Unless known to the program, have provided two references.
- Have a calling schedule on file.
- Have been assigned a supervisor.

Compliance 8.3. The service is overseen by a staff person who has at minimum a BSW degree, or a bachelor's degree and one year experience in social services provision or an AA 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 have contact with their supervisors at least monthly to discuss their assigned clients.

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 client to her/his callers.

- Procedures protect the client'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: Definition of Units

The program uses the correct unit definition in documenting service provided to the client.

Compliance 12.1. Units are counted only for:

- Completed telephone contacts with clients whose need for in-home support is documented in NYC Aging's client 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 client's record in NYC Aging's client data system.
- Completed collateral contacts with a family member/emergency contact regarding client's safety/welfare may be counted as either case assistance or information.

Compliance 12.2. Units reported as telephone reassurance are not also reported as another service – e.g., education/recreation, case assistance, etc.

Recordkeeping

Standard 13: Budgeted Units

The program maintains required records.

Compliance 13.1. Client records include:

- Intake information (eligibility for in-home support) in client data system.
- Client'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 client is no longer receiving the service and reason for termination.
- Documentation of any contacts between client and supervisor/coordinator.

Compliance 13.2. Caller 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.

STANDARD DEFINITIONS OF SERVICE

Naturally Occurring Retirement Community Program
(Note units measured in hours can be reported in quarter hour increments.)

Priority Services	
Priority Services are required to be provided by all NORC programs	
SERVICE NAME	**Case Management**
SERVICE DEFINITION	A comprehensive process that helps older persons with diminished functioning capacity, and/or their caregivers, gain access to and coordinate appropriate services, benefits and entitlements. Case management consists of assessment and reassessment, care planning, arranging for services, follow-up and monitoring at least every two months and discharge. These activities must be provided by or under the direction of the designated case manager or case manager supervisor. Case Management activities for NORC clients receiving services: • A comprehensive assessment is the collection of information about a person's situation and functioning, and that of his/her caregivers, which allows identification of the person's specific strengths and needs in the major functional areas. • A care plan is a formal agreement between the client and case manager and, if appropriate, the client's caregivers regarding client strengths and problems, goals and the services to be pursued in support of goals. • Implementation of the care plan (arranging and authorizing services) includes contacting service providers, conducting case conferences and negotiating with providers for the delivery of needed services to the client as stated in the care plan. • **Follow-up and monitoring of the care plan every two months at a minimum,** ensures that service delivery is meeting the client's needs and being delivered at the appropriate levels and quality. **Contact with the service providers is regular and ongoing.** Reassessment is the formal re-examination of the client's situation and functioning and that of his/her caregivers to identify changes which occurred since the initial assessment/last reassessment and to measure progress toward goals outlined in the care plan. It is done at least annually and more frequently if needed. Changes are made to the care plan as necessary. • Discharge is the termination of case management services. Reasons for discharge may include the client requesting discharge, the attainment of goals described in the care plan, the client needing a type of service other than case management or ineligibility for the service. Case managers may also be functioning in the role of a support coordinator or consultant to informal caregivers. In this role, the case manager may be acting as a teacher, networker, counselor and/or family guide. Counting Clients: For a *client* to be reported as a case management client, he/she must be receiving or expected to receive all the components summarized above.

SERVICE DEFINITION	Case managers may also be functioning in the role of a support coordinator or consultant to informal caregivers. In this role, the case manager may be acting as a teacher, networker, counselor and/or family guide. Counting Units of Service: *Time* spent in any of the following is appropriately reported as case management *units* (one hour = one unit): traveling to a NORC client's home and conducting an assessment, telephoning clients to follow-up on service delivery, discussing services for a specific client with the service provider, and organizing and conducting a case conference concerning a specific client and the case manager inputting client data into the computerized system. While a case manager typically works a seven and a half or eight hour day, this does not imply that each day he/she will generate seven and a half or eight hours of case management units. Time spent in administrative, educational or general activities cannot be counted as units of service. For example, time spent in such activities is not appropriate to report as case management units: • traveling to and participating in trainings or conferences; • participating in a video conference on conducting client assessments; • developing a new form for monitoring in-home service providers; • comparing the in-home service provider's bill for the month to the number of hours authorized for each client and the number of hours actually provided for each client; participating in the monthly meetings of the NORC's staff and partners which feature general discussions of aging network issues, implementation of the NORC budget and personnel procedures.
UNIT OF SERVICE	One hour of service including travel time.

SERVICE NAME	**Case Assistance**
SERVICE DEFINITION	Case Assistance is provided for a limited period of time, and usually addresses a specific issue(s). This may involve one or more contacts with or on behalf of the client but does not involve ongoing care or monitoring. The service may link older persons with appropriate services, entitlements, or other resources, and/or assist them with a personal crisis or problems of daily living. As appropriate to the individual's need, activities include information provisions, assisted referral, entitlement counseling, immigrant assistance, advocacy, supportive contact, and assistance with navigating service systems.
UNIT OF SERVICE	One contact
SERVICE NAME	**Healthcare Management**
SERVICE DEFINITION	A comprehensive process provided by a qualified health professional that helps older persons with diminished functioning capacity, and/or their caregivers by targeting individuals who have immediate and ongoing medical needs, as well as addressing their overall health and well-being. Provides non-reimbursable, individual healthcare consultation and helps identified clients manage chronic conditions, responds to acute episodes, and helps them access the healthcare system. Involves an assessment, care planning, arranging and coordinating services, follow-up and monitoring at least every two months.

UNIT OF SERVICE	One hour of service including travel time.

SERVICE NAME	**Healthcare Assistance/Monitoring**
SERVICE DEFINITION	Health screening, consultation, and regular monitoring of blood pressure and other health indicators for residents who have been identified to be at risk. Includes services provided by a healthcare professional to residents with specific health- related issues or needs on a short-term or episodic basis. Assistance on health- related matters, such as the scheduling of appointments and contacts with pharmacies, provided by casework staff, should also be included.
UNIT OF SERVICE	One contact
Optional Services	
NORC programs should provide a wide range of other services that match the varied needs and interests of all older adults in the community.	
Individual Services	
SERVICE NAME	**Assisted Transportation (Escort)**
SERVICE DEFINITION	Assistance and transportation, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Please note, services reported in the assisted transportation/escort category must involve the personal accompaniment of the older person throughout an outing or trip. Thus, assistance offered by a van driver in operating a wheelchair lift or walking with an older person from the van to his/her front door is not considered assisted transportation/escort—the driver is simply being helpful to the older person as part of regular transportation activities.
UNIT OF SERVICE	Each one-way trip
SERVICE NAME	**Personal Care Level I (Housekeeping/Chore)**
SERVICE DEFINITION	A service that includes some or total assistance with the following tasks on behalf of or to assist a person commensurate with the person's limitations in IADLs: • Making and changing beds; • Dusting and vacuuming the rooms which the person uses; • Light cleaning of the kitchen, bedroom and bathroom; • Dishwashing; • Listing needed supplies; • Shopping for the person; • The person's laundering, including necessary ironing and mending; • Preparing meals, including simple modified diets; • Paying bills and other essential errands; • Escorting to appointments and community activities.

UNIT OF SERVICE	One hour of service

SERVICE NAME	**Personal Care Level II (Home Care)**
SERVICE DEFINITION	A service that includes assistance with the following tasks on behalf of or to assist a client commensurate with the person's limitations in ADLs or limitations in both ADLs and IADLs: Personal Care Level II tasks may include some or total assistance with: • All the tasks listed under Personal Care Level I; • Bathing of the person in the bed, tub or shower; • Dressing; • Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth; • Toileting, including assisting the person on and off the bedpan, commode or toilet; • Walking, beyond that provided by durable medical equipment, within the home and outside the home; • Transferring from bed to chair or wheelchair; • Preparation of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diet; • Feeding; • Administration of medication by the client, including prompting the client of time, identifying the medication for the client, bringing the medication and any necessary supplies or equipment to the client, opening the container for the client, positioning the client for the medication and administration, disposing of used supplies and materials and storing the medication properly; • Providing routine skin care; • Using medical supplies and equipment such as walkers and wheelchairs; • Changing simple dressings.
UNIT OF SERVICE	One hour of service
SERVICE NAME	**Counseling**
SERVICE DEFINITION	A one-to-one relationship between an older person and a worker trained in counseling techniques. The service is designed to help an individual cope with the problems and stress which interfere with normal health and social functioning by alleviating stress or anxiety and to help the client make appropriate choices and plans.
UNIT OF SERVICE	One hour of service
SERVICE NAME	**Telephone Reassurance**
SERVICE DEFINITION	An organized service providing supportive contact and monitoring on an on-going basis via regularly scheduled telephone calls to older persons who live or are temporarily alone and

	have limited ability to leave their homes in order to reduce isolation and help ensure the health and safety of the older adult.
UNIT OF SERVICE	One phone call

SERVICE NAME	**Shopping Assistance**
SERVICE DEFINITION	Shopping on behalf of an older person; must include personal assistance. Do not include if the program provides only transportation to stores.
UNIT OF SERVICE	One contact
SERVICE NAME	**Friendly Visiting**
SERVICE DEFINITION	An organized visit to homebound older persons providing socialization, recreation, and the opportunity to observe and report the client's condition and circumstances.
UNIT OF SERVICE	One contact
SERVICE NAME	**Residential Repair and Maintenance**
SERVICE DEFINITION	Repairs and activities to upgrade and/ or maintain housing for the elderly, including heavy cleaning.
UNIT OF SERVICE	One hour of service
SERVICE NAME	**Personal Emergency Response System (PERS)**
SERVICE DEFINITION	A service which utilizes an electronic device to alert appropriate people of the need for immediate assistance in the event of an emergency situation in an older person's home.
UNIT OF SERVICE	One unit for each month or part of a calendar month that the device is in the person's home.
Group Services	
SERVICE NAME	**Education/Recreation Groups**
SERVICE DEFINITION	Activities organized and scheduled through the NORC program which involve older persons in courses, workshops, other learning activities and satisfying use of free time. **Examples of education/recreation groups include, but are not limited to:** • A yoga demonstration held at the NORC (since this is a one-time demonstration, it is counted as a unit of education/recreation groups. If this was a formal class given on a regular basis, it would be counted as health promotion.); • Sports lessons and events;

	• Performing arts; • Games; • Crafts lessons and events; • Performing arts; • A nature walk conducted each spring at an older adult center; • A day bus trip organized by the center, to Citi Field to see a baseball game. (The bus trip constitutes one unit/session of education/recreation groups. The related units of transportation would be recorded in the transportation category.)
UNIT OF SERVICE	One group session Total attendance is not an unduplicated count. Include each participant every time s/he attends a group session.
SERVICE NAME	**Health Promotion**
SERVICE DEFINITION	Consists of services and activities that promote good health and quality of life, increase awareness and understanding of health lifestyles, promote chronic disease prevention and management and promote physical and mental health. Includes physical fitness programs and health screening tests or activities that encourage early detection of health problems (e.g., blood pressure screening, glaucoma testing, hearing test, etc.). Services and activities that **promote chronic disease prevention and management,** promote physical and mental health, improve or maintain **quality of life**, and increase awareness and understanding of healthy lifestyles. These include but are not limited to: • Evidence-based health promotion programs; • Medication management to prevent incorrect medication and adverse drug reactions; • Routine health screenings such as vision, diabetes, bone density and nutrition; • Medicare preventive services such as education programs on the availability, benefits, and appropriate use of preventive health services; • Preventive nutrition services such as nutrition counseling and education; • Physical fitness programs; • Home injury control services such as screening home environments and education programs on injury and falls prevention at home; • Mental Health services such as screening for depression, provision of educational activities.
UNIT OF SERVICE	Each participant or attendee of a group session, class, or event.
SERVICE NAME	**Support Groups**
SERVICE DEFINITION	Consists of groups that meet on a regular basis to address common issues and provide mutual support (e.g., caregiver support, separation and loss, grief, etc.). Groups may be facilitated by a professional or peer leadership.
UNIT OF SERVICE	One group session Total attendance is not an unduplicated count. Include each participant every time s/he attends a group session.

Transportation	
SERVICE NAME	**Individual or Group Transportation**
SERVICE DEFINITION	Transportation from one location to another. Does not include any other activity. Escort service involving transportation gets reported under Escort only. **Example 1:** The provider takes five people to and from the store. This is reported as ten units of transportation (five people x two trips each). **Example 2:** The NORC organizes a day bus trip to Yankee Stadium to see a baseball game. Forty-three older individuals participate. This is reported as eighty-six units of transportation service (forty-three individuals x two trips each). Additionally, one unit of education/recreation groups is generated and reported. **Example 3:** The provider takes an older individual to the older adult center. After lunch, the provider drives the older individual to a local shopping center to pick up medications and groceries. The older individual is then picked up and transported home. This generates three units of transportation service (one individual x three separate trips/locations).
UNIT OF SERVICE	One unit for each one-way trip per person
Outreach Activities	
SERVICE NAME	**Outreach**
SERVICE DEFINITION	Activities initiated by the NORC for the purpose of identifying potential clients (or their care givers) and encouraging their use of existing services and benefits. This includes face-to-face or telephone contact between a worker and an individual. **Example 1:** Staff visits to a building within the NORC to locate isolated individuals who have never used NORC services. This contact must be conducted one-on- one and not done as a group presentation. **Example 2:** The NORC has a table at a health event where providers conduct face-to-face identification of isolated individuals by discussing the individual's needs and available NORC programs one-on-one. **Example 3:** A third party such as a police officer contacts the NORC and says there is an older person they see when on patrol that appears to be in need of services and asks that NORC staff do an Outreach visit. **Reporting Clarification:** Outreach is when the NORC finds an isolated older person who has no prior knowledge of the NORC, not when an older person finds the NORC.
UNIT OF SERVICE	Each initial first contact made to a client or their care giver(s)

SERVICE NAME	Public Information
SERVICE DEFINITION	A planned effort to provide consumers information about NORC programs and services. Activities include: • Printed materials – the distribution of newsletters, flyers, pamphlets, and brochures; • Mass communication – the use radio, newspaper, television, web pages, and billboards for news and features; and • Presentations – planned events which involve public speaking by staff or partners.
UNIT OF SERVICE	Unit: Each activity or event or each distribution of printed information.