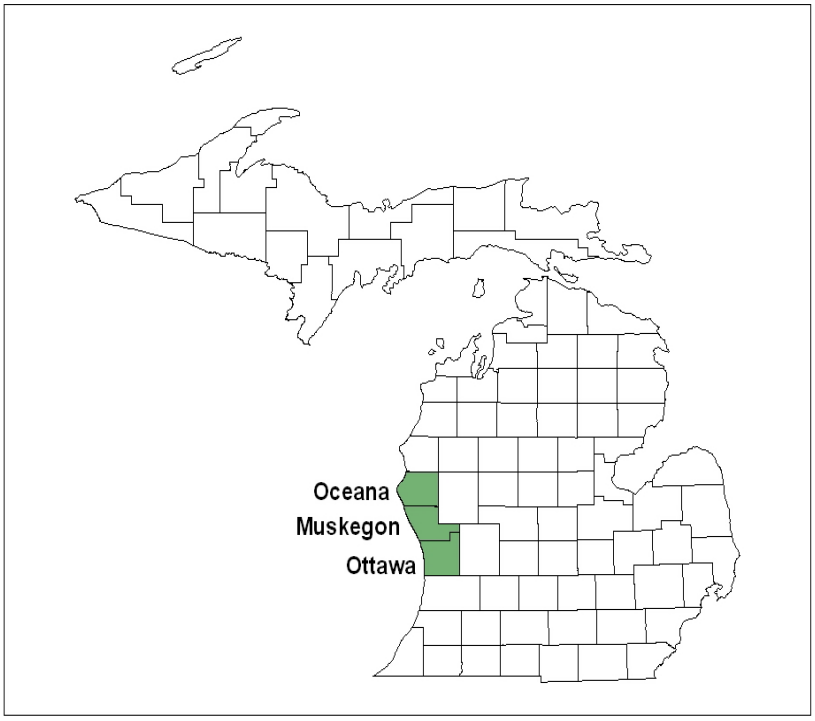
SeniorResources
*Our Name. Our Focus.*

# Annual Implementation Plan FY'2019

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# ANNUAL & MULTI YEAR IMPLEMENTATION PLAN

FY 2017-2019

**Senior Resources** **FY 2019**

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**Approved Multi-Year Plan Highlights**

**The Multi-Year Plan (MYP) Highlights provide an overview of the FY 2017- 2019 MYP and FY 2018 AIP priorities set by the area agency as approved by the Michigan Commission on Services to the Aging (CSA). These highlights serve to provide an overall reference for the established three-year planning period. They also help to provide a framework and context for activities planned during the FY 2019 AIP.**

**The area agency FY 2017-2019 MYP and FY 2018 AIP Highlights approved by the CSA are included as read-only below. No further entry by the area agency is necessary.**

**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, 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. 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.

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.

**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.Aa**

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.

**9. FY 2018 AIP Highlights: Description of any significant new priorities, plans or objectives.**

In addition to the goals listed in the multi-year plan during the next year Senior Resources plans to address three additional areas of interest.

Recognizing that those who suffer from chronic pain tend to have higher rates of depression, anxiety, sleep disturbances and other physical manifestations, Senior Resources will begin to offer an evidenced based pain management workshop. Within the next year we will identify a pain management curriculum, train staff and volunteers in the facilitation of the curriculum and conduct a minimum of 2 workshops aimed to assist participants in identifying and implementing effective pain management interventions.

In cooperation with the National Area Agency on Aging Associations campaign to combat social isolation, Senior Resources will strive to will raise awareness of the problem of isolation and loneliness in several ways, including one-on-one counseling with our participants, leveraging traditional and social media to spread the word about the effects of social isolation and encouraging community awareness and intervention.

Maintaining relevance through the rapidly evolving roles of Health Care Plans is one of the Aging Networks and Senior Resources most pressing opportunities. As plans transition from paying for volume to paying for value, providers have incentives to ensure that their patients' care plans are reinforced and supported outside the clinical setting in their homes and communities. To create a link between the medical and home settings, health care systems will develop a structure in which they can provide the connection or seek partnership with organizations that are established in this service. This presents a decisive opportunity for the Aging Network. We must expand Health Care Plan's and lawmakers knowledge base of the established supports coordination we have provided for years. Over the course of the next year we will be coordinating with our state association to track and demonstrate improved outcomes due to our interventions, quantify how this will relate to a return on the on investment with us and emphasize that we have current systems in place to address this need.

Senior Resources recieved a 3 year accrediation through the Commission on Accreditation of Rehabilitation Facilities (CARF) on May 31, 2016. We are committed to continuous improvement in our internal and participant processes and proud of the quaility of services we deliver to the community.

**Senior Resources** **FY 2019**

**2019 AIP Highlights**

**The FY 2019 AIP Highlights should provide a succinct description of the following:**

**A. Any significant new priorities, plans or objectives set by the area agency for the use of Older Americans Act (OAA) and state funding during FY 2019.**
**B. Current information about contingency planning for potential reduced federal funding (if plans include the pursuit of alternative funding, identify specific funding sources).**
**C. A description of progress made through advocacy efforts to date and focus of advocacy efforts in FY 2019.**

**Please provide a narrative about what, if anything, the area agency is planning that is new for FY 2019, or that is significantly different from the established FY 2017-19 MYP or FY 2018 AIP. In addition, include area agency plans to handle the likelihood of reduced federal funding, including any specific alternative funding sources to be pursued. Finally, describe progress made through Multi-Year Plan (MYP) advocacy efforts to date and the area agency's specific planned advocacy focus in FY 2019.**

There are no significant changes in the 2019 Area Plan then what was presented in the 2017-2019 Multi-year Plan (MYP). Senior Resources will be working towards achievement of the MYP objectives and initiatives.

In the likelihood of reduced federal funding, Senior Resources would prioritize based on services that provide the greatest impact to the participant remaining in the living environment of their choice as well as in-home assistance with activities of daily living.
To accomplish that objective the following activities will occur:

1. Priority services include: Home Delivered Meals, Ombudsman, Case Coordination & Support, Options Counseling and Medical Transportation.
2. Non-priority services include: Caregiver Support & Training, Congregate Meals, Evidence-Based Disease Prevention, Elder Abuse Prevention, Grandparents Raising Grandchildren, Legal Services and Information & Referral.

Purchase of Service/In-Home Services
1. Prioritize in-home services (homemaking, personal care, in-home respite, adult day services, medication management and Personal Emergency Response Units) based on client health and welfare.
2. All priority 1 clients will continue with priority in-home services uninterrupted.
3 In 2018 the Senior Resources board of directors approved a plan to systematically use fund reserves based on a formula to supplement federal and state funding for in-home services. Due to the funding formulary and the fluctuation of fund reserves, the amount of money from this source varies from year to year.
Oceana and Muskegon Counties and parts of Ottawa County have senior millages that provide services and activities to people 60+ years of age. It is important to note that these millage funds combined with Senior Resources budget of federal and state money does not currently meet the total needs of seniors in the areas they serve. So while we consider ourselves fortunate to have these funds available, prioritization of services will still be enacted.

Advocacy efforts are continuous. The 2017 platform for Older Michiganians Day focused on efforts to continue

progress to make Michigan a no-wait state, an effort started by the Silver Key Coalition and supported by a collaboration of providers in the aging network including area agencies on aging. FY2018 included the full $3.6 million requested for in-home services which comes on the heels of the half million additional home delivered meals that the network was able to serve in FY2017. This advocacy work continues with the 2019 appropriations process where flat funding appears likely at the moment. Other platform issues included: protecting Medicaid, legislative attention to the direct care worker crisis in our improved economy, rebalancing Michigan's long term care spending to address more services in the home rather than nursing home; elder abuse prevention where bills were introduced to increase penalties and sentencing guidelines for financial abuse; the need to increase dementia care and support; improving transportation programs which is an ongoing issue; and approval of the Home Accessibility Tax Credit now Senate Bill 184.

In the spring of 2017, advocates were successful in having Section 1852 of SB135 removed from the bill. It had been put in the bill after the bill had been released for review and comment. This section would have required the Department of Health and Human Services to implement a pilot program that would require individuals receiving home- and community-based services through the Medicaid fee-for-service program in certain counties to transition to a long-term service and support program administered by an integrated care organization (ICO). Enrollees could not opt out of the pilot and would be auto-assigned to the integrated care organization. There seems to be a lot of interest from outside parties in taking over Michigan's long-term care system without consideration or thought to build upon programs with a proven track record that are actually working.

Advocacy efforts for 2019 include efforts to improve access to the MI Choice Medicaid
Waiver program, stressing that any changes to Medicaid long term supports should preserve the role of Area Agencies on Aging and the MI Choice program. Currently the MI Choice program serves 15,000 older adults and adults with a disability who need a nursing facility level of care to live independently in their homes. There are currently over 3,200 people in Michigan on waiting lists for the MI Choice Program and recognizing that the MI Choice program costs $78.20 per day, 58% less than the Medicaid nursing daily rate of $187 per day, it is a sounds financial decision to increase MI Choice funding and the role that the Area Agencies play in the administration of this program.

In addition, Senior Resources supports the Silver Key Coalition's request for a $3 million funding increase to support the 6,043 seniors on waiting lists for in-home services provided by the Aging and Adult Services Agency (AASA). AASA in-home services include personal care, homemaking, respite, and home delivered meals. Research shows that seniors who receive
in-home services are five times less likely to have been in a nursing home than those who stayed on a wait list.

There is currently a shortage of direct care workers who provide long-term care to Michigan seniors. Across the state, home care workers have a median income of $10,000, and nearly 30 percent live in households with incomes below the federal poverty level. Senior Resources will support policies that recruit, train, and provide adequate wages including direct care workers talent development initiatives.

Finally, we will continue to support adequate funding for elder abuse prevention programs and policies that aim to prevent physical, psychological and financial abuse. Over 125,000 Older Michiganians are victims of abuse each year with only an estimated 10% of elder abuse cases reported to authorities.

**Senior Resources** **FY 2019**

**Regional Service Definitions**

**If the area agency is proposing to fund a new (not previously approved in this multi-year planning cycle) service category that is not included in the Operating Standards for Service Programs, then information about the proposed service category must be included under this section.**

**Enter the new regional service name, identify the service category and fund source, include unit of service, minimum standards, and rationale for why activities cannot be funded under an existing service definition.**

**Service Name/Definition**

Enhanced Support (ES)
Enhanced Support includes the following processes: intake, assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, enhancing informal supports, reassessment, case conferencing, crisis intervention, and case closure.
The goal of Enhanced Support is to promote and support independence and self-sufficiency. As such, the Enhanced Support process requires the consent and active participation of the participant and/or support team in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.
Enhanced Support is part of a service continuum to aid participants in accessing in-home and community services.

Participants are at risk for nursing home placement.

Rationale (Explain why activities cannot be funded under an existing service definition.)

Senior Resources has identified a group of participants that require more oversight than case coordination and support and are at risk for nursing home placement but do not require the team approach of a social worker and RN team of care management. These participants have low medical needs or their medical needs are stable but they desire in-home and community service coordination, access and support. Enhanced Support will be seamlessly integrated into the Senior Resources service continuum.

| Service Category | Fund Source | Unit of Service |
|---|---|---|
| ☑ Access<br>☐ In-Home<br>☐ Community | ☐ Title III PartB ☐ Title III PartD ☐ Title III PartE<br>☐ Title VII ☐ State Alternative Care ☐ State Access<br>☐ State In-home ☐ State Respite<br>☑ Other State Care Management | Assessment and ongoing support. |

**Minimum Standards**

SERVICE NAME Enhanced Support (ES)
SERVICE CATEGORY Access Services
SERVICE DEFINITION Enhanced Support includes the following processes: intake, assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, enhancing

informal supports, reassessment, case conferencing, crisis intervention, and case closure.
The goal of Enhanced Support is to promote and support independence and self-sufficiency. As such, the Enhanced Support process requires the consent and active participation of the participant and/or support team in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.
Enhanced Support is part of a service continuum to aid participants in accessing community services.

Participants are at risk for nursing home placement.

UNIT OF SERVICE
Provision of one hour of component Enhanced Support functions.

Minimum Standards:

1. An individual possessing a bachelor's degree in social work, or a bachelor's degree in a related field with three years' experience in coordinating services for older adults.
Registered Nurse available for initial/reassessment review and consultation.

2. ES staff will receive ongoing training and supervision as outlined in Senior Resources policies and as necessary.

3. ES coordinators will maintain a confidential record for each person served. The record will include but is not limited to the following documents and information.
a. Completed assessment
b. Person approved plan of care
c. Documentation of service orders
d. Progress notes
e. Person centered planning
f. Person/representative signed forms to include:
i. Acknowledgements/Program Participation/Review of Rights & Responsibilities/Receipt of Notice of Privacy Practices
ii. Consent to Share Information – As needed
iii. Cost Savings Agreement
iv. Others as needed – See full ES guidelines

4. ES provides all participants with an opportunity to donate and participate in the cost savings program for purchased in-home support services.

5. Assessment/reassessment every 90-180 days dependent on the services they receive and/or acuity level.

6. Participants will be moved to Care Management Services/MI Choice Waiver/PACE or other solution as fragility increases and eligibility becomes evident.

Allowable Service Components

1. Assessment – Comprehensive in-person assessment by an ES coordinator. Assessment is completed in Compass.

2. Purchase of Service Plan – A written service plan which states interventions to be sought and secured. The ES coordinator, participant and/or their support team will establish which services will be secured as well as the frequency and duration based on funding limitations. The total service plan is approved by the participant or their representative prior to implementation of service.

3. Arranging Services – ES coordinators serve as agents of the participant in negotiating, arranging and monitoring formal services funded with state and federal funds.

4. Follow-up and monitoring – Reassessment every 90-180 days based on services received or when a significant change occurs in the participant's condition.

5. Identification of unmet needs – Time spent seeking community services as a representative of the participant.

6. Registered Nurse assessment/REA or assessment review as needed as well as phone consultation.

Enhanced Support Guidelines:

- If upon an IA or REA a participant has any condition documented on the Service Utilization – Treatment page of Compass, RN Assessment Q, with the exception of Medical Alert Bracelet, an RN will provide a phone consultation or visit the participant within 14 days of the assessment. If participant is receiving RN services through skilled nursing, hospice, medication management, palliative care etc. supports coordinator communication with that RN will satisfy this requirement.

- Participants that have a condition documented on Service Utilization – Treatment page of Compass, RN Assessment Q, a multi-disciplinary team consisting of an RN and supports coordinator will conduct ES functions.
  - Transfusion
  - Chemotherapy
  - Dialysis*
  - IV medication
  - Oxygen therapy*
  - Radiation
  - Tracheostomy care
  - Ventilator or respirator
  - Infection control (e.g. isolation, quarantine)
  - Suctioning

- o Wound care*
- o Palliative care program*
- o Scheduled toileting program
- o Turning/repositioning program

*Wound Care & palliative care – RN supports coordination involvement not required if there is skilled nursing involvement. ES coordinator will evaluate program status upon discharge from skilled care.
*Oxygen or dialysis - RN visit based on oxygen or dialysis use will be determined for further monitoring upon assessment review

- A RN will review each ES participant assessments/reassessments as needed. Items for review will include:
- Compass RN Assessment sections I-R and T-U
- The person-centered service plan as determined by the participant, their support team and supports coordinator
- Other

- If a participant has any conditions documented on the Service Utilization-Treatment page of Compass, RN Assessment Q, the participant and/or designee will receive a call every 30 days based on participant preference. All other participants will be instructed to contact their supports coordinator as needed. (Self-efficacy)
- Each ES participant, their support team and supports coordinator will contribute to a comprehensive Person Centered Plan of Care. This Plan of Care will direct the coordination of services and can change as often as the participant and their support team request.

**Access Services**

**Some access services may be provided to older adults directly through the area agency without a direct service provision request. These services include: Care Management, Case Coordination and Support, Disaster Advocacy and Outreach Programs, Information and Assistance, Outreach, with specific attention to outreach with underserved populations, including LGBT older adults, and MATF/State Caregiver Support funded Transportation. If the area agency is planning to provide any of the above noted access services directly during FY 2019, complete this section.**

**Select from the list of access services the area agency plans to provide directly during FY 2019 and provide the information requested. Also specify the planned goals and activities that will be undertaken to provide the service in the appropriate text box for each service category.**

**Direct Service Budget details for FY 2019 are to be included under the appropriate tab in the Area Plan Grant Budget. The funding identified in this tab should correspond to the funding (Federal OAA Title III or VII and State funds) identified in the Area Plan Grant Budget, Support Services Detail Page. The Area Plan Grant Budget uploaded and saved in AMPS must include Direct Service Budget details.**

**Care Management**

| | | | |
|---|---|---|---|
| Starting Date | 10/01/2018 | Ending Date | 09/30/2019 |
| Total of Federal Dollars | | Total of State Dollars | $38,864.00 |

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 Coordinator will employ Person Centered Thinking to assure participant choice in services and providing agencies or support persons.
Time Line: Through September 30, 2019.
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, 2019
Outcome: Participant will have awareness of and access to community support services.

Goal: Care Managment participants will be moved to Targeted Care Management or MI Choice/Waiver programs as frailty increases and eligibility requirements are reached.
Time Line: Through September 30, 2019
Outcome: Consumers will have greater ease of access to services.

**Senior Resources** **FY 2019**

| | | | | |
|---|---|---|---|---|
| Number of client pre-screenings: | Current Year: | 200 | Planned Next Year: | 200 |
| Number of initial client assesments: | Current Year: | 65 | Planned Next Year: | 25 |
| Number of initial client care plans: | Current Year: | 65 | Planned Next Year: | 25 |
| Total number of clients (carry over plus new): | Current Year: | 258 | Planned Next Year: | 35 |
| Staff to client ratio (Active and maintenance per Full time care | Current Year: | 35 | Planned Next Year: | 35 |

**Case Coordination and Support**

| | | | |
|---|---|---|---|
| Starting Date | 10/01/2018 | Ending Date | 09/30/2019 |
| Total of Federal Dollars | $71,000.00 | Total of State Dollars | $136,342.00 |

Geographic area to be served

Muskegon

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

Goal: Supports Coordinator will employ Person Centered Thinking to assure participant choice in services and providing agencies or support persons.
Time Line: Through September 30, 2019
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, 2019
Outcome: Participant will have awareness of and access to community support services.

Goal: Case Coordination & Support participants will be moved to Care Management or MI Choice/Waiver as frailty increases and eligibility becomes evident.
Time Line: Through September 30, 2019
Outcome: Participant will have greater ease of access to services.

**Approved MYP Program Development Objectives**

**Program development goals and objectives previously set by the area agency and approved by the CSA in this multi-year planning cycle are included as read-only. For each of these established program development objectives, a text box is included for the area agency to provide information on progress toward the objective to date. This text box is editable.**

**Please provide information on progress to date for each established objective under the section tab entitled "Progress".**

**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

Progress
2017 - AgeWell Services is seeking a LEAN consultant to review food service improvements with a target start date of summer 2017.
After extensive research, AgeWell found ServTracker, an on-line data management system designed for senior

meal programs. Funding was secured from the Glick Foundation, Community Foundation for Muskegon County and private donors. Software will be implemented in August 2017.
AgeWell Services was a recipient of HEALTHY Muskegon funds from the Community Foundation for Muskegon County through the Michigan Health Endowment Foundation. This venture has developed relationships with other grantees working on second harvest initiatives in partnership with Pioneer Resources and the Muskegon Farmers Market.
AgeWell is part of the Muskegon Food Hub, a collaborative effort of the Muskegon Farmer's Market, Cherry Republic, USDA Farm-to-School Initiative, City of Muskegon and Kitchen 242 to purchase and process Michigan produce for Meals on Wheels and Congregate Meal sites. The summer 2017 pilot will focus on lettuce, snap peas, spinach and asparagus. AgeWell Services is currently seeking funding to hire two part-time food preparation, second shift team members to prepare the inventory.

2018 - Since August 2017, 9 AgeWell Services Team Members are being coached in Toyota KATA methodology. "Project LifeWell" is the first project to demonstrate success with the goal to provide "nutritious food on time with a smile at cost support growth." More than 50 hours have been dedicated to this specific project. In addition, two new volunteers were recruited to assist with helping to identify additional projects focused on meal production and inventory management.
ServTracker software will be implemented in February 2018.
AgeWell Services is a proud partner in the pilot program "Muskegon Food Hub" in collaboration with the Muskegon Farmer's Market and two local growers, Visscher Farms and Gold Hart. AgeWell is one of 3 "buyers" of locally grown fresh produce that is picked on Monday, delivered on Tuesday, processed on Wednesday, served or preserved by Thursday. Through this initiative, we have implemented a value-added process, experimenting first with 480 pounds of fresh asparagus. We then introduced 8 other types of fruits and vegetables during the growing season. We are currently seeking grant funding to implement a second shift in our kitchen during the 2018 growing season to preserve more varieties. We are working to address adding a second freezer external to our building in hopes of future expansion of this "Farm-to-Freezer" pilot project.

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.

Progress
2017 - AgeWell Services has worked to eliminate barriers to prepare for a Choice Meal system. One important barrier is funding the new ServTracker software. Second, they need a large, walk-in freezer which is estimated to

cost approximately $40,000. They will begin seeking funding for this project in the summer of 2017.
Site visits to other Michigan Meals on Wheels programs offering choice will take place no later than Fall 2017.
AgeWell staff will engage in discussions about best practices.

2018 - A survey of our participants conducted in the summer of 2017 indicated the following of our HDM program:

- 90% of our individuals indicated the overall meal program and service as “Excellent or good”.
- 45.71% are not interested in a choice frozen meal option at this time.
- 75% do not have a computer or internet service in their home.

This information indicates that the current population we are serving is not interested or ready for the choice meal system. However, we expect this statistic to change as the “Traditionalist” generation is replaced with the “Baby Boomer” generation in the HDM program. We will continue to ask this same question in our surveys as well as continue removing barriers (ie. Freezer space, software, ordering) to eventually implement a choice system. This is no longer a priority focus area for AgeWell Services at this time.

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.

Progress
2017 - AgeWell Services is currently producing meals that are 50% scratch; our goal is to be at 80% scratch cooking. A new internal committee will be created to develop new recipes for main and side dishes.

2018 - AgeWell Services is currently producing meals that are 50% scratch; their goal is to be at 80% scratch cooking. In one year, they have developed 8 new scratch recipes that were very well received by participants.

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.

Progress
2017 - In December, AgeWell closed their oldest meal site. Fellowship Church in east Muskegon County ran successfully for 40 years consecutively but has suffered dramatically from attendance. AgeWell Services is seeking new partnerships, especially in targeted areas of poverty or high concentrations of Hispanic and African American populations.
AgeWell expanded offerings in Jenison at Georgetown Senior Connections by providing an on-site cook at this brand new senior center. Attendance numbers continue to grow at this site.
AgeWell also partnered with The Ladder in Shelby located in Oceana County. This rural community has a generous underserved senior population with a high rate of food insecurity. The Ladder is a multi- generational community center.

2018 - In December 2017, the Pentwater Friendship Center officially closed. This site was averaging 11 participants per day and operating at a loss of $25,000 per year. We are currently working on partnerships with local restaurants in the area to open a new Senior Dine location. In the meantime, participants were provided transportation to and from a neighboring meal site approximately 20 minutes away at the Oceana County Council on Aging.
We have opened a new congregate meal site in east Muskegon at Orchard View Community Center. We also provided a dinner once per month at the Coopersville Farm Museum in collaboration with Four Pointes. Our team is exploring potential meal site locations in Holton, downtown Muskegon and the White Lake area that we hope will open by December 2018.

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.

Progress
2017 - AgeWell Services added two new important positions: Congregate Meal Site Manager and Mission Services Senior Manager. Supported by the Director of Mission Services, this team is responsible for the oversight of all AgeWell Services meal locations. In addition to supporting the Meal Site Coordinators, they are creating a strategy for implementing unique programming.
In the Spring 2017, they plan to conduct a postcard mailing to all adults who attended the DTE Holiday Meals event, inviting them to an “invitation only” event at our meal sites.

2018 – AgeWell Services has implemented unique programming and have plans in the works to increase creativity and attract new congregate site locations.
- They are in the process of identifying new Senior Dine locations as an alternative to the traditional dining experience.
- AgeWell Services is looking to replicate our Tanglewood Park Café (modeled from the Mathers Café

Concept) in downtown Muskegon, bringing this unique dining experience to a very underserved population in the core city of Muskegon County. The café will open by Fall 2018.

- Pairing field trips and access to healthy foods for our Congregate participants. Our team implemented trips to the Muskegon Farmer's Market, paired with a healthy boxed lunch, to increase exposure to the program and reduce isolation. We hope to replicate this with other sites in the future.
- AgeWell Services is researching new locations in Ottawa County for Senior Dine, especially.

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.

Progress
During 2017 Senior Resources and our community partners are scheduled to provide 30 evidence-based prevention/management workshops throughout the region with a potential reach to over 300 older adults. In speaking with seniors and conducting gap analysis with organizations that serve seniors it has become clear that there is community interest in programs such as Arthritis Tai Chi and Enhanced Fitness. These programs are available in some areas of our region but not all with the barrier being access to trained leaders. Senior Resources is actively seeking a Certified Fitness Instructor who would train in the programs and conduct workshops in the undeserved areas.

2018 - In 2017 Senior Resources and our community partners provided 31 evidenced based workshops throughout the region. Many of these workshops were funded through the MI Health Endowment Fund to build capacity in Matter of Balance and Diabetes PATH. We continue to seek funding and sustainability for all evidenced based workshops. Senior Resources has located a Certified Fitness Instructor that we will stipend for services as funding allows.

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.

Progress
2017 - Senior Resources continues to explore the feasibility of implementing the HomeMeds or other medication review program in our region. In the past year we have met twice with representatives from Walgreens to discuss a potential partnership. For planning purposes pharmacists from Walgreens have accompanied a support coordinator on a home visit to assess how medication lists are obtained. Analysis of the viability of this partnership is ongoing.

2018 – Senior Resources partnered with Walgreens to record a 30 minute informational video regarding pharmacy services and medication management. This video was played on a local public access television station and is accessible by our website and/or YouTube. We have learned that most pharmacies utilize software programs that automatically check for drug interactions/duplications. However, Senior Resources is aware that seniors may use multiple pharmacies as medication costs fluctuate among pharmacies. A medication review would be advantageous to those participants. Efforts to collaborate with Walgreens to implement the HomeMeds program has not come to fruition, however Senior Resources recommends to seniors who use more than one pharmacy to review their full medication list with a pharmacist.

**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.

Progress
2017 - AgeWell Services has just developed a new, 8 hours per week part-time person dedicated to being the Tri-County Protection Team Coordinator. Her responsibilities will include the planning and implementation for the A-TEEAM (A Team to Ending Elder Abuse in Muskegon), a multi-disciplinary team coordinated in collaboration with the Muskegon County Prosecutor's Office, law enforcement and Adult Protective Services. The Coordinator will help the team author the county-wide elder abuse investigative protocol, engage stakeholders, implement a case review process and engage law enforcement in training. We hope to have the protocol authored by Summer 2017, training and case coordinator by Fall/Winter 2017.
The team is currently seeking funding to expand staffing, training and a dedicated deputized detective to investigate elder financial fraud and sexual abuse cases.

2018 -

- In December 2017, the Chief of Police (COPs) Board, representing all jurisdictions in Muskegon County, have motioned to approve the language of the Vulnerable Adult Investigative Protocol. The Protocol is in final revisions by DHHS and the Prosecutor's Office.
- The Tri-County Protection Team Coordinator and Executive Director attended a monthly case review in January of the Children's Advocacy Center to observe how their Multi-Disciplinary Team reviews cases of suspected child abuse. We do not anticipate that the case review process will begin until the summer of 2018.
- The Coordinator is working with the Prosecuting Attorney's Association of Michigan (PAAM) to implement a large training for law enforcement which will take place in the Spring of 2018 here in Muskegon.
- The Prosecutor would like to start a "Vulnerable Victims Task Force" incorporating agencies that advocate and service vulnerable victims of crime, including children, elders and domestic violence victims. There is no timeline on this concept.
- Our team is actively seeking grant funding from VOCA and the Prevent Michigan grants to assist with our coordination efforts and hire a deputized detective whose sole focus is on financial exploitation, neglect and abuse of elders.

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.

Progress
2017 - AgeWell Services will explore this effort in early 2019 once the A-TEEAM has been implemented and show results.

2018 -AgeWell Services will explore this effort in early 2019 once the case review process is showing results.

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.

Progress
2017 - The Tri-County Protection Team hosted a new format for training called the “Senior Symposium” with a theme of “Protecting Your Identity”. We plan to repeat this event in September 2017 with a focus on isolation and loneliness. There is a strong correlation of loneliness and “sweetheart” financial fraud, which is an emerging concern in protecting vulnerable adults.
The team is also planning a “Provider’s Conference” in July 2017 which will focus on the same topic from a clinical perspective. Dr. Abore from San Diego, California will be our keynote speaker.

2018 - The Tri-County Protection Team is now hosting two large conferences per year: the Senior Symposium (focused on seniors and caregivers) and Provider’s Conference (individuals and organizations that serve seniors). The Senior Symposium was a tremendous success, the topic focusing on protecting your identity. The Provider’s Conference brought national speaker and gerontologist Dr. Arbore around the topic of Senior Isolation and Loneliness. The event was very well executed and attended. During Financial Literacy Month, three different congregate meal locations hosted guest speakers on the topic of financial exploitation. We also worked with two local credit unions that included information in every transaction envelope. The Coordinator hopes to expand on this initiative this year.

**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.

Progress
2017 - Senior Resources CEO is one of a four-member organizing team that initiated a community effort in southern Ottawa county called Building an Age-Friendly Holland/Zeeland. Two forums have been held with 40-50 individuals representing human service organizations attending. The clear message is that lack of affordable housing and transportation are substantial barriers to community living, not only for older adults but for all persons living in the area. Ottawa County is fortunate to have a group already formed related to housing concerns called Ottawa Housing Next. This group is part of the Building an Age-Friendly Holland/Zeeland and will be reporting out to the larger group as their work takes shape. A transportation task force is being developed with the anticipated convening date of 5/17.

2018 -Ottawa Housing Next, a collaboration of housing stakeholders in the fastest growing municipality in the state, Ottawa, has created a plan to address housing gaps including gaps in senior housing. A large function of the plan is to take a look at local regulations, work with local municipalities, planning and zoning administers, planning commissions and city councils to streamline building processes allowing new affordable housing to be generated in an expedited manner. Best practices will be shared with other areas in the region.

**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.

Progress
2017 - Senior Resources has instituted a new training format for the Tanglewood Park Caregiver Support & Training group. The first 30 minutes of the meeting is a training that follows the information highlighted in the book, Quick Tips for Caregivers, Marion Karpinski, R.N. We provide the book for attendees for a fee or a lending library is available for them to borrow the book. The final hour follows more of a traditional support group format with group members engaging in mutual sharing and learning.
Our intention is to translate the information shared by the training experts into a tool kit available on our website for download. Much of the supplemental information shared is in written form and can easily be replicated or placed onto a web page. In addition, we have updated our website to include national and local links to services and supports specific to caregiver needs.

2018 – In keeping with the new caregiver support format instituted in 2017, Senior Resources continues to develop new training units for caregivers. A six-month self-care for the caregiver module was developed and facilitated. Information regarding available community caregiver resources continues to be shared when there is multi-faceted situations with a referral to a Senior Resources options counselor for further collaboration.

**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.

Progress
2017 - Senior Resources continues to serve as a member of the Specialized Transportation Committees in each of the counties we represent advocating for enhancements to the current transportation structure where funding allows. In the past year, we have supported the Max Transit transportation expansion in southern Ottawa Co. with an anticipated start date of July 2017 into Park Township. We participated in the Prosperity Region 4 strategic planning session and continue to support the development of transportation contracts that facilitate transportation over county lines.

2018 – Senior Resources CEO is one of a four-member organizing team that initiated a community effort in southern Ottawa County called Building an Age-Friendly Holland/Zeeland. Two main issues, transportation and housing, were identified and are being address by committees dedicated to the exploration of barriers, perceived barriers, limitations of the current structure/systems and opportunities to enhance the current structure/systems. The transportation committee is currently looking at enhancements indicated by community members as priorities through a comprehensive survey. They include but are not limited to:
1. Update the "Transportation Matrix" which is a tool that has a detailed explanation of the current transportation options that already exist in the Holland/Zeeland community.
2. Convene a "Communication Think Tank" to put together a strategy for how to better communicate the existing transportation options to older adults as well as family caregivers.
3. Convene a group of residential providers to look for more collaborative ways in which they may meet the mutual needs of their specific clients as many of them own and operate their own fleet of vehicles.
4. Research the strategy of a "Centralized Phone In-Take" that could help direct older adults to the transportation service in the community that is best suited for their unique need.
5. Further investigate Hope Network's "Go LUX" model in Grand Rapids that launched recently and caters to older adults. Could be an option to expand to Holland/Zeeland/Muskegon/North Ottawa in the future.
6. Invite Uber/Lyft to come speak to the group and explore options where we may partner.
7. Research local church bus use to determine if opportunity to share resources.

**Senior Resources** **FY 2019**

8. Compile the results of the "Transportation Study" along with our action plan into a final report to be shared with the public.
Senior Resources will share best practices with other transportation systems within our region.

**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.

Progress
2017 - Senior Resources is piloting a program with the Muskegon Mercy Gerontology office called Let's Stay Home. The doctor's office refers patients that are identified as being at risk of hospitalization to Senior Resources for an intensive 30-day intervention. This demonstrates a preventative approach to potential at risk persons as well has bridges the gap between the medical community and the participants needs in the home. There are four main goals in utilizing this intervention. First, to increase the participants and their caregiver's knowledge of appropriate urgent care and emergency room utilization thereby decreasing unnecessary emergency room utilization or hospitalization. Second, through the assessment process identify needs and increase access to needed services and supports through information, referral and direct service arrangement. Third, to increase the caregiver's knowledge and skills to care for a loved one with complex chronic conditions. Finally, to ensure that participants meet all their scheduled health care appointments.
A Senior Resources Supports Coordinator who has been trained in Care Transitions, is a Medicare and Medicaid Assistance Program Counselor, and has experience as an Options Counselor for Long Term Care will work with the participant to formulate a plan for their care utilizing navigation of community services and direct service provision through our provider network. Each plan will be directed by the participant to meet their needs and the

service array includes home delivered meals, transportation, homemaking, personal care, respite care, and personal emergency response system.
Senior Resources has had 16 referrals to this program and we are in the process of analyzing results of these interventions thus far.

2018 – The Let's Stay Home collaborative is in its second year and the preliminary outcomes have been very encouraging.

- 36 individuals have been served since the program has begun
- 30 of those people had caregivers. 2 people did not have a caregiver and the 4 remaining caregivers did not complete a post survey. Of the 30 that did complete the pre- and post- survey 96% reported improved knowledge and skills post intervention.
- All participants received services in the form of in-home support. 23 received home delivered meals, 14 received homemaking services, 5 received personal care, 5 received respite, and 3 were referred to the Senior Companion program. 16 participants closed to the Let's Stay Home Program transferring into a long-term care program such as PACE or MI Choice Waiver.
- 3 participants missed 1 healthcare appointment during the intervention – 3 missed appointments total
- 8 participants used the emergency room while enrolled in the program. Only one ER visit was deemed avoidable.
- 2 participants were placed in nursing care and passed away before the end of the intervention

**G. Increase evidenced based workshop offerings to include the Stanford Chronic Pain Management Program.**
State Goal Match: 1

Narrative
Senior Resources will train staff and volunteers in the facilitation of the Stanford Chronic Pain Management curriculum and conduct a minimum of 2 workshops throughout our region.
The expected outcome is that participants will be better informed as to how to identify and implement the most effective pain management intervention for them resulting in increased pain management and satisfaction with their life.

Objectives

1. Increase evidenced based workshop offerings to include the Stanford Chronic Pain Management Program.
   Timeline: 10/01/2017 to 09/30/2019

Activities
Senior Resources will train staff and volunteers on the facilitation of the curriculum and conduct a minimum of 2 workshops throughout our region.

Expected Outcome
It is our expectation that participants will be better informed as to how to identify and implement the most effective pain management intervention for them resulting in increased pain management and satisfaction with their life.

Progress
2018 - Two staff members were Master trained in Stanford Chronic Disease Management for Chronic Pain. Two Chronic Pain workshops were offered with one being canceled due to low attendance.

**H. Regional Goal: Area Agencies on Aging will be able to better advocate for and prove the value of Access Services.**
State Goal Match: 0

Narrative
The aging network must expand decision makers knowledge base regarding the value of the access services we have provided for years. We must track and demonstrate improved outcomes due to our interventions, quantify how this will relate to a return on their investment with us and emphasize that we have current systems in place to address this need.

Objectives

1. Area Agencies on Aging will be able to advocate for and prove the value of Access Services.
   Timeline: 10/01/2017 to 09/30/2019

Activities
Senior Resources will research and/or develop and implement a tracking/reporting mechanism to better quantify the monetary impact of access services and using those services to keep people in the community

Expected Outcome
Area Agencies on Aging will be able to track and demonstrate improved outcomes due to our interventions, quantify how this will relate to a return on investment with us and emphasize that we have current systems in place to address this need.

Progress
Senior Resources continues to work with our National Area Agency on Aging Association, the State Area on Aging Association and the Aging and Adult Services Agency to identity measures that will accurately quantify our access interventions. We have learned that different stakeholders have different interests and investments in the programs we provide. For example, providers might be more interested in clinical outcomes, while some legislators might be more interested in cost savings. To ensure that value is proven to all stakeholders, we would like to use a variety of measures that appeal to a broad stakeholder group. Conversations and best practice discovery will continue into 2019 and beyond.

**I. To prevent social isolation and loneliness in older adults.**
State Goal Match: 1

Narrative
It is estimated that one in five adults over age 50 are affected by social isolation, a problem that has been associated with higher rates of chronic disease, depression, dementia and death. Over the next year, Senior Resouces will raise awareness of the problem of isolation and loneliness in a number of ways, including one-on-one counseling with our participants, leveraging traditional and social media to spread the word about the

effects of social isolation and encouraging community awareness and intervention.

Objectives

1. To educate and inform the community regarding the effects of social isolation in older adults and ways to combat this health risk.
   Timeline: 10/01/2017 to 09/30/2019

Activities

Over the next year, Senior Resouces will raise awareness of the problem of isolation and loneliness in a number of ways, including one-on-one counseling with our participants, leveraging traditional and social media to spread the word about the affects of social isolation and encouraging community awareness and intervention. We will provide tools and resources to help people evaluate their isolation risk, reach out to others who may be feeling lonely and disengaged,and find practical ways for them to reconnect with their community.

Expected Outcome

Preventing or addressing loneliness and social isolation will result in an increase quaility of life for older adults as well as decrease health risks associated with social isolation.

Progress

During fiscal year 2017, Senior Resources offered approximately 15 speaking presentations reaching several hundred people that touched on social isolation in older adults, in an effort to increase awareness of the health risks associated with it. We also talked with staff about the topic in order to help them identify it in their participants and provide resources to help combat isolation. The Senior Resources Communications Director wrote 16 stories on participants from across the region who spoke about how their lives were enhanced by accessing and using community services. In addition Senior Resources facilitated the following opportunities on social isolation:

- Nice piece on our local ABC affiliate, WZZM-TV 13, featuring a participant and staff member talking about social isolation
- Local daily newspaper, The Holland Sentinel, did two stories, including one on the front page, featuring a participant. (She has since reconnected with five friends due to these articles!)
- Local weekly paper, The Norton-Lakeshore Examiner, ran a piece featuring the n4a press release and local participant story
- Regional PBS radio station WGVU did a 10-minute interview with the communications director about the campaign
- We included a story on social isolation in our monthly electronic newsletter, Sixty Seconds, which goes to more than 400 people.
- We talked about social isolation on our monthly cable TV show, which airs on a local Muskegon County station
- We shared the information with our Senior Advocates Coalition and Board of Directors and staff
- Sent out 120 brochures about social isolation in personal care bags to our participants
- Put out the brochures in our front lobby and distributed them in a couple of speaking engagements

**Appendices**

**Appendices A and B are not required to be completed or updated for the FY 2019 AIP. Appendix C should only be completed if there are new/changed criteria for selecting providers. Appendices D, E and F should be completed if applicable to the area agency 2019 AIP. Select the applicable appendix from the list on the left and provide information for each appendix.**

**A. Policy Board membership – not required for the FY 2019 AIP**
**B. Advisory Council membership – not required for the FY 2019 AIP**
**C. Proposal Selection Criteria**
**D. Cash-in-Lieu-of-Commodity Agreement**
**E. Waiver of Minimum Percentage of a Priority Service Category**
**F. Request to Transfer Funds**

# FY 2019 AREA PLAN GRANT BUDGET

Rev. 1/2018

Agency: Senior Resources of West MI  Budget Period: 10/01/18 to 09/30/19

PSA: 14  Date: 04/04/18  Rev. No.: 0  

SERVICES SUMMARY

| FUND SOURCE | SUPPORTIVE SERVICES | NUTRITION SERVICES | TOTAL |
|---|---|---|---|
| 1. Federal Title III-B Services | 351,095 | | 351,095 |
| 2. Fed. Title III-C1 (Congregate) | | 448,437 | 448,437 |
| 3. State Congregate Nutrition | | 9,510 | 9,510 |
| 4. Federal Title III-C2 (HDM) | | 231,261 | 231,261 |
| 5. State Home Delivered Meals | | 417,018 | 417,018 |
| 8. Fed. Title III-D (Prev. Health) | 24,600 | | 24,600 |
| 9. Federal Title III-E (NFCSP) | 151,089 | | 151,089 |
| 10. Federal Title VII-A | 3,153 | | 3,153 |
| 10. Federal Title VII-EAP | 6,149 | | 6,149 |
| 11. State Access | 28,385 | | 28,385 |
| 12. State In-Home | 322,898 | | 322,898 |
| 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 | 141,408 | 55,311 | 196,719 |
| b. In-Kind | 141,862 | 110,623 | 252,485 |
| 18. State Respite Care (Escheat) | 60,363 | | 60,363 |
| 19. MATF & St. CG Support | 167,820 | | 167,820 |
| 20. TCM/Medicaid & MSO | 170,577 | | 170,577 |
| 21. NSIP | | 152,768 | 152,768 |
| 22. Program Income | 56,891 | 276,557 | 333,447 |
| TOTAL: | 2,020,218 | 1,701,484 | 3,721,702 |

ADMINISTRATION

| Revenues | | Local Cash | Local In-Kind | Total |
|---|---|---|---|---|
| Federal Administration | 143,691 | 152,497 | 17,000 | 313,188 |
| State Administration | 24,812 | | | 24,812 |
| MATF & St. CG Support Administration | 12,000 | - | - | 12,000 |
| Other Admin | - | | | - |
| Total AIP Admin: | 180,503 | 152,497 | 17,000 | 350,000 |

Expenditures

| | FTEs | |
|---|---|---|
| 1. Salaries/Wages | 3.56 | 214,000 |
| 2. Fringe Benefits | | 64,000 |
| 3. Office Operations | | 72,000 |
| Total: | | 350,000 |

| Cash Match Detail | | In-Kind Match Detail | |
|---|---|---|---|
| Source | Amount | Source | Amount |
| Tanglewood Park Shared Services | 18,050 | Volunteers | 17,000 |
| SRWM Reserves | 120,000 | | |
| Other | 14,447 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total: | 152,497 | Total: | 17,000 |

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.

Pamela Curtis
Signature

CEO
Title

04/09/18
Date

FY 2019 AREA AGENCY GRANT FUNDS - SUPPORT SERVICES DETAIL

Agency: Senior Resources of West MI | Budget Period: 10/01/18 to 09/30/19 | Rev. 1/2018

PSA: 14 | Date: 04/04/18 | Rev. No.: 0 | 

*Operating Standards For AAA's

| Op Std | SERVICE CATEGORY | Title III-B | Title III-D | Title III - E | Title VII A OMB Title VII/EAP | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A | Access Services | | | | | | | | | | | | | | | | |
| A-1 | Care Management | | | | | | | | 38,864 | | | | 160,000 | | 11,932 | 11,932 | 222,728 |
| A-2 | Case Coord/supp | 115,595 | | 15,000 | | 28,385 | | | 107,957 | 44,264 | | | | | 108,672 | 18,672 | 438,545 |
| A-3 | Disaster Advocacy | | | | | | | | | | | | | | | | - |
| A-4 | Information & Assis | 50,000 | | 5,000 | | | | | | | | | | | 6,600 | | 61,600 |
| A-5 | Outreach | | | | | | | | | | | | | | | | - |
| A-6 | Transportation | 43,000 | | | | | | | | | | | | 4,300 | 4,300 | 2,150 | 53,750 |
| B | In-Home | | | | | | | | | | | | | | | | |
| B-1 | Chore | | | | | | | | | | | | | | | | - |
| B-2 | Home Care Assis | | | | | | | | | | | | | | | | - |
| B-3 | Home Injury Cntrl | | | | | | | | | | | | | | | | - |
| B-4 | Homemaking | | | | | | 292,898 | | | | | | | 17,574 | | 32,219 | 342,691 |
| B-6 | Home Health Aide | | | | | | | | | | | | | | | | - |
| B-7 | Medication Mgt | 10,000 | | | | | 30,000 | | | | | | | 2,400 | | 4,400 | 46,800 |
| B-8 | Personal Care | 33,000 | | | | | - | 111,742 | | - | | | | 8,685 | | 15,922 | 169,348 |
| B-9 | Assistive Device&Tech | | | | | | | | | | | | | | | | - |
| B-10 | Respite Care | | | 100,689 | | | | | | | 60,363 | 16,096 | | 10,629 | | 19,486 | 207,263 |
| B-11 | Friendly Reassure | | | | | | | | | | | | | | | | - |
| C-10 | Legal Assistance | 25,000 | | | | | | | | | | | | | | 2,750 | 27,750 |
| C | Community Services | | | | | | | | | | | | | | | | |
| C-1 | Adult Day Care | | | | | | | | | | | 151,724 | | 9,103 | | 16,690 | 177,517 |
| C-2 | Dementia ADC | | | | | | | | | | | | | | | | - |
| C-6 | Disease Prevent | | 24,600 | | | | | | | | | | | | | 2,706 | 27,306 |
| C-7 | Health Screening | | | | | | | | | | | | | | | | - |
| C-8 | Assist to Deaf | | | | | | | | | | | | | | | | - |
| C-9 | Home Repair | | | | | | | | | | | | | | | | - |
| C-11 | LTC Ombudsman | 4,500 | | | 3,153 | | | | | 22,009 | | | 10,577 | | 2,414 | 2,414 | 45,068 |
| C-12 | Sr Ctr Operations | | | | | | | | | | | | | | | | - |
| C-13 | Sr Ctr Staffing | | | | | | | | | | | | | | | | - |
| C-14 | Vision Services | | | | | | | | | | | | | | | | - |
| C-15 | Elder Abuse Prevnt | | | | 6,149 | | | | | | | | | | | 676 | 6,825 |
| C-16 | Counseling | | | | | | | | | | | | | | | | - |
| C-17 | Creat.Conf.CG® CCC | | | | | | | | | | | | | | | | - |
| C-18 | Caregiver Supplmt | | | | | | | | | | | | | | | | - |
| C-19 | Kinship Support | | | 8,000 | | | | | | | | | | | 880 | | 8,880 |
| C-20 | Caregiver E,S,T | | | 22,400 | | | | | | | | | | | 2,464 | | 24,864 |
| *C-8 | Pogram Develop | 70,000 | | | | | | | | | | | | 4,200 | | 7,700 | 81,900 |
| | Region Specific | | | | | | | | | | | | | | | | |
| | Enhanced Support | - | - | - | - | - | - | - | 69,092 | | - | | | | 4,146 | 4,146 | 77,383 |
| | b. | - | - | - | - | - | - | - | - | | - | | | | | | - |
| | c. | - | - | - | - | - | - | - | - | | - | | | | | | - |
| | d. | | | | | | | | | | | | | | | | - |
| | e. | | | | | | | | | | | | | | | | - |
| | 7. CLP/ADRC Services | - | | - | | - | | | - | | | | | | | | - |
| Sp Co | 8. MATF & St CG Sup A | | | | | | | | | | | 12,000 | | | - | - | 12,000 |
| | SUPPRT SERV TOTAL | 351,095 | 24,600 | 151,089 | 9,302 | 28,385 | 322,898 | 111,742 | 215,913 | 66,273 | 60,363 | 179,820 | 170,577 | 56,891 | 141,408 | 141,862 | 2,032,218 |

| Planned Services Summary Page for FY 2019 | | | PSA: 14 | | |
|---|---|---|---|---|---|
| | Budgeted | Percent of the | Method of Provision | | |
| Service | Funds | Total | Purchased | Contract | Direct |
| **ACCESS SERVICES** | | | | | |
| Care Management | $ 222,728 | 5.97% | | | X |
| Case Coordination & Support | $ 438,545 | 11.75% | | X | X |
| Disaster Advocacy & Outreach Program | $ - | 0.00% | | | |
| Information & Assistance | $ 61,600 | 1.65% | | X | X |
| Outreach | $ - | 0.00% | | | |
| Transportation | $ 53,750 | 1.44% | | X | |
| | | | | | |
| **IN-HOME SERVICES** | | | | | |
| Chore | $ - | 0.00% | | | |
| Home Care Assistance | $ - | 0.00% | X | | |
| Home Injury Control | $ - | 0.00% | | | |
| Homemaking | $ 342,691 | 9.18% | X | | |
| Home Delivered Meals | $ 999,251 | 26.76% | X | X | |
| Home Health Aide | $ - | 0.00% | | | |
| Medication Management | $ 46,800 | 1.25% | X | | |
| Personal Care | $ 169,348 | 4.54% | X | | |
| Personal Emergency Response System | $ - | 0.00% | X | | |
| Respite Care | $ 207,263 | 5.55% | X | | |
| Friendly Reassurance | $ - | 0.00% | | | |
| | | | | | |
| **COMMUNITY SERVICES** | | | | | |
| Adult Day Services | $ 177,517 | 4.75% | X | | |
| Dementia Adult Day Care | $ - | 0.00% | | | |
| Congregate Meals | $ 702,233 | 18.81% | | X | |
| Nutrition Counseling | $ - | 0.00% | | | |
| Nutrition Education | $ - | 0.00% | | | |
| Disease Prevention/Health Promotion | $ 27,306 | 0.73% | X | | |
| Health Screening | $ - | 0.00% | | | |
| Assistance to the Hearing Impaired & Deaf | $ - | 0.00% | | | |
| Home Repair | $ - | 0.00% | | | |
| Legal Assistance | $ 27,750 | 0.74% | | X | |
| Long Term Care Ombudsman/Advocacy | $ 45,068 | 1.21% | | | X |
| Senior Center Operations | $ - | 0.00% | | | |
| Senior Center Staffing | $ - | 0.00% | | | |
| Vision Services | $ - | 0.00% | | | |
| Programs for Prevention of Elder Abuse, | $ 6,825 | 0.18% | | X | |
| Counseling Services | $ - | 0.00% | | | |
| Creating Confident Caregivers® (CCC) | $ - | 0.00% | X | | |
| Caregiver Supplemental Services | $ - | 0.00% | | | |
| Kinship Support Services | $ 8,880 | 0.24% | | X | |
| Caregiver Education, Support, & Training | $ 24,864 | 0.67% | X | X | X |
| AAA RD/Nutritionist | $ - | 0.00% | | | |
| **PROGRAM DEVELOPMENT** | $ 81,900 | 2.19% | | | X |
| **REGION-SPECIFIC** | | | | | |
| Enhanced Support | $ 77,383 | 2.07% | | | |
| b. | $ - | 0.00% | | | |
| c. | $ - | 0.00% | | | |
| d. | $ - | 0.00% | | | |
| e. | $ - | 0.00% | | | |
| **CLP/ADRC SERVICES** | $ - | 0.00% | | | |
| **SUBTOTAL SERVICES** | **$ 3,721,702** | | | | |
| **MATF & ST CG ADMINSTRATION** | $ 12,000 | 0.32% | | | X |
| **TOTAL PERCENT** | | 100.00% | 28.00% | 54.00% | 18.00% |
| **TOTAL FUNDING** | **$ 3,733,702** | | $1,045,437 | $2,016,199 | $672,066 |

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.