Exhibit A

Part 1

Statement of Work

Contractor shall provide Advanced Ventilator-Assisted Care Adult Foster Home (AVAC-AFH) services as described herein to Medicaid eligible Individuals who are authorized to receive services at the Contractor's owned and operated licensed Adult Foster Home located at:

Facility Name

Address

City, State Zip

1. Definitions.

In addition to all terms defined in the Contract, the definitions in OAR 411-049 apply to and are incorporated into this Contract. If a conflict exists between any terms defined in this Contract and the terms defined in OAR 411-049, the terms defined in OAR 411-049 shall take precedence.

a. **"Activities of Daily Living" or "ADL"** means those personal, functional, activities required by an Individual for continued well-being, health, and safety. Activities consist of eating, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), cognition, including behaviors.

b. **"Activity Plan"** means a person-centered list of specific private, group and community activities that is developed for each individual based on their activity evaluation. The plan must identify meaningful activities that promote or help sustain the physical and emotional well-being of each individual and which reflects the Individual's activity preferences and needs.

c. **"Area Agency on Aging" or "AAA"** means the ODHS designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to older adults or individuals with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.

d. **"Available"** means being responsible to meet Activities of Daily Living of an individual as well as all other services described in the service plan that are required during a specified period of time.

e. **"Awake**" means to be active and alert and not sleeping.

f. **"Behavior Support Plan"** means a written document that describes person centered strategies which are designed to replace challenging behaviors with functional, positive behaviors. The strategies address environmental, social, and physical factors that affect the behavior(s). The plan must include interventions for caregivers to help them de-escalate, reduce, or tolerate the challenging behavior(s). The plan will be created and taught by a qualified Behavior Consultant.

g. **"Behavior Support Services" (OAR 411-046-0100 through 0220)** mean a set of Medicaid funded services provided by a qualified Behavior Consultant that include:

1. Person-centered evaluation;
2. A Behavior Support Plan;
3. Coaching for designated caregivers on plan implementation;
4. Monitoring to evaluate the plan's impact;
5. Revision of the plan;
6. Updating coaching and activities; and
7. May include consultation with the caregiver on mitigating behaviors that place an individual's health and safety at risk and to prevent institutionalization.

h. **"CA/PS Assessment"** means an assessment completed in a single entry data system, currently denoted as Individual Assessment and Planning System (CA/PS), used for completing a comprehensive and holistic assessment, surveying the Individual's physical, mental, and social functioning, and identifying risk factors, Individual choices and preferences, and the status of service needs.

i. **"Care Plan"** means the Contractor's written description of an Individual's needs, preferences, and capabilities, including by whom, when, and how often care and services shall be provided.

j. **"Care Planning Team"** (CPT) refers to a team made up of the following persons: Diversion/Transition Coordinator or Case Manager, Contractor's Registered Nurse (RN), the Individual and/or the Individual's designated representative, and the Contractor. The Care Planning Team may expand the list of invitees as deemed necessary to include other parties; however, these additional parties are not mandated to attend under this Contract. Attendance may be done in person or by phone.

k. **"Case Manager** (CM) and **Transition Coordinator** (TC)" the State or AAA worker who is responsible for authorizing the Individual's benefits, participating on the Individual's service planning team and submitting rate adjustment requests. This person is the ODHS liaison between the Individual, their family, legal representative, nursing facility social worker and Contractor for all screening, admission and eligibility functions under this Contract.

l. **"Co-morbidity"** describes two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Co-morbidity also implies interactions between the illnesses that can worsen the course of both.

m. **"Community Attendants"** means the caregivers or other employees who escort and assist an Individual with their ADL, IADL, communication, health and safety needs while they are engaging in activities outside of the residence. Family or natural supports can provide this function on behalf of the Contractor if they have the necessary legal authority or Individual's permission.

n. **"Community Based Care"** means licensed facilities settings which include assisted living facilities, residential care facilities, memory care communities, and adult foster homes.

o. **"Complex Wound Care"** Is defined under Nurse Facility OAR 411-070-0091.

p. **"Immediate Community"** means the county where the Individual is currently residing, and any other county the Individual or their representative identifies as being a community in which they have lived in or wish to relocate.

q. "**Individual"** means an individual being served under this Contract, in a licensed Adult Foster Home, who meets the Target Group definition.

r. **"Institutional Setting"** means a facility that is licensed and certified by ODHS as a nursing facility, acute hospitals and psychiatric hospitals.

s. **"Instrumental Activities of Daily Living" or "IADL"** mean those activities other than activities of daily living, required to continue independent living.

t. **"Majority"** means fifty percent or above of the licensed capacity of the service location.

u. **"Nursing Service Plan"** means the plan that is developed by the registered nurse based on an individual's initial nursing assessment, reassessment, or up-dates made to a nursing assessment as a result of monitoring visits.

v. **"ODHS Designee"** refers to the staff person identified and authorized by the Referring Agency as the employee primarily responsible for coordinating the Individual's care with the Contractor, Case Manager, or the Diversion/Transition Coordinator.

w. **"On-Call"** means Available to participate in discussion or for inquires, even when not present at the service location.

x. **"On-Site"** means on or at the specific service location of the Adult Foster Home.

y. **"Oximetry"** refers to the measuring of oxygen saturation of the blood by means of an oximeter.

z. **"Person-Centered Care**" means the process based on a set of principles of supporting an individual to direct their own care through developing a plan rooted in what is important to the Individual while taking into account all the factors that impact the Individual's life. Person-Centered Care promotes a positive relationship between the Individual and staff which is accomplished by staff being knowledgeable about the Individual's life story, routines, and habits, and incorporating that information into the Individual's daily care and activities.

aa. "**Pulmonary hygiene**" refers to a set of methods used to clear mucus and secretions from the airways.

bb. "**Referring Agency"** means either ODHS or an Area Agency on Aging.

cc. **"Rehabilitation Plan"** means a plan created by a licensed therapist to assist an Individual with increasing, maintaining, or developing mobility, cognitive or physical abilities or skills.

dd. **"Several"** means three or more.

ee. **"Specific Needs Services"** refers to the payment process and standards identified in OAR 411-027-0075 (4). Programs with Specific Needs Services contracts provide specialized services designed to meet the needs of Individuals in a specific Target Group which exist as the result of a condition or dysfunction resulting from a physical disability or a behavioral disorder which requires more than the minimum scope of services of this Contractor.

ff. **"Target Group"** (for purposes of this Contract) is the population of Individuals who meet the following documented criteria, upon admission:

1. Requires Ventilator- assisted care that requires daily specialized RN supports for their ventilator care;
2. Currently residing in a nursing facility, being served in an acute care hospital, being diverted or transitioned from Nursing Facility placement, or has a demonstrated history of being unsuccessful treated in other community-based care settings;
3. Require full assistance in one or more of the following ADL tasks – mobility, transfer, toileting or eating;
4. Has Medically Complex Needs such as complex wound care as defined above or complex co-morbidity care needs that requires weekly onsite monitoring or assessment by a RN; and
5. One or more of the following:
    a. Has a service plan which requires daily interventions by trained caregivers; or
    b. Is weaning or is being evaluated for weaning off ventilator- assisted care; or
    c. Requires weekly contact with primary care provider for an unstable medical condition; or
    d. Requires multi-person "hands on" ADL care or 2-person transfers daily; or
    e. Is enrolled in palliative or hospice care with a terminal diagnosis.

gg. "**Tracheostomy**" refers to an opening (made by an incision) through the neck into the trachea (windpipe). A tracheostomy opens the airway and aids breathing.

hh. **"Transition Care Conference"** means a conference arranged by Contractor prior to placement. The following persons must attend or participate by phone: Diversion/Transition Coordinator, Contractors Registered Nurse (RN), Behavior Coordinator, the Individual or Individual's designated representative, and Contractor or their designated representative.

ii. **"Ventilator-Assisted Care"** means the provision of mechanical assistance to replace spontaneous breathing. Devices used include, but are not limited to, mechanical ventilators, manual ventilators, and positive airway pressure ventilators.

jj. "**Weaning"** refers to the gradual process of decreasing ventilator support by,

1. Providing ventilator checks at least every 3 hours;

2. Providing hemodynamic stability checks at least every 3 hours;

3. Tracheostomy care;

4. Providing pulmonary hygiene checks at least every 3 hours or more frequently as needed to check for needed secretion management;

5. Oximetry;

6. Telemetry (if required).

2. Services to be Provided.

a. Contractor shall perform all Work and operate its Adult Foster Home in accordance with the ODHS Adult Foster Homes Administrative Rules, OAR 411-050 through 411-050, and all applicable federal laws.

b. Contractor shall designate a staff person as Contractor's primary contact for communications between Contractor and ODHS. Contractor shall provide this staff information and any changes to this staff designee to ODHS within 10 days of Contract execution or change in staff designee by Contractor.

c. Under this Contract, all Individuals will meet the Target Group and will constitute a majority of the Individuals served within the home. Contractor shall not designate specific areas of its Adult Foster Home for Individuals served under this Contract. Contractor shall provide all private rooms.

d. Contractor shall notify the ODHS Designee of all issues, including any absence of any Individual from the Adult Foster Home, which may affect Contractor's Work or payment for Contractor's Work.

e. Contractor agrees to participate in ODHS or ODHS Designee review of the facility prior to the renewal of Contract period.

f. To be an AVAC-AFH, the provider must:

1. Meet the requirements of OAR 411-050 in addition to the other requirements set forth in this contract;
2. Meet all the requirements for a Class 3 home and a Level A ventilator assisted home; and
3. Have a valid VAC-AFH license and be in good standing with licensing and

APS with no compliance issues.

g. Contractor shall consult with and have available physician and respiratory therapist services, all licensed by the State of Oregon and trained in the care of individuals requiring advanced Ventilator-Assisted Care available on a 24-hour basis and for in-home visits as appropriate. Contractor shall call the appropriate medical professional to attend to the emergent care needs of the Individuals.

h. In addition to the services described in the ODHS Adult Foster Homes Administrative Rules, OAR 411-050 through 411-050, and all applicable federal laws, Contractor shall perform the following services:

(1) Eligibility & Admission Process:

a. Contractor shall notify the ODHS designee of all inquiries or referrals of potential placements and provide the ODHS designee with sufficient time for assessment and determination of approval for admission.

b. Contractor shall screen all potential placements and obtain nursing consultation, as needed, to determine appropriateness of placement.

c. All persons eligible for Specific Needs Services must meet the Target Group definition and be eligible for ODHS services under the currently funded service priority levels in Long-Term Care Service Priorities for Individuals served under OAR 411-015-0000 through 411-015-0100.

d. All Medicaid placements must be prior approved by ODHS, through the 494 processes. Placements not prior approved will not be reimbursed under this Contract.

e. Contractor is required to coordinate a Transition Care Conference with the Care Planning Team Prior to admission.

(2) Discharge Process:

a. No Individual served under this Contract may be discharged from the home without the prior review and approval by the ODHS Designee and the Individual's Care Planning Team.

b. Contractor shall ensure that the Care Planning Team has been convened in a timely manner and has documented attempts to provide supports needed to maintain the Individual's placement in the home. If the Individual's needs cannot be addressed or if the Individual wants to move voluntarily then the Care Planning Team must develop a discharge or transition plan to support the Individual.

c. Documentation of Care Planning Team efforts must be completed prior to and attached to any move out notice(s) required under licensing rules.

d. Individuals approved for admission under this Contract do not have to be discharged if they no longer meet Target Group criteria, If the Individual continues to receive comparable services they may remain in the home at the specific needs contracted rate under this Contract.

e. Involuntary moves, transfers and discharges must be in accordance with the ODHS Adult Foster Homes Administrative Rules OAR 411-050.

f. Contractor shall complete a Form 492, Resident Discharge Report Specific Need Contract documenting all discharges.

g. If consumer experiences a change of condition and wishes to move to a lower level of care the provider shall work with APD/AAA staff to transition the individual.

h. After 60 days from reassessment the rate will adjust as follows:

1. Individual no longer has advanced ventilator needs as defined in this contract but still has ventilator needs - the payment will revert to standard ventilator rate.

2. Individual no longer is reliant on a ventilator and no longer has complex needs - the payment will revert to standard assessed rate as defined in the APD Rate Schedule.

(3) **Staffing:** Staffing levels must comply with the licensing rules of the facility, per OAR 411-050 and OAR 411-050. In addition, staffing shall be sufficient to meet the scheduled and unscheduled needs of the Individuals. Staffing levels during nighttime hours shall be based on the sleep patterns and needs of the Individuals and at a minimum provide the following:

a. Caregivers: There must be a minimum of 2 qualified caregivers who have been trained in accordance with Section (10) of this Contract, "Staff Training," providing direct care services 24 hours per day. Staff must be on-site, awake and alert during their assigned shift.

b. Beyond the caregivers listed in (3)a., there must be additional designated staff, at least 60 hours per month, who are primarily responsible for assisting with unscheduled and fluctuating needs of Individuals and maintaining and implementing Activity, Restorative and as needed Behavior Support Plans. Contractor shall document and provide upon request this staff's schedule, qualifications and responsibilities.

c. The Contractor or resident manager must be On-Call and Available 24/7.

(4) **Nursing:** In addition to staffing requirements found in OAR 411-050 a licensed Registered Nurse (RN), with current Oregon licensure verified through the Oregon State Board of Nursing, must be employed by the Contractor and Available to perform services and consultation as defined in this Contract. RN must be onsite 8 hours daily. Operator must also have a backup on-call RN for a total of two RN's on staff. In addition to nursing requirements of OAR 411-050 the Contractor shall:

a. Assure an adequate number of nursing hours are provided relevant to the census and acuity of the Individual population and the Individuals nursing needs.

b. RN shall assist the contractor with screening prospective Individuals.

c. RN shall assist with the development of the initial Care Plans for each Individual within the first 14 days of move-in;

d. Each Individual must receive a Nursing Service Plan that is attached to and aligned with the required Care Plan. The RN shall participate in or document their review of the quarterly Care Plan and its alignment with the Nursing Service Plan within 48 hours of the Care Plan meeting. The Nursing Service Plan must address the expected frequency of nursing supervision, consultation, and direct service intervention;

e. The Nursing Service Plan must be reviewed quarterly by the RN or more frequently if the Individual experiences a change of condition;

f. The RN has sole discretion to determine at the quarterly review if an individual does not require a Nursing Service Plan and can document that the Individual will not receive nursing services until the next quarterly review or change of condition;

g. RN is responsible for providing or ensuring that each caregiver has the training they need to support each Individual's Nursing Service Plan;

h. RN may provide 'intermittent direct' nursing services to Individuals who require nursing services and the task cannot be delegated to caregivers until the Contractor can arrange to have the nursing need provided by hospice, home health, a licensed health care provider or until the Individual is moved to placement that can provide the required service;

i. RN is responsible for delegation, teaching and documentation of tasks of nursing care as regulated by OAR Chapter 851, Division 047; and

j. RN shall provide a review of the Contractor's medication system and ensure OAR 851-047-0000 is followed regarding the teaching of medication administration. Contractor shall document that the RN has reviewed the medication system.

k. RN must have training and experience serving individuals who require Ventilator-Assisted Care with co-occurring medical complications with a focus on rehabilitation and resumption of the Individuals ability to perform ADLs and IADLs.

l. For Individuals who are appropriate for mechanical ventilation weaning and reconditioning RN will work with Medical Providers to:

    1. Develop objective criteria to judge readiness to wean;
    2. Develop individualized plan to decrease support gradually;
    3. Implement spontaneous breathing trials as appropriate;
    4. Determine appropriate alternative supports;
    5. Develop a "step-down" transition plan at the direction of the physician.

(5) **Care Plans**: Contractor is responsible to develop, and update, Care Plans based on the needs of each Individual, and in accordance with the home's licensure rules, OAR 411-050. In addition, the Contractor shall:

a. Facilitate and schedule quarterly Care Plan meetings for each Individual so that the

Individual, Case Managers, health providers, family and legal representative can participate as needed;

b. Review each Individual's Care Plan with caregivers at least once per month. Documentation of the review must list the participants and any changes made to the Care Plan;

c. Review the Care Plan and treatment goals with the Individual. The Individual's response to the Care Plan must be documented;

d. Document circumstances if the Individual refuses participation in the review of their Care Plan, or if Individual's presence is contraindicated; and

e. Develop and document a daily meal program for nutrition and hydration, which must include snacks that are available and provided throughout each Individual's unique 24/7 sleep and activity routines.

(6) Rehabilitation Plan.

a. The Care Planning Team is responsible for evaluating if an Individual needs a Rehabilitation Plan. Rehabilitation Plans may be needed by Individuals who receive therapy provided under direction of licensed therapists and the therapy plan requires regularly scheduled interventions by caregivers such as but not limited to:

i. Speech therapy, to assist Individuals with speaking, reading, writing or swallowing;

ii. Bowel and bladder retraining;

iii. Activities to promote mobility (movement), muscle control, gait and balance;

iv. Exercise programs to improve movement, prevent or decrease weakness caused by lack of use, manage spasticity and pain, and maintain range of motion;

v. Nutritional counseling; and

vi. Activities to improve cognitive impairments, such as problems with concentration, attention, memory and poor judgment.

b. Rehabilitation Plans must be developed and approved annually by a licensed therapist. The Rehabilitation Plan must define at minimum Individual specific interventions, the frequency of the intervention, the skill set needed to provide the interventions and outcomes that must be documented or reported to a nurse or licensed therapist. Rehabilitation Plans must be reviewed, documented and updated on a quarterly basis by the Care Planning Team.

c. Contractor is responsible for coordinating or designating staff to provide regular communication with the licensed therapist on each Individual's response to the Rehabilitation Plan.

d. Caregivers shall receive training as needed to implement current Rehabilitation Plans.

e. Staff designated to assist with Rehabilitation Plans shall document time spent on Rehabilitation Plan implementation in the Individual's file and have this documentation available to ODHS upon request.

(7) Behavior Support Plans: The Care Planning Team is responsible for evaluating if an individual needs a Behavior Support Plan. Indicators include but are not limited to: Individuals who are receiving psychoactive drugs for behavior; Individuals who have behavior interventions provided by caregivers; Individuals who have behaviors which risk their continued placement or cause disruption to other Individuals or staff.

a. Behavior Support Plans must be developed by a qualified behavior consultant as defined in OAR 411-046-0100 through 411-046-0220;

b. Behavior Support Plans must be reviewed, documented and updated on a quarterly basis by the Care Planning Team;

c. Caregivers shall receive training as needed to implement current Behavior Support Plans; and

d. Staff designated to implement Behavior Support Plans shall document time spent on Behavior Support Plan implementation in the Individual's file and have this documentation available to ODHS upon request.

(8) Activities.

a. Each Individual must be evaluated for activities according to the licensing rules of the facility. Evaluations must address the following:

i. Past and current interests;

ii. Current abilities and skills;

iii. Emotional and social needs and patterns;

iv. Physical abilities and limitations;

v. Adaptations necessary for the Individual to participate; and

vi. If needed, identification of activities needs to supplement the Individual's Behavior Support Plan.

b. The Contractor or a qualified member of the Care Planning Team shall develop an individualized Activity Plan based on the evaluation for each Individual. The Activity Plan must include structured and non-structured activities which meet the preferences of each Individual and are available on day and evening shifts, seven days per week. Activities may include but are not limited to:

i. Occupation or chore related tasks;

ii. Scheduled and planned events (e.g. entertainment, outings);

iii. Spontaneous activities for enjoyment or those that may help diffuse a behavior;

iv. One on one activities that encourage positive relationships between Individuals and staff (e.g. life story, reminiscing, music);

v. Spiritual, creative, and intellectual activities;

vi. Sensory stimulation activities;

vii. Physical activities that enhance or maintain an individual's ability to ambulate or move; and

viii. Outdoor activities.

c. Activity Plans must be reviewed, documented and updated on a quarterly basis.

d. Caregivers must receive training as needed to implement current Activity Plans.

e. Staff designated to develop or implement Activity Plans shall document time spent on activities under this Contract with each Individual in the Individual's file and have this documentation available to ODHS upon request.

f. Provider is responsible for the cost of activity plans. This includes but is not limited to the cost of transportation.

(9) General Health Service: Contactor shall ensure:

a. Policy and protocols exist and are followed to ensure that an Individual's change of condition, and any required interventions are communicated to caregivers on each shift;

b. Individuals are assisted in accessing the health care services they need or to which they are entitled from outside providers;

c. Transportation for local non-emergent transports are arranged or provided for by the facility as needed to meet health care needs, activity needs or to support interventions identified in the Care Plan; and

d. Community Attendants are arranged or provided for on all local community and health related appointments to ensure the Individual's safety and that information needed for the Individual's Care Plan is exchanged.

(10) Staff Training: In addition to the requirements in OAR 411-050 and 411-050, Contractor shall ensure that all staff has the following training:

a. Any home operating without a residential care manager must meet the requirements related to shift caregivers pursuant to OAR 411-050);

b. In addition to the annual training requirements pursuant to OAR 411-050- and OAR 411-050 the Contractor shall ensure that any regularly scheduled caregiver receives 10 additional hours of training each year, based on the individual caregiver's hiring date;

c. Verification of additional hours of training provided to each caregiver must be maintained and made available upon request of ODHS. Documentation must include topic, the trainer and qualifications, the date, hours and attendees name;

d. ODHS reserves the right to require Contractor to provide access to pre-approved training on specific topics; and

e. Additional training hours must meet the following requirements:

1. Are not part of training or coaching required to carry out an individual specific intervention in the Rehabilitation, Nursing, Activity, or Behavior Support Plan;
2. Are not part of training required to meet basic licensure requirements;
3. Are not part of the training required to meet standard vent home licensure requirements.
4. Must be provided by persons other than the Contractor who are qualified to teach the subject;
5. Topic of training must be relevant to the diagnoses and needs of the Target Group and Individuals served or the skills caregivers need to meet these needs; and
6. May include various methods of instruction including but not limited to classroom, web-based training or video. At least 75% of the training hours must be provided by a live presenter or interactive video capacity.

f. All caregiver, activity aid, and licensed Nurses must pass an Advance ventilator course demonstrating competency in caring for a resident advance ventilator needs and or complex medical needs. This class will replace ventilator management course requirement in OAR 411-050.

g. RN's will show completion of medical training with focus on serving individuals requiring advance ventilator care or 2 years of working with residents needing advance medical needs with mechanical ventilation and providing daily direction, supervision of care givers, case management, and rehabilitation.

3. **Specifications or Performance Standards.** DHS requires that the Contractor meets the highest standards prevalent in the industry or business most closely involved in providing the appropriate goods or services.