

# OPERATING STANDARDS FOR SERVICE PROGRAMS

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## **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](http://www.legislature.mi.gov).
- Federal Laws and Regulations can be viewed at [www.first.gov](http://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 55 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 Need** – 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](http://www.michigan.gov/lara).

### **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 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. Volunteers of each program shall receive in-service training at least once each fiscal year. Records shall be maintained which identify the dates of training, topics covered,

and persons attending. (Refer to Transmittal Letter #2020-397 for additional guidance on in-service training, including suggested training topics)

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 do not 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.

## **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.

## **VI. CARE MANAGEMENT PERFORMANCE CRITERIA**

The Michigan Department of Health and Human Services (MDHHS), Aging and Adult Services Agency (AASA), provides an annual allocation of funds to Area Agencies on Aging (AAAs) for the purpose of administering the Care Management Program. Programs shall be operated in compliance with the Operating Standards for Service Programs, General Requirements for Access Service Programs, Standard A-1: Care Management, and with policies and procedures delineated in this document.

### **SERVICE DESCRIPTION**

#### **Definition**

Care Management (CM) is the provision of a comprehensive assessment, plan of care development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals who are aged 60 and over who are medically complex and at risk of, or in need of, a nursing facility level of care due to functional and/or cognitive limitations.

Using a person-centered planning process, services are brokered or directly purchased, according to an agreed-upon service plan, to assist the participant in maintaining independence. CM activities include assessment, service plan development, service arranging/follow up and monitoring and reassessment. Activities are designed to enhance participant autonomy, respect participant preferences, support caregivers and promote efficient use of available resources.

#### **Primary Goals**

The goals of CM are:

- to delay and/or prevent costly, premature or inappropriate institutionalization of high risk older adults.
- to define appropriate levels of care to assist older adults in maintaining independence by utilizing available informal (unpaid) and formal (paid) supports.
- to provide minimal levels of support necessary to enable caregivers to continue their support for the participant.

#### **Eligibility for CM Services**

The Care Management Program serves individuals who are:

- aged 60 and over.
- medically complex with functional and/or cognitive limitations.
- at risk of, but not necessarily in need of, a nursing facility level of care.
- in need of a nursing facility level of care, but not eligible for Medicaid-supported long-term care services.



A person at risk demonstrates one or more of the following characteristics:

- determined medically eligible for nursing facility placement.
- functionally unable to provide self-care without assistance due to illness or declining health and without sufficient support for meeting care needs.
- multiple, complex and diverse service needs.
- a weak or brittle informal support system.
- currently resides in a nursing home, but because of insufficient resources and lack of other supports, is unable to obtain needed community services to return home.

Eligibility for CM is determined through a formal assessment. Eligibility to participate is not based on a person's level of income. AAAs may develop written criteria to further target low income individuals, however participation may not be denied because individuals do not meet low income criteria.

### **Primary CM Functions**

Care management includes all of the following functions:

Assessment - Comprehensive in-person examination of an individual's health status, physical and social/emotional functioning, medications, physical environment, informal support potential and financial status.

Person-Centered Service Plan Development - A written plan of service which states specific interventions to be secured. The participant and the care manager establish which services will be secured and provided, as well as the frequency and duration of services. Each service is approved by the participant or his/her representative and by physicians when

required by funding sources. The total service plan is approved by the participant prior to implementation of services.

Service Arranging - In-home health and social services are arranged and/or purchased by care managers according to the frequency and duration established by the participant and care managers as approved by the participant in the service plan. Care managers serve as agents of the participant in negotiating, arranging and monitoring formal services. Care managers arrange services from participant-approved service plans by establishing the frequency and duration of services within the regulatory and capacity limitations of providers. They also serve as consultants to physicians when arranging direct services that require physician approval. Person-centered advocacy is conducted to ensure access to, and appropriate utilization of, community services.

Follow-up / Monitoring - Ongoing periodic contact with participants and service providers is conducted to ensure service plans are implemented as planned and service needs are being met.

Reassessment - Comprehensive in-person reexamination of the participant's physical and social/emotional functioning, medications, physical environment, informal support potential and financial status.

### **Additional CM Functions**

Gap Filling - Efforts such as purchasing services and equipment are provided to fill crucial identified needs that are not met by existing informal and formal resources.

Social-emotional support - Provided by care managers to participants and their families to facilitate life adjustments and bolster informal support. Family case conferencing is conducted as necessary.

Identification of unmet needs – Care managers document services not currently available to meet the needs of participants. Compilation and analysis of unmet needs information can be useful for AAA planning purposes.

Advocacy - Provided by care managers to assist participants and their families to gain benefits and services they may be entitled to. Care managers assist in accessing public (Medicare/Medicaid) and other third-party benefits and services.

### **Administration and Coordination of CM**

AAAs are authorized to administer care management as a direct service under the Older Americans Act. If subcontracting the service, AAAs ensure that CM providers are service neutral, that is agencies that authorize services for CM participants may not provide those services directly or have direct or indirect ownership or controlling interest in, or a direct or indirect affiliation or relationship with an entity that provides services other than care management, except where there is no other viable provider and a waiver is granted by AASA.

CM agencies must establish arrangements with direct service providers to define operating parameters and avoid duplication in assessment, reassessment and service arrangement functions.

AAAs are responsible for implementing these standards whether CM is provided directly by the AAA or subcontracted.

### **Standards of CM Performance**

1. Program activities shall be conducted in accordance with the values and elements of person-centered planning. Individuals receiving care management services shall have the opportunity to identify and express their goals, choices and needs, and receive services and supports that contribute to realizing goals, honoring choices, and meeting needs. The role of the care manager is to support and facilitate the individual in maintaining the highest level of functioning and independence possible.
2. The participant shall sign a consent to participate which assures their right to accept or refuse services. The consent form shall be signed at assessment and contain the following information:

- participant's agreement to participate in the program.
  - acknowledgement that participant is fully informed of the information in the consent document.
  - acknowledgement of the participant's right to receive or refuse services.
  - a statement that the consent to participate may be revoked upon request of the participant or his/her proxy when the participant is determined legally incompetent or physically unable to withdraw consent to participate.
3. The participant's right to privacy shall be assured. The law (Privacy Act of 1974, as amended, 5USC, Subsection 552a and 42 CFR 431.300-.307) treats all communication with the participant as confidential, whether oral or written, including records derived from such communications. Information disclosed by the participant to the care manager shall be held in strictest confidence and may be released only with prior written consent.
4. The participant shall authorize the use or disclosure of health information protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The written authorization shall include the following information:
- permission to use or disclose protected health information (PHI) for purposes beyond treatment, payment or health care operations.
  - a description of the PHI to be disclosed.
  - purpose for the disclosure.
  - the intended recipient.
  - the date the authorization expires.
5. Qualified staff conduct CM functions. CM functions shall be conducted by a multi-disciplinary team. A team may consist of a registered nurse and a licensed social worker (as described within the Michigan Public Health Code) or be comprised of a registered nurse and an individual with a minimum of two years CM experience.
6. Each program shall require and thoroughly check references of paid staff that will be entering participants' homes. In addition, each program must conduct a criminal background check through the Michigan State Police for each paid and/or volunteer staff person who will be entering participants' homes.
7. Care managers are provided direct supervision in the conduct of program activities.
8. Care managers shall receive in-service training at least twice each fiscal year that is specifically designed to increase their knowledge and understanding of the program and participants, and to improve their skills in completion of job tasks.
9. Care managers shall strive to establish and maintain a positive working relationship with participants.

## **PROGRAM EDUCATION AND REFERRAL**

In an effort to facilitate appropriate referrals to the program, staff provide education to potential referral sources to raise awareness, describe characteristics of the target population, and explain screening criteria. Potential referral sources include key agencies serving the target population (hospitals, home care agencies, human service agencies, and other community agencies) and family/friends.

The AAA shall establish written procedures for managing referrals during periods of time when there is demand for care management services that exceeds program capacity.

## **SCREENING**

Following referral to CM, all applicants are screened to determine their level of need and willingness to receive CM services. Eligibility for an assessment is determined through a screening process utilizing the MI Choice Intake Guidelines (MIG). The MIG, instructions and scoring algorithm can be accessed in the Center for Information Management's (CIM's) COMPASS assessment system.

The screen represents a formal request for participation in the program. The screening process evaluates the applicants' health, social, emotional and environmental needs, and their abilities and needs in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). It considers the level of caregiving currently provided to the applicant, whether that care will continue, and the amount of additional assistance needed.

Referrals are screened through direct questioning of the individual seeking CM services whenever possible. Direct questioning may occur either by telephone or in person. Screening may involve a proxy and/or a referral source to confirm the applicant's need and willingness to receive CM and in-home services.

Screen questions are to be asked as worded, however they may be administered flexibly, rather than in the order they appear on the standardized tool. Additional probative questions are permissible when needed to clarify eligibility. All sections of the screen must be completed and scored.

Applicants who score into Section A are not usually eligible for a CM assessment, and if found not eligible, shall be provided information and referral to a program, agency or community services appropriate to meet their needs. Applicants who score in sections B and C may be eligible for and offered an assessment. Applicants who score in sections D, D1 or E are likely eligible for and should be offered a formal assessment.

Any time the program is at capacity, a list of individuals screened and awaiting assessment shall be established and maintained. At a minimum, the waiting list shall include the name, address, telephone number, referral source, date of screen, and total score. Where program resources are insufficient to meet the demand for services, each CM program shall establish and utilize written procedures for prioritizing clients waiting to receive services, based on social,

functional and economic needs.

### **Minimum Requirements: Screening**

- The AAA shall establish written procedures for all staff performing screening functions.
- The screen shall be completed and scored using the criteria listed above.
- Applicants determined not eligible for an assessment shall be provided information and referral to a program, agency or community services appropriate to meet their needs.
- Referral source and proxies shall be notified of the outcome of the screen.
- Screen information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

### **ASSESSMENT**

The interRAI Home Care Assessment System (IHC) is the basis for the CM Assessment. It is designed to be comparable to the resident assessment instrument congressionally mandated for use in nursing facilities. Care Managers use the IHC to perform a comprehensive evaluation including assessment of the individual's unique preferences: physical, social and emotional functioning; physical environment; natural supports; and financial status.

The assessment requires direct questioning of the applicant and the primary caregiver, if available, observation of the applicant in the home environment, and a review of secondary documents. Whenever possible, the applicant is the primary source of information and the assessment should be performed in the applicant's place of residence.

The IHC and Clinical Assessment Protocols (CAPs) can be accessed in CIM's COMPASS assessment system under the Help tab.

### **Role of the Family and Caregivers in Assessment Process**

The applicant is the primary focus of the assessment and information is gathered from the applicant whenever possible. In addition, family members and caregivers are an essential part of the applicant's support system. With the applicant's permission, their input is elicited as part of the assessment whenever possible.

At the expressed desire of the applicant, or in instances where the applicant is unable to fully participate in assessment activities, input may be sought and accepted from a proxy source, such as a spouse, adult child, a primary caregiver, or another individual involved in the applicant's care on an on-going basis.

In instances where a guardian is assigned to make decisions on behalf of an individual, the guardian must be included in the assessment process to make decisions over which he/she has authority.

### **Role of Other Professionals, Physicians in Assessment Process**

Due to the medical complexity of individuals enrolled in the program, care managers may receive medical information from a physician or other professionals involved with the participant with the participant's written permission. Coordination of care with medical providers allows for a comprehensive service plan.

### **Minimum Requirements: Assessment**

1. Each individual scheduled for assessment shall have been screened for participation in the program.
2. The assessment shall be conducted with active participation of the applicant within 30 calendar days of completion of the screen.
3. The assessment shall be conducted by qualified staff as previously described above.
4. The assessment shall be conducted face-to-face in the applicant's place of residence. For individuals assessed in a setting other than their home, such as a hospital or nursing care facility, care managers shall conduct a home visit within 14 days to assess the proposed living environment.
5. The assessment shall be conducted in its entirety according to the IHC Assessment Form and CAPs.
6. The following activities are conducted as part of the assessment interview:
  - a. Discuss with the applicant feasible alternatives to receiving long term care
  - b. Secure in writing the applicant's informed consent
  - c. Secure in writing the applicant's consent to release confidential information
  - d. Secure in writing the applicant's consent to disclose protected health information for purposes beyond treatment, payment, or health care operations as applicable
  - e. Inform the applicant of the right to appeal actions and decisions
7. Assessment information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

### **IHC CLINICAL ASSESSMENT PROTOCOLS AND TRIGGERS**

The IHC consists of the IHC Assessment and the CAPs. The IHC Assessment Form is the component that enables a care manager to assess multiple key domains of function, health, social support and service use. Particular items also identify individuals who could benefit from further evaluation of specific problems or risks for functional decline. These items, known as triggers, link the assessment to a series of problem-oriented CAPs.

## **Overview, Purpose/Use**

The CAPs contain general guidelines for further assessment and individualized care planning for participants who present issues in trigger conditions. There are multiple CAPs that respond to participant needs in multiple domains. The focus is not just on simple maintenance services or planning a response to an immediate problem. While these are included, the use of CAPs helps clinicians assess for opportunities to rehabilitate function, prevent decline, and maintain participants' strength. In responding to urgent needs, care priorities can be identified. In looking at chronic problems, comprehensive well-being can be maintained.

## **Role in Service Plan Development**

An accurate assessment lays the groundwork for all that follows – problem identification, identification of causes and associated conditions, and specification of necessary service goals and related service approaches. The average participant will trigger on 10-14 CAPs. Problems will be identified in many areas, prompting further review through an in-depth evaluation of problems. The in-depth evaluation of problems helps care managers to think through why a problem exists or why the participant is at risk, providing the necessary foundation on which to base next steps.

## **PERSON-CENTERED SERVICE PLAN DEVELOPMENT**

Person-centered planning is the guiding principle behind service plan development. The Person-Centered Service Plan is a written document detailing the full spectrum of supports and services provided to the participant. It is designed to respond to problems and concerns identified through the assessment, as well as a participant's expressed choices and needs. The service plan shall maximize the participant's strengths, personal control and independent living, while addressing the problems and/or concerns that affect health, safety and quality of life. It takes into consideration the whole person, rather than only those services and supports provided through the care management program. That includes a participant's natural support system and what is needed to support those involved in a caregiving role. The service plan prioritizes those services necessary to address basic health and safety issues.

Participants have the right to choose who will provide the services indicated in the service plan from among providers under contract with the AAA or enrolled in the direct purchase provider pool. If the participant has no preference of provider, the care manager shall select a provider on their behalf based on established selection criteria (quality, availability and cost) for final approval by the participant.

## **Required Service Plan Elements**

There is no required service plan format. Programs may utilize an existing form or develop their own as long as required elements are included. Required elements include:

- participant identification number
- identification of each issue, need, problem, and what it is related to.
- planned intervention for each issue/need/problem



- planned goal and outcome for each issue/need/problem
- date intervention is initiated (start date)
- date goal is met (stop date)
- frequency and duration of service
- participant approval (verbal or in writing) or other disposition (participant will or will not consider)
- signatures of assigned care managers

### **Developing Goals and Interventions**

The service plan shall clearly identify each issue, need, or problem identified during the assessment, reassessment or regular contact with the participant regardless of whether the resulting intervention is on a formal (paid) or informal (arranged) basis.

Goals shall be established for each recommended intervention. The service plan shall clearly identify the intended goal of each intervention. Goals shall be outcome based and measurable through ongoing review during subsequent contact with the participant.

A recommended intervention shall be developed to alleviate identified problem, need or condition. The service plan shall identify recommended frequency of intervention.

### **Resource Utilization/Allocation Strategies**

Exploration of the potential resources for supports and services to be included in the participant's service plan shall be considered in this order:

- the participant
- family, friends, guardian and significant others
- resources in the neighborhood and community
- publicly-funded supports and services

Planning shall address participant's needs with the focus on providing the minimum level of formal services necessary to support the informal caregiver(s) to continue involvement in the provision of care. Services shall not be used to supplant existing informal care except in situations where the provision of services is expected to extend the ability of caregivers to provide continuing support to the participant.

To the greatest extent possible, services from informal caregivers (family, neighbors, and friends) and/or community agencies who provide services at no charge are maximized prior to purchasing services.

Participants may provide financial support toward the cost of the services in accordance with locally established cost sharing practices. Under no circumstances shall services be denied for failure to contribute toward the cost of care.



The program shall pursue and secure all available third-party funding. Effort shall be made to maximize the coordination of skilled and home health benefits funded through Medicare. The programs shall also maximize use of regular Medicaid state plan benefits, veteran's benefits, insurance benefits, and other sources of long term care available to the participant, including patient pay in instances where unused monthly income may result in excess assets if allowed to accumulate over time.

**Minimum Requirements: Person-Centered Service Plan**

1. A written person-centered service plan shall be developed for each participant within 14 days of assessment.
2. The service plan shall be developed with active involvement of the participant.
3. Others, including family members and caregivers, may be involved allies as deemed appropriate by participant. If the participant has a guardian, the guardian must be involved in service planning activities.
4. The service plan considers the participant's IHC assessment, CAPs and triggers in development of necessary service goals and related service approaches. It shall include all required elements described under Required Service Plan Elements above.
5. The participant shall approve the service plan prior to implementation of services. Signature on the service plan designates approval. If the care manager is unable to obtain signature, verbal approval may be obtained for purposes of initiating services. The case record shall document the name of staff person obtaining and date of verbal approval. The participant's signature must be obtained during the next home visit.
6. Service plan information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

**SERVICE ARRANGING**

Care managers arrange services from participant-approved service plans by establishing the frequency and duration of services within the regulatory and capacity limitations of providers. Person-centered advocacy is conducted to ensure access to, and appropriate utilization of, community services.

**Minimum Requirements: Service Arranging**

1. Participant preference in selection of service providers from among those under contract or enrolled in a direct purchase provider pool with the AAA shall be ensured.
2. Care managers shall serve as agents of the participant in negotiating and arranging formal and informal services.
3. Care managers shall serve as the liaison to the participant's personal physicians and secure

approval for service when service plans specify arranging services that require physician approval.

4. A written service authorization shall be completed and submitted to service providers. The service authorization shall delineate each formal service arranged or purchased under the participant's service plan and specify the frequency and duration of service delivery.

### **FOLLOW-UP / MONITORING**

Follow-up and monitoring include contact between the care managers, the participant and/or service providers to ensure providers deliver services as planned and to the satisfaction of the participant. Follow-up and monitoring are the processes used to evaluate the timeliness, appropriateness and quality of services implemented under the participant service plan. All services implemented on behalf of participants are monitored by care managers as a function of service planning and reassessment.

#### **Minimum Requirements: Follow-Up / Monitoring**

1. Follow-up and monitoring is provided to all CM participants. Care managers shall be in contact with participants on at least a monthly basis unless otherwise specified by the participant.
2. Care managers shall serve as agents of the participant in monitoring formal and informal services.
3. Care managers contact newly enrolled participants within fourteen (14) days of the agreed upon service start date to verify that services are provided in the manner arranged and to the satisfaction of the participant. Case Managers may contact the service provider in addition to the participant to verify service provision and identify any issues identified by the provider.
4. Each follow-up/monitoring contact and date is documented in the participant case record.
5. Changes in services negotiated during follow-up/monitoring contacts on behalf of participants are recorded in the case record.
6. Care managers provide oral and/or written feedback to providers regarding services provided according to the service plan when care managers receive participant concerns or complaints.
7. When care managers attempt to arrange a service that cannot start within 30 days due to a waiting list for the service, care managers must contact the provider agency every 30 days until the service is implemented.

### **REASSESSMENT AND/OR PERSON-CENTERED SERVICE PLAN REDEVELOPMENT**

Reassessment provides a scheduled, periodic in-person reexamination of participant functioning for the purpose of identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlined in the participant service plan. It provides a basis upon which care managers make recommendations for service plan adjustments.

The IHC is used for reassessments and completed according to the assessment guidelines found above.

Person-Centered Service Plan redevelopment is a process whereby the care manager, participant and allies meet between the previous and next scheduled assessment to review, refine and improve the last person-centered service plan. The focus is specifically on providing more time for the care manager to support and coordinate a better plan as defined by the participant and their chosen support system.

#### **Minimum Requirements: Reassessment and/or Person-Centered Service Plan Redevelopment**

1. An in-person re-assessment is conducted 90 days after the initial assessment.
2. An in-person reassessment (or an in-person, person centered planning meeting with a redeveloped service plan) is completed 180 days after the first/previous re-assessment.
3. An in-person re-assessment is conducted 180 days after the previous reassessment or person-centered planning meeting with a redeveloped service plan.
4. Repeat the 180-day cycle as listed in number 2 and 3 above.
5. A reassessment is conducted sooner when there are significant changes in the individual's health or functional status, or significant changes in the individual's network of allies (i.e. death of a primary caregiver).
6. Reassessment information is collected on a standardized form and included in the participant case record.
7. Either a multi-disciplinary CM team or an individual care manager can perform reassessments. A team is not required to perform reassessments.
8. Reassessment findings are reviewed with the participant and others as deemed appropriate by the participant. The service plan may be updated, based on mutually agreed upon changes.
9. Reassessment/redeveloped service plan information shall be submitted to the state's data warehouse through the designated data exchange gateway on at least a monthly basis.

## **CASE CLASSIFICATION**

Case status shall be designated for each participant. The following case classifications shall apply to the Care Management Program:

AASA/CM = State or Federal Funded Care Management through AASA. The participant is enrolled in the AASA Care Management Program.

TCM = Targeted Case Management. The participant is:

- enrolled in the AASA Care Management Program
- financially eligible for community Medicaid
- meets NFLOC criteria
- enrolled in the TCM Program

Participants are closed to the CM Program when one of the following occurs:

- the participant moves from the service area
- the participant is institutionalized on a permanent basis
- the participant terminates involvement with the program (e.g., refuses service)
- the participant stabilizes to a point that care management intervention is no longer required
- the participant dies

### **Minimum Requirements: Case Classification**

- Each participant shall be assigned a case classification.
- A reason for transferring participants from one classification to another shall be clearly documented in the participant case record.
- The participant and/or proxy shall be informed of case closure in writing, except when death is the reason for case closure.
- The participant and/or proxy shall be informed of procedures to be followed to re-enter the program if the need for intervention changes.
- Case classification information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

## **COST SHARING**

If the CM Program bills for and receives reimbursement through the Medicaid TCM program it must have a cost sharing process in place for the state funded AASA/CM service for non-Medicaid eligible individuals (Reference AASA TL #393). Cost sharing for in-home services arranged or purchased on behalf of care management participants are treated separately and not included under this requirement

It is the responsibility of the care manager or other designated staff to explain cost sharing to the participant and determine the cost share amount. This activity is most often accomplished during the assessment visit. On a locally determined schedule, a statement shall be sent to the participant requesting payment of the predetermined cost share amount. Subsequent cost

sharing shall be conducted on at least a quarterly basis. Funds generated as a result of CM cost sharing shall be used to support the program.

**Minimum Requirements: Cost Sharing**

- Programs that participate in the Medicaid TCM Program shall have a cost sharing process in place for non-Medicaid eligible individuals.
- Programs shall establish sliding fee schedules based on reasonable gradations of income consistent with the standard of living in the service area to be applied to all individuals enrolled in the program. Cost share amount for participants whose incomes are at or below 100% of the federal poverty level shall be zero.
- Programs shall establish written policies and procedures to guide administration of cost sharing.
- Individuals may not be denied participation in the program for failure to contribute cost share. Participant records shall reflect that an attempt was made to collect the cost share.

**CONFLICT RESOLUTION**

Conflicts between participants and care managers shall be resolved through direct negotiation. If negotiation fails, participant/care manager conflicts shall be referred to the care management supervisor for discussion and resolution. All conflicts not immediately resolved through negotiation shall be documented in the case record.

Programs shall have written participant grievance procedures. Participants shall be provided a copy of the participant grievance procedure at the time of assessment at a minimum. A copy shall also be provided upon participant request. In situations where professional judgment indicates that a change in services is appropriate and the participant does not agree to the change, the participant shall be provided with written information on how to appeal decisions.

When conflicts between participants and service providers arise, care managers shall negotiate resolution to ensure implementation of the service plan to the participant's satisfaction. Resolution may include obtaining services from an alternate provider.

Conflict of professional judgment may arise during the development, implementation and monitoring of the participant service plan. Conflicts between care managers and service providers shall be resolved to promote the implementation of the service plan to the participant's satisfaction. If a conflict between care managers and service providers cannot be readily resolved through direct negotiation, the issue shall be referred to the care management supervisor and service provider supervisor for resolution.

**CASE RECORDS MAINTENANCE**

Records shall be maintained in a detailed and comprehensive manner that conforms to good professional practice, permits effective professional review and audit, and facilitates an adequate system for follow-up.

Programs shall have written policies and procedures in place for maintenance of records to ensure that records are documented accurately and promptly, are readily accessible, and permit prompt and systematic retrieval of information.

### **Minimum Requirements: Case Records Maintenance**

1. A case record shall be established and maintained for each participant served.
2. At a minimum, the case record shall include, but is not limited to the following:
  - completed eligibility screen
  - completed assessment and reassessments
  - consents to release confidential information
  - participant-approved person-centered service plan
  - service orders and instructions to providers
  - progress notes for documenting participant progress/status, contacts with participant, providers and others involved in caring for the participant
  - other documentation and correspondence sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided
3. Case record entries shall be signed or initialed by each care manager making the case record entry. When initials are used, a signature log shall be maintained with employee name, initials and position/title. Case records may be on paper or electronically via date, time, case manager identification or certification (such as in COMPASS).
4. CM programs shall establish local procedures to ensure documentation is completed in a timely manner.
5. Records shall be retained for a minimum of six years following case closure.

### **QUALITY ASSURANCE/QUALITY IMPROVEMENT**

Quality assurance activities are undertaken to determine participant satisfaction with both care management and the services that result from service plan implementation, and to ensure program compliance with established performance criteria. Quality improvement is undertaken to address identified program deficiencies.

#### **Participant Satisfaction**

Programs shall establish specific participant-oriented methods to measure and assure quality, and the frequency with which the methods will be applied. Participant satisfaction should be determined through direct questioning as part of routine activity as well as through written surveys which seek general and/or specific feedback. At a minimum, surveys should address all aspects of care management service delivery, including the degree to which the principles and elements of person-centered planning are utilized in identifying and addressing a participant's needs and desires. Information obtained through participant surveys shall be used to guide both internal and external quality improvement initiatives.

### **State-Level Performance Review**

The CM Program will be evaluated by the assigned AASA field representative as part of the Annual AAA Assessment process. The AAA completes the AASA Care Management Program Assessment Section of the Area Agency on Aging Assessment Guide prior to the assessment visit. The assigned field representative reviews the AAA responses in the Care Management Assessment Section, addresses issues that may come up and reviews documentation of CM protocols and practices as needed during the AAA Assessment visit.

The assigned field representative also reviews a minimum of five CM participant case records to assess whether required documentation is present.

If the CM Program is a TCM provider, the field representative will review at least 2 TCM cases and verify that applicable assessment/reassessment, care planning service arranging, follow-up/monitoring, progress notes and authorized signatures, identifications or certifications are in place to support TCM billing.

### **Program Level Performance Review**

Programs shall establish internal processes to ensure program quality and compliance with established criteria. Such processes shall also be considered clinical peer review to ensure timeliness, completeness and appropriateness of care management activity undertaken on behalf of a participant. Program level performance reviews may be carried out internally if the program has multiple care management teams. Programs with a single team must conduct peer reviews externally in collaboration with another AASA-funded care management program.

Program level performance reviews shall be conducted a minimum of annually. The care manager responsible for the case may not conduct a review of his/her own cases. The number of cases reviewed shall be equal to 10% of the active case load. Programs are responsible for establishing methodology for selection of cases. AAAs who subcontract all or part of the care management program are required to review programmatic, financial and contractual data of subcontracted providers on an annual basis. Utilizing a locally determined procedure, the AAA shall review subcontractor performance against established standards, policies, and procedures. The review shall include a review of state and agency policies and procedures related specifically to care management, as well as review for compliance with contractual requirements. The AAA will provide a written report of findings and recommendations to the subcontracted provider.

### **TARGETED CASE MANAGEMENT**

The purpose of Targeted Case Management (TCM) is to provide AAAs with resources for managing the community-based care needs of Medicaid eligible persons age 60 and older who are not enrolled in the MI Choice waiver program. Provided under auspices of the AASA CM program, TCM is both a program type and a funding source. It is a Medicaid State Plan service (Revision HCFA-PM-87-4, March 1987) approved for a specific participant population (see Target Group C / Eligibility below). TCM Providers must meet federally-approved criteria to



qualify for TCM participation. AASA is responsible for certifying that providers meet criteria on an annual basis. The certification is conducted as part of the AASA Annual AAA Assessment process.

Medicaid is a federal/state jointly funded program. TCM providers are reimbursed only for the annually-adjusted federal percentage portion (FMAP) of approved in-person encounters when billable activities occur. The annual AASA CM allocation is considered the state share contribution.

### **Target Group C / Eligibility**

The target group consists of persons who are:

- At least 60 years old and disabled, or at least 65 years old
- determined to meet NFLOC criteria
- Seeking admission to, or at risk of entering a nursing care facility
- Eligible and enrolled in the AASA Care Management Program
- Documented as having multiple, complex and diverse service needs and a lack of capacity and support systems to address those needs without case management

CM participants who fall into this target group and also meet community Medicaid financial eligibility shall be assigned a case classification of TCM.

### **Qualifications of TCM Provider Agencies**

TCM provider agencies must be certified as meeting the following criteria:

- demonstrated capacity to provide all core elements of case management services including the following:
  - client assessment and reassessment
  - service plan development
  - service arranging (linking/coordination of services)
  - monitoring and follow up of services
- demonstrated experience in coordinating and linking community resources required by the target population.
- demonstrated experience with the target population.
- sufficient staff to meet the cm service needs of the target population.
- an administrative capacity to insure quality of services.
- financial management capacity and system that provides documentation of services and costs.
- capacity to document and maintain individual case records.

### **Qualifications of TCM Case Managers**

TCM Case Managers shall be:

- a registered nurse (RN) licensed to practice in the state of Michigan.

- a social worker licensed to practice in the State of Michigan.
- an individual with a minimum of two years case management experience.

TCM billing will be disallowed for any period of time that a program operates without an RN on staff.

### **CM Activity Eligible for TCM Reimbursement**

TCM reimbursement is available for in-person encounters during which one or more of the following billable activities occurs:

- Assessment
- Service planning
- Service arranging
- Follow-up / Monitoring
- Reassessment

Prescreening is not a billable activity. Do not bill in-person screening activities or any other CM activity not specifically identified above.

### **Case Manager Credentials for Billable Activity that is TCM Reimbursement Eligible**

1. Only in-person billable activities are eligible for reimbursement.
2. When an RN or social worker conducts; an assessment, reassessment, service planning, service arranging or follow up/monitoring, it is considered TCM reimbursement eligible.
3. If an individual with a minimum of two years case management experience conducts a reassessment separate from an RN or social worker, either the RN or social worker must review and sign off on the reassessment to be considered TCM eligible.
4. If an individual with a minimum of two years case manager experience conducts service planning, service arranging, or follow up/monitoring it is considered TCM reimbursement eligible.

These TCM billing guidelines above replace Transmittal Letter #2018-169 TCM Billing and Reimbursement Guidelines.

### **Case Record Documentation**

Case records must clearly document the purpose of the encounter and the individual conducting the visit. Acceptable documentation includes either a Medicaid service log or completed assessment and/or reassessment documents and signed progress notes, whether on paper or electronically via date, time, case manager identification or certification (such as in COMPASS).

## Claims Submission

Per Medicaid policy, encounters must be submitted for payment within 12 months of the date of service. AAAs are encouraged to submit claims on at least a quarterly basis. An exception to the 12-month rule is implemented for claims submitted at fiscal year-end. Such claims must be submitted for processing within 45 days following the end of the fiscal year.

Medicaid identification numbers and eligibility dates should be verified prior to completing and submitting invoices. This information can be verified online by contacting MDHHS Eligibility Verification at:

[http://www.michigan.gov/mdhhs/0,5885,7-339-71551\\_2945\\_5100-57088--,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-57088--,00.html)

Providers without internet access should contact Provider Inquiry at 1-800-292-2550 to verify eligibility.

Claims shall be prepared and submitted under the professional billing format described in the MDHHS Medicaid Provider Manual Billing and Reimbursement for Professionals available on the MDHHS website at:

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

Claims for services rendered must contain the name and individual national provider identifier (NPI) of the provider. As explained in the manual, all claims are submitted and processed through CHAMPS. MDHHS encourages claims to be submitted electronically. Once claims have been submitted and processed through CHAMPS, a remittance advice (RA) is produced to inform providers about the status of claims. Electronic CHAMPS RAs are sent for those choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent via paper if requested through the Provider Enrollment Subsystem. Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments. All claims, electronic or otherwise, must be formatted to HIPPA compliant MDHHS standards, and the files must be submitted to MDHHS for processing. MDHHS requires that NPI numbers be reported in any applicable provider loop or field on the claim.

MDHHS processes claims and issues payments by check or EFT. An RA is issued with each payment to explain the payment made for the claim. If no payment is due or if claims have been rejected, an RA is also issued. If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. The electronic RA is produced in the HIPPA-compliant format. When a claim is initially processed, the claim adjustment reason/remark column on the RA identifies which service lines have been paid or rejected and edits which apply.

If a service line is rejected, a claim adjustment reason/remark code prints in the claim adjustment reason/remark column of the RA. The provider should review the definition of the codes to determine the reason for the rejection and verify that the provider NPI number and beneficiary identification number are correct.

**Cash Receipt / Accounting**

The Federal Medical Assistance Percentage (FMAP) rate is applied to the quarterly amount claim detail. The billing/reimbursement is for one monthly amount. The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year. The (FMAP is computed from a formula that takes into account the average per capita income for each state relative to the national average. The multiplier is based on the FMAP. For every dollar the state spends on Medicaid, the federal government matches at a rate that varies year to year. The correct calculation for the federal match rate is based on \$498.24 (\$519 minus the 4% fee).

MDHHS centralized budget office distributes to AASA quarterly claim detail for each AAA in a Warrant Suspend report. AASA then applies the FMAP rate (Rate of FMAP changes from year to year) and sends a notification to each individual AAA of the availability and amount of each fund transfer (see Example A). **The AAA should record their projected budgeted amount in the AIP budget spreadsheet and record their expenses/reimbursement in the AAA quarterly FSR. To receive funds, the AAA must submit a Cash Request to AASA through the online Aging Information System FIRST module.**

**Subject:** AAA Targeted Case Management (TCM) Reimbursement - 1st Quarter FY XX

Dear AAA Director,

Based on reporting and authorization from the DHHS Budget Office, your agency is now eligible to submit a cash request for the following amount related to Targeted Case Management (TCM). **The Medicaid Reimbursement Rate for this period is .6515 for TCM.**

**\$7,971.84 x 0.6515 = \$5,194.00 (rounded)**

You are eligible to submit a cash request for this amount.

<u>Provider Name</u>	<u>Appropriation Number</u>	<u>Amount</u>	<u>Rate</u>	<u>Reimbursement</u>
Region Area Agency on Aging	<b>46511</b>	<b>\$7,971.84</b>	<b>0.6515</b>	<b>\$5,194.00</b>

Please be advised: Federal OMB Circular A-133, Subpart B, Section .205(i) indicates that

**Example A**

### **TCM Reimbursement Guidelines**

MDHHS and AASA, which reimburse for TCM expenses on a cost-reimbursement basis, require that TCM funds be treated as federal awards.

Please be advised that the federal Office of Management and Budget's Circular A-133, Subpart B, Section .205(i) indicates: "Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis." (Reference Transmittal Letter #2013-264).

The federal Health Care Financing Administration (HCFA)-TCM program, the Catalog of Federal Domestic Assistance (CFDA) number is 93.778.

#### **Guidelines for Expenditure of TCM Reimbursement :**

1. Approved reimbursements from medical service billing claims made for case management activities under the approved Medicaid State plan amendment, as allowed by P.L. 99-272, shall be returned to the AAA region and CM site that generated the revenue.
2. TCM reimbursement shall be used to directly support the care management program.
  - a. Earned reimbursements shall be expended for allowable costs in accordance with the approved budget. Allowable costs include: wages/salaries, fringe benefits, travel, supplies, occupancy, communications, administration, other, and purchase of services for program clients.
  - b. Non-allowable costs include equipment items defined as tangible items with a value of \$5,000 or more, with a life expectancy greater than one year with the exception of computer hardware and/or software necessary to support the care management program and the MI Choice Information System (MICIS).
3. TCM revenues shall be reported and expended on an accrual basis.
  - a. TCM revenues shall be accounted for and expended during the fiscal year in which the original date of service occurred.
  - b. The care management grant provided by AASA serves as match for TCM reimbursement. That grant shall be reduced at fiscal year-end by the amount of unspent TCM revenues.
  - c. Actual Medicaid claims approved shall be reported on the AASA Financial Status Report.
  - d. The AAA shall submit a cash request for payment of TCM funds.

Aging and Adult Services Agency  
**OPERATING STANDARDS FOR SERVICE PROGRAMS**

<b>Service Name</b>	Care Management
<b>Service Number</b>	A-1
<b>Service Category</b>	Access
<b>Service Definition</b>	<p>Care Management (CM) is the provision of a comprehensive assessment, care plan development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals aged 60 and over who are medically complex and at risk of, or in need of, a nursing facility level of care due to functional and/or cognitive limitations.</p> <p>Using a person-centered planning process, services are brokered or directly purchased according to an agreed-upon service plan to assist the participant in maintaining independence. CM functions include assessment, service plan development, service arranging, follow up and monitoring, and reassessment. Activities are designed to enhance participant autonomy, respect participant preferences, support caregivers and promote efficient use of available resources. Activities shall be conducted in accordance with the established AASA CM Performance Criteria.</p>
<b>Unit of Service</b>	One unit per month when any CM activity is provided for a participant.

Updated 6-7-18

**Minimum Standards**

1. Medical eligibility for care management shall be determined using the MI Choice screen and assessment prior to an individual's enrollment in the CM program.
2. Care management functions shall be conducted by a multi-disciplinary team. A team may consist of a registered nurse and a licensed social worker (as described within the Michigan Public Health Code) or be comprised of a registered nurse and an individual with a minimum of two years care manager experience.
3. Care managers shall establish and maintain a confidential record for each participant served. The record shall include, but not be limited to, the following information:
  - a. Completed eligibility screen.
  - b. Completed assessment.
  - c. Consent to release confidential information.
  - d. Participant-approved person-centered service plan.
  - e. Service orders and instructions to providers.
  - f. Progress notes for documenting participant progress/status, contacts with participant, providers and others involved in caring for the participant.
  - g. Reassessment.

- h. Other documentation and correspondence sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided.
  
- 4. MIChoice assessment and reassessment forms and protocols shall be utilized to assess an individual's abilities, health and physical functioning, living situation, informal support potential, and financial status.
- 5. A person-centered service plan, detailing the services to be arranged or purchased, shall be developed with the active involvement of the participant. Others, including family members and caregivers, may be involved as deemed appropriate by the participant. Assessment findings shall be incorporated within the service plan. Service plans shall be modified or adjusted based on reassessment findings or other changes in the participant's condition.
- 6. An in-person reassessment is conducted 90 days after the initial assessment.
- 7. An in-person reassessment (or an in-person, person-centered planning meeting with a redeveloped service plan) is conducted 180 days after the first/previous reassessment.
- 8. An in-person reassessment is conducted 180 days after the previous reassessment or person-centered planning meeting with a redeveloped service plan. A reassessment is conducted sooner when there are significant changes in the individual's health or functional status.
- 9. Ongoing monitoring and follow-up shall be conducted to ensure the participant's health and safety, quality of care, and satisfaction with services.
- 10. Each program shall utilize the Center for Information Management's (CIM's) COMPASS or AASA-approved data systems to track participants, services and billing data.
- 11. Each program shall establish linkages with agencies providing long-term care support services within the program area (e.g., in-home service providers, case coordination and support programs, MI Choice Waiver programs).
- 12. Programs shall ensure staff is available to assist in disaster management activities coordinated by the local emergency operations center as necessary to protect the health and safety of CM participants.



<b>Service Name</b>	Case Coordination and Support
<b>Service Number</b>	A-2
<b>Service Category</b>	Access
<b>Service Definition</b>	The provision of a comprehensive assessment of persons aged 60 and over with a complementing role of brokering existing community services and enhancing informal support systems when feasible. Case Coordination and Support (CCS) includes the assessment and reassessment of individual needs, development and monitoring of a service plan, identification of and communication with appropriate community agencies to arrange for services, evaluation of the effectiveness and benefit of services provided, and assignment of a single individual as the caseworker for each participant.
<b>Unit of Service</b>	One unit per month when any CCS activity is provided for an individual.
<b>Component Functions</b>	Intake, assessment, reassessment, development of service plan, arrangement for each service.

Updated 6-7-18

**Minimum Standards**

1. Each CCS program must have uniform intake procedures and maintain consistent records. Intake may be conducted over the telephone. Intake records for each potential participant must include at a minimum:
  - a. Individual's name, address and telephone number
  - b. Individual's age or birth date
  - c. Physician's name, address and telephone number
  - d. Name, address, and phone number of person, other than spouse or relative with whom individual resides, 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 individual and/or his/her representatives
  - g. Race (optional)
  - h. Gender (optional)
  - i. An estimate of whether or not the individual has an income at or below the poverty level for intake and reporting purposes and at or below 125 percent of poverty level for referral purposes
  
2. If intake indicates a single service need on a one-time or infrequent basis, a less intensive level of support such as information and assistance or options counseling should be offered to the individual. When intake suggests ongoing and/or multiple service needs, a

comprehensive individual assessment of need shall be performed within 10 working days of intake. If intake/assessment suggests ongoing or multiple complex service needs at a level beyond the scope of the CCS program, a more intensive level of support such as Care Management (CM) should be offered to the individual.

3. All assessments and reassessments shall be conducted in person. Each assessment shall provide as much of the following information as is possible to determine the following.

Note: Staff must attempt to acquire each item of information listed below but must also recognize and accept the participant'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) Gender
- (4) Marital status
- (5) Race and/or ethnicity
- (6) Living arrangements
- (7) Condition of environment
- (8) Income and other financial resources, by source (including SSI and GA)
- (9) Expenses
- (10) Previous occupation, special interests and hobbies
- (11) Religious affiliation, if applicable

b. Functional Status

- (1) Vision
- (2) Hearing
- (3) Speech
- (4) Oral status (condition of teeth, gums, mouth and tongue)
- (5) Prosthesis
- (6) Psychosocial functioning
- (7) Limitations in activities of daily living (ADLs and IADLs)
- (8) History of chronic and acute illnesses
- (9) Eating patterns (diet history)
- (10) Prescriptions, medications, and other physician orders

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 past (including identification of those funded through Medicaid)
- (4) Extent of family and/or informal support network
- (5) Hospitalization history
- (6) Medical/health insurance information
- (7) Clergy name, address and telephone number, if applicable

d. Need Identification

- (1) Participant/family perceived
- (2) Assessor perceived and/or identified from referral source/professional community

Each participant shall be reassessed every six months, or as needed to determine the results of implementation of the service plan.

4. A service plan shall be developed for each person determined eligible and in need of CCS. The service plan shall be developed in cooperation with, and be approved by, the participant, the participant's guardian or designated representative. The service plan shall contain at a minimum:
  - a. Statement of the participant's problems, needs, strengths, and resources.
  - b. Statement of the goals and objectives for meeting identified needs.
  - c. Description of methods and/or approaches to be used in addressing needs.
  - d. Identification of services and the respective time frames they are to be obtained/provided from other community agencies.
  - e. Treatment orders of qualified health professional, when applicable.

Each program shall have a written policy/procedure to govern the development, implementation and management of service plans.

5. Each program shall maintain comprehensive and complete case files which include at a minimum:
  - a. Details of participant's referral to CCS program.
  - b. Intake records.
  - c. Comprehensive individual assessment and reassessments.
  - d. Service plan (with notation of any revisions).
  - e. Listing of all contacts (dates) with participants (including units of service per participant).
  - f. Case notes in response to all participant or family contacts (telephone or personal).
  - g. Listing of all contacts with service providers on behalf of participant.
  - h. Comments verifying participant's receipt of services from other providers and whether service adequately addressed participant need.
  - i. Record of all release of information about the participant, signed release of information form, and all case files shall be kept confidential in controlled access files. Each program shall use a standardized release of information form, which is time-limited and specific as to the information being released.
6. Each case file must be assigned status in one of the following categories:
  - a. Open. From initial referral or reassessment of inactive case through current activity in implementing a service plan; or
  - b. Closed. Participant decides to discontinue service, participant needs have been met, another program or agency has assumed responsibility for participant, participant unable to be served and referral of case is not possible, or participant's death.

7. Each program shall maintain a current listing of isolated older persons, with active case files, which can be made readily available to agencies providing emergency services in the event of a disaster.
8. Each program shall employ caseworkers who have a minimum of a bachelor's degree in a human service field or who, by experience or training, have the ability to effectively determine an older person's needs and match those needs with appropriate services. If the program does not employ staff with an appropriate bachelor's degree, access to such a caseworker(s) in the community shall be arranged for purposes of technical support and/or consultation. Participants with identified unmet health needs (physical and/or mental) shall be referred to an appropriate health care agency. Only one caseworker may be currently assigned to each individual case.
9. Each CCS program shall provide information and assistance and outreach as supporting services. However, it is not required that such service provision be reported to AASA.
10. Program staff shall receive in-service training at least twice each fiscal year that is specifically designed to increase their knowledge and understanding of the program and participants, and to improve their skills in completion of job tasks.

Aging and Adult Services Agency  
**OPERATING STANDARDS FOR SERVICE PROGRAMS**

<b>Service Name</b>	Disaster Advocacy and Outreach Program
<b>Service Number</b>	A-3
<b>Service Category</b>	Access
<b>Service Definition</b>	Activities undertaken to assist older persons in their planning, response or recovery from “disaster” or “emergency” as defined by the Michigan Emergency Management Act, as amended. All activities must be aimed specifically at providing necessary assistance for older persons to ensure access to needed service as well as personal and emotional support necessary to assist frail or vulnerable older persons plan for, respond to or work toward recovery. The program is also responsible for linking people with a need to those agencies which have some ability to fill the need that has been identified.
<b>Unit of Service</b>	Each hour of community education activity. Each hour of emergency preparedness, including agency plan preparation, agency staff training, meeting with state and local emergency managers, negotiating contracts with service providers, and exercises at the emergency operation center. Each hour of advocacy and outreach activities with individuals that improve their emergency preparedness or for response and recovery activity for up to one year after a disaster or emergency situation occurs.

updated 3-17-06

**Minimum Standards**

1. Each agency or organization providing services to the aging to be funded or reimbursed under this service definition must have a “mission” defined in an adopted annex of the local emergency preparedness plan prepared under the provisions of the Michigan Emergency Management Act, as amended.
2. Each area agency on aging, or local provider of aging services, must have identified alternative approaches for both responding to a disaster and undertaking appropriate activities to assist victims recover from a disaster, depending upon the resources and structures available. The same functions cited as allowable service components are performed, but the responsibility may be assigned to individuals employed by other agencies and organizations instead of hiring persons by the area agency on aging or contracted service provider.
3. All disaster advocacy and outreach activities shall be under the supervision of an individual who has the educational and work experience necessary to help advocates determine when individuals need assistance beyond the scope of their capabilities. A team concept is acceptable.

Allowable Service Components

Activities conducted under the Disaster Advocacy and Outreach service definition may include, but are not limited to the following:

1. Conducting awareness campaigns alerting the public of local plans in the event of a disaster or state emergency.
2. Providing technical assistance to service providers for developing and implementing plans for assuring the continuation of services in the event of either a disaster or state of emergency.
3. Arranging for appropriate services to be expanded to additional eligible clients needing such services as the result of a disaster or state of emergency.
4. Developing a sound knowledge base of various relief programs.
5. Conducting interviews with older disaster victims.
6. Assessing an older individual's needs, including mental health and cognitive status.
7. Arranging for reassurance and emotional support to older victims.
8. Determination of the best resources for meeting the older person's needs.
9. Identification of individuals with needs exceeding the scope of existing programs and seeking assistance in finding ways to meet those needs.
10. Provision of ongoing support and assistance in returning to normalcy.
11. Provision of assistance in obtaining disaster services after disaster centers have closed.
12. Assisting older individuals in completing forms, negotiations and appeals.
13. Providing assistance to older persons in the Disaster Center.
14. Obtaining and helping provide interagency and public information.
15. Conducting door-to-door canvassing (outreach) to identify older disaster victims, with multiple visits if necessary.
16. Continuing to conduct outreach efforts after the Disaster Center has closed.
17. Seeking to identify older persons who have moved out of the area so that they can be notified of the opportunity to apply for disaster services.
18. Arranging for or providing escort services for relocation and housing searches and to multipurpose senior centers.
19. Neighborhood searches to find isolated or "hidden seniors."
20. Follow up on lists of affected older persons received from other providers and agencies to assure that older victims are receiving services.
21. Maintain liaison with local government and volunteer human services agencies in order to plan for, respond to, or recover from a disaster or emergency event.
22. Conduct a needs assessment of, and coordinate/monitor the provision of assistance to, elderly disaster victims.
23. Develop/provide information on home and community-based services for senior citizens (i.e., senior center, meal sites, and in-home service providers).
24. Monitor the negative impacts of extreme temperatures on the elderly.
25. Conduct outreach activities for older adults on the benefits of emergency preparedness and disaster response planning.
26. Conduct outreach activities for older adults on the benefits of proper preventive measures in response to potential public health emergencies (i.e., epidemics of West Nile virus, SARS, small pox, and influenza).
27. Take necessary action to protect the agency's resources and to ensure the continuation of the agency's critical functions during a disaster or emergency event.

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<b>Service Name</b>	Information and Assistance
<b>Service Number</b>	A-4
<b>Service Category</b>	Access
<b>Service Definition</b>	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.
<b>Unit of Service</b>	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.

<b>Service Name</b>	Outreach
<b>Service Number</b>	A-5
<b>Service Category</b>	Access
<b>Service Definition</b>	Efforts to identify and contact isolated older persons and/or older persons in greatest social and economic need, who may have service needs, and assisting them in gaining access to appropriate services. Outreach <u>does not include</u> comprehensive assessment of need, development of a service plan, or arranging for service provision.
<b>Unit of Service</b>	One hour of outreach service including identification and contact of isolated older persons, assistance in their gaining access to needed services, and follow up.

Minimum Standards

1. Each program shall have a uniform intake procedure which identifies and documents client needs. Persons who appear to have multiple needs shall be referred to a case coordination and support or care management program, where available.
2. Each program shall establish linkages with I&A programs in the project area and be able to assist clients in gaining access to available services, as necessary.
3. A follow-up contact shall be made on an annual basis with at least 15 percent of individuals served to determine whether needed services have been received.
4. Each program located in areas where non-English or limited English speaking older persons are concentrated shall have bilingual personnel available. Such interpreters do not have to be paid staff persons.
5. Each program shall specify annually how it intends to satisfy the service needs of low-income minority individuals in its respective service area.
6. Each program, to the maximum extent feasible, shall provide services to low-income minority individuals in accordance with their need for such services.
7. Each program must meet the specific objectives established by the AAA for providing services to low income minority individuals within the planning and service area.
8. Each program shall identify those eligible for assistance with a special emphasis on older individuals:
  - a. Residing in rural areas.
  - b. With greatest economic need (with particular attention to low-income minority individuals).

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- c. With greatest social need (with particular attention to low-income minority individuals).
  - d. With severe disabilities.
  - e. Who are Native Americans?
  - f. With limited English-speaking ability.
  - g. With Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals).
9. Each program shall make efforts to inform the older individuals identified in number 8., and the caretakers of such individuals, of the availability of assistance.

<b>Service Name</b>	Transportation
<b>Service Number</b>	A-6
<b>Service Category</b>	Access
<b>Service Definition</b>	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.
<b>Unit of Service</b>	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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<b>SERVICE NAME</b>	Options Counseling
<b>SERVICE NUMBER</b>	A-7
<b>SERVICE CATEGORY</b>	Access
<b>SERVICE DEFINITION</b>	Options Counseling (OC) is an interactive process where participants (including family members and caregivers) receive guidance in their deliberations to make informed choices about long-term supports and services. The process is directed by the participant and may include others that the participant chooses or those who are legally authorized to represent the participant.
<b>UNIT OF SERVICE</b>	One unit per month when any OC activity is provided for an individual.

Established 6-7-18

Minimum Standards

1. Each program shall employ staff with a bachelor's degree in a human service field or who, by training or experience, have the ability and knowledge to provide information, assistance, supports, services options, linkages and strategies for participants.
2. Program staff shall be knowledgeable of long-term care support options available within the planning and service area (PSA).
3. Each program shall develop a network of community resources and resource information, including non-traditional services and assistance in order to meet non-traditional service needs and requests.
4. Each program shall maintain linkages with Information and Assistance programs operating in the project area and establish protocols to identify potential participants for referral.
5. Each program shall maintain linkages and develop referral protocols with all Access services as well as Case Coordination and Support (CCS), Care Management (CM), MI Choice Waiver Program, Center for Independent Living (CIL), Veterans Medical Centers, and other resources within the PSA in order to meet service needs and requests.
6. An initial screening via a personal interview shall be provided that includes the participant (and/or their representative and/or family caregiver as indicated) to learn about the person's values, strengths, preferences, concerns, and available resources that they may use for long term support services.
7. Program staff shall explore with participants potential resources to assist participants with long term services and supports, including informal support, privately funded services, publicly funded services and available benefits, among others.

8. Providers of OC must make unbiased referrals reflecting the best outcomes for the participant and shall make efforts to avoid a conflict of interest.
9. Decision support shall also be provided to assist the participant in evaluating the pros/cons of specific choices.
10. The provision of assistance with determining financial eligibility, when appropriate.
11. The provision of assistance with enrollment into public programs and benefits.
12. The program encourages future planning for long term care.
13. The program shall provide a written summary to the participant, which details important issues discussed, participant desires and preferences, and identified strategies.
14. The program must offer follow-up to each participant provided at their direction. Follow-up may be conducted in person, by phone, or electronically as resources allow and the participant prefers.
15. Providers of OC services must have the capacity to:
  - a. Provide private, confidential telephone and face-to-face OC if requested.
  - b. Respond to participants seeking supports and services by using methods and accommodations, which are in compliance with the Americans with Disabilities Act including, but not limited to:
    - i. Adequate, accessible, barrier-free, comfortable and confidential space for OC;
    - ii. Website requests;
    - iii. Email requests;
    - iv. Interpreter requests;
    - v. Alternative material formats;
    - vi. The Michigan Relay Center;
    - vii. Requests via independent facilitators (someone designated by the individual to speak/obtain information on their behalf); and/or
    - viii. Other assistive technology.
  - c. Provide a standard of promptness for returning calls, e-mails or other communications within three business days. Urgent requests may require an immediate response.
16. Program staff shall receive in-service training at least twice each fiscal year that is specifically designed to increase their knowledge and understanding of the program and participants, and to improve their skills in completion of job tasks. (Added training requirements consistent with CM and CCS.)
17. Each program is encouraged to seek Certified Information and Referral Specialist (CIRS) certificates from the Alliance for Information and Referral Systems (AIRS) for individual OC employees and volunteers.



## **VII. GENERAL REQUIREMENTS FOR IN-HOME SERVICE PROGRAMS**

In addition to the General Requirements for all Service Programs, the following general standards apply to all in-home service categories unless otherwise specified.

### **1. Service from Other Resources**

Each in-home service program, prior to initiating service, shall determine whether a potential client is eligible to receive the respective service(s) or any component support service(s) through a program supported by other funding sources, particularly programs funded through the Social Security Act. If it appears that an individual can be served through other resources, an appropriate referral should be made or third-party reimbursement sought. Each program must establish coordination with appropriate local Department of Human Services (DHS) offices to ensure that funds received from AASA are not used to provide in-home services which can be paid for or provided through programs administered by DHS.

For instances where a client enters a Hospice Care program while receiving in-home services under an area plan, the in-home services are not required to be withdrawn. A revised service plan should be developed, with consultation from all service providers involved including the Hospice Care provider, based on the client's needs, preferences and the availability of resources from each provider.

Older Americans Act (OAA) funding may not be used to supplant (or substitute for) other federal, state or local funding that was being used to fund services, prior to the availability of OAA funds.

OAA programs do not qualify as third-party payers for Medicaid purposes.

### **2. Individual Assessment of Need**

Each in-home service program, as identified in the table below, shall conduct an assessment of individual need for each client. Each program with required assessments shall avoid duplicating assessments of individual clients to the maximum extent possible. In-home service providers may accept assessments, and reassessments, from case coordination and support programs, care management programs, home and community-based Medicaid programs, other aging network home care programs, and Medicare certified home health providers. Clients with multiple needs should be referred to care management programs.

Clients shall be assessed within 14 calendar days of initiating service. If services are to be provided for 14 calendar days or less, a complete assessment need not be conducted. In such instances, the program must determine the client's eligibility to receive services and gather the Basic Information specified below).

The assessments are to be used to verify need, eligibility, and the extent to which services are to be provided. The assessment should verify an individual to be served has functional, physical or mental characteristics that prevent them from providing the service for themselves and that an informal support network is unavailable or insufficient to meet their needs. Eligibility is to be verified against established criteria for each respective service category. If an individual is found to be ineligible, the reason(s) are to be clearly stated. Each assessment shall be conducted face-to-face and provide as much of the information specified below as it is possible to determine. Programs must refer individuals thought to be eligible for Medicaid to DHS.

Periodic reassessments must be conducted according to the following chart. Reassessments are to be used to determine changes in client status, client satisfaction, and continued eligibility. Each assessment and reassessment should include a determination of when reassessment should take place.

<b>In-Home Services Requiring Assessments</b>	<b>Minimum Reassessment Frequency</b> (Unless circumstances require more frequent reassessment)
Homemaking	6 months (180 days)
Home Care Assistance	6 months
Home Delivered Meals	6 months
Medication Management	3 months
Personal Care	6 months
Respite Care	6 months
Home Health Aide	3 months (90 days)

When assessments are not conducted by a registered nurse (R.N.) the program must have access to, and utilize, an R.N. for assistance in reviewing assessments, as appropriate, and maintaining necessary linkages with appropriate health care programs.

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. Changes in any item should be specifically noted during reassessments. Assessments must be documented in writing, signed and dated.

Minimum information to be gathered by assessments:

a. Basic Information

1. Individual's name, address and phone number
2. Source of referral

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3. The name, address and phone number of person to contact in case of an emergency
4. The name address and phone number of caregiver(s)
5. Gender
6. Age, date of birth
7. Race and/or ethnicity
8. Living arrangements
9. Condition of residential environment
10. Whether or not the individual's income is below the poverty level and/or sources of income (particularly SSI)

b. Functional Status

1. Vision
2. Hearing
3. Speech
4. Oral status (condition of teeth, gums, mouth and tongue)
5. Prostheses
6. Limitations in activities of daily living
7. Eating patterns (diet history), special dietary needs, source of all meals, and nutrition risk
8. History of chronic and acute illnesses
9. Prescriptions, medications and other physician orders

c. Support Resources

1. Physician's name, address and phone number (for all physicians)
2. Pharmacist's name, address and phone number (for all pharmacies utilized)
3. Services currently receiving or received in past (including identification of those funded through Medicaid)
4. Extent of family and/or informal support network
5. Hospitalization history
6. Medical/health insurance available
7. Clergy name, address and phone number, if applicable

d. Client Satisfaction (at reassessment)

1. Client's satisfaction with services received
2. Client's satisfaction with program staff performance
3. Consistency of services provided

3. Service Plan

Each in-home service program must establish a written service plan for each client, based on the assessment of need, within 14 calendar days of the date the assessment was completed. The service plan must be developed in cooperation with the client, client's guardian or designated representative, as appropriate. The service plan must contain at a minimum:

- a. A statement of the client's problems, needs, strengths and resources.
- b. Statement of the goals and objectives for meeting identified needs.
- c. Description of methods and/or approaches to be used in addressing needs.
- d. Identification of services and the frequency which they are to be provided.
- e. Treatment orders of qualified health professionals, when applicable.
- f. Documentation of referrals and follow-up actions.

To avoid duplication, in-home service programs may accept the service plan developed by a referring case coordination and support, care management, home and community-based Medicaid program, other aging network home care programs, and Medicare certified home health providers.

When the service plan is not developed by a registered nurse (R.N.), in-home service programs must have access to, an R.N. for assistance in developing service plans, as appropriate. Service plans must be evaluated at each client reassessment.

#### 4. In-Home Supervision

Program supervisors must be available to program staff, via telephone, at all times they are in a client's home.

Each in-home service program, except for home delivered meals, must conduct one in-home supervisory visit for each program staff member, with a program client present, each fiscal year. A registered nurse must be available to conduct in-home supervisory visits, when indicated by client circumstances. Additional in-home supervisory visits should be conducted as necessary. The program shall maintain documentation of each in-home supervisory visit.

#### 5. Client Records

Each in-home service program must maintain comprehensive and complete client records which contain at a minimum:

- a. Details of referral to program.
- b. Assessment of individual need or copy of assessment (and reassessment) from referring program.
- c. Service plan (with notation of any revisions).
- d. Programs (except home delivered meals) with multiple sources of funding must specifically identify clients served with funds from AASA; records must contain a listing of all contacts (dates) paid for with funds from AASA, with clients and the extent of services provided (units per client).
- e. Notes in response to client, family, and agency contacts (including notation of all referrals made).
- f. Record of release of any personal information about the client or copy of signed release of information form.
- g. Service start and stop dates.

- h. Service termination documentation, if applicable.
- i. Signatures and dates on client documents, as appropriate.

All client records (paper and electronic) must be kept confidential in controlled access files.

6. In-Service Training

Staff of each in-home service 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 skills at tasks performed in the provision of service. Volunteers of each program shall receive in-service training at least once each fiscal year on training topics per guidance provided by AASA. Records shall be maintained which identify the dates of training, topics covered, and persons attending. (Refer to Transmittal Letter #2020-397 for additional guidance on in-service training, including suggested training topics.

<b>Service Name</b>	Chore
<b>Service Number</b>	B-1
<b>Service Category</b>	In-Home
<b>Service Definition</b>	<p>Non-continuous household maintenance tasks intended to increase the safety of the individual(s) living at the residence. Allowable tasks are limited to the following:</p> <ul style="list-style-type: none"> <li>• replacing fuses, light bulbs, electrical plugs, and frayed cords</li> <li>• replacing door locks and window catches</li> <li>• replacing/repairing pipes</li> <li>• replacing faucet washers or faucets</li> <li>• installing safety equipment</li> <li>• installing screens and storm windows</li> <li>• installing weather stripping around doors</li> <li>• caulking windows</li> <li>• repairing furniture</li> <li>• installing window shades and curtain rods</li> <li>• cleaning appliances</li> <li>• cleaning and securing carpets and rugs</li> <li>• washing walls and windows, scrubbing floors</li> <li>• cleaning attics and basements to remove fire and health hazards</li> <li>• pest control</li> <li>• grass cutting and leaf raking</li> <li>• clearing walkways of ice, snow and leaves</li> <li>• trimming overhanging tree branches</li> </ul>
<b>Unit of Service</b>	One hour spent performing allowable chore tasks.

**Minimum Standards**

1. Funds awarded for chore service programs may be used to purchase materials and disposable supplies used to complete the chore tasks to increase the safety of the individual. No more than \$200 may be spent on materials for any one household per year. Equipment or tools used to perform chore tasks may be purchased or rented with funds awarded up to an amount equal to 10% of the total grant funds.
2. Pest control services may be provided only by appropriately licensed suppliers.
3. Each program must develop working relationships with the Home Repair and Weatherization service providers, as available, in the program area to ensure effective coordination of efforts.

<b>Service Name</b>	Home Care Assistance
<b>Service Number</b>	B-2
<b>Service Category</b>	In-Home
<b>Service Definition</b>	<p>Provision of in-home assistance with activities of daily living and routine household tasks to maintain an adequate living environment for older persons with functional limitations. Home care assistance does not include skilled nursing services.</p> <p>Allowable personal care activities include assistance with bathing, dressing, grooming, toileting, transferring, eating, and ambulation. Allowable homemaking tasks include laundry, ironing, meal preparation, shopping for necessities including groceries, and light housekeeping. The service also includes observation, recording, and reporting changes in clients' health status and home environment.</p> <p>Note: social/emotional support of client may be offered in conjunction with other allowable tasks.</p>
<b>Unit of Service</b>	One hour spent performing allowable home care assistance activities.

**Minimum Standards**

1. Each program must have written eligibility criteria.
2. All workers performing home care assistance services must be trained by a qualified person and must be tested for each task to be performed prior to being assigned to a client. The supervisor must approve tasks to be performed by each worker. Completion of a recognized nurse's aide training course by each worker is strongly recommended.
3. Individuals employed as home care assistance workers must have previous relevant experience or training and skills in assisting with personal care needs, housekeeping, household management, good health practices, observation, and recording and reporting client information.
4. Semi-annual in-service training is required for all home care assistance workers. Required topics include safety, sanitation, emergency procedures, body mechanics, universal precautions, and household management.



<b>Service Name</b>	Home Injury Control
<b>Service Number</b>	B-3
<b>Service Category</b>	In-Home
<b>Service Definition</b>	<p>Providing adaptations to the home environment of an older adult in order to prevent or minimize the occurrence of injuries. Home injury control does not include any structural or restorative home repair, chore or homemaker activities. Allowable tasks include installation or maintenance of:</p> <ul style="list-style-type: none"> <li>• enhanced lighting</li> <li>• ramps for improved and/or barrier-free access</li> <li>• bathroom chairs and grab bars</li> <li>• non-slip treatments</li> <li>• vision or hearing adaptive devices</li> <li>• stairway and/or hallway handrails</li> <li>• smoke and/or gas alarms</li> </ul>
<b>Unit of Service</b>	Installation or maintenance of one safety device in an older adult's residence.

**Minimum Standards**

1. Prior to initiating service, each program must determine whether a potential client is eligible to receive services available through a program supported by other funding sources, particularly programs funded through the Social Security Act. If it appears that an individual can be served through other resources, an appropriate referral should be made.
2. Each program must develop working relationships with chore, homemaker, home care assistance and home repair service providers, as available within the program area, to ensure effective coordination of efforts.
3. Each program must utilize a home environment assessment tool to formally evaluate the circumstances and needs of each client. The program may utilize the MI Choice assessment for initiating service if the client is referred by either a care management or HCBS/ED program.
4. Each program must maintain a record of safety improvements made at each residence including dates, tasks performed, materials used and cost.
5. All safety devices installed must conform to local building codes and meet respective UL<sup>®</sup> safety standards.

6. Funds awarded for home injury control may be used for labor costs and to purchase safety devices to be installed. The program must establish a limit on the amount to be spent on any one residence in a 12-month period. Each program must seek contributions of labor and supplies from the private sector and volunteer organizations, as may be feasible. Equipment or tools needed to perform home injury control tasks may be purchased or rented with grant funds up to an aggregate amount equal to 10% of total grant funds.

<b>Service Name</b>	Homemaking
<b>Service Number</b>	B-4
<b>Service Category</b>	In-Home
<b>Service Definition</b>	<p>Performance of routine household tasks to maintain an adequate living environment for older individuals with functional limitations. Homemaking does not include provision of chore or personal care tasks. Allowable homemaking tasks are limited to one or more of the following:</p> <ul style="list-style-type: none"> <li>• laundry</li> <li>• ironing</li> <li>• meal preparation</li> <li>• shopping for necessities (including groceries) and errand running</li> <li>• light housekeeping tasks (dusting, vacuuming, mopping floors, cleaning bathroom and kitchen, making beds, maintaining safe environment)</li> <li>• observing, reporting, and recording any change in client's condition and home environment</li> </ul> <p>Note: Social/emotional support of client may be offered in conjunction with other allowable tasks.</p>
<b>Unit of Service</b>	One hour spent performing allowable homemaking activities.

updated 3-17-06

Minimum Standards

1. Each program must have written eligibility criteria.
2. Individuals employed as homemakers must have previous relevant experience or training and skills in housekeeping, household management, meal preparation, good health practices, observation, reporting and recording information.
3. Required in-service training topics include safety, sanitation, household management, nutrition and meal preparation.

<b>Service Name</b>	Home-Delivered Meals (HDM)
<b>Service Number</b>	B-5
<b>Service Category</b>	In-Home
<b>Service Definition</b>	The provision of nutritious meals to homebound older persons.
<b>Unit of Service</b>	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 chooses 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.

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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.



<b>Service Name</b>	Home Health Aide
<b>Service Number</b>	B-6
<b>Service Category</b>	In-Home
<b>Service Definition</b>	Performance of health-oriented services prescribed for an individual by a physician which may include: assistance with activities of daily living (ADL), assisting with a prescribed exercise regimen, supervising the individual's adherence to prescribed medication and/or special diets, changing non-sterile dressing, taking blood pressure, and other health monitoring activities.
<b>Unit of Service</b>	One hour spent performing home health aide activities.

**Minimum Standards**

1. Each program must have written eligibility criteria that includes determination that the health related needs of the individual can be adequately addressed in the home.
2. After each home health aide client is reassessed, progress must be reported to the client's physician with a request for renewal of orders for the service plan.
3. In determining which providers will be selected for home health aide services, preference is to be given to certified home health agencies or agencies corporately related to a certified home health agency.
4. All aides performing home health aide services must be directly supervised by an RN. Each aide must have completed a home health aide or nurse aide training curriculum approved by the AAA and be trained for each task to be performed. The supervising nurse must approve tasks to be performed by each aide. An RN must be available for advice and consultation by telephone or otherwise at all times aides are providing service.

<b>Service Name</b>	Medication Management
<b>Service Number</b>	B-7
<b>Service Category</b>	In-Home
<b>Service Definition</b>	<ul style="list-style-type: none"> <li>• Direct assistance in managing the use of both prescription and over the counter (OTC) medication. Allowable program components include:</li> <li>• Face-to-face review of client's prescription, OTC medication regimen, and use of herbs and dietary supplements.</li> <li>• Regular set-up of medication regimen (Rx pills, Rx injectables, and OTC medications).</li> <li>• Monitoring of compliance with medication regimen.</li> <li>• Cueing via home visit or telephone call.</li> <li>• Communicating with referral sources (physicians, family members, primary care givers, etc.) regarding compliance with medication regimen.</li> <li>• Family, caregiver and client education and training.</li> </ul>
<b>Unit of Service</b>	Each 15 minutes (.25 hours) of component activities performed.

updated 3-17-06

**Minimum Standards**

1. Each program shall employ a registered nurse (RN) who supervises program staff and is available to staff when they are in a client's home or making telephone reminder calls. Each program shall employ program staff who are appropriately licensed, certified, trained, oriented and supervised.
2. The supervising nurse shall review and evaluate the medication management care plan and the complete medication regimen, including prescription and OTC medications, dietary supplements and herbal remedies, with each client and appropriate caregiver.

Each program shall implement a procedure for notifying the client's physician(s) of all medications being managed.

3. The program shall be operated within the three basic levels of service as follows:

Level 1: Telephone reminder call/cueing with maintenance of appropriate documentation. Program staff performing this level of service shall be delegated by the supervising nurse.

Level 2: In-home monitoring visit/cueing with maintenance of appropriate documentation. Program staff performing level 2 services shall be delegated by the supervising nurse.

Level 3: In-home medication set up, instructions, and passing and/or assistance with medications (e.g., putting in eye drops, giving pills and injections). Program staff performing level 3 services shall be delegated by the supervising nurse.

4. The program shall maintain an individual medication log for each client that contains the following information:
  - a. Each medication being taken.
  - b. The dosage for each medication.
  - c. Label instructions for use for each medication.
  - d. Level of service provided and initials of person providing service.
  - e. Date and time for each time services are provided.
  
5. The program shall report any change in a client's condition to the client's physician(s) immediately.

<b>Service Name</b>	Personal Care
<b>Service Number</b>	B-8
<b>Service Category</b>	In-Home
<b>Service Definition</b>	Provision of in-home assistance with activities of daily living (ADL) for an individual including assistance with bathing, dressing, grooming, toileting, transferring, eating, and ambulation. Personal care does not include health-oriented services as specified for Home Health Aide Services
<b>Unit of Service</b>	One hour spent performing personal care activities.

Minimum Standards

1. Each program must have written eligibility criteria.
2. All workers performing personal care services must be directly supervised by a professionally qualified person. Each worker must be trained for each task to be performed. The supervisor must approve tasks to be performed by each worker. Completion of a recognized nurse aide training course by each worker is recommended.

<b>Service Name</b>	Assistive Devices and Technologies
<b>Service Number</b>	B-9
<b>Service Category</b>	In-Home
<b>Service Definition</b>	A service that provides assistive devices and technologies which enable individuals to live independently in the community according to their preferences, choices and abilities.
<b>Unit of Service</b>	One device, plus installation and training as appropriate, provided to a program participant.
<b>Service Description</b>	This service helps individuals to learn about and acquire devices, equipment and supporting technologies that assist in the conduct of activities of daily living. Such devices may include, but are not limited to: Personal Emergency Response Systems (PERS), wheel chairs, walkers, lifts, medication dispensers, etc.

Minimum Standards

1. Each program must coordinate with other appropriate service providers in the community in order to avoid an unnecessary duplication of services.
2. All devices installed must conform to local building codes, as applicable, and meet respective UL<sup>®</sup> safety standards.
3. Funds awarded for assistive devices and technologies may be used for labor costs and to purchase devices to be installed.
4. With regard to Personal Emergency Response Systems (PERS), the following additional requirements must be met:
  - a. Equipment used must be approved by the Federal Communication Commission and must meet UL<sup>®</sup> safety standards specifications for Home Health Signaling Equipment.
  - b. Response center must be staffed 24 hours/day, 365 days/year with trained personnel. Response center will provide accommodations for persons with limited English proficiency.
  - c. Response center must maintain the monitoring capacity to respond to all incoming emergency signals.
  - d. Response center must be able to accept multiple signals simultaneously. Calls must not be disconnected for call-back or put in a first call, first serve basis.
  - e. Provider will furnish each responder with written instructions and provide training as appropriate.

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- f. Provider will verify responder and contact names semi-annually to assure current and continued participation.
- g. Provider will assure at least monthly testing of the PERS unit to assure continued functioning.
- h. Provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct participants and responders in the use of the devices, as well as to provide for performance checks.
- i. Provider will maintain individual participant records that include the following:
  - i. Service order.
  - ii. Record of service delivery, including documentation of delivery and installation of equipment, participant orientation, and monthly testing.
  - iii. List of emergency responders.
  - iv. Case log documenting participant and responder contacts.

<b>Service Name</b>	Respite Care
<b>Service Number</b>	B-10
<b>Service Category</b>	In-Home
<b>Service Definition</b>	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.
<b>Unit of Service</b>	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:

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- 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.



Aging and Adult Services Agency

## OPERATING STANDARDS FOR SERVICE PROGRAMS

<b>Service Name</b>	Friendly Reassurance
<b>Service Number</b>	B-11
<b>Service Category</b>	In-Home
<b>Service Definition</b>	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.
<b>Unit of Service</b>	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**

<b>Service Name</b>	Adult Day Services
<b>Service Number</b>	C-1
<b>Service Category</b>	Community
<b>Service Definition</b>	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.
<b>Unit of Service</b>	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:

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- 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.

<b>Service Name</b>	Dementia Adult Day Care
<b>Service Number</b>	C-2
<b>Service Category</b>	Community
<b>Service Definition</b>	Daytime care of any part of the day, but less than 24 hours care, for older persons with dementia provided through a structured program of social and rehabilitative and/or maintenance services in a supportive or group setting other than the client's home. These standards are in addition to AASA Adult Day Services Standards.
<b>Unit of Service</b>	One hour.

Minimum Standards

1. The Dementia Adult Day Care (DADC) program shall be accessible. This means the center is to be located within a convenient distance of clients' homes. The DADC should provide or arrange for transportation, if possible. All drivers and vehicles shall be appropriately licensed and insured. Each program shall develop standards regarding criteria for safe driving records of persons responsible for providing transportation. Drivers shall make every effort to provide physical assistance to persons requiring help in and out of vehicles and buildings and be trained to respond to medical emergencies.
2. All DADC participants shall have a physical exam within six months of program admission. Staff shall establish a care plan objective to work with families to obtain a current medical evaluation. The physician's written authorization and recommendations for activity participation, medication and diet shall be obtained within one month of entering DADC.
3. The program shall demonstrate evidence of outreach services to non-enrolled families through home visits, follow-up phone calls and dissemination of printed materials that clearly describe services provided by the program.
4. The program shall demonstrate evidence of providing opportunities for care givers to discuss concerns, feelings, physical care and stress management techniques via case consultation, care conferences or supportive counseling.
5. The program shall demonstrate evidence of providing care giver information and education about dementia or to assist care givers in obtaining it through referral to local self-help organizations, or dementia resource libraries regarding:



- a. Diagnosis, stages/progression of dementia conditions, aspects of Alzheimer's disease that lead to forgetfulness, misperceptions or misidentification of objects or people.
  - b. Task breakdown, verbal/nonverbal communication approaches and emphasis upon areas of strength and remaining capacity.
  - c. Financial, legal and placement planning considerations.
6. The program shall demonstrate awareness of and referral to other support services as needed, such as family support groups of the Alzheimer's Association, Parkinson's and Huntington's Disease Foundations; in-home, congregate and overnight respite; home-based nursing and personal care services; benefit entitlement programs; and brain autopsy services.
7. The program shall have clear provisions for ensuring the availability of crisis response services for persons with dementia and their families. If this service is not provided directly by the host agency, there is evidence of a formal arrangement with the local community mental health board or center to provide the service.

Availability of crisis services includes the capacity for the program to address situations such as:

- (1) Illness or death of the primary care giver.
  - (2) Suicidal ideation of the care giver or person with dementia.
  - (3) Abusive behavior of the person with dementia or care giver; neglect or exploitation as defined by the Michigan Department of Human Services.
  - (4) Adverse incident during the delivery of service.
8. DADC program staff shall be trained in crisis procedures.
- Staff shall notify the program supervisor of any physical or behavioral changes in a program participant or care giver that may warrant further evaluation or medical attention. Staff shall advise the care giver to seek professional consultation or medical attention for the identified concern.
9. The DADC program shall have a policy to address potential waiting lists. The program supervisor is responsible for monitoring service usage on a weekly basis and contacting families bi-monthly that may be on a waiting list, to apprise them of their status. The program shall demonstrate efforts to provide case consultation to such families to assist care givers in developing a provisional plan of care and refer them to other appropriate services, as available.

Participant and family preferences shall be given consideration in scheduling respite services.

10. The DADC program should have established admission criteria, which includes the following:

- a. Persons with a diagnosis of Alzheimer’s disease or other type of dementia. Other persons who display symptoms of dementia yet have not undergone a diagnostic evaluation may be considered for admission with the provision that written confirmation of diagnosis by a physician shall be obtained within 90 days of admission. Persons with dementia shall constitute the majority of participants.
- b. Persons demonstrating significant impairments in cognition, communication and personal care activities of daily living that may require one or more of the following:
  - 1. Modifications in environmental cues, communication approach and task breakdown to enhance comprehension and participation in identified activities.
  - 2. Supervision to maintain personal safety.
  - 3. Hands-on assistance to perform activities of toileting, grooming, hygiene and bathing.
- c. Person is responsive to redirection and other supportive verbal interventions when angry, anxious, lost or upset.
- d. Person does not have an acute medical illness.
- e. Person is free of communicable respiratory disease and hepatitis.
- f. Client’s family understands and is willing to comply with program policies related to participation in service planning, communication of status changes or planned absences, and payment of fees.

11. The DADC program coordinator shall meet certain staffing requirements:

- a. Each dementia respite program shall have a coordinator who possesses both formal education and prior work experience commensurate with the responsibilities of program development and operation; supervision and training of staff; interagency relations; coordination and maintenance of all appropriate administrative, program and client records. He or she shall be responsible for assuring that full-time coverage is provided during hours of program operation.
- b. The program coordinator shall ensure that individual and group supervision is provided at regularly scheduled intervals.
- c. A person who has at minimum, a bachelor’s degree in health or human services, gerontology or related field, shall supervise all dementia respite program personnel.
- d. Inexperienced personnel shall complete dementia care training prior to being scheduled to work with clients.
- e. All program personnel shall be knowledgeable about Alzheimer’s disease and other related dementias and demonstrate the ability to communicate effectively with people who have dementia.

12. The DADC program shall meet the following requirements:

- a. Use a mixture of both structured and unstructured 1:1 and small group activities that stimulate multiple senses, reminisce and draw upon remaining capacities.
- b. Tailor activities to the functional and cognitive level of individual participants.
- c. Provide a supportive environment which reduces the level of participant anxiety, inactivity and promotes a sense of personhood and identity.

13. The program shall arrange to use program consultants, as necessary, such as medical and mental health professionals, environmental specialists and other therapists. DADC programs shall work toward developing the following as necessary:
  - a. RN (or LPN under RN supervision) to provide physical health and support services a minimum of four hours/month.
  - b. Social worker or certified counselor to coordinate and provide counseling and linkage for a minimum of four hours/month.
  - c. Arrangements to access cognitive and psychiatric specialists to evaluate difficult behaviors and to develop alternative interventions for care givers to try.
  - d. Arrangements to access physical, speech and occupational therapies.
14. The DADC programs shall have a minimum staff/volunteer/student participant ratio of 1:3. At least one staff shall be on site at all times when participants are in attendance.
15. All persons responsible for transporting clients shall have a valid driver's license or chauffeur's license, as required by the Michigan Secretary of State; a safe driving record with not more than three points; and training with valid certification in first aid and CPR.
16. All DADC programs shall have a formal staff development program.
  - a. All staff shall complete an initial training program that includes content in the following areas:
    - 1 Normal aging vs. Alzheimer's disease and related conditions
    - 2 Impact of Alzheimer's disease and related disorders upon the person with dementia and family care givers
    - 3 Communication enhancement techniques
    - 4 Assessment and management of difficult behaviors
    - 5 Physical care techniques related to activities of daily living
    - 6 Emergency response procedures
    - 7 Access to assessment, care giver information and education
    - 8 Access to information and referral to other community services
    - 9 Therapeutic 1:1 and small group activities
    10. Environmental modification and home safety
    11. Adult protective services law
    12. Recipient rights.
  - b. All personnel shall attend, at a minimum, two in-service training programs per year after completing the initial training program above.
  - c. All personnel shall be required to participate in staff meetings, individual and group supervisory conferences, as scheduled, to develop their knowledge and expertise.

17. All DADC programs shall have specific training for volunteers and students:
  - a. This training should include:
    1. Normal aging vs. Alzheimer's disease and related conditions
    2. Impact of Alzheimer's disease and related disorders upon the person with dementia and family care givers
    3. Communication enhancement techniques
    4. Assessment and management of difficult behaviors
    5. Physical care techniques related to activities of daily living
    6. Emergency response procedures (e.g., first aid, arranging for EMS)
    7. Assessment, care giver information and education
    8. Information and referral to other community services
    9. Therapeutic 1:1 and small group activities
    10. Environmental modification and home safety
    11. Adult protective services law
    12. Recipient rights.

<b>Service Name</b>	Congregate Meals
<b>Service Number</b>	C-3
<b>Service Category</b>	Community
<b>Service Definition</b>	The provision of nutritious meals to older individuals in congregate settings.
<b>Unit of Service</b>	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.
- The activity must be sponsored by an aging network agency/group, for example, Council/Commission on Aging, senior center, etc.
  - The sponsoring agency has worked with the nutrition provider to meet the meal standards.
  - The activity, including the meal, must be open to all eligible participants.
  - The take away meal must meet all the requirements of food safety and be foods that are low-risk for food-borne illness.
  - Local health department rules and regulations, if any, supersede this standard and must be followed.
  - The meal site must provide written notification to the AAA nutrition program staff person prior to the event.
  - 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:

- The participant eats the regularly scheduled meal at the meal site; and
- 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:

- The participant is registered at the meal site and eats meals at the regularly scheduled time during the week; and
- 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)

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

**OPERATING STANDARDS FOR SERVICE PROGRAMS**

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. If 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.

<b>Service Name</b>	Nutrition Counseling
<b>Service Number</b>	C-4
<b>Service Category</b>	Community
<b>Service Definition</b>	Provision of individualized advice and guidance to individuals, who are at nutritional risk because of health and/or nutritional history, dietary intake, medications use or chronic illness, about options and methods for improving their nutritional status.
<b>Unit of Service</b>	One hour of advice and guidance.

Minimum Standards

1. Nutrition counseling services shall be performed by a registered dietitian.
2. Each program shall conduct an individual assessment of need for each client which includes at a minimum: nutritional history; both chronic and acute health problems; and, a listing of all prescription and over the counter medications being taken including vitamin and mineral supplements and any herbal treatments being used.
3. Each program shall develop a nutritional care plan for each client based on the individual assessment of need that includes at a minimum:
  - a. A statement of the client’s problems, needs, strengths, and resources.
  - b. Specific goals and objectives for the client.
  - b. Descriptions of methods and approaches to be used.
  - d. Identification of other community resources currently being utilized by the client.
  - e. Current treatment orders, if any, from client’s physician including special diets and orders for liquid nutrition supplements.
4. Each program shall be able and prepared to offer services in a variety of settings including the client’s residence as well as community-based settings.

<b>Service Name</b>	Nutrition Education
<b>Service Number</b>	C-5
<b>Service Category</b>	Community
<b>Service Definition</b>	An educational program which promotes better health by providing culturally sensitive nutrition information (which may also address physical fitness and related health issues) and instruction to participants, and/or caregivers, in group or individual settings.
<b>Unit of Service</b>	One educational session.

Minimum Standards

1. Nutrition education services shall be provided by, or be supervised by, a registered dietician or an individual with comparable expertise.
2. Each program shall establish linkages with local sources of information that meet the standards for accuracy and reliability as set by the American Dietetic Association. Programs may incorporate the purchase of fresh produce as a component of nutrition education services.
3. Nutrition education sessions shall be conducted at senior centers and congregate meal sites, to the extent feasible.

Aging and Adult Services Agency  
**OPERATING STANDARDS FOR SERVICE PROGRAMS**

<b>Service Name</b>	Disease Prevention and Health Promotion
<b>Service Number</b>	C-6
<b>Service Category</b>	Community
<b>Service Definition</b>	<p>A service program that provides information and support to older individuals with the intent of assisting them in avoiding illness and improving health status.</p> <p>Allowable programs include:</p> <ul style="list-style-type: none"> <li>• Health Risk Assessments</li> <li>• Health Promotion Programs</li> <li>• Physical Fitness, group exercise, music, art, dance movement therapy; programs for Multi-Generational Participation</li> <li>• Medication management, screening, and education to prevent incorrect medication and adverse drug reactions</li> <li>• Mental Health Screening Programs</li> <li>• Education programs pertaining to the use of Preventative Health Services covered under Title XVIII of the Social Security Act</li> <li>• Information programs concerning diagnosis, prevention, treatment and rehabilitation of age related diseases and chronic disabling conditions</li> </ul>
<b>Unit of Service</b>	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.



## OPERATING STANDARDS FOR SERVICE PROGRAMS

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*.

<b>Service Name</b>	Health Screening
<b>Service Number</b>	C-7
<b>Service Category</b>	Community
<b>Service Definition</b>	A systematic screening of an older individual's health status, supervised by a registered nurse, in order to identify and/or monitor actual and potential health problems and to determine if referral for medical intervention is indicated.
<b>Unit of Service</b>	One complete health screening for each client, including referral and follow-up. Should not exceed one time per year per client.

Minimum Standards

1. Each client shall receive an annual physical, social and psychological assessment which shall include:

(NOTE: Assessors shall attempt to acquire each item of information listed below but must recognize and accept the client's right to refuse to provide requested items.)

- a. Basic Information (may be completed by client)

1. Individual's name, address and phone number
2. Name, address and phone number of person to contact in case of emergency.
3. Gender
4. Age and date of birth
5. Race and/or ethnicity
6. Living arrangement
7. Type of housing
8. Whether or not individual's income is below the poverty level and/or sources of income (particularly SSI and GA)
9. Date of last physical by a physician.

- b. Health History (can be completed by client)

1. History of illnesses, injuries, health problems, and abnormal signs and symptoms
2. Limitations in activities of daily living
3. Health habits including eating patterns, smoking, and alcohol intake
4. Allergies to medicine, food, etc.
5. Prescription medications and over-the-counter medications currently taken
6. Other treatments and orders by a physician
7. Names of all current physicians and when last seen by each

8. Health or support services currently received or received in the past
9. Social and psychological history
- c. Nurse Assessment (by an RN including review of the client's health history)
  1. Physical Status (visual review)
    - a. Edema in lower extremities
    - b. Stability of walking
    - c. Shortness of breath
  2. Mental and social status.
  3. Abnormal signs or symptoms observed by the RN and reported by client.
  4. Review of results of screening tests.
  5. Vision
    - a. Date of last eye exam
    - b. Condition of glasses
    - c. Age of glasses
    - d. Able to read
    - e. Able to drive
  6. Hearing
    - a. Date of last hearing exam
    - b. Does the assessor have to shout
    - c. Does the client read lips
  7. Hearing Appliance Used
    - a. Condition of hearing aid
    - b. Check for wax in ears
  8. Dental
    - a. Date of last dental exam
    - b. Condition of dental hygiene
2. Each program shall offer or otherwise provide for the following annual screening tests or procedures (a client may choose not to participate in one or more tests):
  - a. Vital signs-temperature, pulse, respiration and blood pressure.
  - b. Hemoglobin or hematocrit
  - c. Stool sample for blood detection
  - d. Height and weight
  - e. Breast exam or instruction in breast exam

- f. Urine test
  - g. Tuberculosis skin test
  - h. Influenza immunization
  - i. Referral for mammogram and pap test as appropriate
  - j. Pneumonia vaccine
  - k. Information on prostate exams
  - l. Referral for dental exams if needed
3. Each program may offer the following annual screening tests or procedures:
- a. Tetanus and diphtheria immunizations
  - b. Random plasma glucose if venous blood draws are done in a non-fasting state or fasting plasma glucose if venous blood draws are done in a fasting state
  - c. Blood chemistry
  - d. Hearing test
  - e. Vision test
  - f. Glaucoma test
  - g. Yearly urinalysis and serum cretin
4. All health screening tests and immunizations shall be done under the on-site supervision of a registered nurse.
5. The program shall be able to offer basic health information in response to screening results and to make referrals for medical intervention as indicated.
6. A follow-up contact with the client shall be made on referrals for medical intervention within 30 days. If the client chooses not to seek medical intervention, an appropriate notation shall be made on his/her screening records. Follow-up shall be made on all annual screens.
7. Each program shall maintain complete records for each client screening including at a minimum:
- a. The annual physical, social and psychological assessment
  - b. Results of tests
  - c. Immunizations received
  - d. Notes in response to follow-up client contact.

Aging and Adult Services Agency  
**OPERATING STANDARDS FOR SERVICE PROGRAMS**

<b>Service Name</b>	Assistance to the Hearing Impaired and Deaf Community
<b>Service Number</b>	C-8
<b>Service Category</b>	Community
<b>Service Definition</b>	Provision of assistance to older persons with hearing impairments or who are deaf, to enable them to better compensate for these losses in daily life. Allowable activities include: education/training relative to community services for rights and benefits of hearing impaired and deaf persons; assistance in obtaining benefits and services; training in techniques for adjusting lifestyle and living arrangements in response to hearing impairments and deafness; and community education on hearing impairments, and deafness and prevention.
<b>Unit of Service</b>	One hour of allowable support activities or each community education session.

Minimum Standards

1. Each program shall have staff who are fluent in American Sign Language and other communication modes suitable to the deaf and hearing impaired.
2. Each program shall establish linkages with other local and state-wide programs offering services to the hearing impaired and have knowledge of the deaf community culture.
3. Each program shall make services available throughout the geographic target area. Service providers must identify sites where services will be delivered and develop a schedule for site-specific service delivery.

<b>Service Name</b>	Home Repair
<b>Service Number</b>	C-9
<b>Service Category</b>	Community
<b>Service Definition</b>	<p>Permanent improvement to an older person's home to prevent or remedy a sub-standard condition or safety hazard. Home Repair Service offers permanent restoration and/or renovation to extend the life of the home and may involve structural changes. Home repair does not involve making aesthetic improvements to a home, temporary repairs, chore or home maintenance that must be repeated. Allowable home repair tasks include:</p> <ul style="list-style-type: none"> <li>• roof repair/replacement</li> <li>• siding repair/replacement</li> <li>• door and window repair/replacement</li> <li>• foundation repair/replacement</li> <li>• floor repair/replacement</li> <li>• interior wall repair</li> <li>• plumbing and drain repair/replacement</li> <li>• insulating/weatherization (including water heater wrap, low-flow shower head, socket sealers, draft stoppers and door sweeps)</li> <li>• stair and exterior step repair/replacement</li> <li>• heating system repair/replacement</li> <li>• ensuring safe and adequate water supply</li> <li>• electrical wiring repair/replacement</li> <li>• obtaining building permits</li> <li>• painting to prevent deterioration in conjunction with repairs</li> </ul>
<b>Unit of Service</b>	Performance of one hour of allowable home repair tasks.

Minimum Standards

1. Home repair services may not be provided on rental property.
2. Each home repair program, prior to initiating service, shall determine whether a potential client is eligible to receive services through a program supported by other funding sources, particularly programs funded through the Social Security Act. If it appears that an individual can be served through other resources, an appropriate referral should be made.

**OPERATING STANDARDS FOR SERVICE PROGRAMS**

3. Each program shall develop working relationships with weatherization, chore and housing assistance service providers, as available, in the program area to ensure effective coordination of efforts.
4. Funds awarded for home repair service may be used for labor costs and to purchase materials used to complete the home repair tasks to prevent or remedy a sub-standard condition or safety hazard. The program shall establish a limit on the amount to be spent on any one house in a 12-month period. Equipment or tools needed to perform home repair tasks may be purchased or rented with funds from AASA up to an amount equal to 10% of total grant funds.
5. Each program shall maintain a record of homes repaired including dates, tasks performed, materials used and cost.
6. The program shall check each home to be repaired for compliance with local building codes. No repairs may be made to a condemned structure.
7. Each program shall utilize a job completion procedure which includes:
  - a. Verification that work is complete and correct.
  - b. Verification by a local building inspector(s) that the work satisfies building codes.
  - c. Acknowledgement by the home owner that the work is acceptable, within ten days of completion.
8. The program shall utilize a written agreement with the owner (purchaser) of each home to be repaired which includes at a minimum:
  - a. A statement that the home is occupied and is the permanent residence of the owner.
  - b. A statement that in the event that the home is sold within two years of completion of work by the program, the owner will reimburse the program the full cost of repairs made to the home.
  - c. Specification of the repairs to be made by the program is to be provided.
9. Each program shall establish and utilize written criteria for prioritizing homes to be repaired which address the condition of the home, client need and appropriateness of the requested repairs.

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**OPERATING STANDARDS FOR SERVICE PROGRAMS**

<b>Service Name</b>	Legal Assistance
<b>Service Number</b>	C-10
<b>Service Category</b>	Community
<b>Service Definition</b>	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).
<b>Allowable Service Components</b>	<p><b>Intake.</b> The initial interview to collect demographic data and identification of the client’s legal difficulties and questions.</p> <p><b>Advice and Counsel.</b> Where the client is offered an informed opinion, possible course of action and clarifications of his/her rights under the law.</p> <p><b>Referral.</b> 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.</p> <p><b>Representation.</b> 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.</p> <p><b>Legal Research.</b> 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.</p> <p><b>Preparation of Legal Documents.</b> Documents such as contracts, wills, powers of attorney, leases, or other documents may be prepared and executed by legal assistance programs.</p> <p><b>Negotiation.</b> Within the rules of professional responsibility, program staff may contact other persons concerned with the client’s legal</p>



<b>Allowable Service Components (cont.)</b>	<p>problem in order to clarify factual or legal contentions and possibly reach an agreement to settle legal claims or obtain services and supports.</p> <p><b>Legal Education.</b> 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.</p> <p><b>Community Collaboration and Planning.</b> 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.</p>
<b>Unit of Service</b>	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.

**OPERATING STANDARDS FOR SERVICE PROGRAMS**

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.

<b>Service Name</b>	Long Term Care Ombudsman/Advocacy
<b>Service Number</b>	C-11
<b>Service Category</b>	Community
<b>Service Definition</b>	<p>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.</p> <p><b>Consultation/Family Support.</b> Provision of assistance to older adults and their families in understanding, identifying, locating, evaluating and/or obtaining long term care services.</p> <p><b>Complaint Investigation/Advocacy.</b> 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.</p> <p><b>Non-Complaint Related Facility Visits.</b> Quarterly visits to each long-term care facility in the project area. More frequent visits may occur where problems exist.</p> <p><b>Community Education.</b> 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.</p> <p><b>Volunteer Support.</b> Conduct of recruitment, training, supervision, and ongoing support activities related to volunteer advocates assigned to assist residents of identified long term care facilities.</p>

<b>Unit of Service</b>	Each hour of family support, complaint investigation/advocacy, community education or volunteer support activities, including travel time to and from long term care facilities.
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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 (MMAAP) 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.

<b>Service Name</b>	Senior Center Operations
<b>Service Number</b>	C-12
<b>Service Category</b>	Community
<b>Service Definition</b>	Provision of support for the operation of a senior center. A senior center is defined as a community facility where older persons can come together for services and activities which enhance their dignity, support their independence and encourage their involvement in and with the community.
<b>Unit of Service</b>	One hour of senior center operation.

**Minimum Standards**

1. Each senior center shall be certified as an accessible facility. Accessibility is defined as the ability of a person with a disability to enter the facility, use the restroom and receive service that is at least equal in quality to that provided to able-bodied participants.
2. Each senior center shall be open a minimum of three days per week and at least 24 hours per week.
3. Each senior center shall be a meal site for a congregate nutrition program funded through Title III, Part C, of the Older Americans Act.
4. Each senior center shall provide directly or make arrangements for the provision of the following services:
  - a. Outreach
  - b. Information and assistance
  - c. Socialization/recreation
  - d. Education
  - e. Volunteer opportunities

It is not required that such service provision be reported to AASA.

5. Each senior center shall demonstrate that it is in compliance with fire safety standards and applicable Michigan and local public health codes regulating food service establishments.
6. Each senior center shall document that appropriate preparation has taken place for procedures to be followed in case of an emergency including:

- a. An annual fire drill.
  - b. Posting and training of staff and regular volunteers on procedures to be followed in the event of severe weather or a natural disaster.
  - c. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency.
7. Each senior center shall be appropriately incorporated under Michigan law or be operated by an organization which is appropriately incorporated or a local unit of government. Each senior center should seek 501 (c)(3) tax exemption unless prohibited by the nature of its incorporation.
  8. Each senior center shall strive to adhere to the Principles for the Operation of Senior Centers as established by the National Institute of Senior Centers.
  9. Each senior center shall provide an opportunity for center participants to have input regarding the governance of the center at the policy making level as well as in daily operations.
  10. Allowable senior center operational costs are limited to:
    - a. Rent
    - b. Utilities
    - c. Communications
    - d. Insurance
    - e. Custodial services
    - f. Ground maintenance
    - g. Supplies



<b>Service Name</b>	Senior Center Staffing
<b>Service Number</b>	C-13
<b>Service Category</b>	Community
<b>Service Definition</b>	Provision of funding to support staff positions at a senior center which may include a senior center director, a senior center program coordinator or a senior center specialist.
<b>Unit of Service</b>	One hour of staff time worked.

Minimum Standards

1. Each program shall strive to adhere to the Principles for the Operation of Senior Centers as established by the National Institute of Senior Centers.
2. Where the program supports a senior center director position, the person occupying this position shall have the authority to perform administrative functions of the senior center.
3. Where the program supports a senior center program coordinator position, the person occupying this position shall be involved in the development of three or more programs at any given time.
4. Where the program supports a senior center specialist position, the person occupying this position shall oversee the operation of a variety of programs and/or services within the senior center.
5. Allowable senior center staffing costs are limited to:
  - a. Wages
  - b. Fringes
  - c. Travel
  - d. Training
  - e. Supplies (not to exceed \$200 for each position to be used only in support of that position).

<b>Service Name</b>	Vision Services
<b>Service Number</b>	C-14
<b>Service Category</b>	Community
<b>Service Definition</b>	<p>Provision of specialized vision services for the visually impaired and older blind persons which include:</p> <ul style="list-style-type: none"> <li>• orientation and mobility training</li> <li>• rehabilitation for activities of daily living (ADL)*</li> <li>• optometric services to help persons with severe vision loss to utilize remaining vision as effectively as possible</li> <li>• group education on prevention of or adjustment to visual impairment</li> </ul> <p>*ADL includes personal hygiene and grooming, meal preparation and kitchen safety, homemaking and leisure pursuits.</p>
<b>Unit of Service</b>	One hour of service provided or one group education session.

**Minimum Standards**

1. Program staff providing rehabilitation training shall have experience and be trained in communication skills including Braille, typing, handwriting, use of recording devices, telephone dialing, manual alphabet and other appropriate skills.
2. Program staff providing orientation and mobility training shall have experience and be trained in techniques, methods, and use of travel aids to visually impaired clients.
3. Optometric services shall be provided by an optometrist that has graduated from an accredited College of Optometry and is licensed to practice optometry in Michigan.
4. The program shall have a coordinator with a minimum of a bachelor degree in Blind Rehabilitation, Occupational Therapy, Rehabilitation Teaching or a related field.
5. Each vision services program shall demonstrate working relationships with other local agencies and organizations offering programs for the blind and with the Commission for the Blind of the Michigan Department of Human Services.

Aging and Adult Services Agency  
**OPERATING STANDARDS FOR SERVICE PROGRAMS**

<b>Service Name</b>	Programs for Prevention of Elder Abuse, Neglect, and Exploitation
<b>Service Number</b>	C-15
<b>Service Category</b>	Community
<b>Service Definition</b>	Activities to develop, strengthen, and carry-out programs for the prevention and treatment of elder abuse, neglect, and exploitation
<b>Unit of Service</b>	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.

<b>Service Name</b>	Counseling Services
<b>Service Number</b>	C-16
<b>Service Category</b>	Community
<b>Service Definition</b>	Professional counseling services provided to older adults, and National Family Caregiver Support Program (NFCSP) eligible caregivers, in order to prevent or treat problems which may be related to psychological and/or psychosocial dysfunction.  The program may also establish peer-counseling programs that utilize older adults as volunteer counselors.
<b>Unit of Service</b>	Each hour of counseling services (including direct client contact and indirect client support). (Indirect client support means information gathering, maintenance of case records, and supervisory consultation on behalf of the client.)

updated 3-17-06

**Minimum Standards**

1. Each program shall conduct a comprehensive assessment of each client which addresses social and psychological function.
2. A treatment plan shall be developed for each client based on the comprehensive assessment. The treatment plan shall be developed in cooperation with and be approved by the client, and/or the client's guardian or designated representative. The treatment 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 the methods and/or approaches to be used.
  - d. Identification of services to be obtained/provided from other community agencies.
  - e. Treatment orders of qualified health professionals, when applicable.

Each program shall have a written policy and procedure to govern the development, implementation and management of treatment plans.

3. The program may provide individual, family and/or group counseling sessions. Family members of clients are eligible for family counseling when appropriate to resolve the problems of the client.
4. The program shall have the flexibility to provide services in a range of settings, appropriate to the client's needs.

## OPERATING STANDARDS FOR SERVICE PROGRAMS

5. Paid staff counselors must have appropriate education and experience and be licensed to practice in the State of Michigan.
6. The program may utilize volunteer peer counselors who are appropriately trained and supervised by paid program staff.
7. The program shall assure that case supervision is available on a weekly basis for each staff counselor. All open cases shall undergo a quarterly case review by the respective staff counselor and appropriate supervisory staff.

<b>Service Name</b>	Creating Confident Caregivers® (CCC)
<b>Service Number</b>	C-17
<b>Service Category</b>	Community
<b>Service Definition</b>	<p>Creating Confident Caregivers® uses the Savvy Caregiver Program, an evidence-based group intervention for informal caregivers of persons with dementia.</p> <p>Eligible participants are active, informal caregivers of persons with dementia/memory loss who are living at home.</p>
<b>Unit of Service</b>	<ul style="list-style-type: none"> <li>• One hour of session attendance by a participant.</li> <li>• One hour of respite care provided for care recipient while a participant attends sessions.</li> <li>• One hour of fidelity/program meeting/calls, monitoring visits, or training other trainers by master trainers.</li> </ul>

**Minimum Standards**

1. Participants must be active, informal caregivers of a person with dementia/ memory loss who lives in a private home, not a paid care facility, such as a nursing home, adult foster care home or home for the aged.
2. The program must use the Savvy Caregiver manual, audio-visual, and printed materials provided to the Aging and Adult Services Agency (AASA) by the program developers.
3. The program is provided consistent with established protocols to maintain fidelity.
4. The program format is six, two-hour weekly sessions.
5. Each CCC Program is provided by a trainer who completed an AASA-approved training program.
6. Each CCC master trainer is certified by the Michigan Commission on Services to the Aging. Certification is for a two-year period based upon training skills, knowledge of the program and ability to monitor program trainers.
7. Each region must use a CCC master trainer to monitor program trainers for consistency and fidelity to the Savvy Caregiver program content.
8. AAAs will collect program documents, e.g., CCC demographic sheet, attendance list and participant evaluation, from trainers and submit them to AASA.

Aging and Adult Services Agency  
**OPERATING STANDARDS FOR SERVICE PROGRAMS**

<b>Service Name</b>	Caregiver Supplemental Services
<b>Service Number</b>	C-18
<b>Service Category</b>	Community
<b>Service Definition</b>	A program intended to provide goods and services to support caregivers (including kinship caregivers), in response to needs that cannot otherwise be met.
<b>Unit of Service</b>	One good or service purchased or each hour of related service provision.

Updated 7-17-20

**Minimum Standards**

1. Each program must maintain linkage with caregiver focal points, as available, within the PSA.
2. Programs may offer Caregiver Supplemental Services to caregivers of any age when the care recipient is aged 60 or over and is unable to perform at least two activities of daily living or requires substantial supervision due to a cognitive or other mental impairment. Programs may offer Caregiver Supplemental Services to individuals aged 55 and over who are kinship caregivers for a child no more than 18 years old.
3. Payments directly to family caregivers are not permitted.

<b>Service Name</b>	Kinship Support Services
<b>Service Number</b>	C-19
<b>Service Category</b>	Community
<b>Service Definition</b>	Provision of support services (which include respite care, supplemental and education, support and training services) in kinship care situations where an individual aged 55 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.
<b>Unit of Service</b>	Each hour of support services provided, or each activity session, as appropriate.

updated 7-17-20

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.



<b>Service Name</b>	Caregiver Education, Support and Training
<b>Service Number</b>	C-20
<b>Service Category</b>	Community
<b>Service Definition</b>	<p>A program intended to provide assistance to caregivers in understanding and coping with a broad range of issues associated with caregiving. Allowable programs include:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Initiatives, which provide support activities for caregivers (including kinship caregivers), i.e., support groups, counseling, information and assistance in connecting with community resources, etc.</li> <li>• 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.</li> </ul>
<b>Unit of Service</b>	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.