Michigan Department of Health and Human Services
Bureau of Aging, Community Living, and Supports
OPERATING STANDARDS FOR SERVICE PROGRAMS

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I. INTRODUCTION AND INSTRUCTIONS FOR USE

The Michigan Department of Health and Human Services (MDHHS), Bureau of Aging, Community Living, and Supports (ACLS Bureau), 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 ACLS Bureau, 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 (OAA), 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, the ACLS Bureau began developing and adopting more explicit state policies which included: Minimum Standards for Congregate Meals, Home Delivered Meals, Adult Day Care, In-HomeServices 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 ACLS Bureau 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.

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

Updated September 15, 2025

Authority Reference

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

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

Required Program Components

A. Contractual Agreement

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

B. Compliance with Service Definitions

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

C. Eligibility

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

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

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

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.

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

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.

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

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)

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

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 or cause to be conducted a criminal background check that reveals information similar or substantially similar to information found on an Internet Criminal History Access Tool (ICHAT) check and a national and state sex offender registry check for each new employee, employee, subcontractor, subcontractor employee, and volunteer who has in-person client contact, in-home client contact, access to a client's personal property, or access to confidential client information:

- ✓ ICHAT: http://apps.michigan.gov/ichat
- ✓ Michigan Public Sex Offender Registry: http://www.mipsor.state.mi.us
- ✓ National Sex Offender Registry: http://www.nsopw.gov

1. Criminal background checks for new hires must be completed prior to the individual working directly with clients or having access to a client's personal property or confidential client information.

2. All Programs are required to update criminal background checks for all employees and volunteers every three years to identify convictions in the event they occur while an individual is employed or providing volunteer service:

   a. All employees and volunteers hired prior to the effective date of this policy must be re-screened within 90 days from the effective date of this policy. Thereafter, criminal background checks for these employees and volunteers must be completed no later than 30 days after every third anniversary from the date of their last background check.

   b. Updated criminal background checks for employees and volunteers hired after the effective date of this policy must be completed no later than 30 days after every third anniversary of their date of hire.

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

c. The use of information obtained from a criminal background check shall be restricted to determining suitability for employment and/or volunteer opportunities. All programs are required to maintain a copy of the results of each criminal background check for paid and volunteer staff in a confidential and controlled access file. The information should not be used in violation of any applicable Federal or State equal employment opportunity law or regulation.

4. Exclusions No employee or volunteer shall be permitted to work directly with clients or have access to a client's personal property or confidential client information if:

a Mandatory Exclusions The results of the criminal background check show that the person has a federal or state felony conviction related to one or more of the following crimes:

- Crimes against a "vulnerable adult" as set forth in MCL 750.145n *et seq*.,
- Violent crimes including, but not limited to, murder, manslaughter, kidnapping, arson, assault, battery, and domestic violence,
- Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion,
- Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution,
- Cruelty or torture,
- Abuse or neglect, or
- Felony involving the use of a firearm or dangerous weapon.

b. Felony Convictions The results of the criminal background check show that the person has a federal or state felony conviction within the preceding 10 years from the date of the background check, including but not limited to:

- Crimes involving state, federal, or local government assistance programs,
- Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion; or
- Drug crimes including, but not limited to, possession, delivery, and manufacturing.

c. Misdemeanor Convictions: The results of the criminal background check show that the person has a federal or state misdemeanor conviction within the preceding 5 years from the date of the background check, including but not limited to:

- Crimes involving state, federal, or local government assistance programs,
- Crimes against a "vulnerable adult" as set forth in MCL 750.145n *et. seq.,*
- Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion,
- Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion,
- Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution,

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

- Drug crimes including, but not limited to, possession, delivery, and manufacturing,
- Cruelty or torture,
- Abuse or neglect,
- Home invasion,
- Assault or battery; or
- Misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.

7. For purposes of the excluded offenses identified above, an individual is considered to have been convicted of a criminal offense when:
   - A judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending,
   - There has been a finding of guilt against the individual by a federal, state, tribal or local court, or
   - A plea of guilty or nolo contendere by the individual has been accepted by a federal, state, tribal or local court.

   Arrest records, by themselves, do not disqualify an individual.

8. All programs are required to maintain documentation of all criminal background checks, including a list of all paid and volunteer staff that are subject to this policy, the date of the most recently completed criminal background check, and the source of the background check. Employees hired prior to the effective date of this policy are not exempt from this requirement.

9. The ACLS Bureau does not consider Senior Community Service Employment Program (SCSEP)enrollees to be *employees* or *volunteers* for the purposes of this policy. Rather, SCSEP enrollees are participants in a federal employment and training program funded by the U.S. Department of Labor (USDoL). As such, Programs that serve as a host agency for SCSEP participants are advised to comply with the USDoL policy described below:

   "Grantees may take the responsibility of providing background checks before placing participants in community service assignments, provided that the background check is conducted because of the requirements of a specific community service assignment, rather than based on a particular participant, and is consistently applied to all applicants considered for that position. We stress that background checks are relevant to the assignment of participants to particular host agency positions only and cannot be used as a basis for denying eligibility. In addition, grantees should be careful to comply with EEOC and any state or local rules regarding the use of background checks."

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS (CONT'*D)*

10. All programs are required to maintain documentation of all criminal background checks, including a list of all paid and volunteer staff that are subject to this policy, the date of the most recently completed criminal background check, and the source of the background check. Employees hired prior to the effective date of this policy are not exempt from this requirement.

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 ACLS Bureau, 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.

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

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 an 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.

II. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS *(CONT'D)*

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.

Y. Supplement, not Supplant

Each program must ensure funds are used to supplement, not supplant, existing federal state, and local funds to support OAA-funded services in compliance with the Older Americans Act. In addition, the programs must ensure any voluntary contributions are used to expand services for which the contributions were received.

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS

OVERVIEW

The Aging Nutrition Program was established by the Older Americans Act [42 U.S. Code Chapter 35, Subchapter 3, Part C – Nutrition Services] to:

- Reduce hunger, food insecurity, and malnutrition;
- Promote socialization of older individuals; and
- Promote the health and well-being of older individuals and delay the onset or progression of adverse health conditions through access to nutrition and other disease prevention and health promotion services.

Congregate Nutrition Services [Title III-C1], established in 1972, and Home-Delivered Nutrition Services [Title III-C2], established in 1978, provide meals and related nutrition services to older individuals in a variety of settings, including congregate facilities such as senior centers, or by home-delivery to prioritized older individuals who are at greatest nutrition risk due to illness, disability, or geographic isolation.

Services are targeted to those in greatest social and economic need with particular attention to low-income individuals, minority individuals, those in rural communities, those with limited English proficiency, and those at risk of institutional care. Older American Act (OAA) nutrition services programs help older individuals remain independent and in their communities.

The following nutrition service standards are encompassed within Health Services, Bureau of Aging, Community Living and Supports (ACLS Bureau) nutrition program services:

- B-5 Home-Delivered Meals
- B-12 Carry-Out Meals
- C-3 Congregate Meals
- C-4 Nutrition Counseling
- C-5 Nutrition Education
- C-25 Supplemental Nutrition Services

The ACLS Bureau 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 increasing food security, lessening

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS (CON'T)

chronic disease risk and improving the overall health of older Michiganders.

Research indicates that in developed countries, the most cited cause for malnutrition is both acute and chronic diseases. Because disease risk typically increases with age, older adults are at the highest risk for malnutrition. 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. **Requests for Proposals**: 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 shall be incorporated into all requests for proposals/bids, contracts, and open solicitations for meals.

2. **Inventory Management**: 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

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

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, HDM, COM, 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.

3. **Nutrition Education**: Monthly nutrition education opportunities shall be made available at each meal site and to COM and HDM participants per program requirements. The emphasis should focus on providing participants the information and tools they need to make healthy food choices that will help prevent and manage chronic disease. Educational sessions should be informative and encourage participants to take responsibility for the food choices they make throughout the day, whether eating at home or eating out. Educational sessions may be provided as presentations, videos, handouts, newsletters, or other person- centered approach.

   Topics shall include, but not be limited to, food, nutrition, and wellness. Nutrition education materials must come from reputable sources. Questions pertaining to the appropriateness of materials and presenters are to be directed to the staff Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN), an individual who registration is eligible, or a Registered Nutrition and Dietetic Technician (NDTR).
   Program materials must consider the literacy level, household status, and caregiver support of the participant. Translation of materials for participants with limited English proficiency should be available.

   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. Healthy eating at home.
   d. Emergency preparedness - What to have on hand.

4. **Assessment of Providers**: Compliance with these standards will be assessed during the annual nutrition assessment of contracted nutrition providers performed by the Area Agency on Aging (AAA).

5. **In-service Training**: 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 be trained as appropriate for the volunteer role. Records shall be maintained which identify the dates of training, topics covered, and persons attending.

6. **Background Checks**: All staff and volunteers, regardless of age, group affiliation, or volunteer frequency, must undergo a background check, in accordance with all ACLS Bureau background check policies outlined in the Operating Standards for All Service Programs.

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

7. **Michigan Food Code**: The nutrition program must operate according to current provisions of the Michigan Food Code.
    a. A copy of the most recent Michigan Food Code, including updates, should be available for reference.
    b. Minimum food safety standards are established by the respective local Health Department.
    c. Programs are encouraged to monitor food safety alerts pertaining to older adults.

8. **Food Protection Manager Certification Training**: Each program that operates a food production kitchen shall have at least one manager, cook, or lead food handler complete a Food Protection 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. Refer to your local Health Department for local regulations.

9. **Food Safety**: Food shall be prepared, held, and served at safe temperatures in accordance with the Michigan Food Code.
    a. Documentation requirements for food safety procedures shall be developed in conjunction with, and be acceptable to, the respective local Health Department.
    b. The safety of food after it has been served to a participant, removed from the meal site, or left in the control of a COM or HDM participant, is the responsibility of that participant.

10. **Purchased Foodstuffs**: The program must purchase foodstuff from commercial sources that comply with the Michigan Food Code.
    a. Unacceptable items include:
        i. Home canned or preserved foods
        ii. Foods cooked or prepared in an individual's home kitchen, including those covered under the Cottage Food Law
        iii. Meat or wild game that is NOT processed by a licensed facility
        iv. Fresh or frozen fish donated by sport fishers
        v. Raw seafood or eggs
        vi. Any unpasteurized products including dairy, juice and honey

11. **Contributed Foodstuffs**: Fresh fruits, vegetables, and wild game from a licensed processor are acceptable contributions.
    a. A list of licensed processors can be found on the MDARD's website: http://www.michigan.gov/MDARDcceptable
    b. Acceptable donated products must be handled and prepared in the same manner as products that are purchased from commercial sources.

12. **Standardized Portions**: Each program shall use standardized portion control

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

procedures to ensure that each meal served is uniform. At the request of a participant, standard portions may be altered to serve less than the standard serving size. A participant may refuse one or more of the food items. At the discretion of the meal site, portions may be increased if supply and budget allow for this consideration.

13. **Food Waste**: Each program shall implement procedures designed to minimize food waste, including leftovers and uneaten meals.

14. **Grantees**: The AAA may adjust the number of nutrition grantees to meet the needs of the region.

15. **Volunteers**: Each meal program may use volunteers, as feasible, in program operations.

16. Nutrition **Services Registration**: Each program shall implement a registration process for each program participant that collects required National Aging Program Information System (NAPIS) data as defined by the ACLS Bureau for the purposes of OAA and Nutrition Services Incentive Program (NSIP) data reporting to the specified federal agency.
    a. The initial registration process shall be completed within ten working days after an individual becomes active in the program and reviewed and updated each fiscal year thereafter.
    b. Participant information may be collected in a variety of ways that includes but is not limited to in-person, by phone, online, paper, electronic means, via kiosk, scan systems, or by proxy. Written procedures should be in place for consistency, confidentiality, and accuracy of data collection.
    c. Nutrition services for which individual participant information is not collected, as defined by the ACLS Bureau, will require reporting of aggregate counts of unduplicated participants by service type.
    d. The completion of a NAPIS registration is not a prerequisite to eligibility and may not be presented to potential participants as a requirement. However, programs should inform participants: that the collected information is voluntary and confidential, of the purpose and value of collecting enrollment information, how the information will be transmitted and stored, and who will have access to the information.

17. **Nutrition Service Unit Documentation**: Each program shall develop a process for documenting participant nutrition service provision that includes, at a minimum, standardized service types and unit measurements, and whether reporting of service units is to be maintained at the individual participant level and/or aggregate service level, as defined by the ACLS Bureau.
    a. Meals eligible to be included in NAPIS meal counts reported to the respective AAA, are those served to eligible individuals, as described under respective

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

congregate, COM and HDM program eligibility criteria, and which meet the specified OAA meal and NSIP eligibility requirements.

b. Mechanisms for tracking nutrition service provision includes but is not limited to, paper, electronic means, via kiosk, scan systems, and by proxy. Written procedures should be in place for consistency, confidentiality, and accuracy of data collection.

18. **Nutrition Services Incentive Program (NSIP)**: The NSIP is authorized by Section 311 of the OAA. The purpose of the NSIP is to provide incentives that encourage and reward effective performance in the efficient delivery of nutritious meals, that meet OAA requirements, to older individuals.
    a. AAAs and their nutrition program service providers are eligible to participate in NSIP. The NSIP provides an allotment of cash to the state for their nutrition programs based on the number of **eligible** Title III-C meals served by the state in the prior federal fiscal 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.
    b. NSIP allocations may only be used to purchase **domestically** produced food that is used in a meal.
    c. Meals counted for purposes of NSIP reporting are those served that meet the Title III-C requirements, including congregate, home-delivered, carry- out, restaurant meal voucher meals, and other innovative delivery models.
    d. NSIP funds should not be used to pay for administration indirect costs, other nutrition services such as education, counseling, oral nutrition supplements, groceries, or food boxes as these do not constitute a meal.
    e. Meals that <u>do not</u> count toward NSIP funding include:
        i. Medicaid (MI-CHOICE Waiver) adult day care meals,
        ii. Adult day care meals for which Child and Adult Care Food Program (7CFR Part 226) funds have been claimed,
        iii. Meals funded by Title III-E served to caregivers under the age of 60, and
        iv. Meals served to individuals under age 60 who pay full price for the meals.
        v. Any meal that does not meet OAA nutritional requirements, including but not limited to special or holiday meals.

        .
    f. Each AAA that has NSIP-only (non-AAA funded) sites must have:
        i. A signed contract or Memorandum of Agreement in place detailing the nutrition requirements for the meal,
        ii. The mechanism for distributing NSIP-only funds, e.g., per meal rate, percentage of total, and
        iii. A written plan for assessment of site based on Title III-C requirements.

19. **Liability Insurance**: Each nutrition program shall carry product liability insurance sufficient to cover its operation.

20. **Voluntary Contributions**: Each program shall be allowed to accept donations for the program per the Code of Federal Regulations (CFR) 45 CFR Part 1321.

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

a. Each program, with input from program participants, shall establish a suggested donation amount that is to be posted at each congregate meal site and provided to COM and HDM participants. The program may establish a suggested donation scale based on income ranges, if approved by the respective AAA. Means testing may not be included as an eligibility criterion.
b. Eligible participants and volunteers under the age of 60 who receive meals shall be afforded the opportunity to donate toward the costs of the meal received.
c. The method of solicitation for the donations is non-coercive,
d. No eligible person is denied services for not contributing,
e. The privacy of each person, with respect to donations, is protected,
f. There are written procedures in place for handling all donations which include the following at a minimum,
    i. Daily counting and recording of all receipts by two individuals,
    ii. Provisions for sealing, written acknowledgement, and transporting 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.

21. **Program Income**: Program income from participant donations must be used in accordance with the additive alternative, as described in the 45 CFR Part 1321. 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.

22. **Adult Foster Care (AFC), Residential Care, and Adult Day Services (ADS) Programs and Providers**: Programs may serve Title III-C funded meals if they align with OAA and ACLS Bureau program requirements. OAA funds cannot be used to pay for meals that are paid for with other funding streams or when the participant's meal cost is included in the daily rate for service charged by the AFC, Residential Care or ADS program or provider.

23. **Referrals:** Each program shall take steps to inform participants about local, state, and federal food assistance programs and provide information and referrals to assist the individual with obtaining benefits. When requested, programs shall assist participants in utilizing Supplemental Nutrition Assistance Program (SNAP) benefits, as participant donations to the program.

24. **Supplements**: Programs shall not use federal or state funds from the ACLS Bureau to purchase vitamins, herbal supplements, or other dietary supplements excluding oral nutrition supplements. The purchase of oral nutrition supplements is allowed under specified program requirements.

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

25. **Oral Nutrition Supplements (ONS)**: ONS are high calorie, liquid dietary oral supplements that some participants may need to enhance their nutrient intake, including but not limited to, Ensure, Glucerna, and Boost.
    a. The program RD/RDN or NDTR must approve all ONS products to be used by the program.
    b. There are multiple ways ONS may be served:
        i. ONS may be served *within* the meal, as an optional part of the meal that replaces another meal component and meets the OAA requirements of 1/3 of the DRI.
        ii. ONS may be served *outside* of a meal, including ONS being served *in addition to* or *separately from* a meal.
    c. ONS Reporting:
        i. ONS may only be counted as a meal in NAPIS and as an NSIP-eligible meal if it is served within a meal that meets OAA nutrition requirements and follows the ACLS Bureau's policy regarding declining meals for no more than five consecutive days.
        ii. Refer to the program requirements outlined in the *Supplemental Nutrition Services* Operating Standard for guidance on ONS offered outside of a meal.
    d. The following is required when serving an ONS to any participant:
        i. A physician order is required annually. The RD/RDN will review the participant medical record every six months for medical necessity and verification that the ONS nutrition prescription remains appropriate.
        ii. A person-centered care plan that is developed, monitored, and updated in coordination with the physician, the appropriate nutrition staff, and the participant.
        iii. Care plans that are kept in the participant's file. The care plans must document, at a minimum, nutritional status; dietary considerations; food preferences and preferred substitutions; requested changes to food preferences and/or dates of change in service; and a signed participant acknowledgement of the requested changes and that the full meal service can resume at any time.

26. **Participant Feedback Process**: Each provider must employ a mechanism for obtaining and evaluating the views of service recipients to inform program development and provide feedback about the quality of services received. The mechanism may include but not be limited to feedback from a project council, program assessments, client surveys, satisfaction surveys, comment cards, etc. The Participant Feedback Process is encouraged to be ongoing and must be offered at least annually.

GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

27. **Complaints**: Complaints from participants should be referred to the nutrition provider that manages the congregate, COM, or HDM program. 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 should be referred to the AAA.

28. **Emergency Preparedness**: Nutrition providers shall work with the respective AAA to develop a written emergency plan that addresses nutrition preparedness. The plan shall be reviewed and approved at the beginning of each multi-year cycle by the respective AAA and then submitted electronically to the ACLS Bureau for review If nutrition emergency management plans are updated between the multi-year cycle period, they shall be reviewed and approved by the AAA and submitted to ACLS for review prior to the Annual Implementation Plan approval.

    The emergency plan shall address, but not be limited to:
    a. Uninterrupted delivery of meals to HDM participants, including, but not limited to the involvement of families and friends, volunteers, informal support systems, and the use of shelf-stable meals.
    b. The provision of at least two, and preferably more, shelf-stable meals and instructions on how and when to use them for HDM participants. Every effort should be made to ensure 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. However, meals that do not meet the DRI requirements do not qualify as NSIP-eligible meals.
    c. A back-up plan for food preparation if the 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.
    g. Appropriate infection control measures, including contactless delivery, social distancing practices and use of personal protective equipment as necessary.

29. **Coordination of Meal Services**: Person-centered planning involves participant choice. Eligible participants are allowed to participate in HDM, Congregate, and COM services interchangeably. Coordination of services is required. An agreement between programs is strongly recommended to ensure policies and procedures are in place to ensure proper documentation,

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

including but not limited to, participant registration, reporting of meal units, separation of funding streams, HDM meal cancellation policies, and meal service schedules of participants.

30. **Staff, Volunteer, and Participant Safety**: Nutrition program staff, volunteers, and participants are not expected to be placed in situations where they feel unsafe or threatened. Each program has a responsibility to report any such instances. Nutrition providers shall work with their AAA to create a "Safety Policy" that addresses verbal and physical threats, including but not limited to bullying, discrimination, aggressive behaviors, abuse, and neglect directed toward any individual from program persons, participants, family members, or pets in a home or congregate setting.

    This policy should include, but is not limited to:
    a. Definition of a verbal or physical threat,
    b. Situations requiring the intervention of multiple staff or volunteers,
    c. Who investigates the report,
    d. What actions should be taken by the individual if they are threatened,
    e. What warnings should be given to the offender,
    f. What actions should be taken for repeated behaviors, up to and including being removed from the program,
    g. How to complete a report and what information should be documented,
    h. When and how to elevate the incident to local authorities.

MEAL PLANNING AND MENU DEVELOPMENT

1. Nutrition providers must demonstrate compliance with the required United States Department of Agriculture's (USDA) Dietary Guidelines for Americans (DGA) and Dietary Reference Intakes (DRI) by using one of the following methods:
    a. **Computer Nutrient Analysis Software** - Computer Nutrient Analysis Software is the preferred menu approval method. This method provides a detailed nutrient profile and allows for increased menu planning flexibility. The nutrition analysis is not required to be listed on the menu but should be made available for reference. 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.
    b. **ACLS Bureau Guide for Meal Patterns** – Meals are designed to follow pattern guidelines by focusing on inclusion of nutrient dense food groups, number of servings, portion sizes, and choosing foods and beverages that limit sugar, fat, and sodium. A nutrient analysis is not required when following the approved ACLS Bureau Guide for Meal Patterns. However, nutrition providers are encouraged to provide a nutrient analysis for any meal if requested by the ACLS Bureau, the AAA, a participant, or a

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

participant's family member or medical provider. For nutrition providers that do not have access to a nutrition analysis program, the USDA Food Data Central is a free resource that can be accessed to determine the nutritional composition of food items.

2. **OAA Meal Requirements** (OAA 339(2)(A)(i)(ii)

Each Nutrition Services meal must: (A) provide(s) meals that—

(i) comply with the most recent Dietary Guidelines for Americans, published by the Secretary and the Secretary of Agriculture, and

(ii) provide to each participating older individual—minimum of 33 1⁄3 percent of the dietary reference intakes established by the Food and Nutrition Board of the National Academies of Sciences, Engineering, and Medicine, if the project provides one meal per day

(I) a minimum of 66 2⁄3 percent of the allowances if the project provides two meals per day, and

(II) 100 percent of the allowances if the project provides three meals per day, and

(III) to the maximum extent practicable, are adjusted to meet any special dietary needs of program participants, including meals adjusted for cultural considerations and preferences and medically tailored meals.

3. 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* and the ACLS Bureau Nutrition Standards.

4. Each program shall utilize a menu development and approval process, which includes, but is not limited to, the following components:
   a. The use of written or electronic standardized recipes.
   b. The provision for review and approval of all menus by an RD/RDN or an individual who is registration eligible, or a NDTR prior to implementation.
   c. Menus should be reviewed, at minimum, when modifications are made and when new guidance is issued by the ACLS Bureau or when the *USDA Dietary Guidelines for Americans* is updated.
   d. Current menus should be posted in a conspicuous place at each meal site and in each location where food is prepared.
   e. The program must be able to provide information on the nutrition content of menus upon request.
   f. The program shall maintain records of RD/RDN menu review and approval, and corresponding menus for each fiscal year period.

5. **Person-Centered Planning**: Nutrition providers must consider person-centered principles when menu planning, including but not limited to:

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

Offer versus Serve: The Nutrition Program must offer participants all menu items and provide nutrition information about the menu/meal that meets their requirements and maximizes health. However, participants may decline to accept any element of the planned meal.

Choice Menus: Menu choice is encouraged to allow for consumer choice and increase participant satisfaction. Choice Menus will comply with menu planning requirements. If more than one menu item is offered, the food item that has lower nutrient value will be counted towards the weekly nutrient average in computer analysis. If using the ACLS Bureau Guide to Meal Patterns, then both meals must meet the guidelines.

Ethnic and Religious Preferences: Nutrition providers are encouraged to provide culturally appropriate meals for an ethnically diverse population. These meals must meet the most recent DGA's and provide a minimum of one third of the DRI's per meal.

Menu Substitutions: Any menu substitutions made to an approved menu must be comparable in nutrient content and serving size to the original menu. All menu substitutions must be documented and reviewed by a dietitian with technical assistance provided as needed or selected from a pre-approved list of food substitutes made by the dietitian.

Alternative menu items: Where feasible and appropriate, tailored meals or alternatives should be offered for individuals with food allergies, digestive issues, chewing issues, and other known medical conditions.
The meals offered must meet the minimum nutrition requirements.

6. The most current edition of the *USDA Dietary Guidelines for Americans* should be incorporated into menu development which emphasizes nutrition and health across the life span.

USDA Guidelines and Key Recommendations

a. Follow a healthy eating pattern across the lifespan. 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. Customize and enjoy nutrient-dense food and beverage choices to reflect personal preference, cultural traditions, and budgetary considerations.
c. Focus on meeting food group needs with a variety of nutrient dense foods and beverages, within recommended amounts and calorie limits.
    i. Use preparation and delivery methods that preserve the nutritional value of foods.
    ii. Include a variety of vegetables from all the sub-groups: dark green, red and orange, legumes, beans, peas, starchy, and others.
    iii. Include a variety of fruits, especially whole fruits.

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS (CON'T)

iv. Consume a variety of grains, at least half of which are fiber-rich whole grains.
v. Choose fat-free, or low-fat dairy, including milk, yogurt, and cheese.
vi. Incorporate a variety of both animal and plant protein foods into meals, including seafood, lean meats and poultry, eggs, legumes, nuts, and seeds.
vii. Include healthy versions of oil in dietary patterns to provide essential fatty acids. Shift to incorporating unsaturated varieties of vegetable oils more often than varieties that are higher in saturated fat.

d. Limit foods and beverages higher in added sugars, saturated fat, and sodium.
   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 milligrams of sodium per day. Additional sodium reduction may be beneficial for individuals with high blood pressure, kidney disease, and other chronic health conditions.

7. **Target Nutrient Requirements:** The target nutrient requirements are based on the characteristics of the predominate older adult population and the Dietary Components of Public Health concern from the most recent DGA's. The 2020-2025 DGA's and DRI's weekly averages for menu planning are to meet the requirements of our target population, a 60+ year-old female (1600-2200 Calories) and 60+ year-old male (2000-2600 Calories).
   a. The most recent under-consumed nutrients of public health concern are calcium, potassium, fiber, and vitamin D.
   b. The **over-consumed nutrients** of public health concern are saturated fat, sodium, and added sugar and should be limited. Consider low or no sodium added processed foods when preparing meals.
   c. **Protein, vitamin C, vitamin B6, and vitamin B12** are of concern for older adults due to decreased absorption and utilization rates among those 50 years and older.
   d. **Vitamin D** is unique in that it is harder to achieve through natural sources and through diet alone. It requires consuming foods and beverages fortified with vitamin D. Therefore, vitamin D will not be listed in the target nutrient requirements.
   e. **Hydration status** is also a concern for older adults. Increased fluids in the form of water, unsweetened beverages, 100% fruit or vegetable juice, and low-fat or fat-free milk or soy beverages are encouraged.
   f. **Carbohydrate regulation** is key to maintaining healthy blood sugar levels. Portion sizes, carbohydrate content foods, and carbohydrate counting education should be available to all consumers.
   g. The chart below provides daily and weekly DGA/DRI requirements for nutrient analysis.

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS (CON'T)

Nutrient	Dietary Guidelines and Dietary Reference Intakes Per Meal Nutrient Requirement	Target Goals for Weekly Averages
Calories	533-866	666
Protein	10-35%	10-35% of calories
Carbohydrate	45-65%	45-65% of calories
Fat	20-35%	20-35% of calories
Saturated Fat	≤10% of calories	≤10% of calories
Fiber	>7-9 g	>7 g
Sodium	≤ 767 mg	≤ 1000 mg
Potassium	> 867-1133 mg	> 867mg
Calcium	≥ 400 mg	≥ 400 mg
Vitamin C	> 25 mg	> 25 mg
Vitamin B6	>0.50 mg	>0.50 mg
Vitamin B12	>0.8 mcg	>0.8 mcg

8. **Other Considerations**:

Desserts: Serving dessert is optional. Fruit for dessert is recommended to decrease added sugar consumption. Nutrient-rich desserts that contain fruit, whole grains, and/or low-fat milk products are encouraged. The use of commercial desserts should be limited to once per week.

Salad and Soup Bar Option: Congregate meal sites may include a salad bar as part, ***or all***, of their meal service. (See chart below.)

Soup/Salad bar	Nutrition Standard Requirements
As a main meal	Must meet all nutrition standard requirements
As a part of a meal, i.e., vegetable or carb (pasta choices)	Must meet the nutrition requirement for the specified meal component(s) included as part of the meal
As an addition to, or add on, to a regular meal	Does not have to meet the nutrition standard requirements

Beverages:

a. Milk, or a milk substitute, must be offered with every meal. Low sugar and low-fat milk choices are recommended. Considerations for lactose intolerance, shelf life, meal pattern preference, and religious and ethnic preferences should be made, choosing alternatives that most closely align with the nutrient profile of milk. See substitution chart in the ACLS Bureau Guide to Meal Patterns.
b. Water must be offered at congregate sites and made available to HDM

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS (CON'T)

participants, as requested.

c. Other beverages such as coffee and tea are optional and can be made available as self-serve at congregate sites.
d. Participants may bring beverages from home, if desired.
e. State and federal funds can be used to purchase beverages and maintain equipment.

9. Special occasion, holiday, or celebratory meals are allowed on a periodic basis. The RD/RDN, an individual who is registration eligible or a NDTR, must review and approve the meal. If these meals do not follow the 1/3 DRI rule, they are not NSIP eligible.

MEAL PATTERNS

1. Meal patterns are designed to meet nutrient needs while not exceeding calorie requirements and staying within limits of overconsumed dietary components such as added sugars, saturated fat, and sodium. The USDA has used current food composition data to develop a methodology based on a mix and proportions of nutrient dense foods that will meet the nutrient needs based on age-sex groups.

2. The following meal patterns, as outlined in the most current version of the *USDA Dietary Guidelines for Americans* are acceptable meal patterns. Meal patterns offer the opportunity to emphasize unique combinations of food groups, a variety of color, textures, and flavors, and educate participants on the benefits of seasoning meals with herbs and spices to limit fat, sodium and calories that can negatively impact health. Meal pattern requirements for the following meal patterns will be met when following the ACLS Bureau Guide to Meal Patterns.

   The USDA MyPlate Method (http://www.choosemyplate.gov) uses the Healthy U.S.-Style Dietary Pattern to provide a visual guide, referred to as MyPlate, that ensures all food groups are being served in appropriate portion sizes to meet the USDA dietary requirements.

   The Healthy U.S.-Style Dietary Pattern is based on types and proportions of foods that Americans typically consume but in nutrient-dense forms and appropriate amounts.

   The Healthy Mediterranean-Style Dietary Pattern is centered around cultural foods in regions that border the Mediterranean Sea and focuses on minimally processed plant-based foods. This dietary pattern is rich in fruits, vegetables, grains, potatoes, beans, legumes, nuts, seeds, olive oil, dairy products, eggs, fish, and some poultry.

   The Healthy Vegetarian Dietary Pattern is a good opportunity to incorporate variety into menus, feature Michigan produce, and highlight the many ethnic,

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

cultural, or religious food traditions that center meals around plant-based foods. Plant-based meal patterns can be served as part of the menu cycle or as an optional meal choice based on participant choice.

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

ACLS Bureau

Guide to Meal Patterns

Food Group	Minimum Number of Servings	Minimum Requirements
Fruits and Vegetables	2-3 servings	Provide food sources high in vitamin C and potassium daily. Limit juice to one serving per meal, if applicable. Encourage no- to low-sodium canned vegetables. 1 serving is equivalent to: • ½ cup cooked, canned, or chopped raw fruits or vegetables • 1 cup leafy raw vegetable (lettuce, spinach, etc.) • 1 medium whole fruit (apple, orange, banana, etc.) • ½ grapefruit • 1/8 melon • ¼ cup dried fruit • 6 oz 100% vitamin C fruit or vegetable juice • 1 small potato or ½ large potato • ½ cup sweet potatoes, yams, corn kernels, squash, peas, or lima beans
Lean Protein Source	2-3 oz equivalent	Meats should be baked, broiled, grilled, or roasted. Limit processed meats to one serving per week. Seafood is encouraged regularly for omega-3 fatty acids. One (1) ounce is equivalent to: • 1 oz cooked lean beef, veal pork, lamb, chicken, turkey, or fish • 1 oz canned tuna or salmon packed in water • 1 oz low-fat cheese • 1 egg • ¼ cup cooked beans or legumes • ½ cup tofu • ¼ cup low-fat cottage cheese • ½ oz nuts or seeds • 1 Tablespoon nut butter
Grains	2-3 servings	At least half of the grains should be whole grain. One (1) serving is equivalent to: • 1 oz bread or grain product • ½ cup cooked cereal, pasta, or rice • ¾ cup dry cereal • 1 slice bread or small dinner roll • ½ English muffin, bun, small bagel, or pita bread • 1--6" tortilla • 1 ¼" square cornbread • 1--2" diameter biscuit or muffin 4-6 crackers

III. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS *(CONT'D)*

ACLS Bureau

Guide to Meal Patterns

Food Group	Minimum Number of Servings	Minimum Requirements
Milk or Milk Alternative	1 serving	One (1) serving is equivalent to: • 8 oz vitamin D fortified skim, 1%, or 2% milk • 8 oz dairy alternative milk fortified with calcium and vitamin D • 8 oz Kefir, plain, low-fat • 8 oz low-fat yogurt • 1 ½ oz cheese • 1 cup pudding made with low-fat milk • ½ cup ricotta cheese • 2 cups cottage cheese* (Two cups is not a realistic serving size but may be used in combination with another serving equivalent to count as an equivalent.)
Oils or Fats	No more than 1 serving	One (1) serving is equivalent to: • 1 Tablespoon vegetable oil or margarine • 1 Tablespoon mayonnaise • 2 Tablespoons low-sodium salad dressing • ½ medium avocado • 1 oz nuts or seeds • 2 Tablespoons nut butter
Condiments	Optional	Encourage herbs, spices, lemon, and vinegar to provide flavor without sodium. Limit foods high in sodium. Condiments include items on the side, such as salad dressing, sugar/sugar substitutes, salt, pepper, butter, and trans-fat free non-dairy coffee creamer.
Beverages	Optional	No- to low-calorie beverages: water, water with lemon, unsweetened tea, coffee, etc.
Desserts	Optional	Recommend fruit for dessert to decrease added sugar consumption. Nutrient-rich desserts that contain fruit, whole grains, and low-fat milk products are encouraged. Commercial desserts should be limited to once per week. Nutrient-rich desserts that include fruit, whole grains, and low-fat milk can count towards meeting the appropriate food group required servings.
Additional Instructions		A food item in one or more food groups can only be classified once as meeting the requirement for a meal. For example: cottage cheese can be counted as a milk/milk alternative *or* a lean protein source, not both. Include a variety of flavors, textures, seasonings, colors, and food groups.

IV. SERVICE DEFINITIONS AND SPECIFIC MINIMUM STANDARDS

All services with definitions approved by the MCSA 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.

. 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.

The ACLS Bureau 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.

V. GENERAL REQUIREMENTS FOR ACCESS SERVICE PROGRAMS *(CONT'D)*

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 MDHHS, ACLS Bureau, provides an annual allocation of funds to 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.

IV. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 the ACLS Bureau.

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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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, and
   - 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

6. Each program shall require and thoroughly check references of paid staff that will be entering participants' homes. In addition, each program must conduct or cause to be conducted a criminal background check that reveals information similar or substantially similar to information found on an Internet Criminal History Access Tool (ICHAT) check and a national and state sex offender registry check for each new employee, employee, subcontractor, subcontractor employee, and volunteer who has in-person client contact, in-home client contact, access to a client's personal property, or access to confidential client information:

   A. ICHAT: http://apps.michigan.gov/ichat
   B. Michigan Public Sex Offender Registry: http://www.mipsor.state.mi.us
   C. National Sex Offender Registry: http://www.nsopw.gov

7. Criminal background checks for new hires must be completed prior to the individual working directly with clients or having access to a client's personal property or confidential client information.

8. All AAAs are required to update criminal background checks for all employees and volunteers every three years to identify convictions in the event they occur while an individual is employed or providing volunteer service:

   A. All employees and volunteers hired prior to the effective date of this policy must be rescreened within 90 days from the effective date of this policy. Thereafter, criminal background checks for these employees and volunteers must be completed no later than 30 days after every third anniversary from the date of their last background check.

   B. Updated criminal background checks for employees and volunteers hired after the effective date of this policy must be completed no later than 30 days after every third anniversary of their date of hire

9. The use of information obtained from a criminal background check shall be restricted to determining suitability for employment and/or volunteer opportunities. All programs are required to maintain a copy of the results of each criminal background check for paid and volunteer staff in a confidential and controlled access file. The information should not be used in violation of any applicable Federal or State equal employment opportunity law or regulation.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

10. Exclusions No employee or volunteer shall be permitted to work directly with clients or have access to a client's personal property or confidential client information if:

A. Mandatory Exclusions - The results of the criminal background check show that the person has a federal or state felony conviction related to one or more of the following crimes:
- Crimes against a "vulnerable adult" as set forth in MCL 750.145n et seq.,
- Violent crimes including, but not limited to, murder, manslaughter, kidnapping, arson, assault, battery, and domestic violence,
- Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion,
- Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution,
- Cruelty or torture,
- Abuse or neglect, or
- Felony involving the use of a firearm or dangerous weapon.

B. Felony Convictions - The results of the criminal background check show that the person has a federal or state felony conviction within the preceding 10 years from the date of the background check, including but not limited to:
- Crimes involving state, federal, or local government assistance programs,
- Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion, or
- Drug crimes including, but not limited to, possession, delivery, and manufacturing.

C. Misdemeanor Convictions - The results of the criminal background check show that the person has a federal or state misdemeanor conviction within the preceding 5 years from the date of the background check, including but not limited to:
- Crimes involving state, federal, or local government assistance programs,
- Crimes against a "vulnerable adult" as set forth in MCL 750.145n et seq.,
- Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion,
- Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion,
- Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution,
- Drug crimes including, but not limited to, possession, delivery, and manufacturing,
- Cruelty or torture,
- Abuse or neglect,
- Home invasion,
- Assault or battery, or
- Misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

11. For purposes of the excluded offenses identified above, an individual is considered to have been convicted of a criminal offense when:
    - A judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending,
    - There has been a finding of guilt against the individual by a federal, state, tribal or local court, or
    - A plea of guilty or nolo contendere by the individual has been accepted by a federal, state, tribal or local court.

Arrest records, by themselves, do not disqualify an individual.

12. All programs are required to maintain documentation of all criminal background checks, including a list of all paid and volunteer staff that are subject to this policy, the date of the most recently completed criminal background check, and the source of the background check. Employees hired prior to the effective date of this policy are not exempt from this requirement.

13. THE ACLS BUREAU does not consider Senior Community Service Employment Program (SCSEP)enrollees to be AAA employees or volunteers for the purposes of this policy. Rather, SCSEP enrollees are participants in a federal employment and training program funded by the U.S. Department of Labor (USDoL). As such, Programs that serve as a host agency for SCSEP participants are advised to comply with the USDoL policy described below:

    "Grantees may take the responsibility of providing background checks before placing participants in community service assignments, provided that the background check is conducted because of the requirements of a specific community service assignment, rather than based on a particular participant, and is consistently applied to all applicants considered for that position. We stress that background checks are relevant to the assignment of participants to particular host agency positions only and cannot be used as a basis for denying eligibility. In addition, grantees should be careful to comply with EEOC and any state or local rules regarding the use of background checks."

14. All programs are required to maintain documentation of all criminal background checks, including a list of all paid and volunteer staff that are subject to this policy, the date of the most recently completed criminal background check, and the source of the background check. Employees hired prior to the effective date of this policy are not exempt from this requirement.

15. Care managers are provided direct supervision in the conduct of program activities.

17. 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

18. 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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, and
- 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 inter RAI Home Care Assessment System (IHC) is the basis for the CM Assessment. It 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

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 fora comprehensive service plan.

Minimum Requirements: Assessment

1. Everyone 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 are 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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).

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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:

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

TCM = Targeted Case Management. The participant is:

- enrolled in the ACLS Bureau 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 ACLS Bureau/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 below100% 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 37
   - 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 ACLS Bureau field representative as part of the Annual AAA Assessment process. The AAA completes the ACLS Bureau 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 ACLS Bureau-funded care management program.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 60 years of age and older who are not enrolled in the MI Choice waiver program. Provided under auspices of the ACLS Bureau 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. The ACLS Bureau is responsible for certifying that providers meet criteria on an annual basis. The certification is conducted as part of the ACLS Bureau 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 ACLS Bureau 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 ACLS Bureau 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 ensure 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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

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

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 that 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.

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 ACLS Bureau quarterly claim detail for each AAA in a Warrant Suspend report. The ACLS Bureau 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 the ACLS Bureau through the online Aging Information System FIRST module.

Subject: AAA Targeted Case Management (TCM) Reimbursement - 1st

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.

Provider Name	Appropriation Number	Amount	Rate	Reimbursement
Regional Area Agency on Aging	46511	$7,971.84	.06515	$5,194.00

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

Example A

TCM Reimbursement Guidelines

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

VI. CARE MANAGEMENT PERFORMANCE CRITERIA *(CONT'D)*

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 the ACLS Bureau 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 ACLS Bureau Financial Status Report.
    d. The AAA shall submit a cash request for payment of TCM funds.

Service Name	Care Management
Service Number	A-1
Service Category	Access
Service Definition	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. 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 the ACLS Bureau CM Performance Criteria.
Unit of Service	One unit per month when any CM activity is provided for a participant.

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.

A-1 CARE MANAGEMENT OPERATING STANDARD *(CONT'D)*

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 the ACLS Bureau-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.

Service Name	Case Coordination and Support
Service Number	A-2
Service Category	Access
Service Definition	The provision of a comprehensive assessment and ongoing monitoring of persons aged 60 and over with a complementing role of brokering existing community services and enhancing informal support system when feasible.
Unit of Service	One hour of service provided

Updated: June 21, 2024

Minimum Standards

1. Each Case Coordination and Support (CCS) program must have uniform intake procedures and maintain consistent records. 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. Name, address, and phone number of emergency contact if available
   d. Self-identified diagnosis/medical conditions Perceived supportive service needs as expressed by individual and/or his/her representatives
   e. Race and ethnicity
   f. Gender identity
   g. Sexual orientation
   h. Communication support needs
   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

A-2 CASE COORDINATION AND SUPPORTS *(CONT'D)*

2. Following the intake process, an initial assessment shall include as much of the following information as possible:

    a. Basic Information
        I. Individual's name, address, and telephone number
        II. Date of birth,
        III. Gender Identity
        IV. Marital status
        V. Race and/or ethnicity
        VI. Living arrangements
        VII. Condition of environment
        VIII. Income and other financial resources, by source (including SSI and GA)
        IX. Expenses
        X. Social Supports, such as hobbies, special interests, etc.
        XI. Spiritual or religious affiliation, if applicable

    b. Functional Status
        I. Vision
        II. Hearing
        III. Speech
        IV. Oral status (condition of teeth, gums, mouth, and tongue)
        V. Durable medical equipment (DME)
        VI. Psychosocial functioning
        VII. Cognitive status
        VIII. Limitations in activities of daily living and instrumental activities of daily living (ADLs and IADLs)
        IX. History of chronic and acute illnesses
        X. Nutritional status
        XI. Medication management needs and considerations

    c. Supporting Resources
        I. Formal supports and services (such as those funded through Medicaid)
        II. Informal support network
        III. History of falls and/or hospital visits in the past 180 days or since last assessment
        IV. Medical/health insurance information

    d. Need Identification
        I. Participant/informal support perceived
        II. Assessed needs

Each participant shall be reassessed yearly, or as needed, to evaluate service plan implementation. At minimum, a monitoring contact shall be attempted 90 days following the initial assessment. Monitoring contacts shall be attempted every 180 days thereafter.

A-2 CASE COORDINATION AND SUPPORTS *(CONT'D)*

3. 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 or legal representative. The service plan shall contain at a minimum:
   a. Statement of the participant's needs, strengths, and resources.
   b. Statement of the goals and objectives for meeting identified needs.
   c. Description of interventions and services used to address identified needs.

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

4. Each program shall maintain comprehensive and complete case files which include at a minimum:
   a. Assessment and reassessments.
   b. Service plan
   c. Dated progress notes documenting coordination of care
   d. Participant verification of services received and satisfaction with quality of service
   e. Record of all release of information and consent forms
   f. Treatment orders of qualified health professionals, when applicable

5. Each program shall have the capacity to produce a current listing of isolated older persons, with open case files, which can be made readily available to agencies providing emergency services in the event of a disaster.

6. Each program shall employ caseworkers who have a bachelor's degree in a human service field or who have experience or training to effectively determine a participant's needs and match those needs with appropriate services.

7. Each case shall have a primary caseworker or team assigned.

8. 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.

9. CCS service components may be delivered in-person, telephonically, virtually, or hybrid. At least one in-person contact is preferred every 365 days.

Service Name	Disaster Advocacy and Outreach Program
Service Number	A-3
Service Category	Access
Service Definition	Activities undertaken to assist older persons in their planning, response, or recovery from "disaster" or "emergency" as defined by paragraph 30.402 (e,h) of the Michigan Emergency Management Act of Act 390 of 1976, as amended. All activities must be explicitly aimed at assisting frail and older persons to ensure access to needed service and personal and emotional support necessary to assist with a plan to respond toward recovery.
Unit of Service	Each hour of community education activity includes: • emergency preparedness, including agency plan preparation • agency staff training • meeting with state and local emergency managers • negotiating contracts with service providers • exercises at the state emergency operation center Each hour of advocacy and outreach activities with individuals that improve their emergency preparedness or response and recovery activity for up to one year after a disaster or emergency occurs.

Updated: May 17, 2024

Minimum Standards

1. Each Area Agency on Aging (AAA) or organization providing aging services to be funded or reimbursed under this service definition must have a "mission statement" defined in an adopted extension of the local emergency preparedness plan prepared under the provisions of the Michigan Emergency Management Act of Act 390 of 1976, as amended.

2. Each AAA or organization of aging services must have an emergency plan with identified alternative plans/approaches for responding to a disaster and undertaking appropriate activities to assist older survivors recover from a disaster, depending on the available resources and structures. The same functions cited as allowable service components are performed and can be provided by other contracted providers or organizations.

3. All disaster advocacy and outreach activities shall be supervised by an individual/team. The individual/team has the educational and work experience necessary to help advocates determine when individuals need assistance beyond their capabilities.

A-3 DISASTER ADVOCACY AND OUTREACH PROGRAMS (CONT'D)

Allowable Service Components

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

1. Maintaining liaison with local government and volunteer human services agencies to plan for, respond to, or recover from a disaster or emergency.
2. Taking necessary action to protect the agency's resources and ensure the continuation of the agency's critical functions during a disaster or emergency to ensure continuity of care.
3. Conducting awareness/preventative campaigns alerting the public of local plans in the event of a public health emergency, disaster, or state emergency.
4. Providing technical assistance to service providers for developing and implementing plans for assuring the continuation of services in the event of a disaster or state of emergency (i.e., extreme temperatures, flooding, and power outages).
5. Arranging for appropriate services to be expanded to additional eligible participants needing such services due to a disaster or state of emergency.
4. Developing a sound knowledge base of various relief programs.
5. Conducting a comprehensive assessment of older disaster survivors, including individual's needs, mental health, emotional support, and cognitive status.
6. Providing ongoing support and assistance in returning to normalcy after disaster centers have ceased operations.
7. Assisting older individuals in completing documentation for needed services.
8. Obtaining and helping provide interagency and public information.
9. Conducting door-to-door canvassing (outreach) to identify older disaster survivors with multiple visits if necessary.
10. Seeking to identify older persons displaced out of the area so they can be notified of the opportunity to apply for disaster services.
11. Following up on lists of affected older persons received from other providers and agencies to ensure that older survivors receive services.

Service Name	Information and Assistance (I&A)
Service Number	A-4
Service Category	Access
Service Definition	Unbiased assistance in accessing resources to older adults and their caregivers including, but not limited to, 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); referral (making contact with a particular provider on behalf of an individual)/person-centered advocacy (efforts that seek to meet individual needs); advocacy intervention (negotiating with a service provider on behalf of a client); and follow-up contacts with clients to ensure services have been provided and have met the respective service need.
Unit of Service	Provision of direct contacts per day (1 unit equals 1 contact with a participant) when any information and assistance (including warm hand off referral/person-centered advocacy) functions are provided. (Note: newsletters and media spots are encouraged but are not to be counted as information-giving units of service.)

Update: May 23, 2023

Minimum Standards

1. Each I&A program shall have a resource file, which is current and 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. I&A can also include a warm handoff referral/person-centered advocacy. The term “warm handoff” originated in customer service and describes the process of a customer being connected to someone who can provide what he or she needs. This can occur either in person or via phone, between the I&A professional and the customer, or in front of the older adult or caregiver (and family if present).

3. Each program shall have bilingual personnel available and/or have the capacity to acquire interpretation services as necessary. Each I&A program is strongly encouraged to have materials in the most commonly spoken languages within the planning and service area (PSA).

A-4 INFORMATION AND ASSISTANCE (CONT'D)

Additionally, each program must have the capacity to serve deaf and hard of hearing persons and visually impaired persons in a manner appropriate to their needs, such as through the Michigan Relay Center.

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

5. 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/person- centered advocacy 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 Area Agency on Aging (AAA) upon request for monitoring and/or planning purposes.

6. A person-centered follow-up contact is encouraged for warm handoff referrals/person- centered advocacy, whether services are negotiated or not, within ten working days, to determine whether services were received, the identified need met, and client satisfaction. Additionally, each I&A program is required to have policies and procedures that address follow up for potential vulnerable adults, including mandated reporting of suspected abuse, neglect, or exploitation of an older adult as required by law. Follow-up contacts are not required for information-giving only contacts.

7. At least once per year, each program must determine the quality of I&A services provided through a sampling of no less than 10% of clients. Additionally, each I&A program is required to have policies and procedures that address how the I&A provider will evaluate the data, their processes for quality improvement, and the method utilized to share results with the AAA.

8. 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, long-term care facilities, veteran services, and community-based Medicaid programs).

9. Older Americans Act (OAA) funded I&A providers must have the capacity to provide ongoing continuing education to their I&A staff.

10. OAA I&A providers are expected to foster coordination among, and collaboration with, other I&A providers and agencies supporting older adults within the PSA.

11. Each I&A program is encouraged to seek agency accreditation and employee certification from the Alliance for Information and Referral Systems (AIRS).

12. Each I&A program shall have a policy that addresses promptness of I&A functions, including the conditions under which timely follow up must be conducted.

1. Service Name	Outreach
2. Service Number	A-5
3. Service Category	Access
4. Service Definition	Efforts to engage, build awareness, and share aging resources and information with older adults, caregivers, community groups, human services agencies, and businesses who interact with the aging community, with an emphasis on those interacting with target populations. Outreach does not include comprehensive assessment of need, development of a service plan, or arranging for service provision.
5. Unit of Service	One hour of outreach service including identification and contact of older persons, assistance in their gaining access to needed services, follow up, presentations, events, and efforts to reach a broader audience.

Updated: October 30,2023

Minimum Standards

1. Each outreach activity 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.

2. Each outreach activity located in areas where non-English or limited English-speaking older persons are a substantial portion of the audience/population shall have bilingual personnel on site (through staff positions, personal services contracts, or volunteer positions). Bilingual personnel are to be available in-service areas where non-English or limited-English speaking persons constitute five percent of the senior population or number 250 seniors, whichever is less. (See the Older Americans Act (OAA) of 1965, amended through P.L. 116-131, Enacted March 25, 2020, Title III of the OAA, Sec. 307(15)).

3. Each outreach activity shall target those eligible for assistance with a special emphasis on:
    a. Lesbian, Gay, Bi-Sexual, Transgender, Queer, (LGBTQ+) individuals
    b. Individuals identified in the Older Americans Act (OAA) of 1965, amended through P.L. 116-131, Enacted March 25, 2020, under Title III, Sec. 306, (4)(B); (4)(C); and (6)(G).

4. **Recommendation:**
    a. Public and Media (PAM) forms may be used to assist in outreach data collection for group events and media outreach.

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

Updated: June 16, 2023

Minimum Standards

1. Older Americans Act (OAA) 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 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 eligible 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. OAA funds may not be used for the purchase or lease of vehicles for providing transportation services, unless approved in writing by the Bureau of Aging, Community Living, and Supports.

3. All drivers and vehicles used for transportation programs supported all or in part by OAA 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 drivers for transportation programs supported entirely or in part by OAA 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.

TRANSPORTATION (CONT'D)

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

6. Each eligible person is allowed one (1) paid or unpaid care attendant to accompany them on each trip.

7. Each program shall operate in compliance with MCL 257.710e regarding seat belt usage.

8. Each program shall attempt to receive reimbursement from other funding sources, as appropriate and available. Examples include, but are not limited to, the American Cancer Society, Veterans Administration, Michigan Department of Health and Human Services, United Way, Department of Transportation programs, etc. Within a respective planning and service area, an area agency on aging 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 Michigan Commission on Services to the Aging at the time of area plan approval.

Service Name	Options Counseling
Service Number	A-7
Service Category	Access
Service Definition	Options Counseling (OC) is an interactive and unbiased process that can help an older person, their family member, or their caregivers to receive options in their deliberations to make informed choices about long term supports and services.
Unit of Service	One unit per month when any OC activity is provided for an individual. One unit equals one individual each month regardless of number, length, or time of contacts within that month.

Minimum Standards

1. Each program shall employ staff with a minimum of an associate'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 Older Americans Act funded Information and Assistance programs within their PSA and establish protocols to identify potential participants for referral (making contact with a particular provider on behalf of an individual)/person-centered advocacy (efforts that seek to meet individual needs).

5. 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, long-term care facilities, veteran services, and community-based Medicaid programs).

6. An initial screening via a personal interview (either in person or by phone) shall be provided that includes the participant (and/or their representative and/or family caregiver as indicated by the participant) 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.

A-7 OPTIONS COUNSELING *(CONT'D)*

8. Providers of OC must make unbiased referrals/person-centered advocacy reflecting the best outcomes for the participant and shall provide information on all applicable programs to avoid a conflict of interest.

9. Each OC program is required to have policies and procedures that address follow up for potential vulnerable person that includes mandated reporting of suspected abuse, neglect, or exploitation of an older adult as required by law.

10. Decision support shall also be provided to assist the participant in making an informed choice including the evaluation by the participant of the pros/cons with each presented option.

11. The provision of assistance with determining financial eligibility, when appropriate.

12. The provision of assistance with enrollment into public programs and benefits.

13. The program encourages future planning for long-term care.

14. The program shall provide a written summary to the participant, which details important issues discussed, participant desires and preferences, resources, and identified strategies.

15. 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.

16. Each program is encouraged to have bilingual personnel available and/or will have the capacity to acquire interpretation services as necessary. Each OC program is strongly encouraged to have materials in the most commonly spoken languages within the PSA. In addition, each program must have the capacity to serve deaf and hard of hearing persons and visually impaired persons in a manner appropriate to their needs.

17. Providers of OC services must have the capacity to:
    a. Provide private, confidential telephone and face-to-face OC as requested.
    b. Respond to participants seeking supports and services by using methods and accommodations, which are compliant 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 (including American Sign Language),
        v. Alternative material formats (including Braille),
        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.

A-7 OPTIONS COUNSELING *(CONT'D)*

18. 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. In-service training requirements shall also be consistent with Care Management (CM) and Case Coordination and Support (CCS) standards of practice.

19. Each program is encouraged to seek employee certification from the Alliance for Information and Referral Systems (AIRS) for individual OC employees and volunteers.

Service Name	Care Transition Coordination and Support
Service Number	A-8
Service Category	Access
Service Definition	The Care Transition (CT) program is intended to provide proactive discharge planning, extensive coaching, and post discharge supports by a Community Health Worker (CHW) and/or other health care professional. This coaching is intended to support adults age 60 or older discharging from a medical care institution to the place they consider to be home preventing re-institutionalization. CT supports include intake, assessment, a development of service(s) plan, person centered planning, services arranging, primary care follow-up, medical transportation coordination, red flag warning education, medication review and weekly follow up.
Unit of Service	Each 15 min (.25 hours) for CT activities provided for an individual.

New September 22, 2022

Minimum Standards

1. Each program shall have a written eligibility criteria and intake process.
    a. Age 60 and over.
    b. 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. Eligibility to participate is not based on a person's level of income.
    c. Participant is not receiving medical care institution transition services and support from another state or federally funded program.
    d. Participants must be admitted to a medical care facility or be within 3 business days of status post discharge from a medical care facility.
    e. Participant cannot be enrolled in MI Choice, MI Health Link or Program of All-Inclusive Care for the Elderly (PACE).
2. Participants are contacted pre-discharge when possible and will have their initial assessment completed within three business days of discharge from a medical care institution.
3. A coordination of services mechanism must be used to verify duplication of care transition services, and thus prevention of duplicate payments.
4. Each program shall maintain National Aging Program Information System (NAPIS) registration for each program participant. The intake process shall be initiated within one week after an individual becomes active in the program.

A-8 CARE TRANSITION COORDINATION AND SUPPORTS *(CONT'D)*

5. Each participant shall receive an initial assessment. Assessors shall attempt to acquire each item of information listed below but must recognize and accept the participant's right to refuse to provide requested items:
   a. Basic Information (may be completed by the participant)
      I. Individual's name, address, and phone number
      II. Name, Address, and phone number of person to contact in case of emergency
      III. Gender as identified by the participant
      IV. Participant Sexual Orientation
      V. Age and date of birth
      VI. Race and/or ethnicity
      VII. Is the participant multi-Racial?
      VIII. Is the participant Hispanic?
      IX. Living arrangements
      X. Type of housing
      XI. Does the participant speak a language other than English at home?
      XII. Legal representative status, (e.g., guardian, durable power of attorney)

   b. Health History
      I. History of illnesses, injuries, and health problems
      II. Allergies to medicine, food, etc.
      III. List of current prescription and over-the-counter medications
      IV. Orders by physician(s)
      V. Names of current physicians
      VI. Diagnoses
      VII. Reason for most recent hospitalization
      VIII. List durable medical equipment needed

6. The program shall operate within the following basic levels of service:
   a. **Person Centered Planning:** Discuss goal setting and participant objectives to identify personal needs and wishes, designing a pathway to services that will support a healthy recovery.
   b. **Service Arranging:** Program staff shall provide information, assistance, supports, services options, linkages, and service plan strategies for participants.
   c. **Accessible Housing Support:** Provide resources and guidance to assure adequate, accessible, barrier-free, supports and durable medical equipment is in place.

A-8 CARE TRANSITION COORDINATION AND SUPPORTS *(CONT'D)*

d. Follow-Up

1. Primary Care Follow Up: Cueing of 7-day primary care follow up
2. Medical transportation coordination
3. Weekly phone call follow-up/check-in for at least 30 days to ensure service plans are implemented as established and service needs are being met.

e. Red Flag warning

1. Confirm participant is knowledgeable about indications that their condition is worsening and how to respond.

f. Outcome Measures Reporting requirements include:

Reducing Readmissions for the Same Diagnosis

1. Was the participant readmitted to a medical care institution within 30 days?
2. Was the participant readmitted to a medical care institution for the same diagnosis within 30 days?
3. If yes, what factors contributed to the readmission?
4. If the participant was readmitted for the same diagnosis, how did the AAA follow up?
5. Type of medical institution (hospital, nursing facility, clinic, etc.).

Medication Management

1. Was a medication review of current and new medications completed with a health professional?

Primary Care Follow Up

1. Did the participant follow up with their primary care physician within 7 days?
2. If no, what were the barriers that contributed to the inability to follow up within 7 days?

Service Arranging

1. What long term supports and services were recommended?
2. Which recommendations did the participant accept?
3. What long term supports and services were received?

Transportation to Medical Appointments

1. Was medical transportation needed?
2. If so, was medical transportation provided?

Service Delivery

1. Each provider must obtain the views of recipients about the quality of services received using the Care Transition participant feedback survey.

A-8 CARE TRANSITION COORDINATION AND SUPPORTS *(CONT'D)*

Accessible Housing Support

1. Did the participant request durable medical equipment?
2. Were there barriers to receiving durable medical equipment?

7. Recommendation:

a. Medication consultation/management: Assure participant is knowledgeable about medications and has a medication management system to assure medications are taken as prescribed.
b. AAA to collaborate with local hospital(s) to strengthen the opportunity for predischarge collaboration efforts.

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 the ACLS Bureau 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).

VII. GENERAL REQUIREMENTS FOR IN-HOME SERVICE PROGRAM *(CONT'D)*

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.

In-Home Services Requiring Assessments	**Minimum Reassessment Frequency** (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.

VII. GENERAL REQUIREMENTS FOR IN-HOME SERVICE PROGRAM *(CONT'D)*

Minimum information to be gathered by assessments:

a. Basic Information
   i. Individual's name, address, and phone number
   ii. Source of referral
   iii. The name, address and phone number of person to contact in case of an emergency
   iv. The name address and phone number of caregiver(s)
   v. Gender
   vi. Age, date of birth
   vii. Race and/or ethnicity
   viii. Living arrangements
   ix. Condition of residential environment
   x. Whether or not the individual's income is below the poverty level and/or sources of income (particularly SSI)

b. Functional Status
   i. Vision
   ii. Hearing
   iii. Speech
   iv. Oral status (condition of teeth, gums, mouth, and tongue)
   v. Prostheses
   vi. Limitations in activities of daily living
   vii. Eating patterns (diet history), special dietary needs, source of all meals, and nutrition risk
   viii. History of chronic and acute illnesses
   ix. Prescriptions, medications, and other physician orders

c. Support Resources
   i. Physician's name, address, and phone number (for all physicians)
   ii. Pharmacist's name, address, and phone number (for all pharmacies utilized)
   iii. Services currently receiving or received in past (including identification of those funded through Medicaid)
   iv. Extent of family and/or informal support network
   v. Hospitalization history
   vi. Medical/health insurance available
   vii. Clergy name, address, and phone number, if applicable

d. Client Satisfaction (at reassessment)
   i. Client's satisfaction with services received
   ii. Client's satisfaction with program staff performance
   iii. Consistency of services provided

VII. GENERAL REQUIREMENTS FOR IN-HOME SERVICE PROGRAM *(CONT'D)*

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).

VII. GENERAL REQUIREMENTS FOR IN-HOME SERVICE PROGRAM *(CONT'D)*

d. Programs (except home delivered meals) with multiple sources of funding must specifically identify clients served with funds from the ACLS Bureau; records must contain a listing of all contacts (dates) paid for with funds from the ACLS Bureau, 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 the ACLS Bureau. 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.

Service Name	Chore
Service Number	B-1
Service Category	In-Home
Service Definition	Non-continuous/intermittent household maintenance tasks intended to increase the safety of the individual(s) living at the residence. Allowable tasks are limited to the following: • replacing fuses, light bulbs, electrical plugs, and frayed cords • replacing door locks and window catches • replacing/repairing pipes • replacing faucet washers or faucets • installing safety equipment • installing screens and storm windows • installing weather stripping around doors • caulking/winterizing windows • repairing furniture • installing window shades and curtain rods • cleaning appliances • cleaning and securing carpets and rugs • washing walls and windows, scrubbing floors • cleaning residence to remove fire and health hazards • pest control • grass cutting and leaf raking • clearing walkways of ice, snow and leaves • trimming impeding vegetation • gutter cleaning/repair • replace toilet parts (wax ring, chain, flapper etc.) • Cleaning of furnaces and replacement of furnace filters • Installation and the removal of portable AC units • Repair/Replacement of mailboxes • Installation of outside markers on the home .
Unit of Service	One hour spent performing allowable chore task.

Updated: June 21, 2024

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 $400 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.

B-1 CHORE *(CONT'D)*

2. Pest control services may be provided only by appropriately licensed suppliers.

3. Each program must develop working relationships with the Home Repair, Home Injury Control and Weatherization service providers, as available, in the program area to ensure effective coordination of efforts.

Service Name	Home Care Assistance
Service Number	B-2
Service Category	In-Home
Service Definition	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. 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. Note: social/emotional support of client may be offered in conjunction with other allowable tasks.
Unit of Service	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.

Service Name	Home Injury Control
Service Number	B-3
Service Category	In-Home
Service Definition	Providing adaptations to the home environment to prevent or minimize the occurrence of injuries to older adults. Home injury control does not include any structural or restorative home repair, chore, or homemaker activities.
Unit of Service	Individuals served

Minimum Standards

Updated May 17, 2024

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 is encouraged to utilize evidence-based toolkits and/or resources (i.e. Safe AT HOME Checklist) for fall prevention for older adults.

4. Each program may track key data for home injury control including:
    - Number and type of device(s) placed and/or installed in the home.
    - Total time (in hours) of completing the safety assessment and installing device(s).

5. Each program must utilize a home environment assessment tool to formally evaluate the circumstances and needs of each client.

Service Name	Homemaking
Service Number	B-4
Service Category	In-Home
Service Definition	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: • laundry • ironing • meal preparation • shopping for necessities (including groceries) and errand running • light housekeeping tasks (dusting, vacuuming, mopping floors, cleaning bathroom and kitchen, making beds, maintaining safe environment) • observing, reporting, and recording any change in client's condition and home environment Note: Social/emotional support of client may be offered in conjunction with other allowable tasks.
Unit of Service	One hour spent performing allowable homemaking activities.

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.

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

Minimum Standards

Updated September 15, 2025

HOME-DELIVERED MEALS

1. **Eligibility:** 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. Homebound individuals or other prioritized older persons
        i. Homebound persons should be prioritized above all others. This includes individuals who are normally unable to leave the home unassisted, and for whom leaving home takes a considerable and taxing effort. These persons may leave home for medical treatment or short, infrequent absences, such as a trip to the barber or to attend religious services.
        ii. Prioritized older persons include those who may be unable to participate in the congregate meal nutrition program because of physical, mental, or emotional difficulties, such as:
            1. A disabling condition, such as limited physical mobility, cognitive or psychological impairment,
            2. Lack of knowledge or skill to select and prepare nourishing and well-balanced meals,
            3. Lack of means to obtain or prepare nourishing meals,
            4. Lack of incentive to prepare and eat a meal alone, or
            5. 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.
    c. 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.*
    d. Participant must be able to consume meals independently or with the assistance of a caregiver.
    e. 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.

B-5 HOME-DELIVERED MEALS (HDM) *(CONT'D)*

2. **Extended Eligibility**: The nutrition provider and the Area Agency on Aging (AAA) should work together to determine extended eligibility based on meal availability, funding, and if it would benefit the participant to provide a meal to another person in the home that does not meet the criteria in #1. Those determined to be eligible for HDMs must complete the necessary National Aging Program Information Systems (NAPIS) documentation. Extended eligibility may apply to the following persons:
    a. A spouse of any age, living full-time in the home, if the HDM assessment finds that it is in the best interest of the HDM-eligible person.
    b. Family members of an HDM-eligible adult who are living with a disability and permanently live with the eligible adult in a non-institutional setting.

3. **Ineligibility Considerations:** 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. **Program Assessment:** Each program shall conduct an assessment of need for each participant, making the best effort to do so within ten working days of the participant entering the program. 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 180 days and 365 days after entering the program. In-person assessment is best practice and recommended. The initial assessment, yearly reassessments, and the 180-day reassessment may be conducted in-person, virtually, or via a telephone. A virtual or 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 participant's well-being.
    d. The program should avoid duplicating assessments of individual participants to the greatest 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, if external assessments/re-assessments encompass the required components and appropriate data sharing agreements are in place, as needed. Participants with multiple needs should be referred to case management programs, as appropriate.

B-5 HOME-DELIVERED MEALS (HDM) *(CONT'D)*

e. Multiple attempts to arrange reassessments should be made and documented, including those with approved family members or caregivers, when appropriate. If a participant refuses a reassessment, per the guidelines listed above, the program shall provide a written notification that meals may be discontinued until the reassessment is performed. 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 (per NAPIS criteria)
      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 the services received
      2. Participant's satisfaction with program staff performance

5. **Coordination of Meal Services:** Each HDM program shall be prepared to coordinate with Carry-out Meal and Congregate Meal programs and shall maintain linkages within community resources, as available, within the Planning and Service Area (PSA).

6. **Person-Centered Meal Planning**: 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 that acknowledge the participant's cultural, religious, and medical needs. All meals must meet the ACLS Bureau Nutrition Standards.

B-5 HOME DELIVERED MEALS (CON'T)

7. **Food Safety Verification**: The program shall verify and maintain records that indicate that each participant can provide safe conditions for the storage, thawing, and reheating of frozen foods, if applicable. Each nutrition provider shall develop a system by which to verify and maintain these records. Specific food safety guidelines can be referenced in the current Michigan Food Code. At a minimum, safe food storage conditions in the home should be verified at the initial assessment, re-assessments, and when emergency meals are delivered. Frozen foods should be kept frozen until such time as it is to be thawed for use.

8. **Nutrition Education**: Guidelines for nutrition education can be found in the Business Practice section of the *General Requirements for Nutrition Service Programs*. In addition, food safety education shall be provided to home-delivered meal participants biannually, at assessment and reassessment, that addresses participant instructions for safe storage and reheating of meals. Food safety education shall address hot, cold, frozen, and shelf-stable meals, as appropriate. Education may be provided in-person, virtually, or through written materials.

9. **Emergency Meals:** All nutrition providers shall provide HDM program participants shelf-stable meals to be used in the event of an emergency.
    a. Each HDM participant shall have a minimum of two shelf stable meals.
    b. Providers shall replenish meals at regular intervals or directly following an emergency resulting in meal delivery cancellations.
    c. Instructional materials must be distributed along with the shelf-stable meals to inform participants when to consume the meals, along with a list of recommended emergency food and equipment (i.e., manual can opener) that should be kept in the home.
    d. This process should be documented in the annual Emergency Management Nutrition Plan. For more information on developing an Emergency Management Nutrition Plan, please review the Business Practices section of the *General Requirements for Nutrition Service Programs*.

10. **Waiting List:** The following shall be considered when an agency has a waiting list:
    a. Each program must develop a prioritization system which should include a screening tool and monitoring plan.
    b. The screening tool may include ADLs, IADLs, malnutrition, food security, chronic health conditions, transportation access, and existing supports and services.
    c. All participants placed on a waitlist must be screened to assess waitlist prioritization.

11. **Meal Requirements:** Each HDM provider shall have the capacity to plan menus and provide meals which meet the ACLS Bureau nutrition requirements as outlined in the Meal Planning and Menu Development and Meal Patterns sections in the *General Requirements for Nutrition Service Programs*.
    a. Meals shall be available at least five days per week.

12. **Home Visit Safety**: Refer to the Business Practices Section of *General Requirements for Nutrition Service Programs* for safety policies related to participants, staff, and volunteers.

Service Name	Home Health Aide
Service Number	B-6
Service Category	In-Home
Service Definition	Performance of health-oriented services prescribed for an individua b 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 diet changing non-sterile dressing, taking blood pressure, and other health monitoring activities.
Unit of Service	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 serves.

Service Name	Medication Management
Service Number	B-7
Service Category	In-Home
Service Definition	• Direct assistance in managing the use of both prescription and over the counter (OTC) medication. Allowable program component include: • Face-to-face review of client's prescription, OTC medication regimen, and use of herbs and dietary supplements. • Regular set-up of medication regimen (Rx pills, Rx injectables, an OTC medications). • Monitoring of compliance with medication regimen. • Cueing via home visit or telephone call. • Communicating with referral sources (physicians, family member primary care givers, etc.) regarding compliance with medication regimen. • Family, caregiver and client education and training.
Unit of Service	Each 15 minutes (.25 hours) of component activities performed.

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.

B-7 MEDICATION MANAGEMENT *(CONT'D)*

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.

Service Name	Personal Care
Service Number	B-8
Service Category	In-Home
Service Definition	Provision of in-home assistance with activities of daily living (ADL) f an individual including assistance with bathing, dressing, grooming toileting, transferring, eating, and ambulation. Personal care does n include health-oriented services as specified for Home Health Aid Services
Unit of Service	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.

Service Name	Assistive Devices and Technologies
Service Number	B-9
Service Category	In-Home
Service Definition	A service that provides assistive devices and technologies which enable individuals to live independently in the community according to their preferences, choices and abilities.
Unit of Service	One device, plus installation and training as appropriate, provided to a program participant.
Service Description	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), wheelchairs, 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® 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® 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.

B-9 ASSISTIVE DEVICES AND TECHNOLOGIES *(CONT'D)*

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.

Service Name	Respite Care
Service Number	B-10
Service Category	In-Home
Service Definition	Provision of companionship, supervision and/or assistance wit 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 residence.
Unit of Service	Each hour of respite care provided.

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.

B-10 RESPITE CARE *(CONT'D)*

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

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

Minimum Standards

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

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

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

4. Each program shall establish and provide to all paid and volunteer reassurance workers a copy of procedures to be followed in emergencies and when a client does not call or answer or is not home as arranged. These procedures must include at a minimum:
    a. Provision for an immediate visit to the client's home by program staff or emergency service personnel (i.e., police, ambulance, fire department, etc.).
    b. Contact of the individual named to be notified in case of an emergency regarding each individual client.
    c. Verification that either subsequent contact has been made with the client or that the client's location has been identified.

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

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

Service Name	Carry-Out Meals (COM)
Service Number	B-12
Service Category	In-Home
Service Definition	The provision of nutritious meals to eligible recipients via carry out.
Unit of Service	One meal served to an eligible participant.

Minimum Standards

Updated October 18, 2024

CARRY-OUT MEALS

1. Carry-Out Meals (COM), also known as “Grab ‘n Go” or “Curbside Pick-up”, include Carry-Out Weekend Meals and Carry-Out Second Meals. COM are complete meals offered to participants at the point of service to be consumed off-site, without in-person or virtual interaction sponsored by the Nutrition Provider. Meals may be provided via shelf-stable, pick up, carry-out, drive-through or similar method. These meals are designed to offer participant choice via person-centered planning. They are meant to serve those who are most economically and socially disadvantaged as defined by ACLS Bureau, and who may not qualify for traditional Home-Delivered Meals (HDM) and may be unable to or choose not to participate in traditional congregate dining.

2. COMs are an optional meal service allowable for both Congregate and HDM meal programs when included as part of an approved area plan or area plan amendment when the following requirements are met:

    a. Title III-C1 Congregate Meals may be provided as set forth in §1321.87(a)(1)(i) of the 45 CFR:
        i. Meals shall not exceed 25% of the funds expended by the State agency under Title III, part C1, to be calculated based on the amount of Title III, part C1 funds available after all transfers as set forth in § 1321.9(c)(2)(iii) are completed;
        ii. Meals shall not exceed 25% of the funds expended by any area agency on aging under Title III, part C1, to be calculated based on the amount of Title III, part C1 funds available after all transfers as set forth in § 1321.9(c)(2)(iii) are completed.
        iii. Meals provided as set forth in paragraph (a)(1)(i) of this section may be provided to complement the congregate meal program:
            A. During disaster or emergency situations affecting the provision of nutrition services;
            B. To older individuals who have an occasional need for such meal; and/or
            C. To older individuals who have a regular need for such meal, based on an individualized assessment, when targeting services to those in greatest economic need and greatest social need.

B-12 CARRY-OUT MEALS (COM) *(CONT'D)*

b. Title III-C2 Home-Delivered Meals may be provided as set forth in §1321.87(a)(1)(i) of the 45 CFR:
   i. Eligibility criteria for home-delivered meals may include consideration of an individual's ability to leave home unassisted, ability to shop for and prepare nutritious meals, degree of disability, or other relevant factors pertaining to their need for the service, including social need and economic need.
   ii. Home-Delivered meals service providers may encourage meal participants to attend congregate meal sites and other health and wellness activities, as feasible, based on a person-centered approach and local service availability.

3. Each program shall have written eligibility criteria for participants. Eligibility includes the following, at a minimum, the participant must:
   a. Be 60 years of age or older.
   b. Complete the required registration process.

4. Extended Eligibility: The nutrition provider and AAA should work together to determine extended eligibility based on meal availability and funding. Those determined to be eligible for COMs must complete the necessary National Aging Program Information Systems (NAPIS) documentation. Extended eligibility may apply to the following persons:
   a. A spouse of any age of the eligible COM participant.
   b. Family members of an eligible adult who are living with a disability and permanently live with the eligible adult in a non-institutional setting.
   c. People with disabilities who live in housing facilities where mainly older adults live, and which also provide congregate nutrition services.
   d. People who provide volunteer services during the meal hours.

5. 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.

6. Each COM program must provide and collect registration from each participant within 10 working days after an individual enters the program. At a minimum, registration must be updated and collected within 365 days from the date of the initial registration. Registration may be completed by the individual and returned in person or may be completed with program staff face-to-face, in-person or virtually. Yearly follow up shall follow the same process as the initial registration or may be completed by telephone. All registrations must be signed and submitted.
   a. Registration and follow up must, at a minimum, include the following:
      i. Basic Information (NAPIS/State Performance Report elements)
         A. Name, Address, Phone Number
         B. Demographics: date of birth, age, gender, geography (rural or non-rural), poverty status, living arrangement, ethnicity, race, gender

B-12 CARRY-OUT MEALS (COM) *(CONT'D)*

C. Nutrition Risk Score via DETERMINE Checklist
D. Functional Status
    - Activities of daily living (ADLs)
    - Instrumental activities of daily living (IADLs)

b. Additional individualized assessment information must be collected, and reassessed annually to determine the *regular* need for COMs, including:
    i. Prioritizing criteria
    ii. Rationale explaining the need for regular COMs
    iii. At the discretion of the provider and the AAA, documentation of existing supports and the needs for additional services and/or referrals.

7. A written procedure for the distribution and documentation of meals is to be developed by the nutrition provider and approved by the AAA. This includes, but is not limited to, how and when participants obtain a meal, the distribution of nutrition education, and allowing a proxy to pick up meals on behalf of the participant.
8. Each nutrition provider, with the approval of the AAA, may decide the frequency of meals provided. This process must include person-centered planning, which may include allowing the participant to attend congregate meals when they have a willingness to attend. It may also include meal choices such as vegetarian as long as they meet the ACLS Bureau Nutrition Standards.
9. Nutrition Education: Guidelines for nutrition education can be found in the "Business Practices" section of the *General Requirements for Nutrition Service Programs*. In addition, food safety education should be provided to participants when meals are taken off-site. Each nutrition provider shall develop a system by which nutrition education shall be administered.

    a. At a minimum, food safety nutrition education must be provided when COMs are initiated, and annually thereafter, when the registration is renewed. This must include information on food storage and can be provided in-person, virtually, or in a written format via a standard flyer.
    b. Each meal shall be labeled with participant instructions for safe storage, reheating, and expiration dates.

10. Each COM program shall be prepared to coordinate with HDM and Congregate Meal programs and shall maintain linkages with community resources, as available, within the Planning and Service Area (PSA).
11. Each COM provider may utilize a waitlist for meals when HDM and/or COM meals are in high demand. When an agency has a waitlist, the following must be considered:
    a. Each program must develop a prioritization system which should include a screening tool and monitoring plan.
    b. All participants placed on a waitlist must be screened to assess waitlist prioritization.
    c. Each program must be able to document how individuals on the waitlist are prioritized.

B-12 CARRY-OUT MEALS (COM) *(CONT'D)*

d. Each COM provider shall have the capacity to provide meals which meet the Older Americans Act and/or state nutrition guidelines by complying with the most recent *USDA Dietary Guidelines for Americans* and meeting a minimum of 1/3 of the Dietary Reference Intakes (DRI).
e. All menus to be approved by a dietitian, an individual who is registration eligible, or a registered Nutrition and Dietetic Technician (NDTR). Menus should include key nutrients and follow dietary recommendations that relate to lessening chronic disease and improving the health of older adults.
f. For more information on meeting the nutrition guidelines, please review the "Meal Planning and Suggested Meal Patterns" section in the *General Requirements for Nutrition Service Programs*.

VIII. COMMUNITY

Service Name	Adult Day Services
Service Number	C-1
Service Category	Community
Service Definition	Adult Day Services provides respite to caregivers. Daytime care of any part of a day but less than 24-hour care for adults with functional and/or cognitive impairment, including dementia provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the participant's and/or caregiver's home. Adult Day Services (ADS) provide meaningful activity, socialization, and enrichment opportunities for eligible participants to help; maximize optimal functioning, promote community living for as long as possible and delay placement into nursing home or other institutional settings.
Unit of Service	1 hour

Updated: September 27, 2024

Minimum Standards

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

    a) May require ongoing supervision in order to live in their own homes or the home of a primary caregiver
    b) May require a substitute caregiver while their primary caregiver needs relief, or is otherwise unavailable
    c) May have difficulty or be unable to perform activities of daily living (ADLs) without assistance
    d) May be socially isolated, lonely and/or distressed as the result of declining social activity
    e) May have frequent hospitalizations or emergency room visits
    f) May be at risk of placement into an institutional setting due to functional level and/or caregiver stress/burnout
    g) May have a dementia related diagnosis, display symptoms of a dementia, or are living with a chronic health condition. A physician's diagnosis is recommended
    h) Must be capable of leaving their residence, with assistance, in order to receive Adult Day Services
    i) May 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

C-1 ADULT DAY SERVICES (ADS) (CONT'D)

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

   a) The individual's name, address, and telephone number
   b) The individual's age or birth date
   c) The name, address, and telephone number of the emergency contact.
   d) Disabilities, or other diagnosed medical conditions
   e) Perceived supportive service needs as expressed by the participant and/or caregiver
   f) Race, gender identity (optional at preliminary screen)

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

   a) <u>Basic Information</u>
      1. Individual's name, address, and telephone number
      2. Date of birth
      3. Sexual orientation, gender identity
      4. Marital status
      5. Race and/or ethnicity
      6. Living arrangements
      7. Condition of home environment, if known
      8. Income and expenses, by source
      9. Previous occupation(s), special interests, and hobbies
      10. Religious affiliation (optional)
      11. Emergency contact(s)
      12. Medical/health insurance and long-term care insurance information
      13. Guardianship documents, if applicable

   b) <u>Functional Status</u>
      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 with activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
      9. History of chronic and acute illnesses
      10. List of medications (prescription, over the counter, supplements, herbal remedies)
      11. Physician orders, if applicable
      12. Eating patterns (diet history) and special dietary needs

C-1 ADULT DAY SERVICES (ADS) (CONT'D)

c) Supporting Resources
   1. Physician's name, address, and telephone number
   2. Preferred pharmacy name, address, and telephone number
   3. Services currently receiving
   4. Extent of family and/or informal support network
   5. Hospitalization history
   6. Preferred hospital
   7. Faith-based support contact name and telephone number

d) Need Identification
   1. Participant perceived
   2. Caregiver perceived
   3. Assessor perceived

e) Admission to the program may be determined through assessment, a trial visit, or recommendation/referral.

f) Caregiver Information and Assessment

   Caregiver information, such as the NAPIS data set, must be updated on a yearly basis.

   Each program is encouraged to use the Modified Caregiver Strain Index on a yearly basis as appropriate.

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 participant, the participant's guardian, or designated representative. The service plan shall contain at a minimum:

   a) A statement of the participant's 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 standard and optional program services to be provided
   e) Treatment orders of qualified health professionals, when applicable
   f) A statement of medications being administered to participant or that the participant is reminded to take while in the program
   g) Persons demonstrating significant impairments in cognition, communication and personal care activities of daily living may require one of 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, and hygiene

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

C-1 ADULT DAY SERVICES (ADS) (CONT'D)

5. Each program shall maintain comprehensive and complete participant files, to be kept confidential and in controlled access storage, which include at a minimum:

    a) Details of participant's referral to Adult Day Services
    b) Emergency contact
    c) Recent photograph of participant
    d) Information gathered from preliminary screening
    e) Assessment of participant's need or copy of assessment (and reassessments) from the referring program, if applicable
    f) Service plan with notation and date of any revisions
    g) Record of participant attendance
    h) Monthly progress notes of participant status indicating maintenance, decline, or improvement
    i) Documentation of all medications taken on premises, including:
        1. The name of each medication
        2. The dosage, frequency, and time each medication is to be taken
        3. Actual time each medication dosage is taken and initials of staff person administering or reminding
        4. Reason given by the participant if refused
        5. Reason for each administration of prescribed PRN medication
        6. Medications must be administered from original pharmacy labeled package
    j) Documentation of standard and optional services provided to the participant
    k) Each program shall have a signed release of information form that is time-limited and specific to the information being released

6. Each Adult Day Service shall provide directly or arrange for the provision of the following standard services for the participant.

    a) Transportation
    b) Personal care: consisting of assistance with ADLs as specified in the participant service plan
    c) Program/Activities: An array of planned activities suited to the needs and preferences of the participants designed to encourage physical exercise, maintain, or restore abilities, prevent deterioration, and offer social interaction. Activity choices should be person-centered and allow for each individual to decide whether or not to participate. If a participant declines an activity, an alternative should be offered.
    d) 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*. Snacks will be made available. Participants in attendance from eight to 14 hours shall receive an additional meal or snacks that meet required nutrition standards. Modified diet menus should be provided, where feasible and appropriate, which take into consideration participant choice, health, religious and ethnic diet preferences. Meals may be acquired from a congregate meal provider where possible and feasible.

C-1 ADULT DAY SERVICES (ADS) (CONT'D)

1. For meal provision within the Adult Day Services setting, Title III-C-1 (OAA congregate meal funding) and state congregate meal funding may only be used as specified in the ACLS Bureau Operating Standards for Services Programs General Requirements for Nutrition Service Programs and C-3 Congregate Meals Service Standard

e) The program shall demonstrate awareness of and offer referrals to other caregiver supports and services as needed.

7. Each Adult Day Service may provide directly or arrange for the provision of the following optional services for the participant. 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 licensed professional
c) Nursing services: provided by a licensed R.N. or by a licensed L.P.N. under R.N. supervision, or by another staff person under R.N. direction and supervision
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

8. Each ADS program shall establish a written policy for medication management and must designate which staff are trained and authorized to administer medications. The medication management policy, which must include a medication training program, must be approved by a registered nurse, physician, or pharmacist. Licensed nurses are required to oversee medication administration but administering medications can be a delegated task performed by trained staff.

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

C-1 ADULT DAY SERVICES (ADS) (CONT'D)

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 participant
    e) When the program becomes unable to continue to serve the participant

10. Each program shall employ a program director/manager with a minimum of a bachelor's degree or applicable knowledge and experience.

11. At least two staff members must be present on the premises whenever two or more participants are in the ADS facility. Volunteers may be counted towards the staffing minimums if they have received the same level of training as paid staff. The program shall continually provide support staff at a minimum of one staff person for each five participants.

12. Program staff shall be provided with an orientation training that includes topics specified in the *General Requirements for All Service Programs*, and the following:

    a) Introduction to the program
    b) The Aging Network
    c) Maintenance of records and files (as appropriate)
    d) The aging process
    e) Ethics
    f) Emergency procedures
    g) Diversity, equity, and inclusion
    h) Normal aging vs. disease symptoms
    i) Techniques for effective communication with program participants
    j) Adult Protective Services law and mandated employee reporting requirements
    k) Participant rights and responsibilities
    l) Assessment and management of responsive behavior
    m) Blood Borne Pathogens and Universal Precautions
    n) Confidentiality/HIPAA
    o) First Aid and CPR/AED
    p) Training to understand, respond to, and address the needs of participants with Alzheimer's disease and other dementias. Including but not limited to:
        1. Explanation of Alzheimer's disease and other dementias and their progression
        2. Assessing and managing responsive behavior
        3. Communication approaches and techniques
        4. Effect of environmental factors on the participant
        5. Impact of the disease on family caregivers

C-1 ADULT DAY SERVICES (ADS) (CONT'D)

It is recommended that Initial training programs include the following:

a) Impact of caregiver stress
b) Regional caregiver supportive services
c) Therapeutic 1:1 and small group engagement
d) Physical care techniques related to activities of daily living
e) Food Safety
f) Information and referral resources in the event of a crisis situation such as:
    1. Illness or death of the primary caregiver
    2. Suicidal ideation of the caregiver or participant
    3. Adverse incident during the delivery of service

Program staff shall be provided in-service training at least twice each year. One training per year shall be focused on caregiving for persons with dementia. Additional trainings may include updates, and refresher trainings on any of the above listed orientation training topics, or other pertinent topics related to Adult Day Services which increase staff knowledge and understanding while incorporating new developments and advancements in geriatric and dementia care. Records shall be maintained which identify the dates of training, topics covered and persons attending.

13. If the program operates its own vehicles for transporting participants 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) Each program shall develop standards regarding criteria for safe driving records of persons responsible for providing transportation
    c) The program will ensure there is a written plan for safe transport that is part of the participant's service plan. This may include any level of assistance: on and off the vehicle, curb to curb, door to door, or door to in-home

14. A monthly calendar of activities must be prepared and posted in a visible place.

15. Each program shall have written policies and procedures that address medical emergencies. Each program shall have first aid supplies available at the service center. A staff person certified in first aid procedures, including CPR, shall be present at all times participants are in the service center. It is recommended that programs have an AED present and in good working condition.

16. Each program shall have written policies and procedures that address emergency situations. Procedures for evacuation shall be posted in each room of the service center. Practice evacuation and tornado drills shall be conducted at least once every six months. The program shall maintain a record of all practice drills.

C-1 ADULT DAY SERVICES (ADS) (CONT'D)

17. Each service center shall have the following furnishings:

    a) At least one straight back or sturdy non-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) Locked storage space is to be made available at the request of a participant or the participant's guardian or designated representative
    e) Tables for both ambulatory and non-ambulatory participants
    f) A telephone that is accessible to all participants
    g) Special equipment as needed to assist persons with disabilities
    h) Bathroom facilities to accommodate persons with disabilities. A minimum of one toilet per ten participants is recommended
    i) Adequate space available for safe arrival and departure

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

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

19. Participants receiving approved days of Adult Day Services are at times unable to attend in person due to various uncontrollable reasons. These reasons may include closure of the service provider, medical, personal, weather, or family related. The provider and/or the agency authorizing services will assess and document the need for provision of short-term intermittent hybrid Adult Day Services to ensure continuity of care. Offering hybrid Adult Day Services is optional and at the discretion of the agency authorizing services and the ADS service provider.

    Hybrid Services/Activities may include, but are not limited to:
    a) Phone calls with family caregivers and participants
    b) Weekly "support group" phone calls with family caregivers and participants
    c) Activity packet development and dissemination to participants
    d) Use of Adult Day Services staff to deliver participants' food and other essential items
    e) Monthly participant assessments
    f) Any other creative activity that helps to engage the participant and relieve the caregiver in a safe and effective manner

Service Name	Dementia Adult Day Care- **INACTIVE STANDARD AS OF MAY 19, 2023**
Service Number	C-2
Service Category	Community
Service Definition	
Unit of Service	

Removed May 19, 2023

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

Minimum Standards

Updated September 15, 2025

CONGREGRATE MEALS

1. **Eligibility:** 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. An individual age 60 or older.
    b. A spouse, of any age.
    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. A volunteer under the age of 60 who directly supports the meal site and/or foodservice operations may be provided a meal if all eligible participants can be served, and meals are available.
        i. 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.
    e. Individuals with disabilities who are under the age of 60 and reside in housing facilities occupied primarily by older individuals where congregate nutrition services are provided may participate in the meal.
    f. To be eligible for a donation-based meal, persons described in items b-d must accompany the eligible adult to the meal site and eat the meal at the meal site.

2. **Ineligibility Considerations:** At the provider's discretion, persons not otherwise eligible under item #1 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.
    a. Ineligible persons include adults, 18-59 years of age, and children under the age of 18.
        i. Children must accompany a meal participant who is age 60 and older.
    b. The provider must document and maintain a record that the full cost of the ineligible meal has been paid.
    c. At the provider's discretion, reservations may be required.

3. **Coordination of Meal Services:** Each Congregate program shall be prepared to coordinate

C-3 CONGREGATE MEALS *(CONT'D)*

with Home-delivered Meal and Carry-out Meal (COM) meal programs and shall maintain linkages with community resources, as available within the Planning and Service Area (PSA).

4. **Meal Site Compliance:** Each congregate meal site shall be able to document the following:
   a. It is operating within an accessible facility.
      i. 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.
      ii. Documentation from a local building official or licensed architect is preferred.
      iii. When a local official is unavailable after a formal written request, a program may conduct accessibility assessments of its meal sites using written guidelines that follow the *ADA Standards for Accessible Design*. Specific requirements are based on when the facility was constructed.
      iv. Considerations must include accessible route, doors, entrances, parking, signage, assembly areas, dining spaces, and bathroom facilities.
      v. These requirements can be found at: https://www.ada.gov/law-and- regs/design-standards/.
      vi. The master checklist template outlining building accessibility requirements shall be reviewed and updated by the respective AAA and approved by the ACLS Bureau no less than every three years.
      vii. The Disability Network of Michigan is a valuable resource for addressing accessibility and inclusion within organizational settings, offering training, technical assistance, and Accessibility ADA Site Reviews.
   b. Compliance with local fire safety standards.
      i. Each meal site must be inspected by a local fire official every three years, at a minimum. Inspection reports shall be uploaded into the Congregate Meal Site Database each time a new one is received.
      ii. When a local fire official is unavailable after a formal written request, a program may conduct fire safety assessments of its meal sites using written guidelines developed from the National Fire Protection Association (NFPA) *Life Safety Code, 2012 edition,* or newer.
      iii. The master checklist template shall be reviewed and updated by the respective AAA and approved by the ACLS Bureau no less than every three years.
      iv. These requirements can be found at: https://www.nfpa.org/.
   c. Compliance with Michigan Food Code and local public health codes regulating food service establishments.
      i. Each meal site and kitchen operated by a congregate meal provider shall be licensed, as appropriate, by the local health department.
      ii. 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.
      iii. The local health department rulings supersede any state rules/mandates concerning licensing of food service establishments, including congregate meal sites and off-site meals.

C-3 CONGREGRATE MEALS *(CONT'D)*

iv. 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. **Minimum Service Requirements**: Special attention should be paid to the number of days open, meals per day, and number of participants.
   a. Each program, through a combination of meal sites, must provide meals at least five days per week.
   b. Each meal site must offer at least one meal per day.
   c. The AAA, in coordination with the nutrition provider, may determine the minimum number of participants served.
   d. The integrity of OAA nutrition programming should be maintained and ensure the following:
      i. Coordination with other meal sites.
      ii. Individuals in greatest social or economic need, and minority and ethnically diverse populations are being served.
      iii. Ensuring the quality of meal service is maintained.
      iv. The cost efficiency of meal programming is considered.
      v. And innovative practices are engaged to ensure congregate meal sites are attracting and retaining participants.
6. **Waivers:** Waivers to the requirements listed in #5 may be granted by the ACLS Bureau when a written request is submitted that includes the following rationale:
   a. The barriers to meeting the minimum requirements.
   b. The justification for the waiver request, including, but not limited to, high poverty regions, underserved populations, and rural or isolated regions.
   c. A plan for the coordination of meal sites or meal service types to effectively serve a defined area to the maximum extent possible to ensure food security.

7. **Meal Site Requests:** The ACLS Bureau must approve all meal site openings, relocations, and closure requests through the Congregate Meal Site Database, located at: https://www.osapartner.net/congmeal/. AAAs should contact the Nutrition Specialist for database access. Requests must be submitted and approved prior to any site change status.

8. **Priority Regions:** 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. Locations of new and/or relocated meal sites should consider prioritizing areas with the following:
   a. High concentration of older adults
   b. High concentration of older adults in poverty
   c. High concentration of underserved populations

C-3 CONGREGRATE MEALS *(CONT'D)*

9. **Opening/Relocation Procedures:** When a meal site is to be opened/relocated, the following procedures shall be followed:
   a. The program shall notify the respective AAA in writing of the desire to open/relocate a meal site.
   b. The program shall present a rationale for opening/relocating the meal site.
   c. The respective AAA shall review and submit the opening/relocation request into the Congregate Meal Site Database. The online application should be fully completed before submitting a written request to the ACLS Bureau. Documents required to be uploaded into the database include:
      i. Fire Safety inspection within the last three years
      ii. Accessibility documentation
      iii. Local Health Department License
      iv. Local Health Department Inspection report
      v. Food Safety Certifications of employees, as appropriate
      vi. Approved waivers
      vii. Date of occupancy
      viii. Proposed date of service
   d. Meal sites must be approved by the ACLS Bureau prior to the provision of any meals at that site.
   e. The ACLS Bureau will review the documents and the request to open/relocate the site. If approved, the ACLS Bureau will notify the requestor, the respective AAA, and the field representative.

10. **Permanent Closure Procedures:** 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, e.g., lack of attendance, inability to meet minimum standards and/or other requirements, loss of resources (funding, personnel, etc.), 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 the area that was served by the meal site, efforts should be made to develop a new site and/or assist participants with attending another existing meal site.
   d. The program shall notify participants 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 Congregate Meal Site Database. Written notification shall include the following and be uploaded into the Congregate
      Meal Site Database:
      i. Location name and address
      ii. Rationale for closing the site
      iii. How participants will be notified
      iv. Closest meal site to the closed site, and transportation options to get participants to the different site

C-3 CONGREGRATE MEALS *(CONT'D)*

v. Proposed date of closure

f. The ACLS Bureau will review the documents and the request to close the site. If approved, the ACLS Bureau will notify the requestor, the respective AAA, and the field representative.

11. **Temporary Meal Site Closures:** If a meal site must be closed or moved temporarily, the following procedures shall be followed:

a. The nutrition provider must notify the respective AAA, and the ACLS Bureau, by using the on-line Temporary Meal Site Closure form.

b. This form must be completed and submitted prior to the closing, or as soon as possible after the closing, depending on the circumstance

c. A link to the form is located on the business partner site: https://www.osapartner.net.

d. Instances in which meal sites must be temporarily closed or relocated may include weather related closures, power outages, etc.

12. **Emergency Preparedness:** 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. Copies of emergency plans must be made available for reference. This includes the AAA's Emergency Management Plan that addresses nutrition preparedness, as outlined in the *General Requirements for Nutrition Service Programs*.

b. The training of staff and volunteers on policies and procedures to be followed in the event of a severe weather storm, natural disaster, medical emergency, or any other crisis.

c. An annual fire drill.

13. **Facility Agreements:** Each program shall have written agreements with the owners of all leased facilities used as meal sites. Written agreements are <u>strongly</u> recommended for donated facilities. If agreements are not in place, the AAA must provide documentation outlining who is responsible for the items below. The agreements shall address, at a minimum:

a. Agreement on utility costs,

b. Responsibility for care and maintenance of facility, specifically including restrooms, equipment, kitchen, storage areas, and areas of common use.

c. Responsibility for snow removal,

d. Responsibility for safety inspections, including fire and handicap accessibility,

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.

14. **NSIP-only Meal Sites:** Upon approval of the respective AAA, a program may enter into an agreement with an organization operating a congregate meal site that is not receiving federal or state funding so that the organization shall receive Nutrition Services Incentive Program (NSIP) funding for meals served to persons age 60 and over.

C-3 CONGREGRATE MEALS*(CONT'D)*

a. Any meal site receiving NSIP-only funding must operate in compliance with all federal requirements and ACLS Bureau Nutrition 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.
b. The program shall have a written agreement with each organization operating NSIP- only meal sites. It shall include a statement indicating that the provider allows anyone eligible for a congregate meal to participate in the NSIP-only meal program.

15. **Congregate Posters**: Each program shall display, at a prominent location in each meal site, the ACLS Bureau Community Nutrition Services poster. The program may create their own poster provided that all the required information is included and clearly presented. The poster shall contain the following information for each program:
    a. The name and contact information of the nutrition project director,
    b. The AAA's name and contact information,
    c. The suggested donation for eligible participants,
    d. The guest fee to be charged for non-eligible participants,
    e. A non-discrimination statement identical to the language on the ACLS Bureau poster which is Health and Human Service language. No additional information should be included on the poster.

16. **Adaptive Eating Equipment:** Each program shall make available, upon request, specialized adaptive eating tableware (assistive plates, bowls, cups, and utensils) for participants.

17. **Potlucks:** Congregate meal programs receiving funds through the ACLS Bureau may not contribute towards, provide staff time, or otherwise support potluck activities, or allow program food stuff to be combined with foods brought in by participants.

18. **Prayer:** Older adults may pray before a meal that is at a site that is funded through ACL 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.

19. **Leftovers:** Leftovers are considered any residual food from a complete meal not eaten by the participant. Leftovers are not considered a COM. Leftovers may be taken out of the meal site if the following conditions are met, and the local health department has no restrictions against it.
    a. A sign shall be posted informing the meal participants that all food removed from the site becomes the responsibility of the individual.
    b. All new congregate participants shall be informed that they are responsible for food taken out of the meal site and shall receive written participant instructions for safe storage and reheating of leftovers annually.
    c. Nutrition providers are not required to provide containers with federal or state funds.

C-3 CONGREGRATE MEALS *(CONT'D)*

20. **Off-site Meals:** Meals consumed off-site are considered congregate dining if:
    a. Participants engage in a social activity organized by the meal site, nutrition provider, AAA, or an aging network agency. Social activities may be conducted in person or virtually and must be open to all eligible participants.
        i. In-person social activities may include, but are not limited to parks, festivals, events, picnics, and tailgates, and may occur indoors or outdoors.
        ii. Virtual social activities may include one-to-one interaction with a program volunteer, or group interaction via a virtual web application such as Google Meet, Zoom, or FaceTime.
    b. Participant attendance for any virtual interaction should be documented by the nutrition provider.
    c. Only one meal is offered per person at an off-site social activity, and the meal is consumed at the event.
    d. Meals meet ACLS Bureau nutrition standards. At a minimum, the preparation and service of off-site meals must follow the food safety requirements as outlined in the Michigan Food Code. In addition, local health department rules and regulations may offer more stringent guidance and must be followed.
    e. A process for approval and reporting should be determined by the AAA and the nutrition provider, including, but not limited to:
        i. The frequency of reporting information,
        ii. The sponsoring agency,
        iii. The date and type of event, and
        iv. The number of participants in attendance.
    f. This information shall be made available to the ACLS Bureau, as requested.

21. **Complimentary Programming and Demonstration Projects:** AAAs and nutrition providers are encouraged to work together to provide innovative and person-centered activities and programs at congregate meal sites during mealtime. Suggestions for special events include, but are not limited to:
    a. Entertainment, informational presentations, educational opportunities, and guest speakers,
    b. Mobile congregate sites or food trucks, and
    c. Cooking demonstrations could include smoothies, vegetarian cuisine, non-traditional food choices, and other trending food concepts.
    d. Refer to the process in 20 (e) and (f) for reporting meals with complementary programming or demonstration projects.

22. **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. Nutrition providers must allow older adults to use congregate meal sites and voucher programs interchangeably.
    b. The restaurant, café, or other food service establishment must be licensed, follow the Michigan Food Code, and be inspected regularly by the local health department.

C-3 CONGREGRATE MEALS *(CONT'D)*

c. The restaurant, café, or other food service establishment agrees to provide at least one meal that meets the ACLS Bureau nutrition standards for meals.
d. The restaurant, café, or other food service establishment must be barrier-free and Americans with Disabilities Act (ADA) compliant and meet local fire safety code requirements for restaurant establishments.
e. 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 holders,
    iii. How billing will be handled, including whether a tip will be included in the unit price. For example, if the meal reimbursement is $6.25, will $.25 be used toward the tip?
    iv. How reporting will take place, including the frequency and what is reported,
    v. Evaluation procedures, and
    vi. A statement that meals must be consumed at the food establishment, leftovers may be taken home, and that participants may purchase additional food and beverages with their own money.
f. A copy of all current documents shall be provided to the AAA nutrition program coordinator for upload into the Congregate Meal Site Database, including recent health department inspections, the food service license, fire safety inspection, ADA inspection, and the food safety certification of at least one employee.
g. 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, including how restaurants, cafés, or other food service establishments are selected to participate and how new establishments can apply to participate,
    iii. How older adults qualify for and where to obtain their vouchers, i.e., at senior centers, nutrition provider's office, or meeting with a nutrition program representative at the restaurant, café, or other food service establishment to obtain vouchers and give donations,
    iv. How frequently menu choices will be reviewed and revised by the AAA Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN), an individual who is registration eligible, or a Registered Nutrition and Dietetic Technician (NDTR), and
    v. The procedure for participants to dine at congregate meals sites and restaurant meal voucher programs interchangeably

C-3 CONGREGRATE MEALS *(CONT'D)*

23. **Adult Foster Care (AFC) and Residential Care Participants**: Congregate meal providers may request that an AFC home/Residential Care program provide staff to assist the residents they bring with meals and other activities in which they wish to participate. If residents and staff of AFC or other residential providers regularly attend a congregate meal site, the nutrition provider may request the facility enter into an agreement regarding donations and payments for meals.

24. **Adult Day Services (ADS)**: An ADS program may serve congregate meals to participants if a senior nutrition provider is available and has service capacity. Funding for ADS meals shall be determined by the AAA.

Service Name	Nutrition Counseling
Service Number	C-4
Service Category	Community
Service Definition	A standardized process that provides individualized advice and guidance to individuals who are at nutritional risk because of health and/or nutritional history, dietary intake, medication use or chronic illness, and addresses options and methods for improving their nutritional status with a measurable goal.
Unit of Service	Hours (partial hour may be reported to two decimal places, e.g.,0.25 hours.)

Updated August 15, 2025

Minimum Standards

1. Nutrition counseling is a supportive process to set priorities, establish goals and create individualized action plans which acknowledge and foster responsibility for self-care, and may include Medical Nutrition Therapy (MNT) services for more in depth guidance related to chronic disease management.

2. Individuals should be referred to nutrition counseling when identified as nutritionally at-risk through a screening process, self-referral, community, or physician referral.

3. Nutrition counseling services shall be provided by a Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN); one-on-one with individuals or caregivers of the individual at nutritional risk.

4. Each program shall ensure that nutrition counseling services align with the Academy of Nutrition and Dietetics evidenced based practices.

5. Assessment of each client may include, but not be limited to:
   a. Anthropometric measurements,
   b. A weight history, including any recent weight changes,
   c. Nutrition-focused physical findings,
   d. A medical history, including chronic and acute health problems,
   e. Recent lab results,
   f. Medication prescriptions and over the counter medications, including vitamins, minerals, and herbal supplements,
   g. A physical activity history,
   h. A food recall of oral intake,
   i. And a statement of the client's concerns and goals.

C-4 NUTRITION COUNSELING (CON'T)

6. The RD/RDN shall develop a nutritional care plan for each client based on the individual assessment that includes at a minimum:
   a. A statement of the client's problems,
   b. Interventions that consider the client's needs, strengths, barriers, and resources, including:
      i. Descriptions of methods and approaches to be used,
      ii. Resources currently being used by the client,
      iii. Current treatment orders, if any, from a client's physician including special diets and orders for oral nutrition supplements, and
      iv. Referrals to other resources or programs.
   c. Person-centered goals and objectives,
   d. And a plan to monitor and evaluate progress.

7. Each program shall be able and prepared to offer services in a variety of settings including the client's residence, community-based settings, and AAA locations, as well as Health Insurance Portability and Accountability Act (HIPAA) compliant virtual telehealth sessions and telephonic sessions.

8. All client health information should be treated as confidential and stored securely.

Service Name	Nutrition Education
Service Number	C-5
Service Category	Community
Service Definition	An intervention targeting OAA participants that uses information dissemination, instruction, or training with the intent to support food, nutrition, and physical activity choices and behaviors (related to nutritional status) to maintain or improve health and address nutrition-related conditions.
Unit of Service	One educational session not duplicated by the client.

Minimum Standards

Updated August 15, 2025

1. This nutrition education service is provided as an intervention for participants with specific nutrition education learning needs beyond the minimum requirement of nutrition education provided within the meal program nutrition education requirements for all program participants.

2. Nutrition education services shall be approved and overseen by a Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN), an individual who is registration eligible, or a Registered Nutrition and Dietetic Technician (NDTR).

3. Each program shall establish linkages with local partners to provide sources of information that meet the standards for accuracy and reliability as set by the Academy of Nutrition and Dietetics.

4. Content must be consistent with the United States Department of Agriculture (USDA) Dietary Guidelines for Americans (DGA); accurate, culturally sensitive, regionally appropriate, and consider personal preferences.

5. Nutrition education sessions may be provided in a variety of settings including but not limited to senior centers, congregate meal sites, farm markets, healthcare facilities and community focal points. The means of education delivery includes in person, virtual, video, audio, online and through distribution of hardcopy materials.

6. Sessions may vary in length, and include but are not limited to classes, workshops, presentations, nutrition project demonstrations, newsletters, and nudging techniques such as social media posts and table tent teachings at congregate meal sites.

C-5 NUTRITION EDUCATION (CON'T)

7. Unduplicated counts of audience size must be reported. Estimated audience sizes are allowable only if unduplicated counts are not known. Refer to the *NAPIS Resource Guide* for more detailed guidance on reporting units and estimated audience size.

8. A post program evaluation component is strongly encouraged at the conclusion of each educational session to evaluate participant outcomes and program effectiveness.

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

Minimum Standards

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

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

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

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

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

Service Name	Health Screening
Service Number	C-7
Service Category	Community
Service Definition	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.
Unit of Service	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)
      i. Individual's name, address and phone number
      ii. Name, address and phone number of person to contact in case of emergency.
      iii. Gender
      iv. Age and date of birth
      v. Race and/or ethnicity
      vi. Living arrangement
      vii. Type of housing
      viii. Whether or not individual's income is below the poverty level and/or sources of income(particularly SSI and GA)
      ix. Date of last physical by a physician.

   b. Health History (can be completed by client)
      i. History of illnesses, injuries, health problems, and abnormal signs and symptoms
      ii. Limitations in activities of daily living
      iii. Health habits including eating patterns, smoking, and alcohol intake
      iv. Allergies to medicine, food, etc.
      v. Prescription medications and over-the-counter medications currently taken
      vi. Other treatments and orders by a physician
      vii. Names of all current physicians and when last seen by each
      viii. Health or support services currently received or received in the past
      ix. Social and psychological history

C-7 HEALTH SCREENING *(CONT'D)*

c. Nurse Assessment (by an RN including review of the client's health history)

i. Physical Status (visual review)
a. Edema in lower extremities
b. Stability of walking
c. Shortness of breath

ii. Mental and social status.
iii. Abnormal signs or symptoms observed by the RN and reported by client.
iv. Review of results of screening tests.

d. Vision
i. Date of last eye exam
ii. Condition of glasses
iii. Age of glasses
iv. Able to read
v. Able to drive

e. Hearing
i. Date of last hearing exam
ii. Does the assessor have to shout
iii. Does the client read lips

f. Hearing Appliance Used
i. Condition of hearing aid
ii. Check for wax in ears

g. Dental
i. Date of last dental exam
ii. 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

C-7 HEALTH SCREENING *(CONT'D)*

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.

Service Name	Assistance to the Hearing Impaired and Deaf Community
Service Number	C-8
Service Category	Community
Service Definition	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.
Unit of Service	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.

Service Name	Home Repair
Service Number	C-9
Service Category	Community
Service Definition	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: • roof repair/replacement • siding repair/replacement • door and window repair/replacement • foundation repair/replacement • floor repair/replacement • interior wall repair • plumbing and drain repair/replacement • insulating/weatherization (including water heater wrap, low-flow shower head, socket sealers, draft stoppers, and door sweeps) • stair and exterior step repair/replacement • heating system repair/replacement • ensuring safe and adequate water supply • electrical wiring repair/replacement • obtaining building permits • painting to prevent deterioration in conjunction with repairs
Unit of Service	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.

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.

C-9 HOME REPAIR *(CONT'D)*

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 the ACLS Bureau 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 homeowner 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.

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

Allowable Service Components (cont.)	**Negotiation.** Within the rules of professional responsibility, program staff may contact other persons concerned with the client's lega problem in order to clarify factual or legal contentions and possibl reach an agreement to settle legal claims or obtain services an supports. **Legal Education**. Legal assistance program staff may prepare and present programs to inform older adults of their rights, the legal system, and possible courses of legal action. **Community Collaboration and Planning.** Legal assistance programs should participate in activities that impact elder rights advocacy efforts for older adults such as policy development, program development, planning and integration activities, targeting and prioritizing activities, and community collaborative efforts.
Unit of Service	Provision of one hour of an allowable service component.

Each area agency on aging (AAA) should contract with the legal assistance program with the capacity to perform the full range of allowable service components that is best able to serve the legal needs of the community given the resources available. AAAs are able to contract with Legal Services Corporation (LSC) grantees, non-LSC non-profit legal programs, private attorneys, law school clinics, legal hotlines or other low-cost legal services delivery systems. Itis 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 ACLS Bureau.

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

C-10 LEGAL ASSISTANCE *(CONT'D)*

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, ACLS Bureau, MPLP and other programs offering technical assistance to legal providers.

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

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

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

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

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

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

13. Each legal assistance program shall report program data through the Legal Services Information System (LSI) application of the ACLS Bureau'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 the ACLS Bureau 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.

Name	Long-Term Care Ombudsman/Advocacy
Service Number	C-11
Service Category	Community
Service Definition	Provision of advocacy, education, information and assistance, and case investigation and resolution to residents of nursing homes, homes for the aged, and adult foster care homes, their family members and friends, staff, and the general public. Each Area Agency on Aging (AAA) or subcontractor providing long term care ombudsman services shall utilize designated ombudsmen to provide services to protect the health, safety, welfare, and rights of residents as follows: **Access.** Provision of in-person or virtual visits and response to telephone calls and email messages to ensure residents have timely access to ombudsman services. **Advocacy.** Activities related to identifying obstacles and deficiencies in long term care delivery systems and developing recommendations for addressing identified problems at the local, state, and national levels. **Community Education.** Provision of information to the public including long term care residents, regarding all aspects of the long-term care system including elder abuse, neglect, and exploitation of vulnerable adults. This component includes formal presentations, consultation, engagement with the media, and distribution of consumer informational materials. **Complaint Investigation.** Intake, investigation, verification, and attempted resolution of individual complaints from residents or others acting on their behalf regarding any action or inaction which may adversely affect the health, safety, welfare, and rights of a long-term care facility resident. Complaint resolution processes include active listening, negotiation, and conflict resolution skills. **Information and Assistance.** Provision of assistance to residents, family members, staff, and the general public regarding any long-term care topic including but not limited to placement options, resident rights, abuse prevention, and community transition services. **Volunteer Support.** Conduct of recruitment, training/mentoring, supervision, and ongoing support activities related to volunteer ombudsmen.
Unit of Service	Each closed complaint and completed ombudsman activity is a unit of service. Ombudsman activities include: • Providing information and assistance • Participation in a resident or family council

C-11 LONG-TERM CARE OMBUDSMAN/ADVOCACY *(CONT'D)*

- Participation in facility survey
- Conducting a facility visit
- Providing training/education

LTC Ombudsman Program services are reported annually to the Administration on Community Living by the SLTCO through the National Ombudsman Reporting System.

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Minimum Standards

1. Each Area Agency on Aging (AAA) or subcontractor providing ombudsman services shall be capable of providing assistance to residents of each long-term care facility in the service area.
2. Each entity desiring to provide ombudsman services shall be designated by the State Long-Term Care Ombudsman (SLTCO) to provide services in the State of Michigan. Individuals employed by and volunteers of the entity must be designated by the SLTCO to provide long-term care ombudsman services.
3. Long-term care ombudsmen (ombudsmen) shall, in accordance with the policies and procedures established by the SLTCO and the State Unit on Aging:
   a. Identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents. With respect to identifying, investigating, and resolving complaints, and regardless of the source of the complaint (*i.e.,* complainant), the ombudsman serves at the direction of the resident of a licensed long term care facility and shall investigate a complaint, including but not limited to a complaint related to abuse, neglect, or exploitation, for the purposes of resolving the complaint to the resident's satisfaction and of protecting the health, welfare, and rights of the resident. The ombudsman may identify, investigate, and resolve a complaint impacting multiple residents or all residents of a facility.
   b. Provide services to protect the health, safety, welfare, and rights of residents by:
      1) Providing information and assistance on long-term care issues to residents, their family members and friends, staff members, and the public;
      2) Referring residents, their family members, and friends to other resources and programs;
      3) Providing unbiased information about long-term care facilities, the rights of residents, sources of payment for care, and guidelines in selecting a long-term care facility or other service to residents and the public;
      4) Offering education sessions to residents and long-term care staff members on a variety of long-term care topics;

C-11 LONG-TERM CARE OMBUDSMAN/ADVOCACY *(CONT'D)*

5) Participating in health fairs and other community events to educate participants on long term care ombudsman services and other long term care topics; and
6) Participating in facility surveys conducted by the state survey agency and providing feedback to the state survey agency regarding ombudsman observations of the long-term care setting.

c. Support residents and their family members when a provider announces intent to end participation in the Medicare or Medicaid program or cease operation voluntarily or due to regulatory action, which requires the relocation of residents to other settings, is a component of the ombudsman program. The local ombudsman will visit the home frequently to ensure residents' rights and choices are honored as well as monitor and report concerns with care and service delivery during these events. The ombudsman program follows up with relocated residents to address any concerns they may have related to the move.

d. Assure that residents in the service area have regular and timely access to the services provided through the ombudsman program and that residents and complainants receive timely responses to requests for information and complaints, in accordance with established ombudsman program policy and procedures.

1) Complaint Response - Complaints alleging abuse, neglect, or exploitation, significant harm to the resident, or involuntary discharge will be responded to within two working days. All other complaints will be responded to within seven working days.

2) Facility Visits - Each federal fiscal year (October 1 – September 30), in-person visits will be conducted as follows:

a. Fifty percent (50%) of nursing homes will receive four routine access visits (the same facility visited once each quarter) meeting the program requirements for observation and resident interaction during the visit;

b. All other nursing homes will receive an in-person visit every 6 months; and

c. Ten percent (10%) of licensed homes for the aged and adult foster care homes will receive an in-person visit.

Note: Each federal fiscal year, the group of nursing homes receiving routine access visits required at (2)(a) will alternate with the group of nursing homes receiving in-person visits required at (2)(b).

e. Promote and provide technical support for the development of resident and family councils as well as provide ongoing support including attendance at council meetings as requested by resident and family councils.

C-11 LONG-TERM CARE OMBUDSMAN/ADVOCACY *(CONT'D)*

f. Coordinate media requests for interviews or ombudsman program information with the SLTCO.

g. Complete data entry related to case investigation and ombudsman activities by the 10th of the month for the work completed in the previous month by the ombudsman and any volunteers managed by the ombudsman. If the 10th falls on a weekend or holiday, the local ombudsman has until the next workday to complete the data entry. The local ombudsman must complete data entry for the work completed by ombudsman volunteers as volunteers are not granted access to the ombudsman database.

h. Where the AAA or subcontractor utilizes ombudsman volunteers, the local ombudsman shall be responsible for the management of volunteer ombudsmen including, but not limited to:

1) Recruiting potential volunteers;
2) Coordinating onboarding and training with the State Office;
3) Providing Initial mentoring of the volunteer during training status;
4) Providing ongoing consultation and case support to volunteers;
5) Assigning homes and setting visiting expectations;
6) Overseeing service delivery;
7) Ensuring at least 18 hours of continuing education is completed annually;
8) Establishing communication tools for referrals and reporting of services;
9) Completing data entry for service provision;
10) Providing recognition of volunteers; and,
11) Processing reimbursement for allowable expenses, if applicable.

4. Ombudsmen shall maintain the confidentiality of residents' and complainants' identity and program records of ombudsman service provision in accordance with policies issued by the SLTCO.

5. Ombudsmen shall be knowledgeable of resources and information related to appeals, legal assistance, and other potential remedies and be able to assist residents with referrals to available services, as requested by the resident. These services and programs may include but are not limited to legal services agencies, local law enforcement, the state survey agency, Medicaid fair hearing office, Medicaid functional and financial eligibility, local health department, Michigan Medicare Assistance Program (MMAP), Medicare appeal and complaint resolution services, Adult Protective Services, and the Attorney General Healthcare Fraud Unit.

6. Ombudsmen shall maintain working relationships with local service programs providing home and community-based waiver services and community transition services, including knowledge of the referral and intake process.

7. Ombudsmen shall make resources and information available to residents, their families and friends, staff and the general public regarding prevention, identification, and reporting of abuse, neglect, and exploitation (ANE). Ombudsmen shall

C-11 LONG-TERM CARE OMBUDSMAN/ADVOCACY *(CONT'D)*

participate in local or state-level teams to address ANE including death review teams and interdisciplinary abuse prevention teams.

8. Ombudsman candidates must complete initial designation training and mentoring in accordance with program policies issued by the SLTCO. Following initial designation, ombudsmen must complete 18 hours of continuing education per federal fiscal year by attending training or case consultation calls hosted by the SLTCO, participating in webinars and other training on long term care topics. In addition, volunteer ombudsmen may report mentoring and case consultation time with the paid ombudsman as continuing education hours.
9. Each entity providing ombudsman services shall operate in compliance with Long Term Care Ombudsman program instructions, issued by the SLTCO, as required by federal and state authorizing legislation and federal ombudsman program regulations.
10. Each AAA shall maintain a financial management system that fully and accurately tracks, and accounts for the use of, all funds received or allocated for long term care ombudsman services.
11. Each AAA or subcontractor providing ombudsman services shall comply with Long Term Care Ombudsman/Advocacy Operating Standards and program policies issued by the SLTCO.

Service Name	Senior Center Operations
Service Number	C-12
Service Category	Community
Service Definition	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.
Unit of Service	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 the ACLS Bureau.

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-12 SENIOR CENTER OPERATIONS *(CONT'D)*

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

Service Name	Senior Center Staffing
Service Number	C-13
Service Category	Community
Service Definition	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.
Unit of Service	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).

Service Name	Vision Services
Service Number	C-14
Service Category	Community
Service Definition	Provision of specialized vision services for the visually impaired and older blind persons which include: • orientation and mobility training • rehabilitation for activities of daily living (ADL)* • optometric services to help persons with severe vision loss to utilize remaining vision as effectively as possible • group education on prevention of or adjustment to visual impairment *ADL includes personal hygiene and grooming, meal preparation and kitchen safety, homemaking, and leisure pursuits.
Unit of Service	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's 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.

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

Minimum Standards

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

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

Service Name	Counseling Services
Service Number	C-16
Service Category	Community
Service Definition	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.
Unit of Service	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.)

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.

5. Paid staff counselors must have appropriate education and experience and be licensed to practice in the State of Michigan.

C-16 COUNSELING SERVICES *(CONT'D)*

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.

Service Name	Caregiver Supplemental Services
Service Number	C-18
Service Category	Community
Service Definition	A program intended to provide goods and services to compliment the care provided by caregivers in response to needs that cannot otherwise be met.
Unit of Service	One good or service purchased

Minimum Standards

1. Each program must maintain linkage with community 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.

3. Programs may offer Caregiver Supplemental Services to individuals aged 55 and over who are kinship caregivers.

4. Payments directly to family caregivers are not permitted. Reimbursement for allowable expenses may be made with proof of purchase.

Service Name	Kinship Support Services
Service Number	C-19
Service Category	Community
Service Definition	Provision of any caregiver service(s) for Kinship Caregivers as described in #2 below.
Unit of Service	Determined by Service Delivered

Updated: December 15, 2023

Minimum Standards

1. Kinship Caregivers must meet one the following criteria (as defined in the Older Americans Act Section 372 (a) (4)):

    a. Individuals age 55 and older who live with and are the primary caregiver for children not more than 18 years of age
    b. Relatives, including parents, age 55 and older who live with and are the primary caregiver for adults ages 18-59 with disabilities

2. The following services may be provided:

    a. Caregiver Information and Assistance

    b. Caregiver Support Groups

    c. Caregiver Training

    d. Caregiver Education

    e. Caregiver Outreach

    f. Respite Care

    g. Caregiver Supplemental Services

    h. Caregiver Counseling Services

    i. Caregiver Case Management

Service Name	Caregiver Education, Support and Training**- Inactive after FY2024**
Service Number	C-20
Service Category	Community
Service Definition	
Unit of Service	

Updated December 15, 2023

Minimum Standards

SERVICE NAME	Caregiver Education
SERVICE NUMBER	C-21
SERVICE CATEGORY	Community
SERVICE DEFINITION	Contacts with a group of older adults, their caregivers, or the general public to inform them of caregiver services or resources available within their communities. Examples include but are not limited to, health fairs, publications, newsletters, brochures, caregiver conferences, publicity or mass media campaigns, and other similar informational activities. These activities are directed at groups and large audiences of caregivers.
UNIT OF SERVICE	Activity

New: December 15, 2023

Minimum Standards

1. Each program must maintain linkage with community focal points, and respite care programs, as available, in the planning and service area to help facilitate opportunities for caregivers to participate in education programs. Respite care may be provided to enable caregiver participation,
   as an additional service, in conjunction with caregiver education programs.

2. Program leaders shall be educated in topics being presented.

3. Caregiver education activities may be provided in community settings, virtually, or on-line through self- guided programs.

SERVICE NAME	Caregiver Training
SERVICE NUMBER	C-22
SERVICE CATEGORY	Community
SERVICE DEFINITION	A service that provides instruction to improve knowledge and performance of specific skills relating to caregiving roles and responsibilities. Skills may include, but are not limited to, activities related to health, nutrition, financial management, personal care, and/or communication.
UNIT OF SERVICE	One hour of training

New: December 15, 2023

Minimum Standards

1. Each program must maintain linkage with community focal points, and respite care programs, as available, in the planning and service area to help facilitate opportunities for caregivers to participate in training programs. Respite care may be provided to enable caregiver participation, as an additional service, in conjunction with caregiver training programs.

2. Program leaders shall be educated in caregiver training topics being presented.

3. Caregiver Training programs may be provided to individuals as well as in group settings. Services may be provided in the community, in-home settings and/or virtually.

SERVICE NAME	Caregiver Support Groups
SERVICE NUMBER	C-23
SERVICE CATEGORY	Community
SERVICE DEFINITION	A service that is led by a trained individual, moderator, or professional, to facilitate discussions on common experiences, concerns of caregivers, and to develop a mutual support system. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the telephone, or online.
UNIT OF SERVICE	Session

New: December 15, 2023

Minimum Standards

1. Each program must maintain linkage with community focal points, and respite care programs, as available, in the planning and service area to help facilitate opportunities for caregivers to participate in group support programs. Respite care may be provided to enable caregiver participation, as an additional service, in conjunction with caregiver support programs.

2. Program leaders shall be educated in caregiver support.

3. Services may be provided in community settings and/or virtually.

Service Name	Caregiver Case Management
Service Number	C-24
Service Category	Access
Service Definition	A service provided for a caregiver that assesses needs, and arranges, coordinates, and monitors services to meet the individual needs of the caregiver.
Unit of Service	Hour

Updated: June 21, 2024

Minimum Standards:

1. Caregiver Case Management (CCM) functions shall be carried out by an individual who has a bachelor's degree in a human service field or who has experience and training to effectively determine a caregiver's needs and match those needs with appropriate services.
2. Each CCM program must have uniform intake procedures and maintain consistent records. Intake records for each potential participant shall include:
    a. Name, address and telephone number
    b. Date of birth
    c. Emergency contact information, if applicable
    d. Race and ethnicity
    e. Gender identity
    f. Sexual orientation
    g. Communication support needs, if applicable

C-24 CAREGIVER CASE MANAGEMENT *(CONT'D)*

3. Following the intake process, an initial assessment shall include as much of the following information as possible:
    a. Participant information gathered at intake
    b. Current status of physical and mental health
    c. Needs of the caregiver
    d. Statement of strengths and challenges
    e. Existing resources
4. A service plan shall be developed with the caregiver to coordinate the formal and informal resources and services to meet the identified needs of the caregiver. Each plan shall include:
    a. Statement of goals and objectives and interventions utilized for meeting identified needs
    b. Description of identified resources and supports
    c. Description of interventions and services used to address the caregiver's identified needs
5. Each caregiver shall be reassessed yearly, or as needed, to evaluate service plan implementation. At minimum, monitoring contacts shall be attempted 90 days following the initial assessment, and ongoing monitoring contacts shall be attempted every 180 days thereafter.
6. CCM service components may be delivered in-person, telephonically, virtually, or hybrid

Service Name	Supplemental Nutrition Services see TL #2024-514
Service Number	C-25
Service Category	Community
Service Definition	A nutrition service provided that does not fall into the previously defined service categories of (B-5) Home Delivered Meals, (B-12) Carry-out Meals, (C-3) Congregate Meals, (C-4) Nutrition Counseling, and (C-5) Nutrition Education.
Unit of Service	One good or service.

Minimum Standards

Updated May 17, 2024

1. The Supplemental Nutrition Services Operating Standard allows for additional nutrition services to eligible participants that meets the purposes of the nutrition program as defined by the Older Americans Act (OAA).

2. Supplemental Nutrition Services may include, but are not limited to, oral nutrition supplements (ONS), groceries, food boxes, and meal kits. These items are not considered prepared meals but rather supplemental nutrition support to existing nutrition services for individuals identified at high nutritional risk.

3. OAA funds may be used for the provision of Supplemental Nutrition Services provided that services comply with all relevant ACLS Bureau policies. Nutrition Services Incentive Program (NSIP) funds may not be used to pay for Supplemental Nutrition Services, as these do not constitute a meal.

4. Refer to the General Requirements for All Service Programs, the General Requirements for Nutrition Service Standards, and relevant nutrition operating standards for additional requirements.