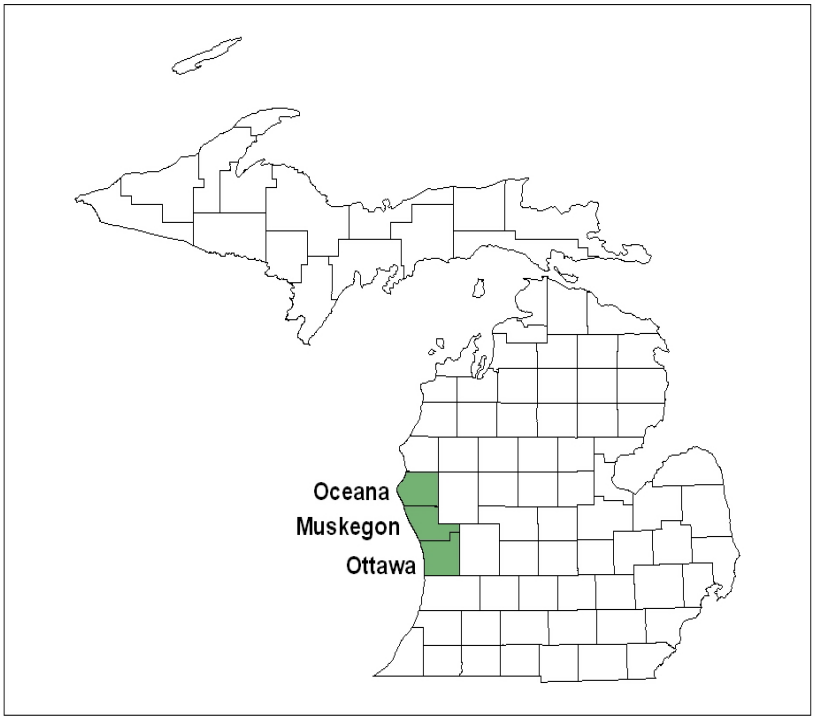
SeniorResources
Our Name. Our Focus.

Multi Year Implementation Plan FY' 2017-2019
Annual Implementation Plan FY'2017



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ANNUAL & MULTI YEAR IMPLEMENTATION PLAN

FY 2017-2019

Senior Resources **FY 2017**

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County/Local Unit of Govt. Review

Senior Resources will send a draft copy of the 2017-2019 Multi Year plan via certified mail or email with a delivery receipt and read receipt request to each chairperson of the county commissioner's board and the administrator of the board for each county in our region no later than May 18, 2016. In a cover letter sent to the chairperson of each board of commissioners, Senior Resources will offer to attend the County Board meeting or any subcommittee of that Board for each county in our region to respond to any questions related to the plan. The letter will indicate that if we do not hear from their local units of government prior to August 3, 2016 with a written or emailed resolution or approval, Senior Resources will assume their board's passive approval of the plan.

Plan Highlights

1. A brief history of the area agency and respective PSA that provides a context for the MYP. It is appropriate to include the area agency's vision and/or mission statements in this section.
Senior Resources was designated as an Area Agency on Aging in 1974 by the State of Michigan to administer the federal Older Americans Act and the Older Michiganians Act funding. Senior Resources has served West Michigan for over 40 years as the gateway to local resources, planning efforts and services to help older adults, their families and caregivers in Muskegon, Oceana and Ottawa Counties.

It is the vision of Senior Resources to promote lifelong dignity and independence. That vision coupled with our mission of providing a comprehensive and coordinated system of services designed to promote the independence and dignity of older persons and their families - a mission compelling us to focus on older persons in greatest need and to advocate for all - guides our purpose.

Senior Resources serves as a focal point and acts as an advocate for the elderly by advancing causes or issues that are vital to their welfare. It is a goal of the agency to inform and educate seniors, families and the public on available services and issues affecting older adults. In addition, Senior Resources staff is active in many local, regional, and statewide groups and organizations. From advocacy at the national and state levels, to partnering with a local senior center or food bank, we recognize the need to be active and involved in all aspects of our community.

We directly provide a variety of services that support individuals, families, and caregivers in the form of case management and options counseling. Our staff talk with thousands of individuals to assist them in gaining information about local services and to access support.

Services provided through contracts include: Long Term Care Ombudsman Program, congregate nutrition, home-delivered meals, adult day care, transportation, legal services, respite care, in-home personal care, kinship and family caregiver support.

It is the agency's specific goal to effectively implement the Older Americans Act by developing and administering a regional area plan for coordinating and contracting with viable agencies for services for persons 60 years and older. The Area Plan outlines a considerable amount of information about our communities such as a demographic overview and provider and service systems, as well as multi-year planning objectives and the 2017 projected expenditure proposals.

2. A summary of the area agency's service population evaluation from the Scope of Services section.
In Region 14 there is an estimated 92,000 people over the age of 60, approximately 18.5% of the total population. 29% of people age 60+ in the Region have a disability and 7% have income levels below poverty. 16% have an income below 150% of the poverty level. Between 2010 and 2013 the population of seniors in Region 14 increased by 1% annually.
There are 6,755 older adults in rural Oceana County, and while the number of older adults living in this community is relatively small, these areas can be very difficult and costly to serve. Aging adults in these communities may face additional barriers to remaining in their homes, staying active, and engaging in the local community, all resulting in increased risk of becoming isolated.

Within this planning timeframe, fiscal years 2017-2019, approximately 32,023 people in the PSA will turn age 60. This will equate to a 35% increase of people over the age of 60 Region-wide.
The sheer number of older adults within the population is increasing dramatically as the baby boomer generation continues to move into retirement age. This significant, new, demographic shift brings not only challenges, but new opportunities as well. Senior Resources strives to engage our community, provide leadership in advocacy and education, and challenge ourselves and community partners to think and act creatively in these unique times.

3. A summary of services to be provided under the plan which includes identification of the five service categories receiving the most funds and the five service categories with the greatest number of anticipated participants.

In home services sufficient to assist older adults and their caregivers to remain in their environment of choice continues to be the focus of service delivery. Home delivered and congregate meals, respite care, adult day services and homemaking are the top funded service catagories and they remain the services with the highest anticipated number of participant utilization.

Individuals in need of homecare services must become clients of either one of the Case Coordination & Support programs or the Care Management program in order to receive services through our Purchase of Service system.Participants choose from a group of contracted personal care, homemaking, in-home respite, and adult day care providers.Supports coordinators, along with the participant and the participant's support team, consider the person's physical, social and financial needs and then, if applicable, make arrangements for in-home services including:home delivered meals, personal care, in-home respite, homemaking, medication management, personal emergency response systems and adult day care.If necessary, transportation services can be arranged, Medicare, Medicaid and other insurance counseling can be provided with additional assistance available through the MMAP Program.Referrals are also made to other applicable community programs.

Throughout the public input process, feedback was provided by the attendees that indicated that navigation of available resources and services is a critical part of essential services for older adults and/or their support team.Our Supports Coordinators and Options Counselors are trained to provide the person and/or their support team with the knowledge, navigation and coordination of all available resources while taking into account the desires of the person and their support team.

Senior Resources has four Options counselors and we have incorporated their service into the Intake Process.Callers identified at the time of the initial contact with an Options Counselor as a candidate at risk for nursing home placement are referred to the appropriate program immediately. The Options counselors role is to not only explain someone's long term care options, butalso initiate a discussion on a person's personal finances/resources and how to best utilize them to make them last for as long as possible and still allow the person to remain in the setting of their choice. Upon hire, Supports Coordinators and Options counselors receive training in long term care options and Senior Resources will continue to provide opportunities for them to enhance their training as an element of ongoing core competency training.

Supports coordinators and/or options counselors will also assist clients in accessing other services funded through Senior Resources such as Long Term Care Ombudsman, Caregiver Support, Health Promotion/Disease

Prevention, and Kinship Care. If a need is identified that cannot be met through Senior Resources, the options counselors and/or supports coordinators will refer the person to the community service provider that can meet their need or will make the referral with permission from the person or designee.

4. Highlights of planned Program Development Objectives.

During the next three year planning cycle, much emphasis is being placed on good nutrition, socialization and wellness opportunities. Our objectives, in partnership with our meal provider AgeWell Services, are to enhance methods in which food is procured, prepared and delivered. In the congregate meal setting, attention will be paid to promoting socialization in ways that appeal to the younger senior as well as meet the needs of the people who have been attending the center for years. We wish to incorporate evidence based wellness opportunities within local communities where older adults are already present. These wellness opportunities will be in response to input from the seniors and their request to know more about a particular area of health.

As advocates for older adults, we wish to promote the prosecution of those who commit elder abuse in our region, statewide and nationally. To address the prosecution of elder abusers in our region, two task force subcommittees of the Tri-County Protection team will develop protocols, by county in Muskegon and Ottawa, which will aid in the investigation of elder abuse cases and assist the prosecutors in holding the offenders accountable. In addition, the Tri-County Protection team will begin a weekly or as needed news e-blast to keep the community apprised of all potential scams and have community trainings scheduled throughout the PSA.

The unprecedented demographic transition underway in the region will require that organizations and individuals take action to support independent, healthy aging for older adults throughout the region. There are many potential stakeholders who are either unaware of the dramatic increases in older adult population or do not fully understand the magnitude of the impact. Ensuring that our region can support healthy aging will be built on local responses that recognize changing conditions and implement appropriate solutions in many unique settings. Senior Resources will support a network of local leaders who carry the message of livable communities throughout the region, as well as promote opportunities for communities to support healthy aging through local millages.

Participants in the AAA's community conversations consistently ranked transportation in the top three when asked to prioritize services most critical to helping them age at home, and many low-income and homeless seniors said public transportation and special transit services were the only ways they could access medical services and food banks. The need for transportation options will grow along with the expanding senior population. The region's ability to help people stay in their own homes as they age will be directly correlated to the transportation services available to them. When livable communities or the addition of affordable housing is being explored by community leaders it is vitally important to advocate for suitable transportation that is functional for all.

As the population ages and more and more people are being cared for by family caregivers, Senior Resources is looking for ways to better support the caregiver with education, training, emotional support, and services. We are advocating at a state level for caregivers to have greater access to information and training after their person has had a hospital or long term care admission. Senior Resources plans to collect information of particular interest to caregivers and have it available in various mediums for ease of access.

It has been shown that chronic illness and multiple emergency room visits commonly results in seniors who are particularly vulnerable to hospital readmissions. Using an evidence based program, Senior Resources plans to

expand our partnership with local health care organizations to provide follow up care for 30 days after an ER visit to eligible seniors in the way of support coordination, medication review, and transportation to physician visits, meals and Personal Emergency Response systems. This effort is proven to support seniors in their home as they gain strength and health.

5. A description of planned special projects and partnerships.

Senior Resources' Board of Directors,staff, and stakeholders have placed a high significance on and included in our agency mission the priority to provide services to the persons most in need. To meet that mission, we partner with over 90 In-Home Care Agencies that are located in and/or provide care throughout our three-county area. In-home services, including personal care, homemaking, respite, and home-delivered meals, remain priority services as well as adult day care and caregiver services.Senior Resources will continue to work with all relevant collaborative bodies to insure that services reach the frailest elderly. We work closely with the established four focal points that are situated throughout the region, two of them councils on aging, one senior wellness center and the AAA.

Senior Resources has been a contracted partner of Pathways since its conception in 2012. The Pathways to Better Health Program was developed from a grant received by Michigan Public Health Institute (MPHI) from the Centers of Medicaid and Medicare (CMS) Innovations Awards. The proposal introduced the role of the Community Health Worker (CHWs) embedded within social service agencies throughout program regions.Muskegon Health Project partnered with MPHI to administer the program in Muskegon, Oceana and Northern Ottawa County. In 2015, the Pathways program approached Senior Resources to dedicate 2 CHWs to a new program. The Care at Hands Program was developed from a grant received by Dr. Stein, CMO Continuing Care with Trinity Health.The Care at Hands model serves Medicare/Medicaid recipients who are hospitalized, transitioning to a skilled nursing home, and then back to the community. A Community Health Worker follows the person for a 90 day period in which they will complete weekly surveys with the participants.The surveys will serve as a tool to track the health outcomes and issues a participant is experiencing. The Community Health worker will connect the participant to programs, resources, and education to improve their health outcomes and reduce risk of re-hospitalization.In addition, the Community Health Worker will collaborate with an RN clinical supervisor regarding identified issues impacting the participant's success to transitioning and remaining in the community.Senior Resources is currently contracted for 2 full time employees dedicated to the Care at Hand Program. The request for services is expected to continue to grow with the rapidly aging population.

The amount of funding Senior Resources receives for services does not keep up with demand. To help alleviate some of the excess demand and at the suggestion of the Administration of Community Services, Senior Resources is partnering with CST Technology.This partnership affords us an opportunity to participate in a private pay Personal Emergency Response System that will provide subscribers and their family members with access to a professionally staffed call center for all their care needs, not just those related to an emergency. Due to CST Technologies' relationship with N4A, this partnership is a way for Senior Resources to gain revenue that is returned back into service delivery.

We continue to work with a variety of volunteer programs and youth summer camps to provide an assortment of chore services. Senior Resources Board of Directors has committed the use of our interest income to support the unmet needs program.We use these funds to purchase items such as dentures, glasses, furnace repairs, ramps, appliances, and emergency transportation.

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Senior Resources contracts with CALL 2-1-1 as our first step in the continuum of care.CALL 2-1-1 is a 24 hour/7 days a week information and assistance call center with call specialists trained in helping families clarify their situation and identify the best solutions. This Information and Assistance is available region-wide.A phone call provides access to information and assistance regarding in-home services, case coordination & support, Care Management/Medicaid Waiver programs, insurance, prescriptions, taxes, transportation, support groups, home repair, housing, and a host of other community services. When the call warrants, a transfer is made to a Senior Resources Options Counselor who can listen to the caller's story, provide education, explore options, and make appropriate referrals as needed.

Several of our contractors and Senior Resources are recipients of United Way funds.Senior Resources will continue to work closely with the United Ways in an effort to provide the broadest amount of service coverage possible. The combination of United Way and Senior Resources funds allows many providers to enhance and expand the amount of service they are providing, rather than duplicate it.

In the Senior Resources service area Oceana County and several townships in Ottawa County receive millage service dollars. The Oceana County Council on Aging and Four Pointes Center for Successful Aging (Ottawa County) are recipients of millage funds in their areas. These funds are used to cover operating expenses for all services and support existing programs within the Councils on Aging. Without these funds both agencies would be forced to cut back or eliminate services to older adults in their areas. Muskegon County will have a senior millage request on the August 2016 ballot.

In Ottawa County, Senior Resources is a member of the Ottawa County Human Resource Council where many community agencies collaborate, including the Community Action Agency. The Community Action Agency carries out the oversight role of the Senior Resources Ottawa County matching funds.Involvement in the Muskegon and Ottawa Human Service Coordinating Councils raises knowledge level of service availability and prevents duplication of services. Senior Resources works with the Public Health Departments on several community collaboratives.In Ottawa County, the Food Policy Council is working to improve healthy choices and special diet options in food pantry selections with an emphasis on training the pantry volunteers in assisting consumers with choices to accommodate special diets.In addition, Senior Resources is part of the Muskegon County Collaborative in which the Muskegon County Health Department is also a member and their executive director is the secretary/treasurer of our Board of Directors.

The Aging and Disability Resources Collaboration of the Lakeshore was granted operational status from the Aging & Adult Services Agency in September 2014. Senior Resources, along with the two Centers for Independent Living (CIL) that function within the PSA, meets twice a year to set the direction of the ADRC, explore ways to better enhance the referral process and decrease the need for community members to tell their story to many different referral sources.In addition to partnering with the CILs in the ADRC capacity, Senior Resources also works in partnership with the CILs in the region to provide the NFT, money follows the person initiative.

We are pleased to have an ongoing partnership with the Muskegon County Sheriff's Office to offer the Project Lifesaver program in Muskegon County.Project Lifesaver is for people living with severe brain injuries or diseases such as Alzheimer's, Dementia, Down's syndrome, or Autism.Individuals who are prone to wander as a result of their disease or injury or become disoriented and confused when in the community are eligible for this

program. There are similar programs in all three counties in the PSA and our marketing has been expanded to include all programs in the region that will locate those that wander. The Muskegon County Volunteer Search and Rescue Unit has joined the partnership and we are happy to work with this important branch of law enforcement and emergency personnel.

As part of the Area

6. A description of specific management initiatives the area agency plans to undertake to achieve increased efficiency in service delivery, including any relevant certifications or accreditations the area agency has received or is pursuing.

Senior Resources is currently seeking Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. CARF accreditation is evidence that an organization continually strives to improve efficiency, fiscal health and service delivery. We are proud of the quality services we deliver and CARF accreditation will further demonstrate that our agency meets internationally developed quality standards and maintains a client-centered focus. In addition, our board of directors and management team recognized that accreditation is increasingly being required as a baseline for organizational contracting with health insurers, government, and other interested stakeholder entities. Our tentative CARF assessment dates are May 2 & 3, 2016.

Senior Resources has embraced the concept of value stream mapping to assist us in discovering processes that could be streamlined and areas of waste that could be eliminated. Through this method Senior Resources has identified areas of inefficiency within our internal processes and created new procedures which have limited the redundancies. In addition, we are committed to continuous improvement using this method and are expanding the process to include our interactions with participants and providers.

7. A description of how the area agency's strategy for developing non-formula resources (including utilization of volunteers) will support implementation of the MYP and help address the increased service demand.

Graduates of Health Promotion Disease Prevention (HPDP) workshops are encouraged to become trainers for the workshop that they attended. We find that alumni of the programs are our greatest champions of the workshops as they have experienced the positive results of participation. For two of the HPDP workshops (Matter of Balance and Diabetes PATH), Senior Resources will compensate the volunteers with a stipend upon successful completion of a workshop.

Senior Resources maintains a Memorandum of Understanding with the Retired and Senior Volunteer Program of West Michigan. This Program assists us in locating appropriate volunteers for our MMAP counselors as well as lay leader and coaches for our evidence based programs.

Senior Resources has an unmet needs fund for those services or products which participants cannot access through standard means. This fund has limited availability and is reserved for participants in the case that all other community service agencies' aid has been exhausted.

Senior Resources is thrilled to have over 30 volunteers specifically trained to facilitate the Medicare/Medicaid Assistance Program (MMAP). Without these volunteers, the MMAP program would not be functional. Senior Resources spends a considerable amount of time in outreach, soliciting additional volunteers to meet the needs of the MMAP program.

For those participants who are able to use personal resources to pay for care, Senior Resources offers a private pay component to our case management program.

8. Highlights of strategic planning activities.

Senior Resources has established an ongoing strategic planning process by which it translates its mission and values into actionable and measurable goals, strategies, initiatives, and programs. The plan provides direction for both long and short-term decision-making by the Board of Directors and senior leadership to fulfill the mission of the organization and make choices among competing demands for capital investment, philanthropy, facilities, and human resources. The most recent strategic planning session took place in 11/15 and was attended by Board members, management team and employees from all departments/levels within Senior Resources.

The three year written, Board-approved Strategic Plan incorporates the following components:

·Mission statement
Values statement
Long term vision statement
Community health needs and assets assessment
Environmental factors assessment
Critical assumptions about the future
Major initiatives and goals (time horizon- 2-3 years)

Data gathering may include input from :

·Community health needs and assets assessment
Environmental assessment, including national, state and local trends in grant funding and advocacy efforts; payment systems; competitive market; capital financing; technology; staff; etc.
Opinions of organizational leaders, including the Board of Directors, senior executive team, clinical staff, and operating unit/department managers
Expert panels of community and industry leaders
Opinions of local community and stakeholder leaders.
Client and caregiver satisfaction surveys
Senior Advocates Coalition
Annual performance reviews/feedback by State and Federal regulatory

·Annual plan and goals (time horizon – 1 year)

Standard format for cascading overall strategic plans and goals into aligned plans for departments, managers and employees

·Strategic performance measurement report format
Active engagement in the process at all levels of the organization.

Using this process and the input provided, Senior Resources has identified three main areas of focus in which all strategic planning goals will be categorized: Area Planning & Program Development; Access to Supports & Services; Advocacy - Local, State & Federal. Under these categories, goals, key strategies, identified action items, measurable objectives, actions needed for success, barriers to success, timeframe, and focus area/responsibility are identified and tracked for reporting to follow agency progress as well as report to various stakeholders and public.

The full Board-approved strategic plan is attached to this document in the appendices.

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Public Hearings

Date	Location	Time	Is Barrier Free	No. of Attendees
05/05/2016	Georgetown Senior Center	12:30 PM	Yes	0
05/10/2016	Tanglewood Park	01:30 PM	Yes	0

Narrative:

Senior Resources staff held 9 input sessions throughout our region in an effort to gain direct input from the populations we serve. All sessions were marketed on our website, sent to local newspapers for advertisement, flyers were distributed at the input sessions location and hosts made personal invitations to possible attendees. At all input sessions, the facilitator presented a concise overview of the tasks assigned to an area agency, the planning process and the reasons why Senior Resources is seeking participants' input. The facilitator introduced a written survey and copies of the survey were distributed.
The facilitator relied on question prompts to aid conversation related to service priorities. They are as follows: what services are the participants currently aware of or currently use, how the participants gain awareness of community services and how the participants navigate community services.
Following is a summary of the verbal information collected. Attendees also had the opportunity to complete a written survey. The results of the written survey were included into the on-line survey and are found below.

Four Pointes Center for Independent Living/ Ottawa County 1/25/16 – 15 attendees

·Lack of affordable senior housing based on income.
Lack of transportation to medical appointments – available but limited. 3 business day notice.
No transportation to legal services.
Lack of weekend and evening transportation.
Lack of transportation to Muskegon, Grand Rapids for medical appointments or other things.
"We need a handyman corner – someplace to call for affordable, trusted repair on cars, homes, etc."
Personal Emergency Response units are very important to being able to stay in our homes.
In -home respite is very important.
Meals on Wheels important to keep people in their homes, however, we would like a service to bring groceries to our homes.
We are not big computer people – still need written information from trusted sources.

Oceana County Council on Aging/Oceana County 1/27/16 – 8 attendees

·Home modification is a high priority. Must be cost effective.
Housekeeping is a needed service.
Activity/socialization/meal at OCCOA is very important as it serves as an activity center and resource center.
Adult day services are very important for caregivers to get a break.
Transportation in the evenings or weekends is limited or not available.
Personal care as needed – good to know it is available.

Oceana County Phone Input

·More activities/things available for those who do not have a lot of resources to pay for activities and/or trips.

Pentwater Friendship Center/Oceana County 1/28/16 – 16 attendees

·Affordable senior housing – independent either with full pay or based on income. Also, assisted living.
Transportation – "When I can't drive, I will have to move." It costs a lot to have someone to take me to the doctors and then back home again. Transportation services not advertised well.
Gap in doctors that specialize in dermatology and rheumatology – all specialists.
Assistance with legal needs – elder care/wills. Cost effective options.
Assistance navigating community/government resources – correct information.
Programs outside of Hart in our community.
Home delivered meals with a daily well check very important – could be done by churches, neighbors etc.
Outreach very important – we need to know what is available. All services listed in one place. Someone from Hart to come to Pentwater.
Blood pressure and/or health checks once a month in a convenient location/s.

Hudsonville Caregiver Support Group/Ottawa County 2/11/16 – 10 attendees

·Family and friends help the most.
Housekeeping, respite and adult day services are very important. Having help come in.
Input on the correct medications for their person.
Workshops for caregivers.
Books have been a good source of information.
Internet – the Alzheimer's reading room.
Information from attorneys or elder care attorneys is important.
Social worker helped with securing services.
Meals at home from Sunset Homes is important to me.
Why does it take so long to get on the Medicaid Waiver program? Funding restrictions on some services.
Support group very important for information sharing.
Where to go for information – senior services need more visibility – need to know about Call 211.

Senior Resources Board of Directors 2/16/16 – 10 attendees

·Transportation (medical and non-medical). Options vary by county and rural vs. urban areas. Oceana has few if any public transportation options. Ottawa and Muskegon have more options such as public bus system, Dial-A-Ride or Demand Response. There is some talk of a Rural Uber that could provide a smart phone app-based, on-demand ride-share alternative to underserved areas.
Homecare - including bathing, homemaking, and grocery shopping when friends and family are not able to assist.
Meals – providing for meals in-home and in congregate settings are both important to offer choice, socialization, and monitoring the situation at home.
Housing – Ken Fisher sits on the Housing Commission in Oceana County and spoke about the lack of options for moderate-income housing, due to lack of public funding for anything above low-income thresholds.

White Lake Senior Center/Muskegon County 2/24/16 – 9 attendees/one elected official attendee

·We need transportation and rides to the doctor's office. We are not expecting MATS to continue the current route to White Lake – there is not enough ridership.

Transportation should be scheduled at more convenient times and better timed with when shopping is available.

Maybe run smaller buses or vans on the White Lake route as there are only 1-2 people on the buses.

The attendees use the VFW, churches, senior center, neighbors and church youth groups as community resources. They receive flu shots, tax information, art classes, nail care, card playing, coffee clatch group, wood carving, movies, etc. at the senior center. They utilize churches for meals and access to youth groups who will do yard work for a donation. The attendees said that in the White Lake area neighbors help neighbors and that is an important part of older adults being able to stay in their homes.

In-home care services are very important for those who can't get out of their homes.

Attendees felt that outreach regarding services are very important. People are unaware of the services available in the community. They suggested we reach them by printed material, local newspapers. No phone calls.

Access to affordable housing is very important to the attendees. There is a 2-3 year wait for senior housing. Many seniors in the area would like to move but there is a long wait.

Caregivers need respite care, the caregiver is loaded down and more attention needs to be given to the caregiver needs. Skilled care a couple of times a week in the home and hospice care is very important at end of life.

<u>Evergreen Commons Adult Day Services Caregiver Support Group/Ottawa County 2/26/16 – 5 attendees</u>

·What services did you use most often with caregiving? Talking to a gerontologist was helpful and the caregiver support group. The caregiver support group.

Did you use in home respite or other services? Was offered but I turned it down. Said no because I was stubborn and my wife did not want anybody's help. Said he was able to handle it at that time. None had in home services. He wishes he had accepted.

Another participant does make use of ADC. Started with 2 days a week and he gave in and let wife go down to 1 day a week because she claimed she didn't like it there. It really is just ½ day a week which isn't enough time. He is living with wife in assisted living. It was his daughter that encouraged him to seek out ADC at Evergreen. Was hard adjustment for her at first but now has adjusted to it.

One participant's wife comes to EC ADC. Both he and his wife were members at EC and utilized pool before her lack of balance/dementia progressed. He has volunteers from church that come give him respite. He likes to do his own cooking.

How do you learn or hear about the services? One participant has wonderful advocates in his daughters who looked into EC and also encouraged to check. The daughters are very involved in community and knew about EC and 'pushed' him to get her mother into ADC.

If you had a question about what's available who would you call? I would call EC or ask my doctor.

Is there information you think I should know about that people want or need? Transportation. Advocacy or an advocate for loved ones; worry about who will do my caregiving when I'm gone. Tools to know how to work with/handle spouse in caregiving.

<u>Regional Supports Coordinators 3/7/16 – 15 attendees</u>

- Transportation – even for participants that receive in-home services the mileage is limited to 10 miles
- Lack of volunteers for transportation – North Ottawa has limited to one ride per week.
- Cross county/state transportation – very difficult to get people to appointments in other counties. Often

appointments are not kept due to no transportation to the appointment.

- Supplies – DME – Can't afford – meals or incontinence supplies
- Specialist co-pays unaffordable again, people many do not go to specialists as they cannot afford the co-pay.
- Light housekeeping and meals – there are not enough hours of service provided. The homemaker can start but not complete the tasks–hours are too limited; homemaking is doing more meal prep – Homemaking is a largely sought after service and the support that it offers is often enough to keep people in their homes for much longer.
- Since there is a home delivered meal waitlist, participants are missing the wellness checks/socialization – in addition people are buying food from convenience stores and dollar stores – very unhealthy. Muskegon Heights does not have a grocery store.
- Personal Care – hospitalizations from wounds or participants experiencing skin breakdown as one bath per week is not adequate and vendors want 3 to 4 hour minimum visit.
- Choose the more cost effective services like homemaking and PERS.
- Willingness to pay for services? Participants feel that these services are "entitlement" services.

<u>Senior Resources Program & Planning Committee 3/16/16 – 7 attendees</u>

- Navigation of services is very important. Attendees stated that people who need services are not aware of services until there is a crisis of need. It would be nice to meet be able to provide people with available resources earlier in the aging process.
- Caregivers also need assistance with the navigation of services. Caregivers are often sandwiched, stressed and do not know where to access services.
- There is healthcare abuse because people do not know about or cannot access primary physician.
- We need to explore nonconventional venues for communication/outreach. Human Resource departments at large corporations, bars, hairdressers, etc.
- Many older adults do not have support people and need assistance writing checks, paying bills and general help with financial matters.
- Home repair and maintenance for older adults in their homes.

Results of the on-line survey

160 people participated in the on-line survey. The link to the survey was distributed to our Constant Contact list serve, our Caregiver Link email list, board and advisory board members, employees and shared many times by other community agencies. The majority of the respondents were 60-69 years old with 26% of respondents. The 70-79 years old bracket was next with 25% of respondents.
There was a very even distribution of respondents by county: 30% from Muskegon, 32% from Oceana, 33% from Ottawa, and 5% other.

The highest priority of <u>Access</u> service needs was identified as follows:
Information & Assistance (help to elderly/support team in finding needed services) - 139 respondents indicated access to this service as a high priority. 5 people indicated that they would able/willing to contribute to the cost for this service.
Outreach (Seniors informed of services and encouraged to use available services) – 136 respondents indicated access to this service as a high priority. 8 people indicated that they would able/willing to contribute

to the cost for this service.
Home Delivered Meals (Nutritional meals delivered to homebound elderly) – 131 respondents indicated access to this service as a high priority. 12 people indicated that they would able/willing to contribute to the cost for this service.
Transportation (Medical) - 126 respondents indicated access to this service as a high priority. 15 people indicated that they would able/willing to contribute to the cost for this service.
Case Coordination (Assisting in accessing or navigating community resources) - 124 respondents indicated access to this service as a high priority. 8 people indicated that they would able/willing to contribute to the cost for this service.
Affordable Housing (Access to housing that is structurally and mechanically safe and that accommodates your needs and preferences) - 122 respondents indicated access to this service as a high priority. 13 people indicated that they would able/willing to contribute to the cost for this service.

The highest priority of In-home service needs was identified as follows:
Respite (Limited in-home care to provide relief to an unpaid caregiver) - 121 respondents indicated access to this service as a high priority. 7 people indicated that they would able/willing to contribute to the cost for this service.
Personal Emergency Response System (Alarm system designed to summon emergency medical personnel) - 121 respondents indicated access to this service as a high priority. 7 people indicated that they would able/willing to contribute to the cost for this service.
Personal Care (Assistance with bath, shampoo, shaving, dressing etc.) - 120 respondents indicated access to this service as a high priority. 14 people indicated that they would able/willing to contribute to the cost for this service.
Home Management (Housekeeping, errands, shopping, laundry, lawn maintenance, snow removal etc.) - 116 respondents indicated access to this service as a high priority. 15 people indicated that they would able/willing to contribute to the cost for this service.

The highest priority of Other Aging service needs was identified as follows:
Caregiver Assistance (Public information on services available; assistance and accessibility services) - 129 respondents indicated access to this service as a high priority. 6 people indicated that they would able/willing to contribute to the cost for this service.
Caregiver Counseling/Support Groups/Training (Advice, guidance and instructions for providing support to caregivers) – 116 respondents indicated access to this service as a high priority. 5 people indicated that they would able/willing to contribute to the cost for this service.
Ombudsman (Receives, investigates, resolves and reports complaints on behalf of nursing home residents) - 111 respondents indicated access to this service as a high priority. 3 people indicated that they would able/willing to contribute to the cost for this service.
Caregiver Supplemental Services (Other services to support the needs of caregivers such as supplemental reimbursement or medical alert buttons, transportation vouchers, gas, etc.) - 95 respondents indicated access to this service as a high priority. 8 people indicated that they would able/willing to contribute to the cost for this service.

Senior Resources **FY 2017**

Senior Resources contacted our community partner, CALL 2-1-1 of the Lakeshore, to inquire about the top five most requested service information topics in fiscal year 2015. They are as follows:

Muskegon County Contacts

4749 Senior I&A Contact

762	16.05%	VITA Program Sites - tax preparation
399	8.40%	Electric Service Payment Assistance
189	3.98%	Gas Service Payment Assistance
180	3.79%	Home Rehabilitation Grants
138	2.91%	Senior Ride Programs

Ottawa County Contacts

869 Senior I&A Contacts

71	8.17%	Electric Service Payment Assistance
66	7.60%	VITA Program Sites - tax preparation
39	4.49%	Food Pantries
38	4.37%	Gas Service Payment Assistance
32	3.68%	Home Maintenance and Minor Repair Services

Oceana County Contacts

167 Senior I&A Contacts

34	20.36%	Electric Service Payment Assistance
25	14.97%	VITA Program Sites - tax preparation
11	6.59%	Heating Fuel Payment Assistance
8	4.79%	Food Pantries
8	4.79%	Home Rehabilitation Grants

In addition, Senior Resources was asked to conduct a senior gaps analysis in Oceana County. On November 6, 2014 a meeting was held at the Hart City Hall Community Center to discuss the gaps in services available to older adults in Oceana County. Gaps would include services that are not currently available, services that are available but lack capacity and services that may only be available in certain areas of the County. A variety of service providers were invited to attend. Some provide services specific to older adults and some provide a broad spectrum of services to a variety of ages including older adults. There were 34 interested parties and 2 facilitators in attendance.

Top 5 Identified Gaps in Services and Why They are Viewed as a Gap

1.Transportation

1.Lack 24 hours/day, 7 days/week

Limiting criteria

Limited in Pentwater, Hesperia, & Walkerville

Inability to cross county lines or transfer for medical transportation

Assisted Living

1.Lack of availability

Limited number of beds

Need for assistance in paying for (or cost effective)

Senior Resources **FY 2017**

Need for continuum of care – independent living >assisted living

Caregiver Support

1.Limited locations

Need for marketing/communication

Peer support needed

Lack of attendance/participation

Need for on-line support forum

Visiting Physicians

1.Limited availability

Need fuller range of services

No hospital rights

Seniors not getting enough hours to meet needs (in-home)

1.Not enough hours of service

Different scale of determination

Prioritization

The credibility of this information comes from the fact that it was collected and reported based on the input from people who work or live within Oceana County, have knowledge of what is and is not available, and have a passion for its older adults.

The information was collected and provided as an instrument for members of Oceana's aging network to take into consideration and use as a development or planning tool or a point of reference when they are considering changes to current senior programs or new programming for older adults within their organization. This information could also be used by a group that might want to address a specific gap within the county.

A similar process was conducted in Ottawa County and while it occurred in 2011, the information collected supports what we learned during the recent public input sessions and from the on-line survey.

The Top 5 Needs Identified by the Ottawa county Gaps Identification Group (in no particular order):

1.

Supports Coordination

It was the consensus of the group to combine supports coordination and assistance with paperwork into one identified gap. It was felt that assistance with paperwork would be provided through a supports coordinator.

The group felt the following components were important:

1.coordination across all services would be more seamless/someone to cut through the chase/no wrong door

the development of an Aging and Disability Resource Collaborative in partnership with 2-1-1

Community awareness – people need to know who to call. Supports coordination that takes into consideration not just the preferences of the whole person but their family and support system as well.

1. Assistance with paper work – group consensus was to combine this need with the first, Case Coordination & Support

Transportation

1.Only available in certain areas

Difficult for disabled or frail consumers as they don't often know when an appointment will end for scheduling.

In the townships that receive senior millage dollars no one has been denied volunteer transportation

Those needing specialized transportation (handicap accessible) are unable to access volunteer transportation

Senior Resources **FY 2017**

The types of non-public available transportation vary by service provider. Example: medical only, jobs only, or shopping
Limited or no night service county-wide
Inability to access transportation outside county lines

1. **Mental Health Services**

1.Lack of affordable mental health services
Community Mental Health system is currently taxed
Not enough specialists in senior related issues in the mental health system
There is a need for mental health services within long term care facilities
Lack of an official diagnosis makes it difficult for senior consumers to initiate/access community services (hoarding, depression, dementia)
Issues related to drug/medication interactions
MiChoice Waiver
Current waiting list is over one year for a cost efficient alternative to nursing home placement
Current waiting list needs to be continually cleaned up as people's needs or situations change
Need for continued advocacy for more service dollars

Gaps analysis process to be conducted in Muskegon County in 2016/2017.

Scope of Services

1. Describe key changes and current demographic trends since the last MYP to provide a picture of the potential eligible service population using census, elder-economic indexes or other relevant sources of information.

Current demographics indicate that the state of Michigan has 2 million people age 60+, with the 85+ year olds the fastest growing segment of the population - a projected 102% increase by 2030. 45% of those 85+ have dementia, with 1 in 5 caregivers dealing with the condition. 80% of caregivers are unpaid family and friends.

In Region 14 there are an estimated 92,000 people over the age of 60, approximately 18.5% of the total population. 29% of people age 60+ in the Region have a disability and 7% have income levels below poverty. 16% have an income below 150% of the poverty level.

Between 2010 and 2013 the senior population in Region 14 increased by 1% annually.

County	Total 60+ pop.	60+ minority pop.	Below poverty	Rural
Muskegon	35,968	12.5%	18.8%	
Oceana	6,755	5%	13%	6,755
Ottawa	49,583	5.5%	9.3%	

Within this planning timeframe, fiscal years 2017-2019, approximately 32,023 people in the PSA will turn age 60. This will equate to a 35% increase of people over the age of 60 Region wide.

Over the past several years, our nation, state, and local communities have experienced challenging economic times. Many areas within our PSA have experienced an economic recovery but others have not. The impact has been felt by all, including older adults. In addition to personal impact, the sheer number of older adults within the population is increasing dramatically as the baby boomer generation continues to move into retirement age. This significant, new, demographic shift brings not only challenges, but new opportunities as well. Senior Resources strives to engage our community, provide leadership in advocacy and education, and challenge ourselves and community partners to think and act creatively in these unique times.

2. Describe identified eligible service population(s) characteristics in terms of identified needs, conditions, health care coverage, preferences, trends, etc. Include older persons as well as caregivers and persons with disabilities in your discussion.

Along with 92,306 people over the age of 60, Senior Resources has within its service area 24,534 (29%) people age 60+ who have a disability. In addition, 12% of the total population in Region 14 have a disability, making them eligible to receive long term care and support services.

In the 2015 Ottawa County Community Needs Assessment (CHNA) there were significant key findings related to health care access. It was found that nine in ten Ottawa County adults have health insurance and/or a medical home. More Ottawa County residents have health insurance or coverage now compared to the last CHNA, largely due to the Affordable Care Act and the Healthy Michigan Plan. However, it was reported that

many are not using their coverage when needed – and especially not for preventive measures because they cannot afford out-of-pocket expenses such as deductibles and co-pays. 51% cited unaffordable co-pays or deductibles as a barrier to accessing health care. In addition, there are far fewer primary care physicians per capita in Ottawa County compared to the state. 57.1 in Ottawa County compared to 78.5 in Michigan.

The prevalence of Alzheimer's disease is higher in Ottawa County compared to peer counties and even more concerning is that the rate of death from Alzheimer's disease is higher in Ottawa County compared to peer counties, the state of Michigan, and the United States. Key informants to the survey have reported a shortage of quality, or even adequate, facilities to care for patients with Alzheimer's Disease/dementia

One in five adults in Ottawa County reported engaging in no leisure time physical activity with 28% of 65-74 year olds and 35% of 75+ saying they do not participate leisure physical activity.

76% of persons age 65-74 and 72% of person age 75+ report that they consume less than 5 fruits or vegetables per day.

Access to dental care remains an issue for older adults of Ottawa County.18% of those age 65-74 and 29% of those age 75+ have not visited a dentist in the past year.

Roughly one in twelve Ottawa County adults have diabetes.17.4% of persons age 65-74 and 17% of persons over the age of 75 have been diagnosed with diabetes.

42% of persons age 65-74 and 49% of persons over the age of 75 have been diagnosed with arthritis.

One in five Ottawa County adults are considered disabled.25% of those age 65-74 and 44% of those age 75+ reported a disability.In addition, 33% of those ages 65-74 and 39% of those age 75+ report being limited in activities because of physical, mental or emotional problems.

23% of those polled said that homecare/assisted living for the elderly was lacking in Ottawa County communities.

Muskegon and Oceana County Community Health Needs Assessment (CHNA) 2015

The top five health care issues for persons age 60+ as ranked in the CHNA in Muskegon County are: Care Coordination/patient advocacy, access to primary care, lack of mental health providers, diabetes and lack of substance abuse providers.

The top five health care issues in Oceana County are: Access to specialty care, access to primary care, cardiovascular disease, hypertension and diabetes.

Several important health issues appeared in the 2016 CHNA process as priority concerns for public health and other community agencies.For Muskegon County, the leading health issues identified in order of most

importance were transportation, depression and social isolation, access to healthy food, physical fitness and senior isolation.In Oceana County, obesity, binge drinking (specific to youths and adults over age 65), depression/anxiety, teen pregnancy and transportation were identified in the top five issues for the community to address.

3. Describe the area agency's Targeting Strategy (eligible persons with greatest social and/or economic need with particular attention to low-income minority individuals) for the MYP cycle including planned outreach efforts with underserved populations and indicate how specific targeting expectations are developed for service contracts.

The federal Older Americans Act requires the AAA to target the following types of populations:

- Greatest economic need,
- Greatest social need,
- Minority status,
- Frail, and
- Rural.

One of the first determinants used to prioritize need is income and assets.Senior Resources is committed to assisting those with adequate income or assets to use their personal resources as conservatively as possible, thus prolonging the availability of the funds.We employ a cost saving program for in-home services allowing the participant and/or their family member/support team to purchase services at a cost that is appropriate to their income or asset level.Those without funds to support them in their homes are of the highestpriority.

Using 2010-2013 American Community Survey (ACS) data and industry methods to classify rural areas, Senior Resources estimates more than 6,755 persons 60 years old and older live in rural Oceana County. While the number of older adults living in this community is relatively small, these areas can be very difficult and costly to serve. Aging adults in these communities may face additional barriers to remaining in their homes, staying active, and engaging in the local community, all resulting in increased risk of becoming isolated.

Senior Resources also weighs the older adults' physical status when prioritizing or targeting populations. Those individuals demonstrating the most frailty as well as lack of formal or informal supports are prioritized as those most in need.

While the definition of greatest social need in the Older Americans Act includes isolation caused by racial or ethnic status, the definition is not intended to exclude the targeting of populations that experience cultural, social or geographic isolation due to other factors. In some communities, such isolation may be caused by minority religious affiliation. In others, isolation due to sexual orientation or gender identity may restrict a person's ability to perform normal daily tasks or live independently. Each planning and service area is tasked with assessing their particular environment to determine those populations best targeted based on greatest social need.

Using the above definition we have expanded our targeting criteria to include Lesbian, Gay, Bisexual and Transgender (LGBT) persons. Studies have shown that LGBT older adults are a largely invisible population. Not only are they undercounted and underserved, they are also understudied. While there have always been

LGBT elders, relatively few have been open about their sexual orientation until recent years.

Nationally, current estimates of LGBT elders 65 and older number 1.5 million and are expected to grow to nearly three million by 2030 —a significant share of the larger 65 and older population.
Aging service providers will face challenges in addressing the needs of LGBT elders. For social, cultural, and legal reasons, the needs of older LGBT people differ from heterosexual and/or non-gender variant people. The social stigma associated with being lesbian, gay, bisexual or transgender continues to stand in the way of full participation in community and society for many LGBT elders, and full and equal access to important services and opportunities. About one-third of lesbian and gay male Baby Boomers (26% of lesbians and 32% of gay men) identify discrimination due to sexual orientation as their greatest concern about aging.

While we will not be tracking participant sexual preferences, we will be making concerted efforts to meet with LGBT leaders in our communities to see how we can better we serve this population as well as provide diversity training for our staff , contracted and in-home service providers.

Senior Resources and our community partners have been exploring ways to engage all target populations. We know there are pockets of minority populations in Muskegon, Oceana and southern Ottawa counties. To effectively involve an outreach in any new community, it is important to identify local programs that serve the population we are wishing to engage. If a group is not currently working with Senior Resources, we are planning to be proactive and reach out to leaders in those communities and/or programs. We will continue to talk with key leaders, to solicit their input. Senior Resources and our contracted providers intend to be flexible in our thinking and approach to engaging underserved populations.

To assist our contracted providers in establishing benchmarks and outreach strategies for underserved populations, we have provided them with a breakdown of age, minority and poverty levels setting, and instructed them to give substantial emphasis to serving eligible persons with the greatest social and/or economic need, with particular attention to low income and 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, and in numbers greater than their relative percentage to the total elderly population within the geographic service area.

4. Provide a summary of the results of a self-assessment of the area agency's service system dementia capability using the ACL/AoA "Dementia Capability Quality Assurance Assessment Tool" found in the Documents Library. Indicate areas where the area agency's service system demonstrates strengths and areas where it could be improved and discuss any future plans to enhance dementia capability.

At this time the Aging & Disability Resource Collaboration of the Lakeshore (ADCRLS) does not have protocols in place to identify persons with dementia, ways of sharing that information, or of identifying caregivers or providing standardized training. The individual agencies that comprise the ADRCLS may have those protocols in place but there are not shared procedures.

Senior Resources does have a variety of standard protocols in place. When it is suspected that a participant is experiencing the symptoms of dementia, a care manager will administer a Mini-Mental State Examination (MMSE). If that test indicates increased odds of dementia or a cognitive impairment, the support coordinator will recommend a full review by a doctor or local Memory Clinic. Through the web based Vendor View system which is used to communicate with the in-home providers, this information will be conveyed to the direct care providers. If the participant lives alone, there is no standardized protocol in place to support the participant. This does not mean the participant goes unsupported, just that there are not standard procedures. The actions taken currently depend largely on the informal support of the participant with dementia who is living alone and the participants' and their support team's desires.

Upon hire and at various points throughout employment, Senior Resources employees are trained on the aging process as well as dementia progression, types of dementia, co-existing conditions, lived experience of dementia, delirium, depression, identifying personal preferences of the person served, loss and grief, communication, therapeutic approach to behavior, observation skills, sexuality, meaningful engagement of the person served on an ongoing basis, therapeutic approach to activity development and implementation, and gathering information about the person served in the following areas:

- History
- Current status
- Important memories
- Favorite stories
- Daily routines
- Comfort/reminiscence objects
- People of importance

New employees must demonstrate each competency within 90 days of their date of hire or have an action plan designed to assist the employee in reaching competency.

Senior Resources' strength lies in the supports coordinators' knowledge and coordination of services. The supports coordinator provides easy access to information about options and services across all stages of the disease, paying attention to facilitating smooth transitions between services and settings. This coordination, coupled with the infrastructure to provide a continuum of care for persons with dementias and their caregivers, seeks to address the progression of the disease from mild to severe and to allow flexibility to move within care systems depending on the needs of the individuals and their families.

Senior Resources **FY 2017**

As the older adult population ages we believe we will need to improve our ability to provide early identification of the disease as well as standardizing a protocol which can guide the options of participants who live alone.

Senior Resources is aware that 80% of caregivers are family and friends and that these caregivers need to be supported to continue to provide care. Senior Resources plans to expand and provide resources to help. We will use trainings, workshops, books and DVDs and any other method requested by the caregiver to assist the caregiver to gain caregiving skills and emotional support. In addition, as identified in our organization's Strategic Plan, we will over the next three years seek partnerships with hospitals/health plans to implement/expand dementia care education as well as strive to provide more communication between health care providers to more fully support caregivers.

Senior Resources advocateds for the state CARE Act which willwould support and equip family caregivers when their person goes into the hospital and as they transition home. The CARE Act requires hospitals to allow patients to designate a family caregiver and provide them with adequate care instructions at hospital discharge. In addition, we advocate for the Michigan Care and Support Pilot Project and support a State Dementia Plan to address issues related to caregiving, primary care, long-term care and public awareness of the disease.

5. When a customer desires services not funded under the MYP or available where they live, describe the options the area agency offers.

When a participant requests a services that is funded under the AIP/MYP but the agency they wish to use does not have a contract with Senior Resources, we will work to acquire a contract with the preferred agency in an effort to honor the customer's request.

Should a participant and/or their caregiver desire a service that is not available where they live or is an unfunded service, Senior Resources employs Person Centered Processes to guide that person in securing services. Through assessment, the support coordinator involvement may take the form of assisting in locating, and with permission, referring the participant to other community agencies that may be able to fill the need. Senior Resources and its employees appreciate that the Person Centered Planning process allows for participant involvement in planning, provides a way of giving choice and control to individuals, assures that the individual is fully integrated in the development, implementation, and management of services and supports, is well-informed and able to make decisions and is aware that he/she has choices, and is aware of rights, risks and responsibilities. If formal services are not available or are insufficient to meet the total needs of the individual, we can assist the participant in locating informal supports in the form of family, friends, neighbors, churches, etc.

Senior Resources believes that participants and their families or caregivers are better able to use personal resources with higher success and greater longevity when presented with all options of care.

6. Describe the area agency's priorities for addressing identified unmet needs within the PSA for FY 2017-2019 MYP.

AASA supported program participants experience a diverse and often unseen assortment of unmet needs among its participants, typically because of limited funding, restrictive program policies, gaps in the service continuum, and/or other access barriers. This has contributed to a service delivery system that makes the best use of existing resources and allowable services. Supports Coordinators will often ask participants and/or family members what is their top three needs and then work with the participant and/or support team to

find resources to meet those needs by assisting them to access public, private, and personal solutions. With the exception of wait lists, these unmet needs are rarely documented, measured or reported.

7. Where program resources are insufficient to meet the demand for services, reference how your service system plans to prioritize clients waiting to receive services, based on social, functional and economic needs.

As aging services are currently experiencing a shortage of service dollars and the prediction is that this will only worsen as the population ages, Senior Resources has dedicated great thought and solicited much input as to how to prioritize participants in need. At this point we are prioritizing participants based on the federal targeting criteria and are still unable to serve all in need.

One of the first determinants used to prioritize need is income and assets.Senior Resources is committed to assisting those with adequate income or assets to use their personal resources as conservatively as possible thus prolonging the availability of the funds.We employ a cost saving program for in-home services, allowing the participant and/or their family member/support team to purchase services at a cost that is appropriate to their income or asset level.The total cost of the in-home services is then supplemented with state and federal funds.

Next we assess physical ability.If the participant is nursing home eligible or at risk of being placed into a nursing home, they score at a higher priority level.

Should that participant have no other formal or informal supports, be isolated or in a rural area, they will be an even higher priority level.

Again, prioritizing using all these determinants, we are still unable to address the complete need in our region and there is a waitlist for Access and in-home services.

8. Summarize the area agency Advisory Council input or recommendations (if any) on service population priorities, unmet needs priorities and strategies to address service needs.

Senior Resources Board of Directors and Program & Planning Committee met to discuss the top service priorities.

Service Navigation and Outreach - Members stated that navigation of available community resources was identified as the top service priority.Members believe that that if older adults and/or their support team can use personal resources for a longer period of time when given all options for care early in the aging process.Attendees stated that people who need services are not aware of services until there is a crisis of need.It would be nice to be able to provide people with available resources earlier in the aging process. Caregivers also need assistance with the navigation of services.Caregivers are often sandwiched, stressed and do not know where to access services.Ideas related to unconventional outreach was discussed including information at beauty shops, barbers, casinos, human resources departments at large corporations, etc.

Housing – There is a lack of affordable housing options for older adults throughout the region. A member sits on the Housing Commission in Oceana County and spoke about the lack of options for moderate-income housing, due to lack of public funding for anything above low-income thresholds.

Transportation - Lack of transportation in all areas of the region was discussed – both medical and non-medical transportation is lacking.

Homecare – All in-home services including bathing, homemaking, and grocery shopping when friends and family are not able to assist.

Meals – providing for meals in-home and in congregate settings are both important to offer choice, socialization, and monitoring the situation at home.

Access to primary physicians – A member stated that there is healthcare abuse because people do not know about or cannot access primary physician. Ottawa County in particular has a low percentage of primary physicians per capita.

Financial Assistance – It was discussed that many older adults do not have support people and need assistance writing checks, paying bills and general help with financial matters. There are some community resources that will assist in managing finances for a fee – explore additional low cost resources.

Home repair and maintenance - Lack of affordable home repair and maintenance for older adults living in their homes. It was mentioned that some senior centers used to provide lower cost options for home repair but it was discontinued due to the liability of sending one person into the house. It was suggested that the agency send two people into the home to negate some of that risk.

9. Summarize how the area agency utilizes information, education, and prevention to help limit and delay penetration of eligible target populations into the service system and maximize judicious use of available funded resources.

Participants that call our office, are referred through the local Call 2-1-1, or referred through an ADRC partner are connected to our in-house options counselors (OC). The OC role is to not only explain someone's long term care options, but also initiate a discussion on a person's personal finances/resources and how to best utilize them to make them last for as long as possible and still allow the person to remain in the setting of their choice.

Family caregiving is one of the most important phenomena of the 21st Century. As the population ages and community-based care of elderly, ill, and disabled persons escalates, relatives and friends will increasingly find themselves responsible for in-home care of relatives and friends. Our OC and support coordination employees provide opportunities for family caregivers to have an awareness of all available community resources, how to access the resources and how to use personal funds thoughtfully so they might last as long as possible. To fill needs for social-emotional support we refer persons whose needs indicate to caregiver support groups and trainings, and Senior Companion respite and in-home respite services.

Senior Resources is continually assessing the needs of the communities we serve regarding health promotion/disease prevention training opportunities. As the population changes, we strive to rapidly respond to their expressed training needs and schedule programs where older adults can access them easily as well as affordably. Senior Resources only promotes evidence-based programs, as their results are proven to produce positive results for the participants.

Our website and social media sites are constantly being reviewed and updated to provide immediate information to the community. We know the internet has completely changed the way we live and how many of us gather information. Not only is it now one of our primary sources of information, but it has revolutionized the way organizations communicate with customers. While we understand that many older Americans may not access the internet for information, we know that over 78% of adult Americans use the internet for information and believe as the population ages it will be an essential part of how we communicate and deliver services.

Senior Resources **FY 2017**

Planned Service Array

	Access	In-Home	Community
Provided by Area Agency	• Care Management • Case Coordination and Support *		
Contracted by Area Agency	• Case Coordination and Support * • Transportation *	• Home Care Assistance • Homemaking • Home Delivered Meals • Home Health Aide • Medication Management • Personal Care • Respite Care	• Adult Day Services • Congregate Meals • Disease Prevention/Health Promotion • Legal Assistance • Programs for Prevention of Elder Abuse, Neglect, and Exploitation • Kinship Support Services * • Caregiver Education, Support and Training
Local Millage Funded	• Case Coordination and Support * • Information and Assistance * • Transportation *	• Home Care Assistance * • Homemaking * • Home Delivered Meals * • Home Health Aide * • Personal Care * • Respite Care * • Friendly Reassurance *	• Adult Day Services * • Congregate Meals * • Senior Center Operations * • Senior Center Staffing *

Senior Resources **FY 2017**

Participant Private Pay	• Care Management • Case Coordination and Support * • Transportation	• Chore • Home Care Assistance • Home Injury Control • Homemaking • Home Delivered Meals • Home Health Aide • Medication Management • Personal Care • Assistive Devices & Technologies • Respite Care • Friendly Reassurance	• Adult Day Services • Dementia Adult Day Care • Congregate Meals • Nutrition Counseling • Nutrition Education • Disease Prevention/Health Promotion • 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 • Programs for Prevention of Elder Abuse, Neglect, and Exploitation • Counseling Services • Creating Confident Caregivers • Caregiver Supplemental Services • Kinship Support Services • Caregiver Education, Support and Training

Senior Resources **FY 2017**

Funded by Other Sources	• Care Management * • Case Coordination and Support * • Disaster Advocacy and Outreach Program * • Information and Assistance * • Outreach * • Transportation *	• Chore * • Home Care Assistance * • Home Injury Control * • Homemaking * • Home Delivered Meals * • Home Health Aide * • Medication Management * • Personal Care * • Assistive Devices & Technologies * • Respite Care * • Friendly Reassurance *	• Adult Day Services * • Dementia Adult Day Care * • Congregate Meals * • Nutrition Counseling * • Nutrition Education * • Disease Prevention/Health Promotion * • 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 * • Programs for Prevention of Elder Abuse, Neglect, and Exploitation * • Counseling Services * • Creating Confident Caregivers * • Caregiver Supplemental Services * • Kinship Support Services * • Caregiver Education, Support and Training *

* Not PSA-wide

Senior Resources **FY 2017**

Planned Service Array Narrative

Due to the lack of adequate funding to address the growing demand for services throughout our PSA, Senior Resources staff and our Board of Directors have had to more closely scrutinize all areas of service provision. In preparation for the multi-year plan, we held a series of focus groups which served to identify needs relevant to geographical area as well as took into account the services that were being provided by other community service agencies. In addition within the past 2 years and at the request of the respective county commissioners, Senior Resources conducted a gap analysis for Oceana and Ottawa counties. This was done to further identify gaps in services and how those gaps can be addressed with current funding and community organizational input. While deciding funding for service provision, those services designed to assist the older adult and their caregiver in keeping the older adult living in their home, if that is the desire, is our foremost goal. To that end, in-home services remain the priority. Even then, Senior Resources and its Board of Directors have made difficult decisions due to lack of funding. In 2014 the Board determined that there was a need to prioritize in-home services and voted that homemaking is a non-essential service to be used only under strict medical need criteria. Older adults still receive the service but must have a documented medical need. When determining community access services we look at what other organizations are providing in terms of service, such as what areas are covered by millages and other funding sources like United Way. We will partner with those agencies if the demand for the service requires it or will direct funding to another service/area need. Senior Resources is always looking for ways to fund additional, applicable programs. Last year, the Area Agency on Aging Association of Michigan proposed and was awarded funds over two years to disseminate the health promotion/disease prevention workshops of Matter of Balance and Diabetes PATH. Because this new money is available, Senior Resources has reallocated the health promotion/disease prevention IIID funding to other evidence based programs. At every point in the allocation process Senior Resources seeks the input of its Program and Planning Advisory Board as well as the full Executive Board of Directors.

Strategic Planning

1. Summarize an organizational Strengths Weaknesses Opportunities Threats (SWOT) Analysis.

Senior Resources management team, board representatives and staff employ a strategic planning process that includes identification of the organizations strengths, weaknesses, opportunities and threats (SWOT).

It was evident that Senior Resources has many strengths including:
·Respectful relationships with federal, state, local elected officials
Active with national, state, local network of aging service organizations & providers
Seen as trusted, neutral entry/focal point that offers diverse care options
Experts in coordinating community-based care
Community convener, facilitator, initiator of new projects and services
Communicate with thousands of older adults via our publications and other marketing methods
National, state, local relationships with aging network and providers
Maintain a proactive/global view of needed aging services both medical and social
Staff Expertise
Excellent fiscal/data management
Chronic Disease Management and Prevention programming
Communication with stakeholders, providers
Key to effective advocacy efforts

However there remain some unknowns or weaknesses:
·Reauthorization of Older Americans Act
Affordable Care Act ramifications
Michigan's Integrated Care Plan
Appropriations
Growing population of elderly needing and anticipating our services
Boomers and younger generations have different expectations
Reliance on the MiChoice Waiver funding

The new climate of older adults and the region's enthusiasm to enhance aging readiness provides us with some substantial opportunities:
·Integrated Care
Care Transitions
Collaborate with local hospitals
Aging & Disability Resource Collaborative
Work in further partnership with community organizations i.e. Pathways in Muskegon and Ottawa counties
Prevention programming
Focus on diabetes & Medicare billing
Diversification of funding
CST partnering opportunity - Carenect
Private pay for waiver services
Assist with PACE expansion in Ottawa County

Michigan Association of Health Care Plans – bundled service provision
Take leadership role in improving how AAAs and Veterans Affairs coordinate services
Proactive marketing to Boomers, Generation X and Generation[LMT1] Y regarding use of financial resources
Initiate a companion care service program

Senior Resources does not lightly enter into or participate in every opportunity that is available or presented. Every opportunity is evaluated using the following criteria:

·Does it meet our mission & vision?
Does it align with our area plan?
Does it play into our strengths?
Does it align with nationally identified core competencies?
Consider short term vs long term impact
Infrastructure in place
Are 'match' dollars required?
Legal liability & risk assessment
Internal screen for staff to be included in preliminary discussions
Can another agency do this better? Are there partnership opportunities?

During the strategic planning process it was noted that senior care services have very few "competitors" or threats as there is more need than any one organization can possibly meet. However the following could be considered threats:

·Nursing Homes
Section Q requires that all options be discussed with the participant and/or family/support team
Reliance, the other Medicaid Waiver provider
Integrated care might create competition
PACE - we compete for same dollars
CILs - we compete for the same dollars
Private Care Management start-ups

2. Describe how a potential greater or lesser future role for the area agency with the Home and Community Based Services (HCBS) Waiver and/or the new Integrated Care Program could impact the organization.

The MiChoice Waiver program provides support for many of the AASA related services including options counseling, communications, case coordination & support, care management and program development. A decrease in our involvement with this program would affect our ability to meet older adults' service needs as well as greatly reduce our ability to collaborate and develop additional programs and resources.

3. Describe what the area agency would plan to do if there was a ten percent reduction in funding from AASA.

If reductions occur, Senior Resources will be forced to dramatically cut services as determined by our

Program and Planning Committee and Board of Directions. All services could be impacted, including transportation, delivering meals to homebound seniors on a daily basis, in-home assistance (homemaking services would be scrutinized most heavily), and many seniors would not receive services at the frequency required for full sustenance.

Without the support necessary to remain in their homes, people could be forced into long-term care facilities and once they exhaust their resources, they become eligible for Medicaid. This is not a viable financial strategy for taxpayers.

Whether funding is decreased, remains stagnant, or slightly increases, the status quo for assisting seniors is unsustainable. That is why Senior Resources is developing new partnerships, strategies and seeking mission minded private pay opportunities. We are working with local governments to expand their capacity to create and maintain environments and social support structures that contribute to independent, healthy aging. Senior Resources plans to more formally partner with faith-based communities and communities to identify and support the services they provide. We will continue to work with the state unit on aging to promote community service, opportunities for volunteerism, and explore new ways the state can help meet the growing needs of older adults and people with disabilities. The next three years will be challenging, but Senior Resources will continue its dedication to making the goals of the Older Americans Act a reality for those living in our PSA

4. Describe what direction the area agency is planning to go in the future with respect to pursuing, achieving or maintaining accreditation(s) such as Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Hospitals (JCAH), or other accrediting body, or pursuing additional accreditations and why.

Senior Resources is scheduled to be surveyed for CARF compliance in the spring of 2016. The accreditation process applies sets of standards to service areas and business practices during an on-site survey. Accreditation is not a one-time event but an ongoing process, signaling to the public that an agency is committed to continuously improving services, encouraging feedback, and serving the community. Accreditation also demonstrates our agencies commitment to enhance its performance, manage its risk, and distinguish its service delivery.

Senior Resources Board of Directors and staff made a commitment to pursue this accreditation as part of our mission and to provide standard service to all participants and their family members. The decision to seek accreditation also came from our desire to provide the best services that we possibly can to our participants. CARF accreditation is a seal of approval that tells others they can rely on us to do not only an effective job, but a superior job.

5. Describe in what ways the area agency is planning to use technology to support efficient operations, effective service delivery and performance, and quality improvement.

Senior Resources believes that using technology will maximize our business productivity. Increased business productivity can be traced to expedient communication between employees. To that end we have begun to use Skype for Business internally. This allows employees to communicate or to gain access to each other when a quick answer to a question is desired. It also allows users to access groups of employees to pose a question and for all responses to be viewed by the group allowing for immediate

resolution.

Senior Resources purchased a cloud based phone system in 2016. This system will allow employees to communicate via voice, text, and fax on multiple devices—including smartphones, tablets, computers, and desk phones. We believe this upgrade will enhance communication between staff, participants and providers.

All home and community staff have been issued tablets, laptops and/or scanners so that assessment data can be immediately entered into the participant data management software called Compass. Scanners have enabled staff to scan required documentation at the participant's home to faster facilitate Medicaid or benefit applications. All computers have been/are being systematically upgraded to Windows 365

We have begun to record employee trainings and place them on the intranet. These trainings are then available for review or for new employee orientation. This allows for continuity of training and ease of access for all employees. In addition, agency policies and procedures, guidelines and forms are accessible on the intranet and available for quick reference by all employees.

Senior Resources communicates with community partners and human service agencies throughout the region with Constant Contact. This tool allows us to send important information via email and track who is receiving the email and reading the information. In addition, we use email to send a monthly newsletter to caregivers who are signed up to receive the publication, Caregiver Link. The Caregiver Link is shared many times over through the email list serves of other community organizations.

Senior Resources is very active on social media and our website. Although older adult surveys show that many older seniors do not access social media for information, members of their support team or caregiver may, as well as the younger baby boomer population. Senior Resources uses social media to advertise community opportunities, national stories or trends or disseminate information related to Senior Resources events. Our organization has a comprehensive website which provides the user with information related to services, advocacy, planning, and links to local and national resources. Providers can access contract information via our website, leading to greater efficiencies and better communications.

Senior Resources uses the Vendor View software system which provides expedited communication regarding services delivery provided to participants and to allow our contracted agencies to bill for services electronically. This has proven to be a more efficient and resourceful way for providers and Senior Resources employees to communicate as well as invoice for services rendered.

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Access Services

Care Management

Starting Date	10/01/2016	Ending Date	09/30/2017
Total of Federal Dollars		Total of State Dollars	$108.913.00

Geographic area to be served

Muskegon, Oceana and Ottawa Countie

Specify the planned goals and activities that will be undertaken to provide the service.

Goal: Supports Coordinators will employ Person Centered Thinking and self-determination to assure consumer choice in services and providing agencies or people.
Time Line: Through September 30, 2017.
Outcome: Consumers will have greater autonomy regarding their care resulting in a higher satisfaction rate and continued compliance.

Goal: Supports Coordinators will assist the consumer and their family in identification of natural supports, personal resources and other community/external resources available for long-term care.
Time Line: Through September 30, 2017.
Outcome: Consumers will have awareness of and access to community support services.

Goal: Case Coordination & Support consumers will be moved to Care Management or MI Choice/Waiver programs as frailty increases and eligibility becomes evident.
Time Line: Through September 30, 2017.
Outcome: Consumers will have greater ease of access to services.

Number of client pre-screenings:	Current Year:	99	Planned Next Year:	200
Number of initial client assesments:	Current Year:	33	Planned Next Year:	65
Number of initial client care plans:	Current Year:	33	Planned Next Year:	65
Total number of clients (carry over plus new):	Current Year:	288	Planned Next Year:	333
Staff to client ratio (Active and maintenance per Full time care	Current Year:	39	Planned Next Year:	45

Case Coordination and Support

Starting Date	10/01/2016	Ending Date	09/30/2017
Total of Federal Dollars	$102.049.00	Total of State Dollars	$107.000.00

Geographic area to be served

Muskegon

Specify the planned goals and activities that will be undertaken to provide the service.

Goal: Supports Coordinators will employ Person Centered Thinking and self-determination to assure participant choice in services and providing agencies or people.

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Time Line: Through September 30, 2017.
Outcome: Participant will have greater autonomy regarding their care resulting in a higher satisfaction rate and continued compliance.

Goal: Supports Coordinators will assist the participant and their family in identification of natural supports, personal resources and other community/external resources available for long-term care.
Time Line: Through September 30, 2017.
Outcome: Participant will have awareness of and access to community support services.

Goal: Case Coordination & Support participant will be moved to Care Management or MI Choice/Waiver as frailty increases and eligibility becomes evident.
Time Line: Through September 30, 2017.
Outcome: Participant will have greater ease of access to services.

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Direct Service Request

Long Term Care Ombudsman

Total of Federal Dollars $12,447.00 Total of State Dollars $32,586.00

Geographic Area Served Muskegon, Oceana and Ottawa

Planned goals and activities that will be undertaken to provide the service in the appropriate text box for each service category.

Goal: Residents of Long term care facilities will be encouraged to actively assert their rights and participate in the complaint process by the local ombusdman. Goal is to maintain/increase level of resolution and client satisfaction with the desired outcomes.
Activities: Face to face visits with residents in long term care facilities, individualized education about residents' rights and complaints processes; communication with long term care facility managers and staff, when appropriate; and communication with residents caregivers/family members/allies and resident councils.

Goal: Allow residents to live as independently as possible in the least restrictive plancement of their choice. To ensure this, Ombudsmen will provide information and assist 10 eligible participants and/or their families in the referral/transisiton process.
Activities: Face to face visits with residents in long term care facilities, communication with long term care facility managers and staff, when appropriate; and communication with residents caregivers/family members/allies and resident councils.

Section 307(a)(8) of the Older Americans Act provides that services will not be provided directly by an Area Agency on Aging unless, in the judgment of the State agency, it is necessary due to one or more of the three provisions described below. Please select the basis for the services provision request (more than one may be selected).
(A) Provision of such services by the Area Agency is necessary to assure an adequate supply of such services.
(B) Such services are directly related to the Area Agency's administrative functions.
(C) Such services can be provided more economically and with comparable quality by the Area Agency.

Provision of such services by the Area Agency is necessary to assure an adequate supply of such services.

Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.
In 2015, Senior Resources was notified by Adult Well Being, then the current Long Term Care Ombudsman service provider, that they would no longer be providing services. At that time Senior Resources explored viable options, opened the proposal process to community agencies and ultimately requested a direct service

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waiver to provide the service when no request for proposals were made.

For FY'17-19, in accordance with AASA requirements, Senior Resources implemented our process to market and recruit community agencies who can provide services throughout the region. The Request for Proposal process FY'2017 did not yield any agencies interested in providing the Ombudsman service. Since Ombudsman is a required service, Senior Resources is requesting to directly provide this service. Senior Resources will offer the Ombudsman position the stability, supplies/equiptment and ongoing support needed to carry out their duties and we have the ability and capacity to fulfill the requirments of this program.

Describe the discussion, if any, at the public hearings related to this request. Include the date of the hearing(s).

Program Development Objectives

Area Agency on Aging Goal

A. Improve the health and nutrition of older adults.
State Goal Match: 1

NARRATIVE

During the next three year planning cycle, much emphasis is being placed on good nutrition, socialization and wellness opportunities. Our objectives, in partnership with our meal provider AgeWell Services, are to enhance methods in which food is procured, prepared and delivered. In the congregate meal setting, attention will be paid to promoting socialization in ways that appeal to the younger senior as well as meet the needs of the people who have been attending the center for years. We wish to incorporate evidence based wellness opportunities within local communities where older adults are already present. These wellness opportunities will be in response to input from the seniors and their request to know more about a particular area of health.

OBJECTIVES

1. Objective: Streamline kitchen, inventory, and purchasing processes to realize efficiencies.
Timeline: 10/01/2016 to 09/30/2017

Activities
Activities: AgeWell Services will engage a Six Sigma Lean consultant volunteer to assess their kitchen processes and identify areas of improvement that will lend itself to efficiencies. They will also research national best software products that can assist the kitchen staff in managing inventory. In addition, AgeWell Services intends to work with local food sources and growers to explore opportunities for food gleaning or second harvest. The staff will develop local relationships with these growers/food sources to reduce food costs and provide fresh food items – working to be more purposeful regarding access to local foods.

Expected Outcome
Fiscal efficiencies regarding home delivered and congregate meals can be realized while improving consumer nutrition and satisfaction and utilizing local food sources

2. Increase participant satisfaction regarding HDM meal choice while maintaining the vital daily well check
Timeline: 10/01/2016 to 09/30/2017

Activities
AgeWell Services will pilot select home delivered meal routes to implement options related to menu choice. These meal choices will include ethnic, therapeutic, and a variety of other meal selections. On these routes, meal delivery will not occur each day but more likely once per week. However, as we believe that the daily well check is an important part of the home delivered meal they will explore other options to ensure the daily health well check is performed. This may take the form of phone call, text message, email, etc.

Expected Outcome
We expect that with the implementation of this objective we can increase participant satisfaction and fiscal efficiencies while maintaining a daily well check with the participant.

3. AgeWell Services will increase/maintain participant satisfaction with meal products while realizing raw food cost savings.
   Timeline: 10/01/2016 to 09/30/2017

   Activities
   AgeWell Services will implement increased scratch cooking on select menu items in their kitchens for home delivered and congregate meals.

   Expected Outcome
   We expect that the participants' satisfaction with meals will remain the same or increase with the implementation of scratch cooking. In decreasing the amount of prepared food that is purchased we believe that raw food costs will decline.

4. Assess congregate sites for viability.
   Timeline: 10/01/2016 to 09/30/2017

   Activities
   AgeWell Services will evaluate current meal sites and consolidate sites as needed. They will facilitate the transition by providing transportation opportunities and other incentives.

   Expected Outcome
   Consolidating meal sites will allow the remaining sites to enhance and expand wellness, enrichment, and workshop opportunities.

5. Make congregate meal sites more attractive to baby boomers.
   Timeline: 10/01/2016 to 09/30/2017

   Activities
   Using best national best practices, AgeWell Services will implement ideas such as dinner clubs, theme meals/events or cooking the meal together to draw younger seniors to the site. In rural areas where there are underserved participants, this goal may take the form of discount dining.

   Expected Outcome
   Congregate meal site attendance will increase and the average age of attendees will lower.

6. To support older adults in the management of their chronic conditions and provide opportunities to encourage them to lead healthy lifestyles.
   Timeline: 10/01/2016 to 09/30/2019

Activities
Senior Resources will continue to coordinate with community partners to provide ongoing evidence based health promotion workshops. Also, we will explore, using input from older adults and their support persons, which additional workshops garner the most interest and implement based on funding.

Expected Outcome
People with chronic conditions who learn how to manage their symptoms can improve their quality of life and reduce their health care costs. In addition, an active healthy lifestyle can help older adults prolong their independence and improve their quality of life.

7. To support older adults in the management of their medications.
Timeline: 10/01/2016 to 09/30/2019

Activities
Senior Resources will implement the evidence based program HomeMeds. Older adults receiving in-home services will have access to a medication review.

Expected Outcome
We believe that employing this program with our in-home participants will limit unnecessary therapeutic drug duplication, thereby reducing falls, dizziness, or confusion possibly caused by inappropriate psychotropic drugs or drug mixes. The final expected outcome would be to reduce unnecessary hospitalization.

B. Protect older adults from abuse and neglect.
State Goal Match: 3

NARRATIVE

As advocates for older adults, we wish to promote the prosecution of those who commit elder abuse in our region, statewide and nationally. To address the prosecution of elder abusers in our region, two task force subcommittees of the Tri-County Protection team will develop protocols, by county in Muskegon and Ottawa, which will aid in the investigation of elder abuse cases and assist the prosecutors in holding the offenders accountable. In addition, the Tri-County Protection team will begin a weekly or as needed news e-blast to keep the community apprised of all potential scams and have community trainings scheduled throughout the PSA.

OBJECTIVES

1. Form investigation teams to aid in elder abuse investigations.
Timeline: 10/01/2016 to 09/30/2019

Activities
Two task force subcommittees of the Tri-County Protection team will develop protocols, by county, that will aid in the investigation of elder abuse cases and assist the prosecutors in holding the offenders

accountable. These task forces will consist of multi-disciplinary teams and provide support for case reviews as well as input.

Expected Outcome
There will be a higher level of successful prosecutions of elder abuse cases in the PSA.

2. Explore national best practices in regards to and implement an elder death review team.
Timeline: 10/01/2016 to 09/30/2019

Activities
Explore national best practices and if indicated, establish an interagency elder death review team. This team will help local agencies identify and review suspicious elder deaths and facilitate communications among people who perform autopsies and people involved in the investigation or reporting of elder abuse or neglect.

Expected Outcome
Results from the death review teams findings can be used to educate the public about the potential deadly outcome of elder abuse. Second, it can help to identify patterns—known as lethality factors—of both perpetrator behavior and victims' situations that contribute to untimely deaths. This knowledge may eventually be used to more accurately predict risk, resulting in earlier intervention and, in some cases, preventing death.

3. Educate the public regarding elder abuse and scams
Timeline: 10/01/2016 to 09/30/2019

Activities
The Tri-County Protection team will send out a weekly e-blast outlining any pertinent abuse or scam information. These e-blasts are sent to older adults, their family members, community organizations, financial institutions, etc.
In addition, the team will hold 3 public education sessions in the next year as well as continue to recruit target organizations for team membership.

Expected Outcome
The public and community organizations and businesses within the PSA will have a heightened awareness regarding elder abuse and scams and how to report it.

C. More communities in the PSA will conduct an aging-friendly community assessment and apply for recognition to AASA as a Community for a Lifetime.
State Goal Match: 0

NARRATIVE

The unprecedented demographic transition underway in the region will require that organizations and

individuals take action to support independent, healthy aging for older adults throughout the region. There are many potential stakeholders who are either unaware of the dramatic increases in older adult population or do not fully understand the magnitude of the impact. Ensuring that our region can support healthy aging will be built on local responses that recognize changing conditions and implement appropriate solutions in many unique settings. Senior Resources will support a network of local leaders who carry the message of livable communities throughout the region, as well as promote opportunities for communities to support healthy aging through local millages.

OBJECTIVES

1. Advocate with local governmental and planning agencies to ensure that an adequate supply of affordable rental and ownership housing options are available in order to meet current and projected needs of older adults promoting aging readiness in community settings. One new community with our PSA will receive recognition as a Community for a Lifetime by 9/30/19.
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   Advocate and collaborate for the production of data necessary for the region's planning purposes, particularly with regard to older adults and special needs populations. Special emphasis for advocacy will be given to access to transportation and healthcare. Older adults who lose the ability to drive are often left at home isolated, with their personal and physical needs unmet, because of too few transportation options – or none at all. In addition, lack of integration between housing and healthcare increases costs and puts the independence of older people at risk. Unfortunately, especially in rural areas, healthcare infrastructure is not readily accessible to many of the most vulnerable older adults. When appropriate, we will advocate to facilitate collaborations between housing and health providers to link residents of affordable senior housing properties with health and other supportive services.

   Expected Outcome
   Advocating for affordable housing and strategies that will provide the necessary resources to help meet the health and social service needs of elderly and younger disabled residents and support them to age successfully in their homes and communities. Focusing not just on individual older adults, but also the communities in which they live, will further seniors' ability to live independently and contribute to their communities.

D. Enhance caregiver efficacy by providing improved access to information and resources.
State Goal Match: 0

NARRATIVE

As the population ages and more and more people are being cared for by family caregivers, Senior Resources is looking for ways to better support the caregiver with education, training, emotional support, and services. We are advocating at a state level for caregivers to have greater access to information and training after their person has had a hospital or long term care admission. Senior Resources plans to collect information of particular interest to caregivers and have it available in various mediums for ease of access.

OBJECTIVES

1. Enhance caregiver efficacy by providing improved access to information and resources.
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   Develop a toolkit to provide to caregivers as they are identified. The toolkit will provide introductory information regarding community resources as well as practical applications for caregivers caring for their person. This toolkit will be available on our website as well as available to working caregivers at their worksites.

   Expected Outcome
   We believe that caregivers provided with information that can ease their caregiver burden will be in better health and less depressed. This will result in the caregiver benefitting more from supportive services and interventions that will fill the gap that currently exists between the overwhelming amount of information and the overworked caregiver.

E. Enhance transportation availability throughout the PSA.
State Goal Match: 0

NARRATIVE

Participants in the AAA's community conversations consistently ranked transportation in the top three when asked to prioritize services most critical to helping them age at home, and many low-income and homeless seniors said public transportation and special transit services were the only ways they could access medical services and food banks. The need for transportation options will grow along with the expanding senior population. The region's ability to help people stay in their own homes as they age will be directly correlated to the transportation services available to them. When livable communities or the addition of affordable housing is being explored by community leaders it is vitally important to advocate for suitable transportation that is functional for all.

OBJECTIVES

1. Enhance transportation availability throughout the PSA.
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   Work in collaboration with transportation and county units in developing a senior transportation advocacy strategy; foster regional coordination and cooperation; strengthening intercounty partnerships; and explore a single call center for scheduling and dispatching in areas with more than one transportation agency providing coverage.

   Expected Outcome
   Ensure that older adults receive safe, predictable transportation services with enhanced geographical and "off hour scheduling" coverage.

F. Reduce hospitalizations for persons with frequent emergency room or hospital admissions.
State Goal Match: 0

NARRATIVE

It has been shown that chronic illness and multiple emergency room visits commonly results in seniors who are particularly vulnerable to hospital readmissions. Using an evidence based program, Senior Resources plans to expand our partnership with local health care organizations to provide follow up care for 30 days after an ER visit to eligible seniors in the way of support coordination, medication review, and transportation to physician visits, meals and Personal Emergency Response systems. This effort is proven to support seniors in their home as they gain strength and health.

OBJECTIVES

1. Reduce hospitalizations for persons with frequent emergency room or hospital admissions.
Timeline: 10/01/2016 to 09/30/2019

Activities
Partner with community hospitals to provide a Care Transitions program for those individuals that have high emergency room utilization. Provide an assessment and supportive services for 30 days after hospitalization.

Expected Outcome
It has been proven that employing this type of intervention combined with supportive services significantly reduces the participant's likelihood to be readmitted to a hospital within 30 days. In addition, the hospital and health plan are less likely to incur further costs and the person is more likely to achieve self-identified personal goals around symptom management and recovery.

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Advocacy Strategy

Over the past several years Senior Resources, along with the national aging network, advocated to encourage Congress to reauthorize and modernize the Older Americans Act (OAA) to meet the needs of today's and tomorrow's older adults. The Act came up for reauthorization in 2011 and has been working under a continuation since then. The act was passed by the House and finalized by Congress in 2016. We believe that priority should be given to preserving the Act's local flexibility; protecting adequate authorization levels; strengthening the aging network's role and capacity in the coordination and provision of long-term services and supports; and improving community preparedness for an aging population.

With the passage of the OAA we will now move on to advocating on a federal level to restore OAA appropriations to 2010 levels but to increase the amount of funding for Title IIIB and other supportive services to help older Americans age successfully and independently in their homes and communities. Funding for federal IIIB services has fallen in recent years to its lowest levels since 2004, yet the demand and cost for providing services increases significantly each year. Senior Resources uses Title IIIB funds for: case coordination & support services, information & assistance, transportation, homecare assistance, respite care, legal services, adult day care, long term care ombudsman and program development.

Locally the need is great - case coordinators saw a 34% increase in the number of people they worked with in 2015. Options counselors and call specialists fielded 25,375 call from 10,434 people. There are currently waiting lists for access services, home delivered meals, in-home services and some medical transportation due to the high demand and stagnant service dollars.

We believe it is long past time to provide an increase for Title III B services. President Obama included a $10 million (3 percent) increase in his FY 2017 budget he sent to Congress in February 2016. Senior Resources, along with our national association, strongly supports that request at a minimum, with a larger goal of restoring III B and all OAA programs to at least FY 2010 levels, which would require a $20.6 million (6 percent) increase. The annual appropriations process that determines FY 2017 OAA funding is just beginning and we will be encouraging grass roots advocacy and participating in state and federal advocacy efforts.

In addition, we wish to educate policymakers so they recognize the pivotal role that the aging network plays in bridging the gap between the health, behavioral health and long term systems and supports to help increase patient safety, improve the quality of care and reduce health care costs. Our national association recommendations for advocacy and their involvement will address the aging network's role in Medicaid managed long term systems and supports, integrated care, care transitions/coordination, Aging and Disability Resource Centers, and prevention and wellness programs that promote the health, security and well-being of the older adults of today and tomorrow.

The Money Follows the Person (MFP) is a federal Centers for Medicare and Medicaid Services (CMS) initiative, but recent changes in the amount of funding that Michigan will receive will have a significant effect on the state as it becomes more difficult to transition people living in nursing homes to a community-based setting due to the lack of transition funds. MFP has been successful throughout the nation in reducing nursing home costs by returning qualified individuals back to the community.

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MFP Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems. Over 51,000 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs as of December 2014. The Affordable Care Act of 2010 strengthened and expanded the MFP program, allowing more states to apply. There are currently forty-three states and the District of Columbia participating in the demonstration.

The Money Follows the Person (MFP) demonstration grant program focuses on helping long-term residents of institutions move back to the community. Specifically, MFP is for people who have resided at least 90 consecutive days in nursing homes, intermediate care facilities for individuals with intellectual disabilities (ICFs-IID), or hospitals. Before the MFP demonstration, few states had any formal transition program for Medicaid enrollees residing in long-term care facilities. People in these facilities who wanted to transition would have done so on their own, with the assistance of family and friends, or through community-based organizations such as a local Center on Independent Living. The MFP demonstration gave states an opportunity to design and implement formal transition programs and to reach people who would not transition otherwise. It also affords state grantees more flexibility in the types of home- and community-based services (HCBS) offered to participants. As a financial incentive for transitioning more individuals to HCBS, states receive an enhanced federal matching rate for most MFP-paid services. The MFP demonstration is built on the premise that many long-term residents of institutions can live successfully in the community with sufficient supports, helping shift the balance of long-term services and supports (LTSS) systems more toward HCBS.

Since 2005, MI Choice Waiver Agents, including Area Agencies on Aging, along with Centers for Independent Living, have enabled over 12,000 nursing home residents on Medicaid to return to their homes or find new homes in their community. In the last five years, over 1,600 nursing home residents have been transitioned each year.

Senior Resources will be advocating to:

- Increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services
- Eliminate barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice
- Strengthen the ability of Medicaid programs to provide home and community based services (HCBS) to people who choose to transition out of institutions
- Put procedures in place to provide quality assurance and improvement of HCBS

The aging network in Michigan has been advocating along with The Silver Key Coalition to make Michigan a No Wait State for in-home services. In-home services are defined as non-Medicaid home and community-based services that assist individuals and family caregivers to manage and/or perform necessary activities of daily living. Specific services are personal care, homemaking, respite, home delivered meals, adult day care, personal emergency response system and medication management. These are services that would be funded under the Community Services, Nutrition Services, and Respite Care line items of the AASAbudget.

In Michigan, the number of persons waiting for these service that are critical to living independently instead of in a nursing home has grown to over 3,300 people. We will advocate to continue progress toward fulfilling a commitment to make Michigan a no wait state for home and community based services by increasing funding

for AASA services by $5 million in FY 2017.

There is support for bill SB395, the home accessibility improvement tax credit, which would authorize an income tax credit of up to $5,000 for a person who purchases or retrofits a residence with modifications that make it accessible for an individual with a disability. This would assist seniors and/or persons with a disability to make home improvements that increase safety and independence, help prevent falls and make caregiving tasks more manageable.

Michigan aging network supports legislation that would help older adults who lost food stamps when Michigan failed to update a benefits process known as “Heat & Eat” in the 2014 Farm Bill. Legislation to update the state contribution to utility assistance from $1/year to $20/year per household would make it possible to restore benefits.

The aging network continues to support adequate funding for elder abuse prevention programs and adequate staff for Adult Protective Services

Regionally, senior millages have been approved by voters in all but 11 of Michigan’s 83 counties. In Region 14 Oceana County has had a senior millage for years as have 9 townships in Ottawa County. Muskegon County Commissioners have approved to have senior millage placed on the ballot for vote by Muskegon County residents on August 2, 2016. Senior Resources is part of the task force in support of this millage. The purpose of the millage is to provide persons age 60 or older with a variety of services which will sustain and support them so they may remain safely at home for as long as possible. Services could include: safe at home services, transportation, in-home care, home-delivered and congregate meals, wellness programs and health education, respite care and more.

Leveraged Partnerships

1. Include, at a minimum, plans to leverage resources with organizations in the following categories:

a. Commissions Councils and Departments on Aging.

b. Health Care Organizations/Systems (e.g. hospitals, health plans, Federally Qualified Health Centers)

c. Public Health.

d. Mental Health.

e. Community Action Agencies.

f. Centers for Independent Living.

g. Other

a) Commissions and Councils on Aging – We have two Councils on Aging within our PSA and they serve as focal points for Senior Resources. Four Pointes Center for Independent Aging serves nine townships in the northern part of Ottawa County and we contract with them for Case Coordination & Support and transportation services. They have a congregate meal site as well as a home delivered meal route that is based from that building. Four Pointes and Senior Resources collaborate to provide health promotion/disease prevention classes as well as support groups and trainings and life enrichment.
Oceana County Council on Aging serves the entire county of Oceana. Senior Resources contracts with them for Case Coordination & Support and transportation. They have a congregate meal site. Oceana County Council on Aging and Senior Resources collaborate to provide health promotion/disease prevention classes.

The Oceana County Council on Aging and Four Pointes Center for Successful Aging are recipients of millage funds in their areas. These funds are used to cover operating expenses for all services and support existing programs within the Councils on Aging. Without these funds both agencies would be forced to cut back or eliminate certain services to older adults in the areas they serve.

b) Health Care Organizations – Senior Resources has collaborated with Mercy Health in a Care[AF1] Transition pilot program. This program is designed to assist consumers who access the emergency room multiple times in a predefined time period in accessing community resources to meet their needs. The consumer is assigned a Senior Resources Support Coordinator that will assist with coordination of meals, transportation, follow up healthcare visits, emergency response button, etc. The services that were offered to clients allowed them to receive nutritional support, rest and the assistance in going to medical appointments. Combining this with the expertise of our Care Coach in finding long term solutions to these issues and connecting them with proper resources provided the support that these participants are lacking informally.
Health Project (Part of Mercy Health) – The Pathways to Better Health Program was developed from a grant received by Michigan Public Health Institute (MPHI) from the Centers of Medicaid and Medicare (CMS) Innovations Awards. The proposal introduced the role of the Community Health Worker (CHWs) embedded within social service agencies throughout program regions. Muskegon Health Project partnered with MPHI to administer the program in Muskegon, Oceana and Northern Ottawa County. Senior Resources has been a contracted partner of Pathways since its inception in 2012. In 2015, the Pathways program approached Senior Resources to dedicate 2 CHWs to a new program. The Care at Hands Program was developed from a grant received by Dr. Stein, CMO Continuing Care with Trinity Health. The Care at Hands model will serve Medicare/Medicaid recipients that are hospitalized, transitioning to a skilled nursing home, and then back to the community. A Community Health Care worker will be following the person for a 90 day period, in which they will complete weekly surveys with the participants. The surveys will serve as a tool to track the health outcomes

and issues a participant is experiencing. The Community Health worker will connect the participant to programs, resources, and education to improve their health outcomes and reduce risk of re-hospitalization. In addition, the Community Health Worker will collaborate with an RN clinical supervisor regarding identified issues impacting the participant's success to transitioning and remaining in the community. Senior Resources is currently contracted for 2 full time employees dedicated to the Care at Hand Program.

c) Public Health - Senior Resources has used public health assessments to assist with area planning and to identify gaps in services. We refer to the Public Health Departments for flu shots, educational trainings and environmental health notices and information. A representative from Senior Resources sits on each county Human Service Coordinating body and we partner with Public Health on Emergency Coordinating/Preparedness Committees.

d) Mental Health – Senior Resources has an awareness of Mental Health services and share clients with them through the Medicaid Waiver Program. We have found that services are difficult to access unless a participant is Medicaid Waiver eligible. Senior Resources has an awareness of their programming and makes referrals as appropriate.

e) Community Action Agencies – The Community Action Agency serves as fiduciary and provides assessment oversight for the Ottawa county match funds. In addition, we partner with CAA to offer clients utility assistance, weatherization and commodities. Senior Resources refers participants as appropriate.

f) Centers for Independent Living (CILs) - In addition to partnering with the CILs in the Aging & Disability Resource Collaboration (ADRC) capacity, Senior Resources also works in partnership with the CILs in the region to provide the NFT, money follows the person initiative. Senior Resources views the regional ADRC as a way to leverage our resources to assist our clients using creative measures. We will continue to enhance our efforts to collaborate with community resources and work with community programs as appropriate. The formation of our regional Aging & Disability Collaboration of the Lakeshore has afforded the participating agencies the opportunity to gain awareness of the community services that are available and offer them to clients in an improved coordination effort.

Our local ADRC continues to provide input to a Long Term Care Options Counseling booklet published by Senior Resources that includes all long term care options in the region. This booklet was distributed to all ADRC partner agencies to provide continuity of information being provided to the public. It is also available on ADRC partner websites and will continue to be updated approximately every six months to ensure current and accurate information.

Other : Senior Resources participates in the Senior Marketing Groups in both Muskegon and Ottawa counties and our staff are encouraged to participate in various other committees and boards that are appropriate to the clientele we serve. We participate in community functions as appropriate.

2. Describe the area agency's strategy for FY 2017-2019 for working with ADRC partners in the context of the access services system within the PSA.

Senior Resources views the regional Aging and Disability Resource Collaboration (ADRC) as a way to leverage our combined resources to assist our participants using creative measures. We will continue to

enhance our efforts to collaborate and work with community programs and resources as appropriate. The formation of our regional Aging & Disability Collaboration of the Lakeshore has afforded the participating agencies the opportunity to gain awareness of the community services that are available and offer them to clients in an improved coordination effort.

Our local ADRC continues to provide input to a Long Term Care Options Counseling booklet published by Senior Resources that includes all long term care options in the region. This booklet was distributed to all ADRC partner agencies to provide continuity of information being provided to the public. It is also available on ADRC partner websites and will continue to be updated approximately every six months to ensure current and accurate information.

3. Describe the area agency's strategy for developing, sustaining, and building capacity for Evidenced-Based Disease Prevention (EBDP) programs including the area agency's provider network EBDP capacity.

The AAA will continue funding health prevention and wellness programs with the goal of helping older adults acquire the tools needed to maintain their health, reduce risk of developing chronic disease and managing their health to live as independently as possible. As resources permit, Senior Resources will continue providing currently funded services and expanding and integrating services to include more chronic disease self-management and evidence-based disease programs. We will also work with the state unit on aging and other community partners to capture discretionary grant dollars to expand these services in our region.

Community Focal Points

Describe the rationale and method used to assess the ability to be a community focal point, including the definition of community. Explain the process by which community focal points are selected.

A focal point is a facility or entity designated to encourage the maximum collocation and coordination of service for older individuals in a given area or community. For Senior Resources a community is defined as a county. In the case of Ottawa County it is the northern half and the southern half which are existing natural divisions for that county. In our region the focal points are Evergreen Commons, Four Pointes and Oceana County Council on Aging and Senior Resources. All of our focal points are also senior centers or reside in the same building as senior centers. To be a focal point in the Senior Resources region an agency must be a funded provider of the case coordination & support program and also be a part of an agency that serves seniors in the entire county or a large geographic area of a county. Organizations interested in becoming a Case Coordination & Support (focal point) site must apply and be approved for funding through our regular Request for Proposal process, which occurs every three years in conjunction with the three-year area plan. In addition to Case Coordination & Support, all focal points are access points for information & assistance and volunteer opportunities and are seen as the place to seek information about senior issues in their community. Through Case Coordination & Support the client will be assessed and in-home services can be arranged including home delivered meals, personal care, in-home respite, homemaking, and adult day care. If necessary, transportation services can be arranged, Medicare, Medicaid and other insurance counseling can be provided, and assistance is available at each with the Medicare Prescription Drug Program. If client problems indicate, referrals are made to Care Management/Waiver as appropriate and available.

Provide the following information for each focal point within the PSA. List all designated community focal points with name, address, telephone number, website, and contact person. This list should also include the services offered, geographic areas served and the approximate number of older persons in those areas. List your Community Focal Points in this format.

Name:	Evergreen Commons
Address:	480 State Street, Holland, MI 49423
Website:	www.evergreencommons.org
Telephone Number:	616-396-7100
Contact Person:	Amiee Dekker, Director of Senior Care Services, Suzanne Visser, Case Coord
Service Boundaries:	Southern Ottawa County (County Line North to Filmore Rd.)
No. of persons within boundary:	49,583 County wide
Services Provided:	Case Coordination, Meals, Homemaking, Information, Adult Day Care Respite Activities, Health Programs, Support Groups

Name:	Four Pointes Center for Sucessful Aging
Address:	1051 S. Beacon Blvd., Grand Haven, MI 49417
Website:	www.noccoa.org
Telephone Number:	616-842-9210

Senior Resources **FY 2017**

Contact Person:	Susan Stuk, Executive Director, Kim Kroll, Nancy Waters, Kate Laughlin Case Coord.
Service Boundaries:	Northern Ottawa County (County Line South to Filmore Road)
No. of persons within boundary:	49,583 County wide
Services Provided:	Case Coordination, Meals, Homemaking, Information, Transportation, Activities, Support Group

Name:	Oceana County Council on Aging
Address:	621 E. Main, Hart, MI 49420
Website:	www.oceanacountycouncilonaging.com
Telephone Number:	231-873-4461
Contact Person:	Kathleen Premer, Executive Director, Sylvia Slater, Case Coordinator
Service Boundaries:	Oceana County
No. of persons within boundary:	6,755
Services Provided:	Case Coordination, Meals, Homemaking, Information, Transportation, Activities

Name:	Senior Resources
Address:	560 Seminole Rd. Muskegon, MI 49444
Website:	srwmi.org
Telephone Number:	231-733-3585
Contact Person:	Long Term Care Options Counselors
Service Boundaries:	Muskegon, Oceana, Ottawa Counties
No. of persons within boundary:	35,968
Services Provided:	Case Coordination, Care Management, Medicaid Waiver, MMAP

Other Grants and Initiatives

1. Describe other grants and/or initiatives the area agency is participating in with AASA or other partners.

In Region 14, Evergreen Commons, a focal point for the Holland/Zeeland area, is contracted with Senior Resources to provide the Powerful Tools for Caregivers (PTC) training. Research studies find high rates of depression and anxiety among caregivers and increased vulnerability to health problems. Caregivers frequently cite restriction of personal activities and social life as problems. They often feel they have no control over events, and that feeling of powerlessness has a significant negative impact on caregivers' physical and emotional health.

The 6-week PTC class has been shown to have a positive impact on caregiver health for a diverse group of caregivers including rural, ethnic minorities, adult children of aging parents, well-spouses/partners, and caregivers at differing stages in their caregiving role, living situations, financial and educational backgrounds. Data collected from class participant evaluations indicates the PTC program improves, self-care behaviors: (increased exercise, use of relaxation techniques and medical checkups), management of emotions: (reduced guilt, anger, and depression), self-efficacy (increased confidence in coping with caregiving demands) and use of community resources: (increased utilization of community services. As Senior Resources works to improve the health of older adults in our region, we will continue to seek input from people in the region and respond with programs and workshops to meet those needs.

Senior Resources has enjoyed a partnership with The Pathways to Better Health Program for 4 years. The Pathways to Better Health was developed from a grant received by Michigan Public Health Institute (MPHI) from the Centers of Medicaid and Medicare (CMS) Innovations Awards. The proposal introduced the role of the Community Health Worker (CHWs) embedded within social service agencies throughout program regions. Muskegon Health Project partnered with MPHI to administer the program in Muskegon, Oceana and Northern Ottawa County. Senior Resources has been a contracted partner of Pathways since its inception in 2012. In 2015, the Pathways program approached Senior Resources to dedicate 2 CHWs to a new program. The Care at Hands Program was developed from a grant received by Dr. Stein, CMO Continuing Care with Trinity Health. The Care at Hands model serves Medicare/Medicaid recipients that are hospitalized, transitioning to a skilled nursing home, and then back to the community. A Community Health Care worker follows the person for a 90 day period in which they will complete weekly surveys with the participants. The surveys will serve as a tool to track the health outcomes and issues a participant is experiencing. The Community Health worker will connect the participant to programs, resources, and education to improve their health outcomes and reduce risk of re-hospitalization. In addition, the Community Health Worker will collaborate with an RN clinical supervisor regarding identified issues impacting the participant's success to transitioning and remaining in the community. Senior Resources is currently contracted for 2 full time employees dedicated to the Care at Hand Program. The request for services is expected to continue to grow with the rapidly aging population.

Ottawa County human services agencies are preparing to pilot a Pathways program and Senior Resources is part of the community task force that will assist in shaping how that program will operate in Ottawa County.

Senior Resources partners with MMAP, Inc. to provide Medicare/Medicaid assistance to those in our region and continues to serve as regional coordination for this valuable program. The regional coordinator as well as

a site coordinator is housed in Muskegon County at our Tanglewood Park location. Ottawa County has two MMAP sites, one serves southern Ottawa County, Evergreen Commons, and the other serves northern Ottawa County and is located at Four Pointes, Center for Successful Aging. Oceana County Council on Aging is the MMAP site for Oceana County and has counselors available for consultation. The site coordinator for each MMAP site provides volunteer oversight, assures that the required reporting is submitted to the regional/state office and conducts community outreach programs as opportunities arise.

We currently have over 30 active counselors covering our 3 county region. Without these dedicated volunteers the MMAP program would not be able to meet the needs of so many of our community members. In addition, all of the Senior Resources options counselors (OC) are MMAP trained and prepared to answer questions related to Medicare/Medicaid. Their awareness of MMAP guidelines allows the OC greater aptitude to recognize eligibility for a program and inform the caller regarding options for care.

2. Describe how these grants and other initiatives will improve the quality of life of older adults within the PSA.

Senior Resources believes that opportunities for older adults and/or their support team access to workshops that will provide them the tools to manage their caregiving responsibilities with less stress and longergevity. In addition, providing a mechinism for people to be aware of all services available to them should help them access community services and use their own resources with greater sucess. The MMAP program and the service it provides is vital to a large portion of the senior population. Without the counseling of the MMAP volunteers many seniors would not be aware of benefits available to them.

3. Describe how these grants and other initiatives reinforce the area agency's planned program development efforts for FY 2017-2019.

Implementing this framework of grants and initiatives are vital in meeting the challenges outlined in this plan. We realize that communities must be involved and finite resources must be used wisely. The collective efforts of Senior Resoruces and its partners contribute to the efforts towards meeting needs as outlined in this plan. Supporting caregivers and providing older adults and/or their support team with a streamlined way to access services addresses 2 of the top 5 needs as stated in the public input sessions.

FY 2017 AREA PLAN GRANT BUDGET

Rev. 4/2016

Agency: Senior Resources of West Michigan Budget Period: 10/01/16 to 09/30/17

PSA: 14 Date: 04/08/15 Rev. No.: AIP-FY17

SERVICES SUMMARY

FUND SOURCE	SUPPORTIVE SERVICES	NUTRITION SERVICES	TOTAL
1. Federal Title III-B Services	376,535		376,535
2. Fed. Title III-C1 (Congregate)		474,039	474,039
3. State Congregate Nutrition		9,510	9,510
4. Federal Title III-C2 (HDM)		245,782	245,782
5. State Home Delivered Meals		417,018	417,018
8. Fed. Title III-D (Prev. Health)	26,098		26,098
9. Federal Title III-E (NFCSP)	162,126		162,126
10. Federal Title VII-A	8,002		8,002
10. Federal Title VII-EAP	6,473		6,473
11. State Access	28,385		28,385
12. State In-Home	222,298		222,298
13. State Alternative Care	111,742		111,742
14. State Care Management	215,913		215,913
16. St. ANS & St. NHO	66,273		66,273
17. Local Match			
a. Cash	75,323	55,150	130,473
b. In-Kind	117,543	93,000	210,543
18. State Respite Care (Escheat)	73,594		73,594
19. MATF & St. CG Support	146,554		146,554
20. TCM/Medicaid & MSO	150,577		150,577
21. NSIP		132,076	132,076
22. Program Income	40,550	321,500	362,050
TOTAL:	1,827,986	1,748,075	3,576,061

ADMINISTRATION

Revenues		Local Cash	Local In-Kind	Total
Federal Administration	142,731	20,000	27,000	189,731
State Administration	24,868			24,868
MATF & St. CG Support Administration	11,500			11,500
Other Admin	58,000			58,000
Total AIP Admin:	237,099	20,000	27,000	284,099

Expenditures

	FTEs	
1. Salaries/Wages	2.17	
2. Fringe Benefits		
3. Office Operations		
Total:		-

Cash Match Detail		In-Kind Match Detail	
Source	Amount	Source	Amount
TWP Partners	20,000	Volunteers	27,000
Total:	20,000	Total:	27,000

I certify that I am authorized to sign on behalf of the Area Agency on Aging. This budget represents necessary costs for implementation of the Area Plan. Adequate documentation and records will be maintained to support required program expenditures.

Signature Title Date

FY 2017 AREA AGENCY GRANT FUNDS - SUPPORT SERVICES DETAIL

Agency: Senior Resources of West Michigan | Budget Period: 10/01/16 to 09/30/17 | Rev. 4/2016

PSA: 14 | Date: 04/08/15 | Rev. No.: AIP-FY17 |

SERVICE CATEGORY	Title III-B	Title III-D	Title III - E	Title VII	State Access	State In-Home	St. Alt. Care	State Care Mgmt	St. ANS St. NHO	St. Respite (Escheat)	MATF & St. CG Sup.	TCM-Medicaid MSO Fund	Program Income	Cash Match	In-Kind Match	TOTAL
1. Access																
a. Care Management	-							108,913				140,000		10,000	11,667	270,580
b. Case Coord/supp	134,699		14,500		28,385			107,000	42,300					25,000	11,667	363,551
c. Disaster Advocacy	-												-	-	-	-
d. Information & Assis	50,000		4,436										-	25,000		79,436
e. Outreach	-												-	-	-	-
f. Transportation	41,338												5,300	4,523	1,500.00	52,661
2. In-Home																
a. Chore	-												-			-
b. Home Care Assis	36,661					54,500	30,000		1,964				5,000	-	13,700.00	141,825
c. Home Injury Cntrl	-												-	-	-	-
d. Homemaking	-					85,000							4,500	-	9,500.00	99,000
e. Home Health Aide	-												-	-	-	-
f. Medication Mgt	10,000						16,284						1,600	-	3,000.00	30,884
g. Personal Care	-					19,000							800	-	2,250.00	22,050
h. Assistive Device&Tech	-					45,500							600	-	5,100.00	51,200
i. Respite Care	-		99,487			18,298	65,458			73,594	11,054		12,500	-	30,000.00	310,391
j. Friendly Reassure	-												-	-	-	-
3. Legal Assistance	24,992												-	-	2,800.00	27,792
4. Community Services																
a. Adult Day Care											124,000		9,500	-	13,800.00	147,300
b. Dementia ADC													-	-		-
c. Disease Prevent		26,098											-	-	2,900.00	28,998
d. Health Screening													-	-	-	-
e. Assist to Deaf													-	-	-	-
f. Home Repair													-	-	-	-
g. LTC Ombudsman	4,445			8,002					22,009			10,577	-	5,000	-	50,033
h. Sr Ctr Operations													-	-	-	-
i. Sr Ctr Staffing													-	-	-	-
j. Vision Services													-	-	-	-
k. Elder Abuse Prevnt				6,473									-	-	725.00	7,198
l. Counseling													-	-	-	-
m. Creat.Conf.CG® CCC			6,000										-	-	667.00	6,667
n. Caregiver Supplmt													-	-	-	-
o. Kinship Support			8,110										-	2,500	-	10,610
q. Caregiver E,S,T			29,593										-	3,300	-	32,893
5. Program Develop	74,400												750	-	8,267.00	83,417
6. Region Specific																
a.	-	-	-	-	-	-	-	-		-			-	-	-	-
b.	-	-	-	-	-	-	-	-		-			-	-	-	-
c.	-	-	-	-	-	-	-	-		-			-	-	-	-
d.																-
e.																-
7. CLP/ADRC Services	-		-		-			-								-
8. MATF & St CG Sup Adm											11,500					11,500
SUPPRT SERV TOTAL	376,535	26,098	162,126	14,475	28,385	222,298	111,742	215,913	66,273	73,594	146,554	150,577	40,550	75,323	117,543	1,827,986

Planned Services Summary Page for FY 2017			PSA: 14		
Service	Budgeted Funds	Percent of the Total	Method of Provision		
			Purchased	Contract	Direct
ACCESS SERVICES					
Care Management	$ 270,580	7.57%			X
Case Coordination & Support	$ 363,551	10.17%		X	X
Disaster Advocacy & Outreach Program	$ -	0.00%			
Information & Assistance	$ 79,436	2.22%		X	X
Outreach	$ -	0.00%			
Transportation	$ 52,661	1.47%		X	
IN-HOME SERVICES					
Chore	$ -	0.00%			
Home Care Assistance	$ 141,825	3.97%	X		
Home Injury Control	$ -	0.00%			
Homemaking	$ 99,000	2.77%	X		
Home Delivered Meals	$ 975,414	27.28%		X	
Home Health Aide	$ -	0.00%			
Medication Management	$ 30,884	0.86%	X		
Personal Care	$ 22,050	0.62%	X		
Personal Emergency Response System	$ 51,200	1.43%	X		
Respite Care	$ 310,391	8.68%	X		
Friendly Reassurance	$ -	0.00%			
COMMUNITY SERVICES					
Adult Day Services	$ 147,300	4.12%	X		
Dementia Adult Day Care	$ -	0.00%			
Congregate Meals	$ 772,661	21.61%		X	
Nutrition Counseling	$ -	0.00%			
Nutrition Education	$ -	0.00%			
Disease Prevention/Health Promotion	$ 28,998	0.81%	X		
Health Screening	$ -	0.00%			
Assistance to the Hearing Impaired & Deaf	$ -	0.00%			
Home Repair	$ -	0.00%			
Legal Assistance	$ 27,792	0.78%		X	
Long Term Care Ombudsman/Advocacy	$ 50,033	1.40%			X
Senior Center Operations	$ -	0.00%			
Senior Center Staffing	$ -	0.00%			
Vision Services	$ -	0.00%			
Programs for Prevention of Elder Abuse,	$ 7,198	0.20%		X	
Counseling Services	$ -	0.00%			
Creating Confident Caregivers® (CCC)	$ 6,667	0.19%	X		
Caregiver Supplemental Services	$ -	0.00%			
Kinship Support Services	$ 10,610	0.30%		X	
Caregiver Education, Support, & Training	$ 32,893	0.92%	X		
AAA RD/Nutritionist	$ -	0.00%			
PROGRAM DEVELOPMENT	$ 83,417	2.33%			X
REGION-SPECIFIC					
a.	$ -	0.00%			
b.	$ -	0.00%			
c.	$ -	0.00%			
d.	$ -	0.00%			
e.	$ -	0.00%			
CLP/ADRC SERVICES	$ -	0.00%			
MATF & ST CG ADMINSTRATION	$ 11,500	0.32%			X
TOTAL PERCENT		100.00%	23.45%	57.84%	18.20%
TOTAL FUNDING	**$ 3,576,061**		$838,315	$2,068,679	$650,746

Note: Rounding variances may occur between the Budgeted Funds column total and the Total Funding under the Method of Provision columns due to percentages in the formula. Rounding variances of + or (-) $1 are not considered material.

AREA AGENCY ON AGING--OPERATING BUDGET

PSA: 14 Budget Period: 10/01/16 to: 09/30/17 Date of Budget: 04/19/16

Agency: Senior Resources of West MI Rev. No.: AIP-FY17

	Operations		Program Services/Activities									
	Admin	Program Develop	MMAP Programs	Title III Case Coordination	St TSR Merit	HCBS (MiChoice)	St Care Management	St Access CCS	MI Health Endowment	Unmet Needs	LTC Ombuds	TOTAL
REVENUES												
Federal Funds	142,731	75,307	43,300	102,049	-	17,086,562		-	-	-	12,447	17,462,396
State Funds	24,868	-	-	-	11,500	-	215,913	28,385	75,352	-	32,586	388,604
Local Cash	20,000	-	-	5,000	-	-	15,000	96,960	-	-	4,000	140,960
Local In-Kind	27,000	9,000	22,500	11,667	-	-	11,666	-	-	-	3,800	85,633
Interest Income	-	-	-	-	-	-	-	-	-	30,000	-	30,000
Fund Raising/Other	58,000	100,000	6,000	134,500	-	70,000	170,000	-	-	5,000	-	543,500
TOTAL	272,599	184,307	71,800	253,216	11,500	17,156,562	412,579	125,345	75,352	35,000	52,833	18,651,093
EXPENDITURES												
Contractual Services	500	-	500	100	-	79,000	1,000	300	100	-	-	81,500
Purchased Services	-	-	-	87,479	-	13,617,469	43,040	10,000	34,000	35,000	-	13,826,988
Wages and Salaries	128,143	100,605	19,667	110,976	9,259	2,485,595	254,658	76,745	26,572	-	33,619	3,245,840
Fringe Benefits	21,654	18,362	4,028	19,254	1,532	431,251	44,183	14,978	5,447	-	2,602	563,292
Payroll Taxes	9,803	7,696	1,505	8,490	708	190,148	19,481	5,871	2,033	-	2,572	248,307
Professional Services	13,500	2,000	4,000	1,500	-	126,000	7,600	4,800	1,050	-	150	160,600
Accounting & Audit Services	1,500	1,500	1,200	1,200	-	40,000	5,000	3,500	500	-	500	54,900
Legal Fees	-	200	-	-	-	-	-	-	-	-	-	200
Occupancy	4,500	2,200	8,000	1,650	-	49,000	4,300	2,400	1,000	-	-	73,050
Insurance	1,000	100	500	100	-	5,000	300	100	50	-	100	7,250
Office Equipment	17,000	100	1,500	2,100	-	5,100	2,050	550	100	-	1,500	30,000
Equip Maintenance & Repair	5,500	-	500	200	-	1,000	100	100	-	-	-	7,400
Office Supplies	1,000	2,000	500	1,000	-	20,000	2,000	500	300	-	450	27,750
Printing & Publication	6,000	29,844	200	100	-	4,000	200	300	2,500	-	190	43,334
Postage	21,000	1,500	1,000	400	-	7,000	2,000	200	200	-	300	33,600
Telephone	3,000	1,500	1,500	1,500	-	40,000	4,000	1,500	500	-	800	54,300
Travel	6,000	4,000	1,500	5,000	-	45,000	10,000	3,000	500	-	4,000	79,000
Conferences	5,000	3,200	2,000	500	-	11,000	1,000	500	500	-	2,250	25,950
Memberships	-	-	-	-	-	-	-	-	-	-	-	-
Special Events	500	500	1,200	-	-	-	-	-	-	-	-	2,200
In-Kind Expense	27,000	9,000	22,500	11,667	-	-	11,666	-	-	-	3,800	85,633
Other	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	272,599	184,307	71,800	253,216	11,500	17,156,562	412,579	125,345	75,352	35,000	52,833	18,651,093

Appendices

APPENDIX A

Board of Directors Membership

	Asian/Pacific Islander	African American	Native American/ Alaskan	Hispanic Origin	Persons with Disabilities	Female	Total Membership
Membership Demographics	0	1	0	0	0	6	15
Aged 60 and Over	0	0	0	0	0	2	0

Board Member Name	Geographic Area	Affiliation	Elected Official	Appointed	Community Representative
Tim Erickson	Muskegon	Retired Financial Advisor			Yes
Ron Giza	Muskegon	Retired CFO			Yes
Holly Huges	Muskegon	91st District Representative	Yes		
Kathy Moore, Secretary/Treasure	Muskegon	Muskegon County Health Dept.		Yes	
Ken Uganski	Muskegon	Mercy Health Partners			Yes
Sherry White, Board Chairperson	Muskegon	Hines Corp.			Yes
Ken Fisher	Oceana	Hispanic Center			Yes
Bernice Salisbury	Oceana	Community Representative			Yes
Tim Breed	Ottawa	Holland Community Hospital			
Joel Elsenbroek	Ottawa	Sunset Manor			Yes
Kathy Hanes	Ottawa	Allendale Seniors			Yes
Tina Kramer	Ottawa	Administrator, Laurals			Yes
Tom Reinsma	Ottawa	Scholten & Fant, Attorney			
Dr. Gary Robertson	Ottawa	Retired Physician			Yes
Gary Scholten	Ottawa	Retired Ottawa County			Yes

APPENDIX B

Advisory Board Membership

	Asian/ Pacific Islander	African American	Native American/A laskan	Hispanic Origin	Persons with Disabilities	Female	Total Membership
Membership Demographics	0	0	0	0	0	6	11
Aged 60 and Over	0	0	0	0	0	5	9

Board Member Name	Geographic Area	Affiliation
Anne Soles	Oceana	Shepherds Staff
Barb Boelens	Ottawa	Retired Assisted Living Apartments
Bill Vandyke	Ottawa	Retired Social Security
Cheryl Szcytko	Ottawa	Health Care Associates and Home Care
Diane Cunningham	Muskegon, Oceana, Ottawa	Meals Provider Representative
Gary Scholten	Ottawa	Retired Ottawa County
Joel Elsenbroek	Ottawa	Sunset Manor
Kathy Hanes	Ottawa	Allendale Seniors
Ken Fisher	Oceana	Hispanic Center
Peter Thune	Ottawa	Retired Clergy
Rolina Vermeer	Ottawa	Retired Senior Center Activity Director