# Tri-County Office on Aging

## Fiscal Year 2020 – 2022 Request For Proposal

## Application Packet

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# 1. Application Overview

## APPLICATION OVERVIEW

**I. APPLICATION INFORMATION** - Organizations proposing to deliver service through the Tri-County Aging Consortium, also known as Tri-County Office on Aging (TCOA) under the Annual Implementation Plan must follow designated application procedures. TCOA provides for the establishment of annualized fixed-sum contracts.

**A. SERVICE CATEGORY AND PROJECTED FUNDING LEVEL:** The anticipated dollar amount available for fiscal year 2020 (October 1, 2019 through September 30, 2020) for annual contracts is $1,589,376. **We have not incorporated any cuts into these amounts.** As soon as this is known, updated information will be forwarded. The following lists estimated funds by service category available through a competitive bidding process:

### ACCESS SERVICES

**Information & Assistance:** Assistance to individuals in finding and working with appropriate human service providers that can meet their needs which may include: information-giving, group presentations, referral, advocacy intervention and follow-up contacts with clients to ensure services have been provided and have meet the respective service need.

Up to $79,000

**Volunteer Medical and Nutrition Transportation:** Centrally organized services for transportation of older persons to and from community facilities in order to receive support services, reduce isolation, and otherwise promote independent living.

Medical: Up to $2,700
Nutrition: Up to $2,400

### IN-HOME SERVICES

**Home Delivered Meals:** The provision of nutritious meals to homebound older persons.

Up to $732,172

**Volunteer Respite Care:** Provision of companionship, supervision and/or assistance with activities of daily living for persons with mental or physical disabilities and frail elder persons in the absence of the primary care giver(s). This is to be provided with qualified, trained volunteers.

Up to $14,000

### COMMUNITY SERVICES

**Adult Day Service:** Daytime care of any part of a day, but less than 24 hour care, for functionally and/or cognitively impaired elderly persons provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the client's home.

Up to $115,910

**Congregate Nutrition:** Provision of nutritious meals to older individuals in congregate settings.

Up to $529,354

**Disease Prevention/Health Promotion:** A service program that provides information and support to older individuals with the intent to assist them in avoiding illness and improving health status.

*Please Note: As of April 1, 2012 all funded programs in this service category must be classified as "Evidence Based Disease Prevention" programs meeting specific research criteria. For a full list of eligible programs please see attached list.*

Fitness and Other Evidence Based Disease Prevention Programs: $30,773

**Legal Assistance:** Provision of legal advice and representation by an attorney (including counseling or other appropriate assistance by a paralegal or law student under the supervision of an attorney), and counseling or representation by a non-lawyer, where permitted by law.

Up to $27,500

**Long-Term Care Ombudsman/Advocacy:** Provision of assistance to residents of long-term care facilities to resolve complaints through problem identification and definition, education regarding rights, provision of information on appropriate rules and referrals to appropriate community resources. The service also involves assistance to prospective long-term care facility residents and their families regarding placement, financing and other long-term care options. Identification and sharing of best practices in long-term care service delivery, with an emphasis on promotion of the Eden Alternative, is also part of the service.

Up to $40,000

**Prevention of Elder Abuse, Neglect and Exploitation:** Activities to develop, strengthen, and carry-out programs for the prevention and treatment of elder abuse, neglect, and exploitation

Up to $6,343

**Kinship Support Services:** Provision of support services (which include respite care, supplemental and education, support and training services) where an individual aged 60 or over is the primary caregiver for a child no more than 18 years old. Kinship support services may be provided at locations other than the client's residence.

Up to $7,215

**Friendly Reassurance:** Making regular contact, though either telephone or in-home visits, with homebound older persons to assure their wellbeing and safety and to provide companionship and social interaction.

Up to $2,000

**TOTAL FUNDS $1,589,376**

**B. APPLICATION STRUCTURE** - All applications are structured in the following three parts. (See attached Application for format.)

| | |
|---|---|
| **Part I SERVICE INFORMATION** | Calls for programmatic information regarding proposed service(s) and the applicant agency. |
| **Part II ASSURANCES** | Includes signed compliance documents and statutory assurances which will govern program operations. |
| **Part III BUDGET** | Provides for a complete budget narrative with yearly expense projections. |

**C. ELIGIBLE APPLICANTS FOR FUNDING** - Public, private non-profit and for profit organizations and political subdivisions of the state who offer services which meet minimum standards and serve the Michigan counties of Clinton, Eaton and Ingham are eligible applicants. For profit-making organizations, prior approval from the Michigan Aging and Adult Services Agency (AASA) is required.

**D. POPULATION TO BE SERVED** - All persons sixty (60) years of age or older who are residents of Clinton, Eaton and Ingham Counties are eligible for federal and state funded service delivery regardless of race, color, religion, sex, national origin, ancestry, sexual orientation, age, disability, disabled or Vietnam era veteran status, marital status and other protected characteristics.

**E. TARGET POPULATION** - Although all individuals aged sixty (60) years or older are eligible to receive federal and state funded service, substantial emphasis must be given to serving older persons with the greatest social, physical and economic need.

**II. SELECTION PROCESS** - The grant application and selection process is conducted in a manner that provides for free and open competitive bidding on all services to be provided in the region. TCOA reserves the right to accept or reject any or all proposals. Awards shall be made to the responsible applicant whose proposal appears to be most advantageous to TCOA with all factors, including cost, being considered. Proposals may be denied at the determination of the Administrative Board. The established timetable will be strictly adhered to. **Proposals received after the published due date will <u>not</u> be considered eligible for funding.**

**A. FISCAL YEAR 2020 RFP TIMETABLE**

| | |
|---|---|
| Public Notice Published in Newspapers | April 14-20, 2019 |
| Application Available online starting | May 1, 2019 |
| Public Hearings (Charlotte Public Library – 226 S. Bostwick, Charlotte, MI 48813) | May 6, 2019 – 10:00 A.M. |

| | |
|---|---|
| (St. Johns – Briggs Public Library – 108 E. Railroad St. St. Johns, MI 48879) | |
| | May 6, 2019 – 3:00 P.M. |
| (Tri-County Office on Aging – 5303 S. Cedar St. Lansing, MI 48911) | |
| | May 9, 2019 – 1:00 P.M. |
| Proposal Review Committee Selected | May 9, 2019 |
| Proposal Training Workshop – Tri-County Office on Aging | May 14, 2019 – 10:00 A.M. |
| **Proposals Due** | **June 7, 2019 – 5:00 P.M.** |
| **(One signed original and three copies)** | |
| Proposal Review by Committee | June 17-21, 2019 |
| Competitive Applicant Hearing and Review | June 24-28, 2019 |
| Advisory Council Recommendations | July 11, 2019 – 1:00 P.M. |
| Administrative Board Decisions | July 15, 2019 – 3:30 P.M. |
| Notification of Grant Awards & Denials Week of | July 15, 2019 |
| Appeal Requests Due To Consortium | August 2, 2019 – 5:00 P.M. |
| Contracts Sent Week of | September 2, 2019 |
| Contract Period Begins | October 1, 2019 |

**B. SUBCONTRACTOR SELECTION** - TCOA requires applicants to complete a full application package. There will be one-year contracts awarded. Incomplete applications will not be accepted

**C. PROPOSAL REVIEW PROCESS** - All proposals received will be reviewed and evaluated by a committee of TCOA Advisory Council members and, at times, Administrative Board members. Competitive applicants will have the opportunity to give a five (5) minute oral presentation, highlighting their proposal. At that time the Review Committee will have the opportunity to ask questions. The Committee will use the following Proposal Review Criteria as the basis for making recommendations for funding to the full Advisory Council. The entire Advisory Council will then review recommendations and make their recommendations to the TCOA Administrative Board. The Administrative Board will make the final selection of annual contractors.

**D. PROPOSAL REVIEW CRITERIA** - Applicants are required to comply with ASAA minimum operating standards. An unwillingness, inability or failure to comply with the service specifications or the application submission requirements will adversely affect the applicant's chances for funding and/or may render the application unacceptable. Applicant's past performance as a provider of the service will be considered. Previous experience of a positive nature will prove helpful to applicants; an unfavorable history may adversely affect the applicant in the review process. Lack of prior experience will not necessarily be reviewed as a negative factor but may be grounds for rating such an application relatively lower than others from applicants with favorable experience.

Applicants are reviewed and rated according to the following Criteria:

**a. Organization**

1. Is purpose & structure clear and understandable; is it consistent with the service and funds being requested?
2. Experience in managing programs relative to the service.
3. Staffing and training and use of volunteers (if relevant), including minority, longevity, and bi-lingual.
4. Staff performance and quality assurance measures.

**b. Program Plan**

1. Is the service program plan practical and feasible?
2. Outreach efforts to potential clients.
3. Ease and efficiency of referral process.
4. Client satisfaction initiatives; results of client surveys should be included.
5. Impact of the program on the community; including innovation and potential of continuation of program without TCOA funds.
6. Program duplication and how program would interface with others.

**c. Client Considerations**

1. Does the plan show how it would reach older persons most in need of assistance (social, physical & economic priority)?
2. Practical coordination efforts, specific information on types and number of referrals and working relationships, how and frequency of communication with other services.
3. Emergency procedures clear, efficient and timely.

**d. Financial and Budget Considerations**

1. Agency budget process appropriate and goes through proper channels.
2. Audits appropriate, current (last 2 years) and no major findings.
3. Donation solicitations clear and appropriate.
4. Other resources to support the program, including but not limited to appropriate match (budget).
5. Cost per unit, cost per client and total cost of the program.

The Proposal Review Committee, at its discretion, may recommend certain applicants for funding by conducting an abbreviated review process, which could eliminate the oral presentations. Conditions under which this may occur include:

1. The applicant is under current contract with the TCOA;
2. A complete proposal was submitted;
3. Lack of competition in a specific service category; and
4. Request for funding does not exceed funds available for a specific service category.

**E. CONTRACT RENEWAL PROCEDURES** - For the applicants who are selected as annual contractors for the three (3) year period, one (1) year contracts will be issued unless conditions warrant a full RFP process. The TCOA Administrative Board will authorize the contract renewals after the approval of requested application materials. All materials must be complete and accurate. The contract renewal materials requiring submission may include but are not limited to:

**Contract Renewal Requirements:**

1. Changes - Summary of any anticipated program changes;
2. Additional - Any additional information not requested in the original proposal or contract;
3. Budget - Updated budget and unit cost; and
4. Requirements - All assurances and required signatures.

**Conditions under which a new RFP is issued may include:**

1. Inadequate contractor performance;
2. Subsequent amendments to the multi-year plan or Annual Application;

3. Significant changes in the scope or nature of the service to be provided as related to state or federal requirements;
4. Particularly competitive service environments which may offer opportunity for significant cost savings of federal or state dollars; or
5. Significant contractor change in its administrative authority or organizational structure.

**F. POLICY WAIVERS -** All policies and procedures of TCOA shall be strictly adhered to except in those cases where waivers are specifically allowed under the Michigan Aging and Adult Services Agency (AASA) rules and regulations. In such cases a written request for the waiver, including the rationale for such a request, must be submitted to TCOA for approval. Approval must be given prior to any change in operations. Waiver requests pertaining to Minimum Service Standards should be submitted by the applicant as part of the application process, or during the contract renewal process. Consideration of and recommendations regarding such requests will be determined as part of the proposal review process.

**G. NOTICE OF AWARD** - Written notification of the TCOA Administrative Board decisions will be mailed within seven (7) days to applicants regarding the approval or denial of service proposals.

**H. APPEALS** - Those applicants whose proposals are denied by the TCOA have the right to appeal the decision. Written intent to appeal must be sent to TCOA within ten (10) days from the official notice of the decision. The appeal should include a narrative statement outlining the funding that was being applied for and the justification for appealing the decision to deny funding.

**I. CONTRACT NEGOTIATIONS** - Final negotiation of contracts authorized by the TCOA Administrative Board will be conducted by TCOA staff after Board decisions have been announced but prior to actual project start-up of the Fiscal Year (October 1). Negotiations may be necessary if issues arise regarding funding conditions, unit cost, client service levels, budget concerns, or other program related concerns.

## III. FUNDING INFORMATION

**A. FUNDING SOURCES -** Both State and Federal monies are available through TCOA. Federal and State funds are to provide for direct aging service costs and not intended to stabilize organizations or provide for their solvency. Selected annual contractors are to use their entire grant award in the respective year; funds cannot be carried over into the next fiscal year.

Title III is the principle federal source of funds for planning and services for older persons established through the Older Americans Act. Title III-B social service programs; Title III-C congregate meal services and for meals delivered to homebound elderly; Title III –D medication education; Title III- E respite; Title III-F disease prevention & health promotion; Title VII-A elder abuse prevention. Escheat and Tobacco Settlement, and State funds including categorical funding in the following areas: home delivered meals, congregate meals, nursing home ombudsman, and respite.

**B. MATCHING REQUIREMENTS** - the funding philosophy of aging-service programs assumes some local resources are available for local programs. Therefore, all funding is on a percentage basis, with both Federal and State monies requiring a **match**. The minimum match of service costs that TCOA requires is ten percent (10%) of in-kind and/or cash.

Example: $10,000 Annual Grant request

a. $10,000 divided by .90 = $11,111 (sum of awards & match)
b. $11,111 times .10 + $1,111 (10% local match amount)

Documentation that match is being provided is submitted as a component of the financial reporting for reimbursement. Technical assistance regarding reporting requirements will be provided to successful applicants. Definitions of matching sources are provided in the specific application instructions.

**C. PROGRAM INCOME** - Program income includes, but is not limited to, donations from clients received by an annual contractor for services provided with contract funds. Program income is used for budgeted line items to expand the service and reduce the need for federal and state funding participation. Regulations, which govern program income, include:

**1. Opportunity** - Older persons must be given an opportunity to contribute; however, an older person who requests services cannot be denied a service because he/she will not or cannot contribute to the cost of the service;

**2. Privacy** - The privacy of contributions made by older persons must be protected;

**3. Expand Services** - Program income must be used to expand or increase service delivery for allowable costs only, and cannot be used as match for federal or state funds;

**4. Budgeting** - Program income must be budgeted in the service for which it is received **before** being spent;

**5. Handling** - The person handling program income must be bonded and all funds must be properly counted and reported to the bookkeeper for accounting/audit purposes;

**6. Accounting** - Program income must be accounted for separately within the subcontractor's accounting records;

**7. Carry Over** - Program income cannot be carried from one fiscal year to the next.

**D. COST-SHARING -** State funds for respite require a client cost-sharing component. Programs not using TCOA developed forms for determining and assuring cost sharing must have their forms approved by TCOA prior to implementing their use.

**E. METHODS OF REIMBURSEMENT** - TCOA uses performance-based unit cost contracts.
**Unit Cost Reimbursement** - Under a unit cost reimbursement structure, the budget submitted establishes a fixed unit cost reimbursement rate for each unit of service delivered. Monthly reimbursement received by a subcontractor from TCOA is based on the number of units provided in that month. Service quality is monitored under existing standards and definitions. Annual contractors must establish a clear audit trail of the units of service claimed for reimbursement (i.e. worker time sheets signed by the client to verify that services were performed).

**F. GUIDELINES FOR THE UNIT REIMBURSEMENT SYSTEM**

**1. Fixed Rate** - Unit reimbursement is understood as a method of payment for contracted services based on a fixed unit rate that is determined prior to the finalizing of a contract for services. Individual contracted unit rates will vary with various annual contractors.

**2. Quality** - The primary consideration in use of this system is to ensure the provision of quality, cost efficient units of service at the contracted rate, and during the entire contract period. Service quality will be monitored under existing service standards and definitions.

**3. Contract** - The boilerplate contract will be used. Should additional funding be awarded during the contract year, service will be increased relative to the established unit rate, unless contract renegotiations are requested.

**4. Reporting** – Annual contractors will be required to submit monthly financial reports and quarterly programmatic reports as required by the type of service being provided.

**5. Audit** – Annual contractors must establish a clear audit trail for the units of service that are claimed for reimbursement.

**6. Renegotiations** - The contract will allow for mutual review and possible renegotiations of the unit rate as appropriate.

## IV. REPORTING

**A. FINANCIAL** - Providers will receive payment for services on a monthly basis through a unit cost reimbursement method as determined by the individual contract or agreement. A monthly report is due within ten (10) days following the last day of each month. Matching resources provided by service providers will be reported as part of the monthly reporting process.

To alleviate cash flow problems on annual contracts, a one-month advance may be available upon request to TCOA followed by monthly reimbursements. The advance and reimbursements must be reconciled to the total expenditures at the end of the fiscal year. Availability of all advances is dependent on the availability of cash-on-hand at TCOA.

**B. PROGRAMMATIC** – Annual contractors will report programmatic activities through quarterly reports. Reimbursement for the final month of a particular quarter will be contingent not only on receipt and approval of the monthly financial report but of the programmatic information and reports as well. The TCOA programmatic reports and the application package request information about units of service and unduplicated client counts. Definitions for unit of service vary for the different service categories and are stated as part of the Minimum Service Standards.

The unduplicated client count refers to the counting of a person receiving a service only one time within the fiscal year. A client is counted as unduplicated the first time he/she receives a particular service and is not counted again as unduplicated for the entire contract period. Since only new clients are reported in the unduplicated count, it is expected that planned number of units of service will be greater than the number of unduplicated clients. At the beginning of a Fiscal Year the entire unduplicated count is started over.

Annual contractors must keep track of reported units of service and unduplicated clients for each service category within their filing system. Verification of reported programmatic activity is a part of the TCOA on-site monitoring.

# 2. Application

# Tri-County Aging Consortium
# Application for Funding Fiscal Year 2020
**(October 1, 2019 through September 30, 2020)**

Applicant Agency _____ Project _____

Director Name _____ Contact Name _____

Address _____ Address _____

City/State _____ Zip _____ City/State _____ Zip _____

Federal ID # _____ Phone (____)_____

Email _____

Legal Status: □ Private □ For Profit □ Private/Non-Profit □ Other_____

Minority Status: Are one-half of the policy board minority individuals? □Yes □No
Proof of Insurance for contract period attached: □Yes □No

**Program Plan**

| **Service** | | | |
|---|---|---|---|
| County(s) to be served | | | |
| Funds Requested | $ | $ | $ |
| Number of Units | | | |
| Unit Cost to TCOA | | | $ |
| Total Unit Cost | $ | $ | $ |
| Unduplicated Clients | | | |
| Average Client Cost | $ | $ | $ |

**TERMS AND CONDITIONS**: It is understood and agreed by the undersigned that:

1) Funds awarded as a result of the request are to be expended for the purpose set forth herein and in accordance with all applicable laws, regulations, policies and procedures of the Area Agency, the State Aging Unit, the Administration on Aging, and the U.S. Department of Health and Human Services (DHHS);
2) Any changes in the proposal as approved will be submitted in writing by the applicant and upon notification of approval by the Area Agency shall be deemed incorporated into and become a part of this agreement;
3) The Assurance of Compliance with the DHHS Regulation issued pursuant to Title VI of the Civil Rights Act of 1964 applies to this proposal as approved;
4) Funds awarded by the Area Agency may be terminated at any time for violations of any terms and conditions, and requirements of this agreement;
5) All grant awards are contingent upon availability of funds.
6) Any funds awarded are based annual contract. Payment is based on a defined unit rate for services rendered. Annual contractors are *not* considered sub-recipients of state or federal funds.

Signature of person authorized to sign for the applicant agency.

_____ _____
Name and Title Date

# APPLICATION

The following is the format to be used in writing your grant application for the Tri-County Office on Aging. Do not change the order of the categories or numbered questions. Attach any documents, forms and/or policies and procedures your agency uses to support your responses. Please number your pages and begin with page "2". (The cover sheet must be page one.) Do not use any covers, folders, or bindings other than staples and clips.

## A. Organization

1. What is the overall purpose of your agency? (Attach an organizational chart/description of your agency, description of the program seeking funding, and by-laws.)

2. Describe your agency's past experience in delivering services and how it is related to this application.

3. Describe the staffing planned for each proposed service including job descriptions, number of FTE's to be assigned to this program, number of bilingual staff (including the languages spoken) and number of minority staff.

4. How are staff members for this project recruited, oriented, and trained? Please include information on the process of completing background checks for staff members.

5. How, if relevant, are volunteers recruited, trained, evaluated, and used to implement the service? How many volunteers does your organization utilize? State your rationale if volunteers are not to be used. (Attach job descriptions of volunteer positions for your proposed program.)

6. How often, by whom and how, is staff/volunteer performance evaluated? Describe measures taken to improve a staff persons performance when there have been deficiencies in evaluations. (Attach an evaluation form.)

7. Describe measures taken to assure program quality within the proposed service(s). (Attach a client complaint resolution procedure.)

8. Does your organization, or any of your key staff members, have additional specialized certifications, training or education related to the program you are seeking funding for?

## B. Program Plan

1. Describe the proposed service(s).

2. How will potential clients learn of the service(s) your agency provides? (Attach brochures, flyers or literature that has been developed.)

3. Describe how a client or referral source contacts your agency to receive service(s).

4. How is client satisfaction assessed? How often is client satisfaction assessed? Provide any recent (within the last 12 months) summary results of client satisfaction survey.

5. Describe any new or innovative steps your agency has taken, or proposes to take, in the delivery of proposed service(s).

6. Describe the impact on the community if your agency does or does not receive the funding for the proposed service(s).

7. List all other programs in the tri-county area which provides similar service and how your program interfaces with those programs.

**C. Client Considerations**

1. It is a mandate from the Federal Government to give substantial emphasis to serving older persons with the greatest social, physical and economic need, including minority individuals. How does (will) your program comply with the mandate?

2. Describe your present clientele (i.e.: according to the above targeted priority.)

3. Is your program currently meeting all Michigan Office of Services to the Aging standards for this service category regarding service to clients?

4. What is the daily average number of clients your program serves?

5. What priority criteria does the program have to handle demand for services that exceed resources? Be specific.

6. What procedures are in place to cope with medical and weather related emergencies? How and when are clients contacted when changes are made in scheduled service and how is this documented?

**D. Financial**

1. Describe your agency's annual budget process.

2. Describe your agency's/program's audit process. (Attach a copy of your most recent completed program audit and summary letter.)

3. Describe how donations will be solicited.

4. List other resources the program uses to provide services and describe how the 10% match requirement will be met.

5. State the cost per unit, the cost per client, the total cost of the program, and show how this was calculated.

**D. Attachments**

1. Organizational chart of the agency and program.
2. Agency/program by-laws and/or Articles of Incorporation.
3. Client Complaint Resolution Procedure.
4. Brochures, flyer, an/or program literature.
5. Referral and follow-up forms.
6. Job description(s) of each staff person and/or volunteer related to the proposed project.
7. Audit and summary letter.
8. List of names, addresses and phone numbers of your agency's governing and/or advisory board members.
9. Letters of support.
10. A list of any additional special certifications, accreditations, etc. your organization or staff has received relating to the program you are seeking funding for. (If application, not required)

# 3. Proposal Review Criteria

## PROPOSAL REVIEW CRITERIA

The following criteria are used to guide the proposal review process. The numbers next to a statement/question correspond to the Grant Application format. At the far left, the numbers indicate the points assigned to each of the criteria. There are a total of 100 points.

| Points | | |
|---|---|---|
| **25** | **A**. | **Organization** |
| 5 | 1. | Is the purpose & structure clear and understandable, does it coincide with the funds being requested? Were appropriate documents included? |
| 5 | 2. | Experience in managing programs relative to the service. |
| 8 | 3-5. | Staffing, training and use of volunteers (if relevant) including longevity, minority, and bi-lingual. Were job descriptions included? |
| 7 | 6-8. | Staff performance and quality assurance measures. Were evaluation forms and complaint resolution procedures included? |
| **25** | **B**. | **Program Plan** |
| 5 | 1. | Is the service program plan practical and doable? |
| 2 | 2. | Outreach efforts to potential clients. Were sample outreach materials included? |
| 3 | 3. | Ease and efficiency of referral process. |
| 5 | 4. | Client satisfaction initiatives; results of surveys should be provided for total points. |
| 5 | 5-6. | Impact on the community; including innovation & potential of continuation of program without TCOA funds. |
| 5 | 7. | Program duplication and how program would interface with others. |
| **25** | **C**. | **Client Considerations** |
| 10 | 1. | Does the plan show how to reach older persons most in need? |
| 10 | 2-4. | Current clientele information, compliance, and daily average. Were social, physical, and economic need included in the discussion? Was the minority population served addressed? |
| 1 | 5. | Priority criteria in place. |
| 4 | 6. | Emergency procedures are clear, efficient and timely. |
| **25** | **D**. | **Financial and Budget Considerations** |
| 2 | 1. | Agency budget process appropriate and goes through proper channels. |
| 2 | 2. | Audits appropriate and up to date. |
| 2 | 3. | Donation solicitation clear and appropriate. |
| 4 | 4. | Other resources to support the program, including but not limited to appropriate match (budget). |
| 15 | 5. | Cost per unit, cost per client and total cost of the program, compared to other bidders including cost-sharing procedure for those receiving funds. |

**Attachments – Were all attachments included? (Required for application to be considered complete)**

# 4. AASA Minimum Service Standards

# I. INTRODUCTION AND INSTRUCTIONS FOR USE

The Michigan Department of Health and Human Services, Aging and Adult Services Agency (AASA), Operating Standards for Service Programs comprises the operating guidelines to be followed by providers of services to older persons in Michigan. This manual represents a compilation of the policies, standards, rules, regulations and statutes most directly relating to service programs. It is intended for use by the Aging and Adult Services Agency (AASA), Area Agencies on Aging (AAAs), and the network of service providing agencies. Statewide Operating Standards are adopted by the Michigan Commission on Services to the Aging (MCSA) following input, review, and comment by the stakeholders of the Michigan Aging Network.

Prior to the 1981 amendments to the Older Americans Act, the Federal Administration on Aging promulgated specific regulations regarding service provision. In addition, program instructions to state agencies, area agencies, and service providers detailed expected and required activities. Since the 1981 amendments, federal direction has been reduced significantly. Accordingly, AASA began developing and adopting more explicit state policies which included Minimum Standards for Congregate Meals, Home Delivered Meals, Adult Day Care, In-Home Services and Senior Centers. This document resulted from a review of these standards and an aggregation of other major policies into one comprehensive publication.

General requirements affecting all service programs and nutrition service programs are separately identified in Section II. In Section III, each service is identified separately by name and number, and grouped according to the categories of Access, In-Home, and Community. A statement of each service definition is also presented. Specific minimum standards are identified for each service and are considered required components unless written to be optional or recommended.

Interpretations of the applicability of any service definition or minimum standard shall be made only by the Director of the AASA in response to a written inquiry. Amendments and/or revisions of any definition or minimum standard shall be made only by action of the MCSA.

All definitions and minimum standards in this document remain in effect unless a specific waiver has been approved by the MCSA. Waivers will not be granted where a specific requirement is mandated by federal or state statute, regulation or an Administrative Rule.

An AAA may develop a service definition and appropriate minimum standards, to be funded within its respective Planning and Service Area (PSA), which is not identified within this document. All regional service definitions and minimum standards must be presented within the Multi-Year Area Plan (MYP) and/or the Annual Implementation Plan (AIP) for each fiscal year it will be funded.

# II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS

Authority Reference

- Michigan Commission on Services to the Aging (MCSA).
- Michigan Public Act referred to in the standards can be viewed at www.legislature.mi.gov.
- Federal Laws and Regulations can be viewed at www.first.gov.
- Policy Statement.

Service programs for older persons provided with state and/or federal funds awarded by the Michigan Commission on Services to the Aging must comply with all general program requirements established by the Commission.

**Required Program Components**

A. Contractual Agreement

Services are to be provided under an approved area plan through formal contractual agreements, including direct purchase agreements, between the area agency on aging and service providers. Assignment of responsibilities under the contract or execution of subcontracts involving an additional party must be approved in writing by the area agency on aging. Direct service provision by the area agency must be specifically approved as part of the area plan. Each contract and direct purchase agreement must contain all required contract components as detailed in Operating Standards for Area Agencies on Aging.

B. Compliance with Service Definitions

Only those services for which a definition and minimum standards have been approved by the MCSA may be funded with state and/or federal funds awarded by the MCSA. Each service program must adhere to the definition and minimum standards to be eligible to receive reimbursement of allowable expenses.

C. Eligibility

Services shall be provided only to persons 60 years of age and older unless otherwise allowed under eligibility criteria for a specific program (such as a spouse under 60 of a meal program participant).

Services provided under Title III-Part E (The National Family Caregiver Support Program) may be provided to caregivers age 60 or over, caregivers of any age when the care recipient is aged 60 or over, and to kinship care recipients when the kinship caregiver is aged 60 or over.

Services provided under Tobacco Respite Care (adult day services and respite care) may be provided to adults aged 18 or over.

D. Targeting of Participants

1. Substantial emphasis must be given to serving eligible persons with greatest social and/or economic need with particular attention to low-income minority individuals. "Substantial emphasis" is regarded as an effort to serve a greater percentage of older persons with economic and/or social needs than their relative percentage to the total elderly population within the geographic service area.

   Each provider must be able to specify how they satisfy the service needs of low-income minority individuals in the area they serve. Each provider, to the maximum extent feasible, must provide services to low-income minority individuals in accordance with their need for such services. Each provider must meet the specific objectives established by the area agency on aging for providing services to low-income minority individuals in numbers greater than their relative percentage to the total elderly population within the geographic service area.

2. Participants shall not be denied or limited services because of their income or financial resources. Where program resources are insufficient to meet the demand for services, each service program shall establish and utilize written procedures for prioritizing clients waiting to receive services, based on social, functional and economic needs.

   Indicating factors are included for:

   **Social Need** – isolation, living alone, age 75 or over, minority group member, non-English speaking, etc.

   **Functional Nee**d – handicaps (as defined by the Rehabilitation Act of 1973 or the Americans With Disabilities Act), limitations in activities of daily living, mental or physical inability to perform specific tasks, acute and/or chronic health conditions, etc.

   **Economic Need** – eligibility for income assistance programs, self-declared income at or below 125% of the poverty threshold, etc. [Note: National Aging Program Information System (NAPIS) reporting requirements remain based on 100% of the poverty threshold].

   Each provider must maintain a written list of persons who seek service from a priority service category (Access, In-Home, or Legal Assistance) but cannot be served at that time. Such a list must include the date service is first sought, the service being sought and the county, or the community if the service area is less than a county, of residence of the person seeking service. The program must determine whether the person seeking service is likely to be eligible for the service requested before being placed on a waiting list.

Individuals on waiting lists for services for which cost sharing is allowable, may be afforded the opportunity to acquire services on a 100% cost share basis until they can be served by funded program.

3. Elderly members of Native American tribes and organizations in greatest economic and/or social need within the program service area are to receive services comparable to those received by non-Native American elders. Service providers within a geographic area in which a reservation is located must demonstrate a substantial emphasis on serving Native American elders from that area.

E. Contributions

1. All program participants shall be encouraged to and offered a confidential and voluntary opportunity to contribute toward the costs of providing the service received. No one may be denied service for failing to make a donation.

2. Cost sharing may be implemented according to the Michigan Aging and Adult Services Agency Cost Sharing Policy (refer to Transmittal Letter #393).

   Private pay or locally funded fee-for-service programs must be separate and distinct from grant funded programs.

3. Except for program income, no paid or volunteer staff person of any service program may solicit contributions from program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

4. Each program must have in place a written procedure for handling all donations/contributions, upon receipt, which includes at a minimum:

   a. Daily counting and recording of all receipts by two, unrelated individuals.
   b. Provisions for sealing, written acknowledgement and transporting of receipts to either deposit in a financial institution or secure storage until a deposit can be arranged.
   c. Reconciliation of deposit records and collection records by someone other than the depositor or counter(s).

F. Confidentiality

Each service program must have written procedures to protect the confidentiality of information about older persons collected in the conduct of its responsibilities. The procedures must ensure that no information about an older person, or obtained from an older person by a service provider is disclosed in a form that identifies the person without the informed consent of that person or of his or her legal representative. However, disclosure may be allowed by court order, or for program monitoring by authorized federal, state or local agencies which are also bound to protect the confidentiality of client information. All client information shall be maintained in controlled access files. It

is the responsibility of each service program to determine if they are a covered entity with regard to HIPAA regulations.

G. Referral and Coordination Procedures

Each service program shall establish working relationships with other community agencies for referrals and resource coordination to ensure that participants have maximum possible choice.

Each program shall be able to demonstrate linkages with agencies providing access services. Each program must establish written referral protocols with Case Coordination and Support, Care Management, and Home and Community Based Medicaid Programs operating in the respective service area.

H. Services Publicized

Each service program must publicize the service(s) in order to facilitate access by all older persons which, at a minimum, shall include being easily identified in local telephone directories.

I. Older Persons at Risk

Each service program shall have a written procedure in place to bring to the attention of appropriate officials for follow-up, conditions or circumstances that place the older person, or the household of the older person, in imminent danger.
(e.g. situations of abuse or neglect).

J. Disaster Response

Each service program must have established, written emergency protocols for both responding to a disaster and undertaking appropriate activities to assist victims to recover from a disaster, depending upon the resources and structures available.

K. Insurance Coverage

Each program shall have sufficient insurance to indemnify loss of federal, state and local resources, due to casualty, fraud or employee theft. All buildings, equipment, supplies and other property purchased in whole or in part with funds awarded by the MCSA are to be covered with sufficient insurance to reimburse the program for the fair market value of the asset at the time of loss. The following insurances are required for each program:

1. Worker's compensation
2. Unemployment
3. Property and theft coverage (including employee theft)
4. Fidelity bonding (for persons handling cash)
5. No-fault vehicle insurance (for agency owned vehicles)
6. General liability and hazard insurance (including facilities coverage)

The following insurances are recommended for additional agency protection:

1. Insurance to protect the program from claims against program drivers and/or passengers.
2. Professional liability (both individual and corporate).
3. Umbrella liability.
4. Errors and Omissions Insurance for Board members.
5. Special multi-peril.

L. Volunteers

Each program that utilizes volunteers shall have a written procedure governing the recruiting, training, and supervising of volunteers that is consistent with the procedure utilized for paid staff. Volunteers shall receive a written position description, orientation training and a yearly performance evaluation, as appropriate.

M. Staffing

Each program shall employ competent and qualified personnel sufficient to provide services pursuant to the contractual agreement. Each program shall be able to demonstrate an organizational structure including established lines of authority. Each program must conduct, prior to employment or engagement, a criminal background review through the Michigan State Police for all paid and volunteer staff. An individual with a record of a felony conviction may be considered for employment at the discretion of the program. The safety and security of program clients must be paramount in such considerations.

N. Staff Identification

Every program staff person, paid or volunteer, who enters a participant's home must display proper identification which may be either an agency picture card or, a Michigan driver's license and some other form of agency identification.

O. Orientation and Training Participation

New program staff must receive orientation training that includes at a minimum, introduction to the program, the aging network, maintenance of records and files (as appropriate), the aging process, ethics and emergency procedures. Issues addressed under the aging process may include, though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation.

Service program staff is encouraged to participate in relevant AASA or area agency sponsored or approved in-service training workshops, as appropriate and feasible. Records that detail dates of training, attendance, and topics covered are to be maintained. Training expenses are allowable costs against grant funds. Each service program should budget an adequate amount to address its respective training needs.

P. Complaint Resolution and Appeals

Complaints - Each program must have a written procedure in place to address complaints, from individual recipients of services under the contract, which provides for protection from retaliation against the complainant.

Appeals - Each program must also have a written appeals procedure for use by recipients with unresolved complaints, individuals determined to be ineligible for services or by recipients who have services terminated. Persons denied service and recipients of service who have services terminated, or who have unresolved complaints, must be notified of their right to appeal such decisions and the procedure to be followed for appealing such decisions.

Each program must provide written notification to each client, at the time service is initiated, of her/his right to comment about service provision and to appeal termination of services.

Complaints of Discrimination – Each program must provide written notice to each client, at the time service is initiated, that complaints of discrimination may be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, or the Michigan Department of Civil Rights.

Q. Service Termination Procedure

Each program must establish a written service termination procedure that includes formal written notification of the termination of services and documentation in client files. The written notification must state the reason for the termination, the effective date, and advise about the right to appeal. Reasons for termination may include, but are not limited to the following:

1. The client's decision to stop receiving services;
2. Reassessment that determines a client to be ineligible;
3. Improvement in the client's condition so they no longer are in need of services;
4. A change in the client's circumstances which makes them eligible for services paid for from other sources;
5. An increase in the availability of support from friends and/or family;
6. Permanent institutionalization of client in either a acute care or long term care facility. If institutionalization is temporary, services need not be terminated; and,
7. The program becomes unable to continue to serve the client and referral to another provider is not possible (may include unsafe work situations for program staff or loss of funding).

R. Service Quality Review

Each provider must employ a mechanism for obtaining and evaluating the views of service recipients about the quality of services received. The mechanism may include client surveys, review of assessment records of in-home clients, etc.

S. Civil Rights Compliance

Programs must not discriminate against any employee, applicant for employment or recipient of service because of race, color, religion, national origin, age, sex, sexual orientation, height, weight, or marital status. Each program must complete an appropriate DHHS (Federal Department of Health and Human Services) form assuring compliance with the Civil Rights Act of 1964. Each program must clearly post signs at agency offices and locations where services are provided in English, and other languages as may be appropriate, indicating non-discrimination in hiring, employment practices and provision of services.

T. Equal Employment

Each program must comply with equal employment opportunity and affirmative action principles.

U. Universal Precautions

Each program must evaluate the occupational exposure of employees to blood or other potentially hazardous materials that may result from performance of the employee's duties and establish appropriate universal precautions. Each provider with employees who may experience occupational exposure must develop an exposure control plan which complies with Federal regulations implementing the Occupational Safety and Health Act.

V. Drug Free Workplace

Each program must agree to provide drug-free workplaces as a precondition to receiving a federal grant. Each program must operate in compliance with the Drug-Free Workplace Act of 1988.

W. Americans With Disabilities Act

Each program must operate in compliance with the Americans With Disabilities Act.

X. Workplace Safety

Each program must operate in compliance with the Michigan Occupational Safety and Health Act (MOISHA). Information regarding compliance can be found at www.michigan.gov/lara.

Revised 4-20-18

# III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS

## OVERVIEW

The Michigan Department of Health and Human Services, Aging and Adult Services Agency (AASA) encourages nutrition providers to operate nutrition programs for older adults that allow for choice and flexibility, while maintaining federal and state standards and requirements. The meals should include key nutrients and follow dietary recommendations that relate to lessening chronic disease and improving the health of older Michiganders. Diabetes, hypertension, and obesity are three of the most prevalent chronic conditions among all adults in Michigan. Special attention should be paid to nutritional factors that can help prevent and manage these and other chronic conditions.

## BUSINESS PRACTICES

1. Nutrition providers must be able to produce a nutrient analysis for a meal when requested by AASA, the area agency on aging (AAA), a participant, or a participant's family member or medical provider. Nutrition analysis does not have to be listed on the menu. All nutrition providers should purchase, or have access to, an electronic nutritional analysis program. Providers may use up to $1,000 in state or federal nutrition funds to purchase or maintain such a program. Local funds may be used if the costs exceed $1,000.

2. A record of the menu actually served each day shall be maintained for each fiscal year's operation.

3. Each program shall use an adequate food cost and inventory system at each food preparation site facility. The inventory control shall be based on the first-in/first-out method and conform to generally accepted accounting principles. The system shall be able to provide food costs, inventory control records, and other cumulative reports on food and meal costs as requested.

   For programs operating under annual cost-reimbursement contracts, the value of the inventory on hand at the end of the fiscal year shall be deducted from the total amount expended during that year. For programs operating under a unit-rate reimbursement contract, the value of the inventory on hand at the end of the fiscal year does not have to be considered. Each program shall be able to calculate the component cost of each meal provided according to the following categories:
   a. Raw food: All costs of acquiring foodstuff to be used in the program.
   b. Labor: All expenditures for salaries and wages, including valuation of volunteer hours, for personnel involved in food preparation, cooking, delivery, serving, and cleaning of meal sites, equipment and kitchens; all expenses for salary and wages for persons involved in project management.

c. Equipment: All expenditures for purchase and maintenance of items with a useful life of more than one year or with an acquisition cost of greater than $5,000.
d. Supplies: All expenditures for items with a useful life of less than one year and an acquisition cost of less than $5,000.
e. Utilities: All expenditures for gas, electricity, water, sewer, waste disposal, etc.
f. Other: Expenditures for all other items that do not belong in any of the above categories (e.g. rent, insurance, fuel, etc.) are to be identified and itemized. Where a provider operates more than one meal/feeding program (congregate, home-delivered meal (HDM), waiver, catering, etc.), costs shall be accurately distributed among the respective meal programs. Only costs directly related to a specific program shall be charged to that program.

4. Each program shall provide or arrange for monthly nutrition education sessions at each meal site and as appropriate to HDM participants. Emphasis should focus on giving the participant the information and tools to make food choices in relation to health and wellness, and to any chronic diseases they may have, including making choices at the meal site, at home, and when they eat out. Educational sessions should be encouraging and informative, as well as encourage participants to take responsibility for the food choices they make throughout the day.

   Topics shall include, but not be limited to, food, nutrition, and wellness issues. Nutrition education materials must come from reputable sources. Questions pertaining to appropriateness of materials and presenters are to be directed to the staff dietitian, regional dietitian or Dietetic Technician, Registered (DTR). Program materials distributed must take into consideration the level of literacy, living alone status, caregiver support and translation of materials as appropriate for older adults with limited English proficiency. At least once per year, the following topics must be covered.
   a. How food choices affect chronic illnesses
   b. Food safety at home and when dining out
   c. Food choices at home
   d. Emergency preparedness- what to have on hand

5. Compliance with these standards will be part of the nutrition assessment done by the AAA.

6. Staff and volunteers of each program shall receive in-service training at least twice each fiscal year, which is specifically designed to increase their knowledge and understanding of the program, and to improve their skills at tasks performed in the provision of service. Records shall be maintained which identify the dates of training, topics covered, and persons attending.

7. All staff and volunteers must undergo a background check (Operating Standards for Area Agencies on Aging (AAA) Indicator #7, Standard B-3, and Transmittal Letter #2012-253). This includes persons who are delivering meals at a special event, or fund-raiser, or any other occasion whereas they would only be delivering a few times. If a group of volunteers from a business or agency participates in the meal delivery representing that business or agency, arrangements may be made for the business or agency to certify that background checks have been completed for their employees, and only no/low risk employees have been cleared to participate.

   Nutrition providers may waive the background check requirement for volunteers who are under the age of 18 and/or those who are packing meals or doing other activities that do not involve direct contact with a meal program participant and are under the supervision of nutrition provider staff and/or adult leaders.

## MENU DEVELOPMENT

1. Meals may be presented hot, cold, frozen or shelf-stable and shall conform to the most current edition of the *USDA Dietary Guidelines for Americans* (DGA) and the AASA Nutrition Standards.

2. Each program shall utilize a menu development process, which places priority on healthy choices and creativity, and includes, at a minimum:
   a. Use of written or electronic standardized recipes;
   b. Provision for review and approval of all menus by one of the following: a registered dietitian (R.D.) or an individual who is dietitian registration eligible, or a DTR;
   c. Posting of menu to be served in a conspicuous place at each meal site, and at each place food is prepared. The program must be able to provide information on the nutrition content of menus upon request; and
   d. Modified diet menus may be provided, where feasible and appropriate, which take into consideration participant choice, health, religious and ethnic diet preferences.

3. The nutrition program must operate according to current provisions of the Michigan Food Code. Minimum food safety standards are established by the respective local Health Department. Each program must have a copy of the most recent Michigan Food Code and all updates available for reference. Programs are encouraged to monitor food safety alerts pertaining to older adults.

   Each program, which operates a kitchen for food production, shall have at least one key staff person (manager, cook or lead food handler) complete a Food Service Manager Certification Training Program that has been approved by the Michigan Department of Agriculture and Rural Development (MDARD). A trained and certified

staff member may be required at satellite serving and packing sites. Please refer to your local Health Department for local regulations on this issue.

The time period between preparation of food and the beginning of serving shall be as minimal as feasible. Food shall be prepared, held and served at safe temperatures. Documentation requirements for food safety procedures shall be developed in conjunction with, and be acceptable to, the respective local Health Department.

The safety of food after it has been served to a participant and when it has been removed from the meal site or left in the control of a HDM participant, is the responsibility of that participant.

Purchased Foodstuffs- The program must purchase foodstuff from commercial sources which comply with the Michigan Food Code. Unacceptable items include: home canned or preserved foods; foods cooked or prepared in an individual's home kitchen (this includes those covered under the Cottage Food Law); meat or wild game NOT processed by a licensed facility; fresh or frozen fish donated by sport fishers; raw seafood or eggs; and any un-pasteurized products (i.e., dairy, juices and honey).

Acceptable contributed foodstuff include: fresh fruits and vegetables and wild game from a licensed processor. A list of licensed processors can be found on the Michigan Department of Agriculture and Rural Development website (http://www.michigan.gov/MDARD).

Acceptable donated products must be handled and prepared just like products that are purchased from commercial sources.

4. Each program shall use standardized portion control procedures to ensure that each meal served is uniform. At the request of a participant, standard portions may be altered or less may be served than the standard serving size. A participant may refuse one or more items. Less than standard portions shall not be served to 'stretch' available food to serve additional persons.

5. Each program shall implement procedures designed to minimize waste of food (leftovers/uneaten meals).

6. The Area Agency on Aging (AAA) may adjust the number of nutrition grantees to meet the needs of the region.

7. Each meal program is encouraged to use volunteers, as feasible, in program operations.

8. Each program shall develop and utilize a system for documenting meals served for purposes of the National Aging Program Information System (NAPIS). Meals eligible to be included in NAPIS meal counts reported to the respective AAA, are those served

to eligible individuals (as described under respective program eligibility criteria) and which meet the specified meal requirements. The most acceptable method of documenting meals is by obtaining signatures daily from participants receiving meals. Other acceptable methods may include, but not limited to, HDMs maintaining a daily or weekly route sheet signed by the driver which identifies the participant's name, address, and number of meals served to them each day.

9. Each program shall use a uniform intake process and maintain a NAPIS registration for each program participant. The intake process shall be initiated within one week after an individual becomes active in the program. Completion of NAPIS registration is not a prerequisite to eligibility and may not be presented to potential participants as a requirement.

10. Nutrition Services Incentive Program (NSIP) – AAAs and their nutrition program service providers are eligible to participate in NSIP. The purpose of the NSIP is to provide incentives to encourage and reward effective performance in the efficient delivery of nutritious meals to older individuals. The NSIP provides an allotment of cash to the state for their nutrition programs based on the number of ***eligible*** Title IIIC meals served by the state that year, as reported in NAPIS. The State of Michigan has elected to receive cash in lieu of commodities. NSIP cash is allocated to AAAs based on the number of NSIP-eligible meals served by all AAAs as reported through NAPIS. NSIP cash may only be used for meals served to individuals through the congregate meal program or HDM program. The program must make a reasonable attempt to purchase foods of U.S. origin with NSIP funding. Meals counted for purposes of NSIP reporting are those served that meet the Title IIIC requirements and are served at a congregate or HDM setting.

    Meals that <u>do not</u> count toward NSIP funding include:
    a. Medicaid (MI-CHOICE Waiver) adult day care meals;
    b. Adult day care meals for which Child and Adult Care Food Program (7 CFR Part 226) funds have been claimed;
    c. Meals funded by Title IIIE served to caregivers under the age of 60; and
    d. Meals served to individuals under age 60 who pay the full price for the meal.

    Each AAA that has NSIP-only (non-AAA funded) sites must have:
    a. A signed contract or Memorandum of Agreement in place detailing the nutrition requirements for the meal;
    b. The mechanism for distributing NSIP only funds; e.g. per meal rate, percentage of total; and
    c. Written plan for assessment of site based on Title IIIC requirements.

11. Each nutrition program shall carry product liability insurance sufficient to cover its operation.

12. Each program, with input from program participants, shall establish a suggested donation amount that is to be posted at each meal site and provided to HDM participants. The program may establish a suggested donation scale based on income ranges, if approved by the respective AAA. Volunteers under the age of 60 who receive meals shall be afforded the opportunity to donate toward the costs of the meal received.

13. Program income from participant donations must be used in accordance with the additive alternative, as described in the Code of Federal Regulations (CFR). Under this alternative, the income is used in addition to the grant funds awarded to the provider and used for the purposes and under the conditions of the contract. Use of program income is approved by the respective AAA as part of the budget process.

14. Each program shall be allowed to accept donations for the program as long as the following apply:
    a. The method of solicitation for the donations is non-coercive;
    b. No qualified person is turned away for not contributing;
    c. The privacy of each person with respect to donations is protected;
    d. There are written procedures in place for handling all donations which includes the following at a minimum;
        i. Daily counting and recording of all receipts by two individuals;
        ii. Provisions for sealing, written acknowledgement and transporting of daily receipts to either deposit in a financial institution or secure storage until a deposit can be arranged; and
        iii. Reconciliation of deposit receipts and daily collection records by someone other than the depositor or counter.

15. Each program shall take steps to inform participants about local, State and Federal food assistance programs and provide information and referral to assist the individual with obtaining benefits. When requested, programs shall assist participants in utilizing Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as “food stamps,” as participant donations to the program.

16. Programs shall not use funds from AASA (federal and state) to purchase vitamins or other dietary supplements.

17. Complaints from participants should be referred to the nutrition provider that hosts the site or manages the HDMs. Each nutrition provider shall have a written procedure for handling complaints. The nutrition provider and AAA nutrition staff shall develop a plan for what type of complaints need to be referred to the AAA.

18. Nutrition providers shall work with the respective AAA to develop a written emergency plan. The emergency plan shall address, but not be limited to:

a. Uninterrupted delivery of meals to HDM participants, including, but not limited to use of families and friends, volunteers, shelf-stable meals and informal support systems;
b. Provision of at least two, and preferably more, shelf-stable meals and instructions on how to use for HDM participants. Every effort should be made to assure that the emergency shelf-stable meals meet the nutrition guidelines. If it is not possible, shelf-stable meals will not be required to adhere to the guidelines.
    - MI-CHOICE participants may receive two emergency meals that are billed to MI-CHOICE. Additional emergency meals may be billed to Title III-C2.
c. Back-up plan for food preparation if usual kitchen facility is unavailable;
d. Agreements in place with volunteer agencies, individual volunteers; hospitals, long-term care facilities, other nutrition providers, or other agencies/groups that could be on standby to assist with food acquisition, meal preparation, and delivery;
e. Communications system to alert congregate and HDM participants of changes in meal site/delivery;
f. The plan shall cover all the sites and HDM participants for each nutrition provider, including sub-contractors of the AAA nutrition provider; and
g. The plan shall be reviewed and approved by the respective AAA and then submitted electronically to AASA for review.

## MEAL PLANNING

1. Menu standards are developed to sustain and improve a participant's health through the provision of safe and nutritious meals using specific guidelines. These guidelines should be incorporated into all requests for proposals/bids, contracts and open solicitations for meals.

2. The Older Americans Act requires that meal components meeting the 33 1/3 percent of the DRI must be offered if one meal is served per day. If two meals are served, meal components with 66 2/3 percent of the DRI must be offered.

3. Nutrition providers must use person-centered planning principles when doing menu planning. Food should be offered, not served. Choices should be offered as often as possible. This is for both congregate and HDM participants. If possible, this should include offering alternatives for food allergies, digestive issues and chewing issues.

4. Follow the five guidelines from the most current edition of the *USDA Dietary Guidelines for Americans.*
    a. Follow a healthy eating pattern across the lifespan. All food and beverage choices matter. Choose a healthy eating pattern at an appropriate calorie level

to help achieve and maintain a healthy body weight, support nutrient adequacy, and reduce the risk of chronic disease.

b. Focus on variety, nutrient density, and amount. To meet nutrient needs with calorie limits, choose a variety of nutrient-dense foods across and within all food groups in recommended amounts.
c. Limit calories from added sugars and saturated fats and reduce sodium intake. Consume an eating pattern low in added sugars, saturated fats, and sodium. Cut back on foods and beverages higher in these components to amounts that fit within healthy eating patterns.
d. Shift to healthier food and beverage choices. Choose nutrient-dense foods and beverages across and within all food groups in place of less healthy choices. Consider cultural and personal preferences to make these shifts easier to accomplish and maintain.
e. Support healthy eating patterns for all. Everyone has a role in helping to create and support healthy eating patterns in multiple settings nationwide from home, to school to work to communities.

5. Key recommendations from the DGA to consider when planning meals.
    a. Consume a healthy eating pattern that accounts for all foods and beverages within an appropriate calorie level.
        i. A variety of vegetables from all of the sub-groups- dark green, red and orange, legumes (beans and peas), starchy, and other
        ii. Fruits, especially whole fruits
        iii. Grains, at least half of which are whole grains
        iv. Fat-free, or low-fat dairy, including milk, yogurt, and cheese
        v. A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes, nuts and seeds
        vi. Oils

    b. Nutrient-dense meals shall be planned using preparation and delivery methods that preserve the nutritional value of foods.
        i. Consume less than 10% of calories per day from added sugars.
        ii. Consume less than 10% of calories per day from saturated fats.
        iii. Consume less than 2300 grams of sodium per day (this may be averaged in your meal plans).
    c. The target for carbohydrate per meal is 75 grams. If the nutrition provider is following one of the suggested meal patterns from the Dietary Guidelines for Americans, listed below, the CHO grams should follow that pattern.
    d. See “Suggested Meal Patterns” below for more information.

6. Other Considerations:
    a. Desserts: Serving of dessert is optional. Suggested, but not limited to, desserts are: fruit, fruit crisps with whole grain toppings, pudding with double

milk, gelatin with fruit, low-fat frozen yogurt, Italian ices. Use of baked, commercial desserts should be limited to once per week.

b. Beverages:

Congregate: Milk and water must be offered with every meal. Coffee and/or tea, or other beverages, are optional.

Home Delivered: Milk, or a milk substitute, must be offered with every meal. If requested, water shall be provided.

Milk may be skim, 1%, 2%, full-fat or chocolate. It should be available to participants but is not required.

7. Special occasion or celebratory meals are allowed on a periodic basis. These meals do not have to follow the 1/3 DRI rule. The registered dietician, or DTR, must have knowledge of the meal and grant approval of it.

8. Breakfast may include any combination of foods that meet the AASA Meal Planning Guidelines.

9. Special Menus. To the extent practicable, adjust meals to meet any special dietary needs of program participants for health reasons, ethnic and religious preference and provide flexibility in designing meals that are appealing to program participants.

## SUGGESTED MEAL PATTERNS

1. The Plate Method (http://www.choosemyplate.gov) may be used as the meal pattern.

2. The Healthy U.S.-Style Eating pattern may be used as the meal pattern (Dietary Guidelines for Americans, 2015-2020, Appendix 3, Table A3-1, page 80).

3. The Healthy Mediterranean-Style eating pattern may be used as the meal pattern (Dietary Guidelines for Americans, 2015-2020, Appendix 4, Table A4-1, page 84).

4. Vegetarian meals can be served as part of the menu cycle or as an optional meal choice based on participant choice, cultural and/or religious needs and should follow the MDHHS Aging and Adult Services Agency Meal Planning Guidelines to include a variety of flavors, textures, seasonings, colors, and food groups at the same meal. (Dietary Guidelines for Americans, 2015-2020, Appendix 5, Table A5-1, page 87).

   Vegetarian meals are a good opportunity to provide variety to menus, feature Michigan produce and highlight the many ethnic, cultural, or religious food traditions that use vegetables and grains in greater amounts at the center of the plate and in different combinations with fruits, vegetables, grains, herbs and spices for added flavor, calories and key nutrients.

## IV. SERVICE DEFINITIONS AND SPECIFIC MINIMUM STANDARDS

All services with definitions approved by the Michigan Commission on Services to the Aging are contained in the following section. All specific minimum standards for each service are identified in the following section. Fundable services, grouped according to category, are as follows:

A. Access
Care management, case coordination and support, disaster advocacy and outreach, information and assistance, outreach, transportation, and options counseling.

B. In-Home
Chore, home care assistance, home injury control, homemaking, home delivered meals, home health aide, medication management, personal care, personal emergency response, respite care, and friendly reassurance.

C. Community
Adult day services, dementia adult day care, congregate meals, nutrition counseling, nutrition education, disease prevention and health promotion services, health screening, assistance to the hearing impaired and deaf, home repair, legal assistance, long-term care ombudsman/advocacy, senior center operations, senior center staffing, vision services, prevention of elder abuse, neglect and exploitation, counseling services, specialized respite care, caregiver supplemental services, kinship support services, and caregiver education, support and training.

Updated 6-7-2018

# V. GENERAL REQUIREMENTS FOR ACCESS SERVICE PROGRAMS

There are increasing demands from a rapidly growing population of older adults and caregivers for various access and service coordination programs. Demand often exceeds supply and public funding is not keeping pace. Consequently, AAAs must plan effectively to ensure their Planning and Service Area (PSA) offers a range of service coordination options with various intensity levels. This should also result in efficient use of available resources.

AASA requires there to be a range of access services available in the PSA and outlined in the Multi-Year Plan's (MYP) Planned Service Array. In addition, the available PSA service coordination options are highlighted in the MYP's Community Service Coordination Continuum from least intensive to most intensive. These two service coordination continuums, along with the MYP narrative, form a conceptual framework for the AAA's PSA-specific access and service coordination program mix.

In addition to the general requirements for all service programs, the following general standards apply to these access service categories: Information and Assistance, Options Counseling (OC), Case Coordination and Support (CCS), Care Management (CM), Access Regional Service Definitions and the support service categories that are listed within the Community Living Program/Aging and Disability Resource Center (CLP/ADRC) budget.

1. Information and Assistance (A-4) and/or CLP/ADRC-type services may generally be used as some of the least intensive forms of access for one-time contacts and minimal follow-up assistance.

2. Options counseling (A-7) may be used for individuals who require some level of short-term assistance and need guidance in their deliberations to make informed choices about long-term supports and services.

3. Case Coordination and Support (A-2) may be used for individuals who have more than one service need/desire and require assessment and ongoing follow-up.

4. Access Regional Service Definitions may be developed and approved to provide service coordination at levels between Information and Assistance and Care Management when there is a solid rationale.

5. Care Management (A-1) may be used for those individuals who are: a) medically complex, with functional and/or cognitive limitations; b) at risk of a Nursing Facility Level of Care (NFLOC); and c) in need of NFLOC and not eligible for the MI Choice Waiver.

6. Each access program shall demonstrate effective linkages with agencies providing long-term care participant support services within the PSA. Such linkages must be sufficiently developed to provide for prompt referrals whether for initiating services or in response to a participant's changing needs or respective eligibility status.

7. State CM funds may be used to support CCS, CLP/ADRC and/or Access Regional Service Definitions at a lesser intensity than CM or CCS. However, there must be some level of state CM funding allocated to CM as part of the AIP Budget.

8. The in-home support services for any long-term care participant may be funded from a combination of federal, state, local, private and Medicaid resources (dependent upon Medicaid eligibility).

9. Currently enrolled MI Choice Waiver participants are NOT allowed to concurrently receive covered services paid for with Older Americans Act and state funding under an area plan.

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| **Service Name** | Information and Assistance |
| **Service Number** | A-4 |
| **Service Category** | Access |
| **Service Definition** | Assistance to individuals in finding and working with appropriate human service providers that can meet their needs which may include; information-giving (e.g., listing the providers of a particular service category so an individual may make their own contact directly); group presentations; referral (making contact with a particular provider on behalf of an individual); advocacy intervention (negotiating with a service provider on behalf of a client); and, follow-up contacts with clients to ensure services have been provided and have met the respective service need. |
| **Unit of Service** | Provision of one hour of component information and referral (I&A) functions (Note: newsletters and media spots are encouraged but are not to be counted as information-giving units of service). |

Minimum Standards

1. Each I&A program shall have a resource file, which is current that includes a listing of human service agencies, services available, pertinent information as to resources and ability to accept new clients and eligibility requirements. The program shall be able to provide adequate information about community resources and agencies to all callers so they may make their own contact directly.

2. Each program located in areas where non-English or limited English speaking older persons are concentrated shall have bilingual personnel available or have the capacity to acquire interpretation services as necessary. In addition, each program must have the capacity to serve hearing impaired persons and visually impaired persons in a manner appropriate to their needs, such as through the Michigan Relay Center.

3. Where walk-in service is available, there shall be adequate space to ensure comfort and confidentiality to clientele during intake and interviewing.

4. Each program shall maintain records (for three years or until audit has been closed) of the nature of calls received, the agencies and/or organizations to which referrals are made and the service for which referrals are made, the results of follow-up contacts, and any client files maintained. Such information regarding service transactions shall be reported to the AAA upon request for monitoring and/or planning purposes.

5. A follow-up contact shall be made on all referrals, whether services are negotiated or not, within ten working days to determine whether services were received, the identified need met, and client satisfaction. Follow-up contacts are not required for information-giving only contacts.

6. Each program must determine the quality of I&A services provided, through a sampling of no less than 10% of clients, at least annually

7. Each program shall demonstrate effective linkages with agencies providing long-term care support services within the program area (i.e., case coordination and support, care management, and MI CHOICE waiver programs).

8. Funded I&A providers, responsible for the entire PSA service area, must have the capacity to provide training and technical assistance to local I&A providers, especially designated Community Focal Points. Funded PSA wide I&A providers are expected to foster coordination among, and collaboration with, local comprehensive I&A systems.

9. Each program is encouraged to seek Certified Information and Referral Specialist (CIRS) certificates from the Alliance for Information and Referral Systems (AIRS) for individual I&A employees and volunteers.

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| **Service Name** | Transportation |
| **Service Number** | A-6 |
| **Service Category** | Access |
| **Service Definition** | Centrally organized services for transportation of older persons to and from community facilities in order to receive support services, reduce isolation, and otherwise promote independent living. |
| **Unit of Service** | One, one-way trip per person, or one educational session. |

Minimum Standards

1. Older Americans Act funds may be used to fund all or part of the operational costs of transportation programs based on the following modes:

   a. Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The program may include a passenger assistance component.

      (1) Route Deviation Variation--where a normally fixed-route vehicle leaves scheduled route upon request to pick up the client.

      (2) Flexible Routing Variation--where routes are constantly modified to accommodate service requests.

   b. Public Transit Reimbursement: Characterized by partial or full payment of the cost for an older person to use an available public transit system. (Either fixed route or demand/response). The program may include a passenger assistance component.

   c. Volunteer Reimbursement: Characterized by reimbursement of out-of-pocket expenses for individuals who transport older persons in their private vehicles. The program may include a passenger assistance component.

   d. Older Driver Education: Characterized by systematic presentation of information and training in techniques designed to assist older drivers in safely accommodating changes in sensory and acuity functioning.

2. Older Americans Act funds may not be used for the purchase or lease of vehicles for providing transportation services, unless approved in writing by AASA.

3. All drivers and vehicles used for transportation programs supported all or in part by Older Americans Act funds must be appropriately licensed and inspected as required by the Secretary of State and all vehicles used must be covered by liability insurance.

4. All paid drivers for transportation programs supported entirely or in part by Older Americans Act funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. Such assistance must be available unless expressly prohibited by either a labor contract or insurance policy.

5. All paid drivers for transportation programs supported entirely or in part by Older Americans Act funds shall be trained to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

6. Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

7. Each program shall attempt to receive reimbursement from other funding sources, as appropriate and available. Examples include the American Cancer Society, Veterans Administration, Human Services Agency, Department of Community Health, Medical Services Administration, United Way, Department of Transportation programs, etc. Within a respective PSA, an AAA may use an alternative unit of service (e.g., vehicle miles or passenger miles) when appropriate for consistency among funding sources. Such an alternative unit of service must be approved by the MCSA at the time of area plan approval.

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| **Service Name** | Home-Delivered Meals (HDM) |
| **Service Number** | B-5 |
| **Service Category** | In-Home |
| **Service Definition** | The provision of nutritious meals to homebound older persons. |
| **Unit of Service** | One meal served to an eligible participant. |

Updated 4-27-18

## HOME-DELIVERED MEALS

1. Each program shall have written eligibility criteria which places emphasis on serving older persons in greatest need and includes the following, at a minimum:
    a. Participant must be 60 years of age or older.
    b. Participant must be homebound, i.e., normally is unable to leave the home unassisted, and for whom leaving takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences, such as a trip to the barber or to attend religious services.
    c. Participant must be unable to participate in the congregate meal nutrition program because of physical, mental or emotional difficulties, such as:
        i. A disabling condition, such as limited physical mobility, cognitive or psychological impairment;
        ii. Lack of knowledge or skill to select and prepare nourishing and well-balanced meals;
        iii. Lack of means to obtain or prepare nourishing meals;
        iv. Lack of incentive to prepare and eat a meal alone; or
        v. Lack of an informal support system: has no family, friends, neighbors or others who are both willing and able to perform the service(s) needed, or the informal support system needs to be supplemented.
    d. The person's special dietary needs can be appropriately met by the program, as defined by the most current edition of the *USDA Dietary Guidelines for Americans*.
    e. Participant must be able to feed him/herself.
    f. Participant must agree to be home when meals are delivered, to contact the program when absences are unavoidable, and to work with the program staff if participating in both HDM and congregate programs.

2. Extended Eligibility.

The nutrition provider and the AAA should work together to determine if it would benefit the participant to provide a meal to another person in the home that does not meet the criteria in #1. These include the following.

a. An individual, between the ages of 18-59, living with a disability who resides in a non-institutional household with a person who is an HDM participant may receive a meal.
b. A spouse, or other individual 18 or older, living full-time in the home may receive a meal if the HDM assessment finds that it is in the best interest of the HDM-eligible person.
c. An unpaid caregiver 18 or older, may receive a meal if the HDM assessment finds that it is in the best interest of the HDM-eligible person.

3. At the provider's discretion, persons not otherwise eligible may be provided meals if they pay the full cost of the meal. The full cost of the meal includes raw food, preparation costs, and any administrative and/or support services costs. Documentation that full payment has been made shall be maintained. Eligibility criteria shall be distributed to all potential referring agencies or organizations and be available to the general public upon request.

4. Each program shall conduct an assessment of need for each participant making the best effort to do so within 14 days of initiating service. At a minimum, each participant shall receive two assessments per year, a yearly assessment and a six-month reassessment, making the best effort possible to conduct them at 6 months and 12 months. The initial assessment and yearly reassessment must be conducted in person. The six-month reassessment may be either in person or a telephone assessment. A telephone assessment may be used if the participant meets the following criteria.
    a. Is able to complete a telephone assessment by themselves, or with the assistance of a family member, caregiver or friend.
    b. Has no significant HDM delivery issues.
    c. The HDM driver, delivery person, family, and/or caregivers have no significant concerns for the participants' well-being.
    d. The nutrition provider may deem a participant not eligible for the telephone reassessment at any time during their participation in the program. In-person assessment will then replace the telephone reassessment.
    e. The program should avoid duplicating assessment of individual participants to the extent possible. HDM programs may accept assessments and reassessments of the participants conducted by case coordination and support programs, care management programs, other in-home service providers, home and community-based Medicaid programs, other aging network home care programs, and Medicare certified home health providers. Participants with multiple needs should be referred to case management programs as may be appropriate.

f. If the HDM program is the only program the participant will be currently enrolled in, the assessments and reassessments must, at a minimum, include the following.
    i. Basic Information
        1. Individual's name, address and phone number
        2. Source of referral
        3. Name and phone number of emergency contact
        4. Names and phone numbers of caregivers
        5. Gender
        6. Age, date of birth
        7. Living arrangements
        8. Whether or not the individual's income is below the poverty level, and/or sources of income (particularly Supplemental Security Income).
    ii. Functional Status
        1. Vision
        2. Hearing
        3. Speech
        4. Changes in oral health
        5. Prostheses
        6. Current chronic illnesses or recent (within the past six months) hospitalizations.
    iii. Support Resources
        1. Services currently receiving
        2. Extent of family and/or informal support network.
    iv. Participant Satisfaction (Reassessment only)
        1. Participant's satisfaction with services received
        2. Participant's satisfaction with program staff performance

5. Each HDM program shall demonstrate cooperation with other meal programs and providers and other community resources.

6. Each program may provide up to three meals per day to an eligible participant based on need as determined by the assessment. Providers are expected to set the level of meal service for an individual with consideration given to the availability of support from family and friends and changes in the participant's status or condition. This process must include person-centered planning, which may include allowing the participant to attend congregate meals when they have transportation and/or assistance to attend. It may also include meal choices such as vegetarian, as long as they meet the AASA Nutrition Standards.

7. The program shall verify and maintain records that indicate each participant can provide safe conditions for the storage, thawing, and reheating of frozen foods, if

applicable. Frozen foods should be kept frozen until such time as it is to be thawed for use. Frozen food storage should be maintained at 0 degrees Fahrenheit. Each nutrition provider shall develop a system by which to verify and maintain these records.

8. All nutrition providers shall provide to HDM program participants shelf-stable meals to be used in an emergency. Educational materials must be distributed along with the shelf-stable meals to instruct the participant when to use the meal, along with a list of recommended emergency food and equipment (i.e. manual can opener) that should be kept in the home. HDM volunteers, drivers, and staff should create a plan to regularly check with participants to assure they still have their shelf-stable meal. If the participant no longer has the shelf-stable meal, another must be delivered as soon as possible. Shelf-stable meals should be replaced at regular intervals. Each HDM participant shall have a minimum of two shelf-stable meals. Please see General Guidelines #18 for more information.

9. Each program must complete a prioritizing pre-screen for each individual placed on a waiting list for HDMs.

10. Each program must be able to document their criteria for prioritizing individuals being placed on a waiting list.

11. Each HDM provider shall have the capacity to provide meals which meet the nutrition guidelines in the most current edition of the *USDA Dietary Guidelines for Americans,* which calls for each meal to be 1/3 of the Dietary Reference Intakes (DRI). Meals shall be available at least five days per week.

12. Liquid Supplements. Liquid supplements may be purchased with OAA Title III-C funds; however, liquid supplements may not be counted as a meal in NAPIS. Liquid supplements are a component of a meal, and may be requested by a participant, under the following conditions.
    a. A physician order, renewed every six months, stating the need for the additional supplement.
    b. A care plan for participants receiving liquid supplements with their meal shall be developed in consultation with the participant's physician.
    c. A signed form, kept in the participant file, indicating what parts of the meal the participant choses to receive: beverage, main entrée, fruit, dessert, liquid supplement. The form must also include a statement acknowledging that the participant can reinstate any part of the meal at any time, upon request.
    d. The regional dietician or DTR must approve all liquid supplement products to be used by the program.

13. Person-centered planning and choice. HDM participants may elect to have all, or part, of the HDM delivered to them. Each nutrition provider should have a form that is updated every six months during the reassessment indicating if the participant has chosen to receive only part of the meal. The form should have the following, at a minimum:
    a. A statement that indicates the participant is choosing to opt out of the full meal, and then indicating which parts of the meal they would like.
    b. A statement that the participant can opt back into the full meal at any time, by notifying the HDM office, or telling the delivery people.
    c. A signature, initials, or mark of the participant.
    d. The form should be kept in the participant's file.

14. Home Visit Safety. Assessors, HDM drivers, delivery people and other nutrition program staff are not expected to be placed in situations that they feel unsafe or threatened. Nutrition providers shall work with their AAA to create a "Home Visit Safety Policy" that addresses verbal and physical threats made to the assessor(s), drivers or other program persons, by participants, family members, pets (animals) or others in the home during the assessment.

    This policy should include, but is not limited to:
    a. Definition of a verbal or physical threat;
    b. How a report should be made/who investigates the report;
    c. What actions should be taken by the assessor or driver if they are threatened;
    d. What warnings should be given to the participant;
    e. What actions should be taken for repeated behaviors;
    f. What information gets recorded in the chart; and
    g. Situations requiring multiple staff/volunteers.

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| **Service Name** | Respite Care |
| **Service Number** | B-10 |
| **Service Category** | In-Home |
| **Service Definition** | Provision of companionship, supervision and/or assistance with activities of daily living for persons with mental or physical disabilities and frail older persons in the absence of the primary care giver(s). Respite care may be provided at locations other than the client's residence. |
| **Unit of Service** | Each hour of respite care provided. |

updated 3-17-06

Minimum Standards

1. Each program must establish written eligibility criteria which include at a minimum:

    a. That clients must require continual supervision in order to live in their own homes or the home of a primary care giver, or require a substitute care giver while their primary care giver is in need of relief or otherwise unavailable; and/or
    b. That clients may have difficulty performing or be unable to perform activities of daily living (ADLs) without assistance as a result of physical or cognitive impairment.

2. Respite care services include:

    a. Attendant care (client is not bed-bound) - companionship, supervision and/or assistance with toileting, eating and ambulation; and,
    b. Basic care (client may or may not be bed-bound) - assistance with ADLs, routine exercise regimen, and assistance with self-medication.
    c. Respite care may also include chore, homemaking, home care assistance, home health aide, meal preparation and personal care services. When provided as a form of respite care, these services must also meet the requirements of that respective service category.

3. Each program shall ensure that the skills and training of the respite care worker to be assigned coincides with the service plan of the client, client needs, and client preferences. Client needs may include, through are not limited to, cultural sensitivity, cognitive impairment, mental illness, and physical limitation.

4. An emergency notification plan shall be developed for each client, in conjunction with the client's primary caregiver.

5. Each program shall establish written procedures to govern the assistance to be given participants in taking medications, which includes at a minimum:

a. Who is authorized to assist participants in taking either prescription or over the counter medications and under what conditions such assistance may take place. This must include a review of the type of medication to be taken and its impact upon the client.
b. Verification of prescriptions and dosages. All medications shall be maintained in their original, labeled containers.
c. Instructions for entering medications information in client files, including times and frequency of assistance.
d. A clear statement of the client's and client's family responsibility regarding medications to be taken by the client while participating in the program and provision for informing the client and client's family of the program's procedures and responsibilities regarding assisted self-administration of medications.

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| **Service Name** | Friendly Reassurance |
| **Service Number** | B-11 |
| **Service Category** | In-Home |
| **Service Definition** | Making regular contact, through either telephone or in-home visits, with homebound older persons to assure their wellbeing and safety and to provide companionship and social interaction. |
| **Unit of Service** | Each contact with a homebound older person. |

Minimum Standards

1. Friendly reassurance programs may use service funds to pay wages for reassurance workers. Service funds may also be used to pay for calling expenses, out of pocket expense for in home visits, and program supplies.

2. Reassurance workers shall receive an orientation training which covers at a minimum: the needs of isolated, homebound elderly persons; the functions and limitations of reassurance contacts; communication and interpersonal skills; and, emergency procedures.

3. Each program shall have a staff person designated to provide direction to both paid and volunteer reassurance workers and be available for contact in emergency or problem situations.

4. Each program shall establish and provide to all paid and volunteer reassurance workers a copy of procedures to be followed in emergencies and when a client does not call or answer or is not home as arranged. These procedures must include at a minimum:

    a. Provision for an immediate visit to the client's home by program staff or emergency service personnel (i.e., police, ambulance, fire department, etc.).
    b. Contact of the individual named to be notified in case of an emergency regarding each individual client.
    c. Verification that either subsequent contact has been made with the client or that the client's location has been identified.

5. Each program shall develop procedures for screening prospective clients and reassurance workers to attempt to match persons who are compatible.

6. Each program shall require each paid and volunteer reassurance worker to agree to not solicit contributions of any kind, attempt the sale of any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy while making a reassurance contact.

## VIII. COMMUNITY

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| **Service Name** | Adult Day Services |
| **Service Number** | C-1 |
| **Service Category** | Community |
| **Service Definition** | Daytime care of any part of a day but less than twenty-four-hour care for functionally and/or cognitively impaired elderly persons provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the client's home. |
| **Unit of Service** | One hour of care provided per client. |

updated 3-17-06

Minimum Standards

1. Each program shall establish written eligibility criteria, which will include at a minimum:

    a. That participants must require continual supervision in order to live in their own homes or the home of a primary caregiver.
    b. Participants must require a substitute caregiver while their primary caregiver is in need of relief, or otherwise unavailable.
    c. That participants may have difficulty or be unable to perform activities of daily living (ADLs) without assistance.
    d. That participants must be capable of leaving their residence, with assistance, in order to receive service.
    e. That participants would benefit from intervention in the form of enrichment and opportunities for social activities in order to prevent and/or postpone deterioration that would likely lead to institutionalization.

2. Each program shall have uniform preliminary screening procedures and maintain consistent records. Such screening may be conducted over the telephone. Records for each potential client shall include at a minimum:

    a. The individual's name, address and telephone number.
    b. The individual's age or birth date.
    c. Physician's name, address and telephone number.
    d. The name, address and telephone number of the person to contact in case of emergency.
    e. Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems.

f. Perceived supportive service needs as expressed by the individual.
g. Race and Sex (Optional)
h. An estimate of whether or not the individual has an income at or below the poverty level.

Intake is not required for individuals referred by a case coordination and support, care management or HCBS/ED waiver program.

3. If preliminary screening indicates an individual may be eligible for Adult Day Services, a comprehensive individual assessment of need shall be performed before admission to the program. All assessments shall be conducted face to face. Assessors must attempt to acquire each item of information listed below, but must also recognize, and accept, the client's right to refuse to provide requested items.

a. Basic Information

1. Individual's name, address and telephone number
2. Age, date and place of birth
3. Sex
4. Marital status
5. Race and/or ethnicity
6. Living arrangements
7. Condition of environment
8. Income and other financial resources, by source
9. Expenses.
10. Previous occupation(s), special interests and hobbies
11. Religious affiliation

b. Functional Status

1. Vision
2. Hearing
3. Speech
4. Oral status (condition of teeth, gums, mouth and tongue)
5. Prostheses
6. Psychosocial functioning
7. Cognitive functioning
8. Difficulties in activities of daily living
9. History of chronic and acute illnesses
10. Medication regimen (Rx, OTC, supplements, herbal remedies), and other physician orders
11. Eating patterns (diet history) and special dietary needs

c. Supporting Resources

1. Physician's name, address and telephone number
2. Pharmacist's name, address and telephone number

3. Services currently receiving or received in the past
4. Extent of family and/or informal support network
5. Hospitalization history
6. Medical/health insurance information
7. Long term care insurance
8. Clergy name, address and telephone number

d. Need Identification

1. Client perceived
2. Caregiver perceived, if available
3. Assessor perceived

e. Determination of Whether Individual Is Eligible for Program

An initial assessment is not required for individuals referred by a case coordination and support, care management, or HCBS/ED waiver program. Admission to the program may be based on the referral.

4. A service plan shall be developed for each individual admitted to an Adult Day Service program. The service plan must be developed in cooperation with, and be approved by, the client, the client's guardian or designated representative. The service plan shall contain at a minimum:

a. A statement of the client's problems, needs, strengths, and resources.
b. A statement of the goals and objectives for meeting identified needs.
c. A description of methods and/or approaches to be used in addressing needs.
d. Identification of basic and optional program services to be provided.
e. Treatment orders of qualified health professionals, when applicable.
f. A statement of medications being taken while in the program.

Each program shall have a written policy/procedure to govern the development, implementation and management of service plans. Each client is to be reassessed every three months to determine the results of implementation of the service plan. If observation indicates a change in client status, a reassessment may be necessary before three months have passed.

5. Each program shall maintain comprehensive and complete client files which include at a minimum:

a. Details of client's referral to adult day care program.
b. Intake records.
c. Assessment of individual need or copy of assessment (and reassessments) from the referring program.
d. Service plan (with notation of any revisions).
e. Listing of client contacts and attendance.
f. Progress notes in response to observations (at least monthly).

g. Notation of all medications taken on premises (including 1. the medication, 2. the dosage, 3. the date and time, 4. initials of staff person who assisted, and 5. comments).
h. Notation of basic and optional services provided to the client
i. Notation of any and all release of information about the client, signed release of information form, and all client files shall be kept confidential in controlled access files. Each program shall use a standard release of information form which is time-limited and specific as to the information being released.

6. Each adult day care program shall provide directly or make arrangements for the provision of the following services. If arrangements are made for provision of any service at a place other than program operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place.

a. Transportation.
b. Personal care.
c. Nutrition: one hot meal per eight-hour day which provides one-third of recommended daily allowances and follows the meal pattern of the General Requirements for Nutrition Programs. Participants in attendance from eight to fourteen hours shall receive an additional meal in order to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided, where feasible and appropriate, which take into consideration client choice, health, religious and ethnic diet preferences. Meals shall be acquired from a congregate meal provider where possible and feasible.
d. Recreation: consisting of planned activities suited to the needs of the client and designed to encourage physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction.

7. Each adult day care program may provide directly or make arrangements for the provision of the following optional services. If arrangements are made for provision of any service at a place other than program operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place.

a. Rehabilitative: physical, occupational, speech and hearing therapies provided under order from a physician by licensed practitioners.
b. Medical support: laboratory, x-ray, pharmaceutical services provided under order from a physician by licensed professionals.
c. Services within the scope of the Nursing Practice Act.
d. Dental: under the direction of a dentist.
e. Podiatric: provided or arranged for under the direction of a physician.
f. Ophthalmologic: provided or arranged for under the direction of an ophthalmologist.
g. Health counseling.
h. Shopping assistance/escort.

8. Each program shall establish written policies and procedures to govern the assistance to be given participants in taking medications while participating in the program. The policies and procedures must address:

a. Written consent from the client, or client's representative, to assist in taking medications.
b. Verification of medication regimen, including prescriptions and dosages.
c. Training and authority of staff to assist clients in taking medications.
d. Procedures for medication set up.
e. Secure storage of medications belonging to and brought in by participants.
f. Disposal of unused medications.
g. Instructions for entering medication information in client files, including times and frequency of assistance.

9. Each provider shall establish a written policy/procedure for discharging individuals from the program that includes, at a minimum, one or more of the following:

a. The participant's desire to discontinue attendance.
b. Improvement in the participant's status so that they no longer meet eligibility requirements.
c. An increase in the availability of caregiver support from family and/or friends.
d. Permanent institutionalization of client.
e. When the program becomes unable to continue to serve the client and referral to another provider is not possible.

10. Each program shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The program shall continually provide support staff at a ratio of no less than one staff person for each ten participants. Health support services may be provided only under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, it shall be accomplished through a written agreement that clearly specifies the terms of the arrangement.

11. Program staff shall be provided with an orientation training that includes, in addition to the topics specified in the General Requirements for All Service Programs, assessment/observation skills and basic first-aid.

Program staff shall be provided in-service training at least twice each year, which is specifically designed to increase their knowledge and understanding of the program, aging process issues, and to improve their skills at tasks performed in the provision of service. Issues addressed under the aging process may include, though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation. Records shall be maintained which identify the dates of training, topics covered and persons attending.

12. If the program operates its own vehicles for transporting clients to and from the service center the following transportation minimum standards shall be met:

a. All drivers and vehicles shall be appropriately licensed, and all vehicles used shall be appropriately insured.

b. All drivers shall be required to assist persons to get in and out of vehicles. Such assistance shall be available unless expressly prohibited by either a labor contract or an insurance policy.
c. All drivers shall be trained to respond to medical emergencies.

13. Each program shall have first aid supplies available at the service center. A staff person knowledgeable in first-aid procedures, including CPR, shall be present at all times participants are in the service center.

14. Procedures to be followed in emergency situations (fire, severe weather, etc.) shall be posted in each room of the service center. Practice drills of emergency procedures shall be conducted once every six months. The program shall maintain a record of all practice drills.

15. Each service center shall have the following furnishings:

a. At least one straight back or sturdy folding chair for each participant and staff person.
b. Lounge chairs and/or day beds as needed for naps and rest periods.
c. Storage space for participants' personal belongings.
d. Tables for both ambulatory and non-ambulatory participants.
e. A telephone that is accessible to all participants.
f. Special equipment as needed to assist persons with disabilities.

All equipment and furnishings in use shall be maintained in safe and functional condition.

16. Each service center shall demonstrate that it is in compliance with fire safety standards and the Michigan Food Code.

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| **Service Name** | Congregate Meals |
| **Service Number** | C-3 |
| **Service Category** | Community |
| **Service Definition** | The provision of nutritious meals to older individuals in congregate settings. |
| **Unit of Service** | Each meal served to an eligible participant. |

Updated 4-27-18

## CONGREGATE MEALS

1. Each program shall have written eligibility criteria that places emphasis on serving older individuals in greatest need and includes the following, at a minimum:
    a. Age 60 or older.
    b. A spouse under the age of 60 who accompanies an eligible adult to the meal site.
    c. Family members of an eligible adult who are living with a disability and permanently live with the eligible adult in a non-institutional setting.
    d. An unpaid caregiver who is under the age of 60 and is registered in the National Aging Programs Information System (NAPIS) and accompanies person being cared for to meal site.
    e. To be eligible for a donation-based meal, persons described in items b.-d. must, on most days, accompany the eligible adult to the meal site and eat the meal at the meal site.
    f. A volunteer under the age of 60 who directly supports meal site and/or food service operations may be provided a meal:
        i. After all eligible participants have been served and meals are available; and
        ii. A fee is not required for volunteers under the age of 60, but contributions should be encouraged and accepted. These meals are to be included in the National Aging Programs Information System (NAPIS) meal counts.
    g. Individuals with disabilities who are not older individuals but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided may participate in the meal.

2. At the provider's discretion, persons not otherwise eligible may be served, if meals are available, and they pay the full cost of the meal. The full cost includes raw food, preparation costs, and any administrative and/or supporting services costs. Documentation that full payment has been made shall be maintained. Persons not

eligible under item #1 who pay the full price for a meal, and are 18 and over, must wait until all eligible persons have been served, unless the meal has been reserved in advance.

Children (under the age of 18) who accompany a meal participant who is over the age of 60, must pay full price, but may go through the line with the adult they are with.

3. Each congregate nutrition provider shall be able to provide information relative to eligibility for HDMs and be prepared to make referrals for persons unable to participate in the congregate program and who appear eligible for a HDM program.

4. Each congregate meal site shall be able to document the following.
    a. That it is operated within an accessible facility. Accessibility is defined as a participant living with a disability being able to enter the facility, use the restroom, and receive service that is at least equal in quality to that received by a participant not living with a disability. Documentation from a local building official or licensed architect is preferred. A program may also conduct accessibility assessments of its meal sites when utilizing written guidelines approved by the respective AAA.

    b. That it complies with local fire safety standards. Each meal site must be inspected by a local fire official no less frequently than every three years. For circumstances where a local fire official is unavailable after a formal (written) request, a program may conduct fire safety assessments of its meal sites when using written guidelines approved by the respective AAA.

    c. Compliance with Michigan Food Code and local public health codes regulating food service establishments. Each meal site and kitchen operated by a congregate meal provider shall be licensed, as appropriate, by the local health department. The local health department is responsible for periodic inspections and for determining when a facility is to be closed for failure to meet Michigan Food Code standards. The local health department rulings supersede any state rules/mandates concerning licensing of food service establishments, including congregate meal sites and off-site meals. The program shall submit copies of inspection reports on all facilities to the respective AAA within ten days of receipt. It is the responsibility of the program to address noted violations promptly.

5. Each program, through a combination of its meal sites, must provide meals at least once a day, five or more days a week. Programs may serve up to three meals per day at each meal site.

6. Each site shall serve meals at least three days per week with a minimum annual average of **10 eligible participants** per serving day. If the service provider also operates a HDM program, HDMs sent from a site may be counted toward the 10

meals per day service level. Waivers to this requirement may be granted by the respective AAA only when the following can be demonstrated.

a. Two facilities must be utilized to effectively serve a defined geographic area for three days per week.
b. Due to a rural or isolated location, it is not possible to operate a meal site three days per week.
c. Seventy-five percent or more of participants at a meal site with less than 10 participants per day are in great economic or social need. Such meal sites must operate at least three days per week.

7. Congregate meal sites currently in operation by the program may continue to operate unless the respective AAA determines relocation is necessary to serve socially or economically disadvantaged older persons more effectively. New and/or relocated meal sites shall be located in an area which has a significant concentration of the 60 and over population living at or below the poverty level or with an older minority or ethnic population comprising a significant concentration of the total over-60 aged population. AASA must approve, through the Congregate Meal Site Database, the opening of any new and/or relocated meal site prior to the provision of any meals at that site.

8. When a meal site is to be permanently closed, the following procedures shall be followed.
    a. The program shall notify the respective AAA in writing of the intent to close a meal site.
    b. The program shall present a rationale for closing the meal site which is based on lack of attendance, inability to meet minimum standards and/or other requirements, loss of resources, or other justifiable reason.
    c. The respective AAA shall review the rationale and determine that all the options for keeping the site open or being relocated have been exhausted. If there remains a need for service in the area that was served by the meal site, efforts should be made to develop a new meal site and/or assist participants to attend another existing meal site.
    d. The program shall notify participants at a meal site to be closed of the intent to close the site at least 30 days prior to the last day of the meal service.
    e. The respective AAA shall complete the steps for closure in the AASA on-line database. The following information is needed to close a site and should be entered into the database.
        i. Rationale for closing the site.
        ii. How participants will be notified.
        iii. Closest meal site to the closed site, and transportation options to get participants to the different site.
    f. AASA will review the documents and the request to close the site. If approved, AASA will notify the requestor, the respective AAA and field representative.
    g. The site can be found at: https://www.osapartner.net/congmeal/.

9. Each program shall document that appropriate preparation has taken place at each meal site for procedures to be followed in case of an emergency, including:
    a. An annual fire drill;
    b. Staff and volunteers shall be trained on procedures to be followed in the event of a severe weather storm or natural disaster and the county emergency plan; and
    c. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency.

10. Each program shall have written agreements with the owners of all leased facilities used as meal sites. Written agreements are recommended for donated facilities, but not required. The agreements shall address at a minimum:
    a. Responsibility for care and maintenance of facility, specifically including restrooms, equipment, kitchen, storage areas and areas of common use.
    b. Responsibility for snow removal;
    c. Agreement on utility costs;
    d. Responsibility for safety inspections;
    e. Responsibility for appropriate licensing by the local health department;
    f. Responsibility for insurance coverage;
    g. Responsibility for approval of outside programs, activities and speakers; and
    h. Other issues as desired or required.

11. A program may enter into an agreement with an organization operating a congregate meal site in order for that organization to receive Nutrition Services Incentive Program (NSIP) funding for meals served to persons aged 60 and over, upon approval of the respective AAA. Any meal site receiving NSIP-only funding must operate in compliance with all federal requirements and state operating standards pertaining to the congregate meal program and assure the availability of adequate resources to finance the operation of the meal site without charge to program participants. The program shall have a written agreement with each organization operating NSIP-only meal sites, which shall include a statement indicating the provider allows anyone that meets the eligibility for a congregate meal indicated in these standards, is permitted to participate in the NSIP-only meal program.

12. Each program shall display, at a prominent location in each meal site, the AASA Community Nutrition Services poster. The program may use its own poster as long as all the required information is included and clearly presented. The poster shall contain the following information for each program: the name of the nutrition project director, the nutrition project director's telephone number, the suggested donation for eligible participants, the guest fee to be charged non-eligible participants, and, a statement of non-discrimination identical to the language on the AASA poster (this is the USDA-required language). Additional information pertaining to the program shall not be displayed so as to avoid any misunderstanding or confusion with information presented on the poster.

13. Each program shall make available, upon request, food containers (assistive plates, bowls, cups) and utensils for participants who are living with disabilities.

14. Congregate meal programs receiving funds through AASA may not contribute towards, provide staff time, or otherwise support potluck dinner activities, or allow program foodstuff to be combined with foods brought in by participants.

15. Each program shall have a project council comprised of program participants, to advise program administrators about services being provided. Program staff shall not be members of the project council. The project council shall meet at least once per year, in person, and notes from all meetings shall be shared with the respective AAA nutrition program, as well as saved for future reference.

16. Temporary Meal Site Closings. If a meal site must be closed or moved temporarily, the nutrition provider must notify the AAA, and AASA by using the on-line Temporary Meal Site Closure form. This form must be completed and submitted prior to the closing, or as soon as possible after the closing. A link to the form is located on the business partner site: https://www.osapartner.net

17. Prayer. Older adults may pray before a meal that is at a site that is funded through AoA or the State of Michigan. It is recommended that each nutrition program adopt a policy that ensures that each individual participant has a free choice whether to pray either silently or audibly, and that prayer is not officially sponsored, led, or organized by persons administering the Nutrition Program or the meal site.

18. Leftovers from the meal (items not eaten by the participant) may be taken out of the meal site if the following conditions are met.
    a. The local health department has no restrictions against it;
    b. A sign shall be posted near the congregate meal sign informing the meal participants that all food removed from the site becomes the responsibility of the individual that is removing the food;
    c. All new congregate participants receive written material about food safety and preventing food-borne illness when they sign up;
    d. All participants receive written material about food safety and preventing food-borne illness annually;
    e. The individual is required to sign a waiver statement that states that they understand that they are responsible for food taken out of the site; and
    f. Containers may not be provided through federal or state funds by the nutrition provider for the leftovers.

19. If a regular congregate meal participant is unable to come to the site due to illness, the meal may be taken out of the site to the individual for no more than seven days. If needed for more than seven days, the participant should be evaluated for HDMs. If the person taking out the meal for the ill participant is also a regular congregate participant, they may also take their meal out.

20. Off-site meals. Off-site meals that are part of an organized older adult activity are allowed if the following conditions are met.
    a. The activity must be sponsored by an aging network agency/group, for example, Council/Commission on Aging, senior center, etc.
    b. The sponsoring agency has worked with the nutrition provider to meet the meal standards.
    c. The activity, including the meal, must be open to all eligible participants.
    d. The take away meal must meet all the requirements of food safety and be foods that are low-risk for food-borne illness.
    e. Local health department rules and regulations, if any, supersede this standard and must be followed.
    f. The meal site must provide written notification to the AAA nutrition program staff person prior to the event.
    g. The AAA nutrition program staff person must inform AASA Nutrition Program Coordinator of the date, time, and sponsoring agency of the activity prior to the event, via fax or email.

21. Second Meal. Nutrition providers may elect to offer second meals at any dining site. A second meal is defined as a shelf-stable meal, a frozen meal, or a meal that is low-risk for food borne illness. A congregate meal participant may qualify for a second meal if:
    a. The participant eats the regularly scheduled meal at the meal site; and
    b. The participant has requested a second meal following the nutrition provider's process (i.e. phone request).

    The second meal must meet the AASA nutrition standards. Donations may be accepted for second meals. The second meal is given to the participant when they leave the congregate site. It must be stored properly until the participant is ready to leave for the day. The second meal is to be counted as a congregate meal in all record keeping. The second meal option does not apply to NSIP-only sites.

22. Weekend Meal(s). Nutrition providers may elect to offer weekend meals at any dining site. A weekend meal is defined as a shelf-stable meal, a frozen meal, or a meal that is low-risk for food borne illness. A congregate meal participant may qualify for a weekend meal if:
    a. The participant is registered at the meal site and eats meals at the regularly scheduled time during the week; and
    b. The participant has requested weekend meal(s) following the nutrition provider's process. (i.e. phone request).

    The weekend meal must meet the AASA nutrition standards. Donations may be accepted for weekend meals. Arrangements for weekend meal pick up should be made with the nutrition provider/site manager in advance. The weekend meal is to be counted as a congregate meal in all record keeping. The weekend meal option does not apply to NSIP-only sites.

23. Participant Choice. Person-centered planning involves participant choice. Participants in this program are allowed to participate in both the HDM and congregate program at the same time. For example, an HDM participant may have a friend or family member that can take them to a congregate site one day per week, or on a random basis. Proper documentation must be kept as to the HDM schedule and the congregate meal schedule. An agreement between programs is encouraged. Participants using this option should be reminded to contact the HDM office to cancel their meal for the days they are at the congregate site.

24. Voucher Meals. Nutrition providers may develop a program using vouchers for meals to be eaten at a restaurant, café, or other food service establishment. The program must meet the following standards.
    a. The restaurant, café, or other food service establishment must be licensed, and follow the Michigan Food Code, and is inspected regularly by the local health department.
    b. The restaurant, café, or other food service establishment agrees to provide at least one meal that meets AASA nutrition standards for meals.
    c. The restaurant, café, or other food service establishment must be barrier-free and Americans with Disabilities Act (ADA) compliant.
    d. The nutrition provider and restaurant, café or other food service establishment must have a written agreement that includes:
        i. How food choices will be determined;
        ii. How food choices will be advertised/offered to voucher holder;
        iii. How billing will be handled (will a tip be included in the unit price, i.e. if the meal reimbursement is $6.25, will $.25 be used toward the tip?);
        iv. How reporting takes place (frequency and what is reported);
        v. Evaluation procedures;
        vi. A statement that voucher holders may take leftovers home; and that they may purchase additional beverages and food with their own money.
    e. A copy of the written agreement shall be given to the AAA nutrition program coordinator.
    f. A written plan must be developed and kept on file that includes consideration of the following items.
        i. Location of the restaurant, café, or other food service establishment in relation to congregate meal site locations;
        ii. Establishment of criteria for program participation- how restaurants, café, or other food service establishments are selected to participate and how new establishments can apply to participate;
        iii. How older adults qualify for and obtain their vouchers, i.e. senior centers, nutrition provider office, nutrition program representative meets with older adults at the restaurant, café, or other food service establishment to issue vouchers and collect donations; and
        iv. How frequently menu choices will be reviewed and revised by the AAA Dietitian or DTR.

g. Nutrition providers must allow older adults to use congregate meal sites and voucher programs interchangeably. If a nutrition provider chooses to do so, the plan described in item f. above must detail how this will be done.

25. Adult Foster Care (AFC) and other Residential Care Participants. AFC or other residential providers that bring their residents to congregate meal sites shall be requested to pay the suggested donation amount for meals provided to residents and staff 60 years of age or older. For those AFC residents and staff under the age of 60, the guest charge must be paid as posted at each meal site. The congregate meal provider may request the AFC program to provide staff to assist the residents they bring with meals and other activities that they wish to attend. AFCs, adult day programs, or other residential providers may enter into a contractual agreement regarding donations and payment for meals if the practice occurs regularly or is long-term.

26. Complimentary Programs/Demonstration Projects. AAAs and nutrition providers are encouraged to work together to provide programming at the congregate meal sites that include activities and meals. Suggestions for demonstration projects include, but are not limited to:
    a. Offering a take-out meal upon completion of an activity at the meal site that does not occur immediately before or after the meal;
    b. Mobile congregate sites that move to different locations to serve, also known as 'pop-up' sites; and
    c. New meal options such as smoothies, vegetarian choices, and other non-traditional foods.

    All demonstration projects must be approved by the AAA and AASA and must follow the nutrition standards.

## MEAL COMPONENTS

27. Salad and Soup Bar Option. Congregate meal sites may include a salad bar as part, ***or all*** of their meal service. (See chart for information as to how to add it in)

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| Soup/Salad bar as main meal | Must meet all nutrition standard requirements |
| Soup/Salad bar as a part of a meal, i.e. vegetable or carb. (pasta choices) | Must meet nutrition requirement for the element it is used for |
| Soup/Salad bar is an addition to, or add on, to a regular meal. | Does not have to meet nutrition standards or criteria |

28. Beverages: Milk and water must be offered with every meal. Coffee and/or tea, or other beverages, are optional.
    a. Milk may be skim, 1%, 2%, full-fat or chocolate. It should be available to participants but is not required.
    b. Water can be available as self-serve, in a pitcher, or at a drinking fountain that has a special attachment for filling cups. You do not need to purchase water in bottles, or pre-fill cups with water.
    c. f you choose to offer coffee and/or tea, this may also be self-serve. You may provide hot water for instant coffee and tea, or you may brew coffee. Individuals may also bring in their own tea bags and instant coffee if they choose to.
    d. You may use your state and federal congregate meal funds to purchase these products, as well as to keep equipment such as coffee makers, in good repair.

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| **Service Name** | Disease Prevention and Health Promotion |
| **Service Number** | C-6 |
| **Service Category** | Community |
| **Service Definition** | A service program that provides information and support to older individuals with the intent of assisting them in avoiding illness and improving health status.<br><br>Allowable programs include:<br><br>• Health Risk Assessments<br>• Health Promotion Programs<br>• Physical Fitness, group exercise, music, art, dance movement therapy; programs for Multi-Generational Participation<br>• Medication management, screening, and education to prevent incorrect medication and adverse drug reactions<br>• Mental Health Screening Programs<br>• Education programs pertaining to the use of Preventative Health Services covered under Title XVIII of the Social Security Act<br>• Information programs concerning diagnosis, prevention, treatment and rehabilitation of age related diseases and chronic disabling conditions |
| **Unit of Service** | One activity session or hour of related service provision, as appropriate. |

updated 3-17-06

Minimum Standards

1. Each program shall utilize staff that has specific training and/or experience in the particular service area(s) being provided. Continuing education of staff in specific service areas is encouraged.

2. Each program, in targeting services, shall give priority to geographic areas which are medically underserved and in which there are a significant number of older individuals who have the greatest economic need for such services.

3. Each program is encouraged to facilitate and utilize a regional health coalition to plan for and implement services. Members of the regional health coalition should include one or more members of the Michigan Primary Care Association and other organizations such as: local public health departments; community mental health boards; cooperative extension agents; local aging service providers; local health practitioners; local hospitals; and local MMAP providers.

4. Disease prevention and health promotion services should be provided at locations and in facilities convenient to older participants.

5. Medication management services may be provided to individual clients with Title III-Part D funds only through use of the “In-home Services Medication Management” service definition, service number B-7 of the *AASA Operating Standards for Service Programs*.

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| **Service Name** | Legal Assistance |
| **Service Number** | C-10 |
| **Service Category** | Community |
| **Service Definition** | Provision of legal assistance through cases, projects, community collaborations and other services that provide the most impact whether for an individual client or group of older adults. Such assistance may be provided by an attorney, paralegal or student under the supervision of an attorney. Legal Services is priority service under the Older Americans Act (OAA). |
| **Allowable Service Components** | **Intake.** The initial interview to collect demographic data and identification of the client's legal difficulties and questions.<br><br>**Advice and Counsel**. Where the client is offered an informed opinion, possible course of action and clarifications of his/her rights under the law.<br><br>**Referral**. If a legal assistance program is unable to assist a client with the course of action that he/she wishes to take, an appropriate referral should be made as available. Referral may also be necessary when the individual's need is outside of program priorities or can be more appropriately addressed by another legal entity.<br><br>**Representation.** If the client's problem requires more than advice and counsel and the case is not referred to another entity, the legal assistance program may represent the person in order to achieve a solution to the legal problem. Representation may include legal research, negotiation, preparation of legal documents, correspondence, appearance at administrative hearings or courts of law, and legal appeals where appropriate.<br><br>**Legal Research**. The gathering of information about laws, rights or interpretation of laws that may be performed at any point after intake has occurred, to resolve an individual's legal problems. This information is used to assist legal assistance programs in case work, client impact work and program and policy development.<br><br>**Preparation of Legal Documents**. Documents such as contracts, wills, powers of attorney, leases, or other documents may be prepared and executed by legal assistance programs.<br><br>**Negotiation.** Within the rules of professional responsibility, program staff may contact other persons concerned with the client's legal |

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| **Allowable Service Components (cont.)** | problem in order to clarify factual or legal contentions and possibly reach an agreement to settle legal claims or obtain services and supports.<br><br>**Legal Education**. Legal assistance program staff may prepare and present programs to inform older adults of their rights, the legal system, and possible courses of legal action.<br><br>**Community Collaboration and Planning.** Legal assistance programs should participate in activities that impact elder rights advocacy efforts for older adults such as policy development, program development, planning and integration activities, targeting and prioritizing activities, and community collaborative efforts. |
| **Unit of Service** | Provision of one hour of an allowable service component. |

Each area agency on aging (AAA) should contract with the legal assistance program with the capacity to perform the full range of allowable service components that is best able to serve the legal needs of the community given the resources available. AAAs are able to contract with Legal Services Corporation (LSC) grantees, non-LSC non-profit legal programs, private attorneys, law school clinics, legal hotlines or other low-cost legal services delivery systems. It is a conflict of interest for any AAA to have in-house counsel serve as the Title IIIB legal services provider.

Minimum Standards

1. Each legal assistance program shall have an established system for targeting and serving older adults in greatest social and economic need within the OAA defined program target areas of income, health care, long term care, nutrition, housing, utilities, and protective services, defense of guardianship, abuse, neglect and discrimination. Each program shall complete and re-evaluate annually a program priority report and plan for targeting services to the most socially and economically vulnerable. This report shall be provided to the AAA and the Michigan Aging and Adult Services Agency (AASA).

2. Each legal assistance program shall work to develop outcome measures to reflect the impact of legal services intervention on individual clients and older adults in the greatest social and economic need in the service area. These outcomes shall be used for program development.

3. Services may be provided by an attorney licensed to practice law in the State of Michigan or a paralegal or student under the supervision and guidance of an attorney licensed to practice law in the State of Michigan.

4. Legal assistance programs may engage in and support client impact work, including but not limited to class action suits where a large group of older adults are affected by a legal inequity. For client impact work, programs are encouraged to utilize technical assistance resources such as the Michigan Poverty Law Program (MPLP).

5. Each legal assistance program shall demonstrate coordination with local long-term care advocacy programs, aging services programs, Aging and Disability Resource Centers (ADRCs), elder abuse prevention programs and service planning efforts operating within the project area.

6. When a legal assistance program identifies issues affecting clients that may be remedied by legislative action, such issues shall be brought to the attention of the AAA, AASA, MPLP and other programs offering technical assistance to legal providers.

7. Each legal assistance program shall provide assurance that it operates in compliance with the OAA, as set forth in 45 CFR Section 1321.71.

8. As part of an integrated legal services delivery system, each legal assistance program that is not part of a Legal Services Corporation (LSC) project grantee shall have a system to coordinate its services with the existing LSC projects in the planning and service area in order to concentrate the use of funds provided under this definition to individuals with the greatest social and economic need. Each program shall also coordinate with the Legal Hotline for Michigan Seniors (LHMS) and the Counsel and Advocacy Law Line (CALL). Where feasible, each program should also coordinate with other low-cost legal service delivery mechanisms, the private bar, law schools, and community programs in the service area to develop the targeting and program priority plan.

9. Each program shall make reasonable efforts to maintain existing levels of legal assistance for older individuals being furnished with funds from sources other than Title III Part B of the OAA.

10. A legal assistance program may not be required to reveal any information that is protected by attorney/client privilege. Each program shall make available non-privileged, non-confidential, and unprotected information which will enable the AAA to perform monitoring of the provider's performance, under contract, with regard to these operating standards.

11. Each legal assistance program should participate in statewide and local legal service planning groups including MPLP's Elder Law Task Force. Each legal assistance program is expected to participate in at least two Task Force meetings per year. Participation by conference call/webinar is acceptable.

12. Each legal assistance program should participate in elder law training and technical assistance activities.

13. Each legal assistance program shall report program data through the Legal Services Information System (LSI) application of AASA's Aging Information System (AIS). Legal assistance programs will submit/post data in the LSI quarterly. Data shall be submitted no later than 30 days after the end of the quarter. AAAs will utilize the LSI to retrieve needed legal services program data and will consult with AASA prior to requiring additional reports or data from the legal program. The requirement for legal assistance programs to report data through the LSI shall be included in AAA/legal assistance program contracts.

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| **Service Name** | Long Term Care Ombudsman/Advocacy |
| **Service Number** | C-11 |
| **Service Category** | Community |
| **Service Definition** | Provision of assistance and advocacy services to residents of long term care facilities to resolve complaints through problem identification and definition, education regarding rights, provision of information on appropriate rules, and referrals to appropriate community resources. The service also involves assistance to prospective long term care facility residents and their families regarding placement, financing and other long term care options. Identification and sharing of best practices in long term care service delivery, with an emphasis on promotion of culture change, is also part of the service. Each program must provide the following elements.<br><br>**Consultation/Family Support**. Provision of assistance to older adults and their families in understanding, identifying, locating, evaluating and/or obtaining long term care services.<br><br>**Complaint Investigation/Advocacy**. Receipt, investigation, verification and attempted resolution of individual complaints from residents or others acting on their behalf regarding any action which may adversely affect the health, safety, welfare and rights of a long-term care facility resident. Complaint resolution processes include negotiation, mediation, and conflict resolution skills. This component also includes activities related to identifying obstacles and deficiencies in long term care delivery systems and developing recommendations for addressing identified problems.<br><br>**Non-Complaint Related Facility Visits.** Quarterly visits to each long-term care facility in the project area. More frequent visits may occur where problems exist.<br><br>**Community Education**. Provision of information to the public including long term care facility residents, regarding all aspects of the long-term care system elder abuse, neglect and exploitation. This component includes formal presentations, licensed facility and agency consultation, activities with the print and electronic media, development of consumer information materials.<br><br>**Volunteer Support**. Conduct of recruitment, training, supervision, and ongoing support activities related to volunteer advocates assigned to assist residents of identified long term care facilities. |

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| **Unit of Service** | Each hour of family support, complaint investigation/advocacy, community education or volunteer support activities, including travel time to and from long term care facilities. |

updated 8-20-09

Minimum Standards

1. Each program shall be capable of providing assistance to residents of each long-term care facility in the service target area.

2. Each entity desiring to operate a local Ombudsman program shall be designated by the State Long Term Care Ombudsman (SLTCO) to provide services in the State of Michigan. Individuals employed by local Ombudsman providers must be certified as local ombudsman by the SLTCO.

3. Each designated local ombudsman program will adhere to program directions, instructions, guidelines, and Ombudsmanager reporting requirements issued by the SLTCO in the following areas:

    a. Recruiting, interviewing and selection, initial training, apprenticeship and assessment of job readiness and credentialing of new local ombudsman staff and ombudsman volunteers;
    b. Ongoing education, professional development, performance evaluation, as related to the annual certification and designation process;
    c. Assignment to workgroups, task forces, special projects, meetings, both internal and external;
    d. Conduct of local ombudsman work and activities;
    e. Attendance at training/professional development events, staff meetings, quarterly training sessions and other educational events, or attendance as a presenter, as necessary;
    f. Implementation and operation of the ombudsman volunteer program.

4. Each program shall maintain the confidentiality of client identity and client records in accordance with policies issued by the SLTCO.

5. Each program shall establish linkage with Legal Assistance and Medicare/Medicaid Assistance Programs (MMAP) operating in the project service area and be able to assist clients in gaining access to available services, as necessary.

6. Each program shall maintain working relationships with AASA funded Care Management and Michigan Department of Community Health HCBS/ED Waiver projects operating in the project service area.

7. Each program shall work to prevent elder abuse, neglect and exploitation by conducting professional/paraprofessional training, community outreach, public education, case consultation, and/or interdisciplinary teams shall be implemented through a coordinated, interagency approach.

8. Each program shall participate in coordinated, collaborative approaches to prevent elder abuse, neglect and exploitation which shall include the participation of, at a minimum, adult protective services staff of local Department of Human Services, long term care ombudsman/advocacy programs, and legal assistance programs operating in the project service area.

9. Each program shall develop and maintain, for the purposes of coordination, relationships with state and local law enforcement agencies and courts of competent jurisdiction.

10. Each program shall develop and maintain an effective working relationship with the local nursing home closure team for their area as designated by the Department of Community Health, Bureau of Health Systems.

11. Each program shall be able to demonstrate working relationships with local offices of the Department of Human Services, and local county public health agencies.

12. Program staff shall be familiar with the complaint resolution processes of the Michigan Department of Community Health's Bureau of Health Systems; Department of Human Services, Bureau of Child and Adult Licensing; MPRO; and the Michigan Office of the Attorney General's Health Care Fraud Unit.

13. Program staff shall receive training in the following areas: common characteristics, conditions and treatments of long term care residents; long term care facility operations; long term care facility licensing and certification requirements; Titles XVIII and XIX of the Social Security Act; interviewing, investigating, mediation and negotiation skills; culture change, management of volunteer programs, and other areas as designated by the SLTCO.

14. Each program shall operate in compliance with Long Term Care Ombudsman program instructions, issued by the SLTCO, as required by federal and state authorizing legislation.

15. Each program shall maintain a financial management system that fully and accurately tracks, and accounts for the use of, all funds received from AASA and area agencies on aging.

16. Each program shall comply with Long Term Care Ombudsman/Advocacy Operating Standards and SLTCO program policy standards.

| | |
|---|---|
| **Service Name** | Programs for Prevention of Elder Abuse, Neglect, and Exploitation |
| **Service Number** | C-15 |
| **Service Category** | Community |
| **Service Definition** | Activities to develop, strengthen, and carry-out programs for the prevention and treatment of elder abuse, neglect, and exploitation |
| **Unit of Service** | One hour of contact with organizations to develop coordinated, comprehensive services for the target population. In addition to contact with other aging subcontract organizations, elder abuse subcontract agencies shall count contact with the Department of Human Services, Adult Protective Services, law enforcement, health care professionals, community mental health, and other relevant service entities when the reason for the contact is to meet the above service definition. |

Minimum Standards

1. Professional/paraprofessional training, community outreach, public education, case consultation, and/or interdisciplinary teams shall be implemented through a coordinated, interagency approach.

2. The coordinated, comprehensive approaches to prevent elder abuse, neglect, and exploitation shall include the participation of, at a minimum, adult protective services staff of local Department of Human Services, long-term care ombudsman/advocacy programs, and legal assistance programs operating in the service area.

| | |
|---|---|
| **Service Name** | Kinship Support Services |
| **Service Number** | C-19 |
| **Service Category** | Community |
| **Service Definition** | Provision of support services (which include respite care, supplemental and education, support and training services) in kinship care situations where an individual aged 60 or over is the primary caregiver for a child no more than 18 years old. Kinship support services may be provided at locations other that the client's residence. |
| **Unit of Service** | Each hour of support services provided, or each activity session, as appropriate. |

updated 3-17-06

Minimum Standards

1. Each program must establish written eligibility criteria which include at a minimum:

   a. That the child must require support services as a result of the kinship care relationship.
   b. That the kinship caregiver must be a grandparent or relative caregiver who has a legal relationship to the child or is raising the child informally.

2. Each program shall conduct an evaluation of the care giving situation to ensure that the skills and training of the respite care worker to be assigned coincides with the situation. The program may utilize volunteer respite care workers.

3. Each program must develop and maintain procedures to protect the safety and wellbeing of the children being served by the program.

4. An emergency notification plan shall be developed for each care recipient and respective caregiver.

6. Supervision must be available to program staff at all times.

| | |
|---|---|
| **Service Name** | Caregiver Education, Support and Training |
| **Service Number** | C-20 |
| **Service Category** | Community |
| **Service Definition** | A program intended to provide assistance to caregivers in understanding and coping with a broad range of issues associated with caregiving. Allowable programs include:<br>• Education programs, including development and distribution of printed materials, pertaining to physical, emotional and spiritual aspects of caregiving as well as current research and public policy concerns.<br>• Initiatives, which provide support activities for caregivers (including kinship caregivers), i.e., support groups, counseling, information and assistance in connecting with community resources, etc.<br>• Training programs pertaining to techniques for providing personal care services to care recipients and to address care giving skills for efficacy and caregiver confidence when caring for the care recipient. |
| **Unit of Service** | One activity session. One hour of allowable education, support and/or training program activities. |

Minimum Standards

1. Each program must maintain linkage with caregiver focal points, and respite care programs, as available, in the PSA to help facilitate opportunities for caregivers to attend education, support and training programs. Respite care may be provided, as an ancillary program component, in conjunction with caregiver education, support and training programs to enable caregiver participation.

2. Each program shall utilize staff that has specific training and/or experience in the particular service area(s) being addressed. Continuing education of staff in specific service areas is encouraged.

3. Caregiver Education, Support and Training programs may be provided to individuals as well as in group settings. Services may be provided in both community and in-home settings.

5. Budget Documentation Form

**Tri-County Office on Aging** | **Annual Contractor** | **Grant Period: Oct. 1, 2019 - Sept. 30, 2020**

**AAA Region VI** | **SUMMARY BUDGET** | **Amended Date:_____**

| **Agency Name** | **Project Title/ Service >>>>>** | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |
| **UNITS OF SERVICE** | | | | | | |
| #DIV/0! **$0.00** Rate | $0.00 | | | | | |
| | | | | | | |
| | | | | | | |
| **TOTAL** | | | | | | |
| **MATCH** | | | | | | |
| CASH | SERVICE(S) | | | | | |
| | $0.00 | | | | | |
| | | | | | | |
| | | | | | | |
| SUBTOTAL | | | | | | |
| IN-KIND | SERVICE(S) | | | | | |
| #DIV/0! **$0.00** | $0.00 | | | | | |
| | | | | | | |
| | | | | | | |
| SUBTOTAL | | | | | | |
| **TOTAL** | | | | | | |
| **BUDGET** | | | | | | |
| TOTAL Grant/Program Income | $0.00 | | | | | |
| Program Income | **$0.00** | | | | | |
| Grant Allocation Amount | **$0.00** | | | | | |
| LOCAL (10%) on Grant Allocation | $0.00 | | | | | |
| CASH | | | | | | |
| IN-KIND | $0.00 | | | | | |
| **TOTAL FUNDS (Program Income and Match)** | $0.00 | | | | | |

# 6. Eligible Evidence Based Disease Prevention (EBDP) Programs

**Eligible Programs for Evidence Based Disease Prevention Program Funding:**

**Stanford Chronic Disease Self-Management Program (CDSMP); (PATH)**
This is a 6 week, 2.5 hours per week, workshop designed to help individuals manage chronic conditions. The workshop has a wide range of activities and skill building exercises that helps the participant learn to communicate with their medical provider, make better food choices, and get more active. Also available in Spanish.
Website: http://patienteducation.stanford.edu/

**Diabetes Self-Management Program (DSMP); (Diabetes PATH)**
This program is a specialized program for individuals with Type II (non-insulin dependent) diabetes and their families. Same format and self-management skills as the CDSMP course listed above with different content info. Also available in Spanish.
Website: http://patienteducation.stanford.edu/

**Arthritis Self-Management Program (ASMP)**
People with different types of rheumatic diseases, such as osteoarthritis, rheumatoid arthritis, fibromyalgia, lupus, and others, attend together. Subjects covered include: 1) techniques to deal with problems such as pain, fatigue, frustration and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) healthy eating, 6) making informed treatment decisions, 7) disease related problem solving, and 8) getting a good night's sleep. Also available in Spanish.
Website: http://patienteducation.stanford.edu/

**Chronic Pain Self-Management Program (CPSMP)**
Same core program as other Stanford programs. Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, isolation, and poor sleep 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) pacing activity and rest, and, 7) how to evaluate new treatments.
Website: http://patienteducation.stanford.edu/

**On-Line Chronic Disease Self-Management (Bettter Choices, Better Health)**
This is a free workshop for participants, Participants can help you get the support they need and find practical ways to deal with pain, fatigue, and stress. Includes better nutrition and exercise choices, understanding new treatment options, and learning better ways to talk with your doctor and family about your health. Held entirely on-line. Up to 25 others in an interactive workshop and participate in easy-to-follow online

sessions, which are posted each week for six weeks. You may refer interested clients to this website to participate. OSA receives information about participants once per year.
Website: https://selfmanage.org/BetterHealth/SignUp

**On-Line Chronic Disease Self-Management –Diabetes**
Based on the earlier Living With Ongoing Health Problems online program. Groups of about 24 people with type 2 diabetes participate together. Workshops are facilitated by two trained moderators, one or both of whom are peers with diabetes. Topics covered include: 1) healthy eating and menu planning, 2) managing blood glucose, 3) techniques to deal with problems such as fatigue, frustration and isolation, 4) appropriate exercise for managing blood glucose and for maintaining and improving strength, flexibility, and endurance, 5) appropriate use of medications, 6) communicating effectively with family, friends, and health professionals, 7) goal-setting, and, 8) disease related problem solving.
Website: http://patienteducation.stanford.edu/internet/diabetesol.html

**On-Line Healthier Living with Arthritis**
Same program as the Arthritis Self-Management Program listed above in an on-line version.
Website: http://patienteducation.stanford.edu/internet/arthritisol.html

**Positive Self-Management Program for HIV**
Workshop has the same core as the other Stanford self-management workshops. Subjects covered include: 1) how to best integrate medication regimens into daily life so they can be taken consistently, 2) techniques to deal with problems such as frustration, fear, fatigue, pain and isolation, 3) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) evaluating symtoms, 7) advanced directives, and 8) how to evaluate new or alternative treatments.
Website: http://patienteducation.stanford.edu/programs/psmp.html

**Active Living Every Day (ALED)** This program was developed by the Cooper Institute, Brown University and Human Kinetics. It is a 20 week, self-paced course to help people with sedentary lifestyles become and stay physically active.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/active-living-every-day.html

**EnhanceFitness (EF):** EnhanceFitness, developed by the University of Washington in collaboration with Senior Services, is a group exercise program. Classes meet 3 times per week and are led by a certified fitness instructor.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/enhance-fi.html

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

**Healthy Eating for Successful Living Among Older Adults:** Healthy Eating for Successful Living in Older Adults, developed by the Lahey Clinic in collaboration with other Boston-area organizations, is both an education and support program to assist older adults in self-management of their nutritional health. The workshop is conducted over 6 weekly sessions.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/healthy-eating-for-successful.html

**Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)**: Healthy IDEAS designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. This case manager-led program typically lasts for 3-6 months. It was developed by the Huffington Center on Aging at Baylor College of Medicine, Sheltering Arms and the Care for Elders Partnership in Houston.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/healthy-ideas-identifying.html

**Healthy Moves for Aging Well**: Healthy Moves for Aging Well was developed and tested by the Partners in Care Foundation in collaboration with other Southern California organizations. This physical activity program enhances the activity level of frail, high-risk sedentary older adults and is supported by case managers as an additional service of their community-based case management program.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/healthy-moves-for-aging-well.html

**Medication Management Improvement System**: The Medication Management Improvement System (MMIS) was adapted from the Vanderbilt University Medication Management Model by the Partners in Care Foundation in California. This intervention is designed to enable social workers and nurse case managers to identify and resolve certain medication problems that are common among frail older adults.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/medication-management.html

**HomeMeds** is an evidence-based, technology-enabled intervention that addresses medication safety among older aduts by connecting homecare and other community-based services to health care providers. Simply making better use of the information

already being gathered in the home helps unmask potential medication problems so they can be resolved. HomeMeds addresses major gaps in care that leave home-dwelling older adults at risk for adverse medication effects, providing unique information not typically available to prescribers, such as adverse effects, patients' use of over-the-counter medications, duplications resulting from multiple prescribers or hospital stays, and adherence problems. Physicians are more likely to change prescribing behaviors when given this information together with recommendations from a consultant pharmacist. Using existing effort and a non-medical workforce, a technology core, and sources of funding outside of Medicare and Medicaid, HomeMeds is affordable and saves healthcare dollars by preventing serious adverse drug events that cause ED use, hospitalization and institutionalization.
http://www.homemeds.org/

**A Matter of Balance: Managing Concerns About Falls (MOB):** Volunteer Lay Leader Model, adapted from Boston University Roybal Center by Maine's Partnership for Healthy Aging, teaches practical coping strategies to reduce the fear of falling. This group-based course is led by trained lay leaders over 8 sessions lasting 2 hours.
Website: http://www.mmc.org/mh_body.cfm?id=432

**Stepping On**: Developed at the University of Sydney, Australia, this program is designed to improve fall self-efficacy, encourage behavior change, and reduce falls. It is comprised of seven weekly two-hour sessions, with a follow-up occupational therapy home visit.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/stepping-on.html

**Strong For Life**: Developed by Boston University, this home-based exercise program increases strength, balance, and overall health. Volunteer coaches instruct participants in their homes on how to exercise using an exercise video and monitor their performance.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/strong-for-life.html

**T'ai Chi: Moving for Better Balance**: Developed out of the Oregon Research Institute, this simplified, 8-form version of T'ai Chi, offered in community settings, has been proven to decrease the number of falls and risk of falling in older adults.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/tai-chi-moving-for-better.html

**Active Choices:** Active Choices is a six-month physical activity program that helps individuals incorporate preferred physical activities in their daily lives. The program is individualized for each person. Staff or volunteers are trained to provide regular, brief telephone-based guidance and support, and mail follow-up is delivered to participants' homes.

Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/active-choices.html

**The Arthritis Foundation Exercise Program:** Offers low-impact exercises that can be done either sitting or standing to help relieve stiffness and pain and to build strength and stamina. The class was developed by physical therapists specifically for people with arthritis or related conditions.
Website: http://www.arthritis.org/exercise.php or contact the Arthritis Foundation, Michigan Chapter: http://www.arthritis.org/michigan/

**Arthritis Foundation Tai Chi Program**: Brings the gentle, graceful, flowing power of Sun-style tai chi to your community. This joint-friendly exercise program, developed by a physician and tai chi master, will both relax you and increase your mental and physical energy. Host sites are members of the Arthritis Foundation Exercise Alliance.
Website: http://www.arthritis.org/tai-chi.php contact the Arthritis Foundation, Michigan Chapter: http://www.arthritis.org/michigan/

**Prevention and Management of Alcohol Problems in Older Adults.** The brief alcohol intervention approach is designed specifically for an older adult population and relies on concepts of motivational interviewing to enhance participants' commitment to change their behavior. Program components include: alcohol screening, assessments, brief interventions, and a guide to referral for more intensive care.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/prevention-and-management-of.html

**PEARLS: Program to Encourage Active, Rewarding Lives for Seniors** PEARLS is a highly effective method designed to reduce depressive symptoms and improve quality of life in older adults and in all-age adults with epilepsy. During six to eight in-home sessions that take place in the client's home and focus on brief behavioral techniques, PEARLS counselors empower individuals to take to action and make lasting changes so that they can lead more active and rewarding lives.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/program-to-encourage-active.html

**Fit and Strong!** Fit and Strong! combines flexibility, strength training and aerobic walking with health education for sustained behavior change among older adults with lower extremity osteoarthritis (OA). Fit & Strong! works with providers across the country to deliver an eight-week program that improves lower extremity stiffness, lower extremity pain, lower extremity strength, aerobic capacity, participation in exercise and caloric expenditure, and self-efficacy for exercise.
Website: http://www.ncoa.org/improve-health/center-for-healthy-aging/fit-and-strong.html

**Walk With Ease.** The Arthritis Foundation Walk With Ease program can teach you how to safely make physical activity part of your everyday life. Walk With Ease offers support, information and tools to help you succeed and is designed for people with arthritis and other chronic conditions, such as diabetes, heart disease and hypertension. Website: http://lmt.arthritis.org/ways-to-move/walk-with-ease.php

**Creating Confident Caregivers**
Creating Confident Caregivers ™ uses the Savvy Caregiver Program, an evidence based program for family members caring for a loved one with dementia at home. Two-hour sessions are held once a week for six weeks and lead by staff trained in the program. Caregivers receive a caregiver manual and respite is provided while the caregiver attends the program. This program provides information about dementia, teaches skills and attitudes to manage stress, and increases effective caregiving.
Contact Sally Steiner at: 517-373-8810 or steiners@michigan.gov for more information.

**Powerful Tools for Caregivers**
This 6-week program will help you take care of yourself while caring for a relative or friend (no professional caregivers, please). You will benefit from the workshop whether you are helping a parent, spouse, friend or someone who lives at home, in a nursing home, or across the country. Please note that this workshop will not focus on specific diseases or hands-on caregiving for the care receiver.
https://www.powerfultoolsforcaregivers.org/

**T-CARE**
TCARE® is a caregiver assessment and referral protocol developed by Dr. Rhonda JV Montgomery and colleagues in 2007. The TCARE® protocol guides care managers, caregiver supports coordinators and family caregivers through an assessment, consultation and care planning process. It enables trained staff in community settings to accurately assess caregiver needs and link them to appropriate services that will effectively support them through different phases of their caregiving journey. The care consultation process is an educational process that helps caregivers understand the potential benefits of the services that have been offered and thereby promotes adherence to a mutually created caregiver care plan. In short, the TCARE® process facilitates effective targeting of support services and participation by caregivers with care plans tailored to their specific needs, hence improves caregiver outcomes (lower stress and burden levels, lower depression and reduction of intention to place person cared for).
Contact Dan Doezema at: 231-929-2531 or Doezemad@michigan.gov for more information.

Allowable costs include:

- Staff time to administer the program and/or conduct workshops and leader trainings.
- Costs incurred to conduct a class/workshop, including room rental fees and purchase of supplies
- Transportation of seniors to the center where the program is being conducted

- Costs incurred to conduct a leader training
- Costs incurred to send an individual from the PSA to leader training
- Payment of stipends to staff/others to monitor fidelity of classes in PSA
- Payment of stipends to instructors/coaches
- Providing recruitment assistance; publicity, printing of materials for agency within the PSA specific to EBDP programs
- Payment of class or leader materials such as books, tapes, handweights, or other supplies required to teach the class
- For TCARE:

  Covered services include staff time spent with: Screening, assessing, consulting, care planning, supports coordination, monitoring and re-assessing caregivers using the TCARE Care Protocols, and TCARE training and certification activities.
- For Creating Confident Caregivers:

  Fifty percent (50%) of funds must be used for direct service.