MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Programs

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MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

I. INTRODUCTION AND INSTRUCTIONS FOR USE

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

Background

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

Instructions

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

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

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

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

II. A. GENERAL REQUIREMENTS FOR ALL SERVICE PROGRAMS

Authority Reference

Michigan Commission on Services to the Aging (MCSA)

Michigan Public Acts referred to in the standards can be viewed at www.legislature.mi.gov.

Federal laws and regulations can be viewed at www.first.gov.

Policy Statement

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

Required Program Components

A. Contractual Agreement

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

B. Compliance With Service Definitions

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

C. Eligibility

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

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

Services provided under Merit Award Trust Fund (adult day services and respite care) may be provided to adults aged 18 and over.

D. Targeting of Participants

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

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

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

   Indicating factors include:

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

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

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

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

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

3. Elderly members of Native American tribes and organizations in greatest economic and/or social need within the program service area are to receive services comparable to those

received by non-Native American elders. Service providers within a geographic area in which a reservation is located must demonstrate a substantial emphasis on serving Native American elders from that area.

E. Contributions

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

2. Cost sharing may be implemented according to the Michigan OSA Cost Sharing Policy (refer to Transmittal Letter #393).

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

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

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

F. Confidentiality

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

G. Referral and Coordination Procedures

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

Each program shall be able to demonstrate linkages with agencies providing access services. Each program must establish written referral protocols with Case Coordination and Support, Care

Management, and Home and Community Based Medicaid Programs operating in the respective service area.

H. Services Publicized

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

I. Older Persons at Risk

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

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

K. Insurance Coverage

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

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

The following insurances are recommended for additional agency protection:

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

L. Volunteers

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

M. Staffing

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

N. Staff Identification

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

O. Orientation and Training Participation

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

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

P. Complaint Resolution and Appeals

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

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

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

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

Q. Service Termination Procedure

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

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

R. Service Quality Review

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

S. Civil Rights Compliance

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

T. Equal Employment

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

U. Universal Precautions

Each program must evaluate the occupational exposure of employees to blood or other potentially hazardous materials that may result from performance of the employee's duties and establish appropriate universal precautions. Each provider with employees who may experience occupational

exposure must develop an exposure control plan which complies with Federal regulations implementing the Occupational Safety and Health Act.

V. Drug Free Workplace

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

W. Americans With Disabilities Act

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

X. Workplace Safety

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

II. B. GENERAL REQUIREMENTS FOR NUTRITION SERVICE PROGRAMS

1. Meals may be presented hot, cold, frozen or shelf-stable and shall conform to the following meal pattern:

Meal Requirements	Servings per meal	Notations
Bread or Bread Alternate	2 servings bread, rice, pasta, cereal A starchy vegetable may replace one bread serving.	Encourage whole grains.
Vegetable	2 servings: 1 serving = ½ cup or equivalent measure	Fresh, frozen, or canned and prepared without added sodium. Focus on deep colored and dark green leafy vegetables. Cooked dried beans or peas are a good fiber source.
Fruit	1 serving: ½ cup or equivalent measure (may serve an additional fruit instead of a vegetable)	Fresh, frozen, canned, or dried. Deep colored fruits and good sources of Vitamin C are encouraged daily.
Milk or Milk Alternate	1 serving: 1 cup or equivalent measure	Encourage low-fat or skim milk, buttermilk, yogurt or cottage cheese.
Meat or Meat Alternate	1 serving: 2-3 oz or equivalent measure	Encourage lean and low-fat meats and cheeses. Dried beans and peas are a good choice. Peanut butter, cottage cheese, tofu, and eggs also qualify.
Fats	1 serving: 1 teaspoon or equivalent measure	Select choices that are good sources of mono-and poly-unsaturated fats. Limit total fat to no more than 30% of total daily calories. Each week's meals shall contain no more than 25 grams average total fat.
Dessert	Optional	Choose nutrient dense desserts such as fruits, whole grain quick breads, puddings with limited fats and sugars. Limit high calorie desserts such as pies, cakes, cookies etc.
Sodium	No more than 1200 mg per meal average weekly total.	Select and prepare foods with less salt or sodium and use salt-free seasonings.
Fiber	3 choices out of a 5 day week high fiber	Choose whole grains, fruits and vegetables

[Note: the Older Americans Act requires that each meal provide, at a minimum, 33 1/3 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.]

2. In addition to the meal pattern above, servings shall conform to the following:

Bread or Bread Alternate

- 1 small 2 ounce muffin
- 2" cube cornbread
- 1 biscuit, 2.5" diameter
- 1 waffle, 7" diameter
- 1 slice French toast
- ½ English muffin
- 1 tortilla, 6" diameter
- 2 pancakes, 4" diameter
- ½ bagel
- 1 small sandwich bun
- ½ cup cooked cereal, grits, barley, bulgur or masa
- 4-6 crackers
- ½ large sandwich bun
- ¾ cup ready to eat cereal
- ¼ cup granola
- 2 graham cracker squares
- ½ cup bread dressing/stuffing
- ½ cup pasta, noodles, rice

A variety of enriched and/or whole grain bread products, particularly those high in fiber, are recommended.

Vegetables

- A serving of vegetable (including dried beans, peas and lentils) is generally ½ cup cooked or raw vegetable; ¾ cup 100% vegetable juice; or, 1 cup raw leafy vegetable. For pre-packed 100% vegetable juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh or frozen vegetables are preferred. Canned vegetables are acceptable but may be high in sodium.
- Vegetables as a primary ingredient in soups, stews, casseroles or other combination dishes should total ½ cup per serving.
- Starchy vegetables, such as potatoes, sweet potatoes, corn, yams, or plantains, may replace one of the two bread servings.

Fruits

- A serving of fruit is generally a medium apple, banana, orange, or pear; ½ cup chopped, cooked or canned fruit; or ¾ cup 100% fruit juice. For pre-packed 100% fruit juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh, frozen, or canned fruit should be preferably packed in juice, light syrup or without sugar.

Milk or Milk Alternates

- One cup low-fat, skim, whole, buttermilk, low-fat chocolate, or lactose-free milk fortified with Vitamins A and D should be used. Lowfat or skim milk is recommended for the general population. Powdered dry milk (1/3 cup) or evaporated milk (1/2 cup) may be served as part of a home delivered meal.
- Milk alternates for the equivalent of one cup of milk include:
  1 cup yogurt
  1 ½ cups cottage cheese
  8 ounces tofu (processed with calcium salt)
  8 ounces calcium fortified soy milk
  1+½ ounces natural or 2 ounces processed cheese

Meat or Meat Alternates

- Two to three ounces of cooked meat or meat alternate should generally be provided for the lunch or supper meal. Meat serving weight is the edible portion, not including skin, bone, or coating.

  <u>The following are equivalent to 1 ounce of meat</u>
  - 1 large egg
  - 1 ounce cheese (nutritionally equivalent measure of pasteurized process cheese, cheese food, cheese spread, or other cheese product). It is best to choose low-fat cheese such as mozzarella, feta, ricotta, etc.
  - ½ cup cooked dried beans, peas or lentils (separate from vegetable serving)
  - 2 tablespoons peanut butter or 1/3 cup nuts
  - ¼ cup cottage cheese
  - ½ cup tofu, or 4 ounces
  - ¼ cup tempeh

- A one ounce serving or equivalent portion of meat, poultry, or fish may be served in combination with other high protein foods.
- Except to meet cultural and/or religious preferences and for emergency meals, avoid serving dried beans, peas, lentils, peanut butter or peanuts, and tofu for consecutive meals or on consecutive days.
- Imitation cheese (which the Food and Drug Administration defines as one not meeting nutritional equivalency requirements for the natural, non-imitation product) cannot be served as meat alternates.
- In order to limit the sodium content of the meals, serve cured and processed meats (e.g., ham, smoked or Polish sausage, corned beef, wieners, luncheon meats, dried beef) no more than once a week.

Accompaniments

Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, and garnishes. Examples include: mustard and/or mayonnaise with a meat sandwich; tartar sauce with fish; salad dressing with tossed salad; margarine with bread or rolls. Whenever feasible, provide reduced fat

alternatives. Minimize use of fat in food preparation. Fats should be primarily from vegetable sources and in a liquid or soft (spreadable) form that are lower in hydrogenated fat, saturated fat, and cholesterol.

Desserts

Serving a dessert is optional. Healthier desserts generally include fruit, low-fat puddings, whole grains, low-fat products, and limited sugar items such as quick breads (banana or pumpkin bread). Fresh, frozen, or canned fruits packed in their own juice are often encouraged as a dessert item in addition to the serving of fruit provided as part of the meal.

Beverages

Fluid intake should be encouraged, as dehydration is a common problem in older adults. It is a good practice to have drinking water available.

Vegetarian Meals

Vegetarian meals can be served and should follow the principle of complementary proteins, where proteins from plant sources (legumes such as cooked dried beans and peas) are combined with grains (rice, breads, pasta) at the same meal. Vegetarian meals are a good opportunity to provide variety to menus and highlight the many ethnic food traditions found in Michigan.

Breakfast Meals

A breakfast meal may contain three fruit servings and no vegetable as an option to the required meal plan.

3. Each program shall utilize a menu development process, which places priority on healthy choices and creativity and includes, at a minimum:

   a. Use of written, standardized recipes.
   b. Cycle menus are encouraged for costs containment and/or convenience, but are not required. Programs are encouraged to consult with the regional dietitian during the menu development process.
   c. Provision for review and approval of all menus by the regional dietitian who must be a registered dietitian, or an individual who is dietitian-registration eligible.
   d. Posting of menu to be served in a conspicuous place at each meal site and at each place food is prepared. The program must be able to provide information on the nutrition content of menus upon request.
   e. Modified diet menus should be provided, where feasible and appropriate, which take into consideration client choice, health, religious and ethnic diet preferences.
   f. A record of the menu actually served each day shall be maintained for each fiscal year's operation.
   g. Written procedures for revising menus after they have been approved.

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

   Each program, which operates a kitchen for food production, shall have at least one key staff person (manager, cook or lead food handler) complete a Food Service Manager Certification Training Program that has been approved by the Michigan Department of Agriculture. A trained and certified staff member is preferred, but not required, at satellite serving and packing sites.

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

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

   The program must use foodstuff from commercial sources which comply with the Michigan Food Code. Unacceptable items include: home canned or preserved foods; foods cooked or prepared in an individual's home kitchen; meat from any animal not killed by a licensed facility; any wild game taken by hunters; fresh or frozen fish donated by sport fishers; raw seafood or eggs; and, any un-pasteurized products (i.e., dairy, juices and honey).

   The program may use contributed foodstuff only when they meet the same standards of quality, sanitation and safety as apply to food stuffs purchased from commercial sources.

   Acceptable contributed foodstuff include: fresh fruits and vegetables; wild game from a licensed farm processed within two hours of killing by a licensed processor.

5. Each program shall use standardized portion control procedures to ensure that each meal served is uniform and satisfies meal pattern requirements. Standard portions may be altered at the request of a participant for less than the standard serving of an item or if a participant refuses an item. Less than standard portions shall not be served in order to "stretch" available food to serve additional persons.

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

7. Each program shall use an adequate food cost and inventory system at each food preparation facility. The inventory control shall be based on the first-in/first-out (FIFO) method and conform to generally accepted accounting principles (GAAP). The system shall be able to provide daily food costs, inventory control records, and monthly compilation of daily food costs.

   For programs operating under annual cost-reimbursement contracts, the value of the inventory on hand at the end of the fiscal year shall be deducted from the total amount expended during that year.

For programs operating under a unit-rate reimbursement contract, the value of the inventory on hand at the end of the fiscal year does not have to be considered. Each program shall be able to calculate the component costs of each meal provided according to the following categories:

a. Raw Food — All costs of acquiring foodstuff to be used in the program.

b. Labor — (i) Food Service Operations: all expenditures for salaries and wages, including valuation of volunteer hours, for personnel involved in food preparation, cooking, delivery, serving, and cleaning of meal sites, equipment and kitchens; (ii) Project Manager: all expenses for salary wages for persons involved in project management.

c. Equipment — All expenditures for purchase and maintenance of items with a useful life of more than one year or with an acquisition cost of greater than $5,000.

d. Supplies — All expenditures for items with a useful life of less than one year and an acquisition cost of less than $5,000.

e. Utilities — All expenditures for gas, electricity, water, sewer, waste disposal, etc.

f. Other — Expenditures for all other items that do not belong in any of the above categories (e.g. rent, insurance, fuel etc.) to be identified and itemized.

Where a provider operates more than one meal/feeding program (congregate, HDM, waiver, catering, etc.), costs shall be accurately distributed among the respective meal programs. Only costs directly related to a specific program shall be charged to that program

8. Each program shall provide or arrange for monthly nutrition education sessions at each meal site and as appropriate to home bound clients. Topics shall include, but are not limited to, food, nutrition, wellness issues, consumerism and health. All nutrition education materials and presenters must be approved by the regional dietitian.

9. The AAA may adjust the number of nutrition grantees to meet the needs of the region**.**

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

11. Each program shall develop and utilize a system for documenting meals served for purposes of the Nutrition Services Incentive Program (NSIP). Meals eligible to be included in NAPIS meal counts reported to the respective AAA, are those served to eligible individuals (as described under respective program eligibility criteria) and which meet the specified meal pattern requirements.

The most acceptable method of documenting meals is by obtaining signatures daily from participants receiving meals. Other acceptable methods may include, for example, for home delivered meals, maintaining a daily or weekly route sheet signed by the driver which identifies the client's name, address, and number of meals served to them each day.

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

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

14. Each program, with input from program participants, shall establish a suggested donation amount that is to be posted at each meal site and provided to home delivered meal participants. The program may establish a suggested donation scale based on income ranges, if approved by the respective AAA. Non-senior volunteers who receive meals shall be afforded the opportunity to donate towards the cost of the meal received.

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

16. Each program shall have a written procedure in place for handling all donations which includes at a minimum:

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

17. Each program shall take steps to inform participants about local, State and Federal food assistance programs and assist individuals as feasible to obtain benefits. When requested, programs shall assist participants in utilizing Federal Food Assistance Program benefits as participant donations to the meal program.

18. Programs shall not use funds from OSA to purchase dietary supplements.

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

III. SERVICE DEFINITIONS AND SPECIFIC MINIMUM STANDARDS

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

A. Access

Care management, case coordination and support, disaster advocacy and outreach, information and assistance, outreach and transportation.

B. In-Home

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

C. Community

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

A. GENERAL REQUIREMENTS FOR ACCESS SERVICE PROGRAMS

In addition to the general requirements for all service programs, the following general standards apply to all access service categories unless otherwise specified.

Statement of Intent

Case coordination and support (CCS), care management (CM) and the Home and Community Based Services for the Elderly and Disabled (HCBS/ED) waiver programs are considered to be long-term care client support services. These three programs have many common functions and activities as well as a consistent focus. The general requirements for access service programs are intended to provide a framework for efficient and effective integration of these programs within the Michigan aging network.

1. A long-term care client shall be served by the CCS program until it has been determined they are in need of a nursing facility level of care based on functional limitations. Once such a determination has been made, the client is to be referred to the appropriate CM program. CCS programs are to be funded through Older Americans Act Title III, Part B.

2. A long-term care client shall be served by the CM program when they have been determined to need a nursing facility level of care based on functional limitations but is not determined to be Medicaid eligible. Once Medicaid eligibility has been determined, the client is to be referred to the appropriate waiver program. CM programs are to be funded through state care management funds and may utilize Older Americans Act Title III, Part B funds.

3. A long-term care client shall be served by the waiver program when they have been determined to need a nursing facility level of care based on functional limitations and is Medicaid eligible. Waiver programs are to be funded through Medicaid.

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Access Services

SERVICE NAME	Care Management
SERVICE NUMBER	A-1
SERVICE CATEGORY	Access
SERVICE DEFINITION	The provision of a comprehensive assessment, care plan development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals aged 60 and over who are in need of a nursing facility level of care due to the presence of functional limitations. Services are brokered or directly purchased, according to an agreed-upon care plan, to assist the client in maintaining independence. Care management functions include eligibility determination, assessment, care plan development, supports, coordination, reassessment and on-going monitoring. Activities shall be conducted in accordance with established performance criteria.
UNIT OF SERVICE	Assessment and ongoing care management of an individual.

Minimum Standard

1. Medical eligibility for care management shall be determined using the MI Choice screen prior to an individual's enrollment in the CM program.

2. Care management functions shall be conducted by a multi-disciplinary team consisting of a registered nurse and social worker.

3. Care managers shall establish and maintain a confidential record for each client served. The record shall include but not be limited to the following information:

   a. Completed telephone screen
   b. Completed assessment
   c. Client-approved plan of care
   d. Documentation of service orders, linkage forms
   e. Progress notes which serve as a log for documenting pertinent contacts with client, providers and others involved in caring for the client
   f. Reassessment
   g. Correspondence pertaining to client's care
   h. Person centered planning.

4. MI Choice assessment and reassessment forms and protocols shall be utilized to assess an individual's abilities, health and physical functioning, living situation, informal support potential, and financial status.

5. A plan of care detailing the services to be arranged or purchased shall be established for each enrolled client. Assessment findings shall be utilized to establish the plan of care. Care plans shall be modified or adjusted based on reassessment findings or other changes in the client's condition.

6. Reassessments shall be conducted:

   a. Within 90 days of assessment or previous reassessment for active cases, and
   b. Within 180 days of assessment or previous reassessment for maintenance cases.

7. Ongoing monitoring and follow-up shall be conducted to ensure the client's health and safety, quality of care, and satisfaction with services.

8. Each program shall utilize the MI Choice Information System (MICIS) according to established protocols to track client data, services data, and billing data.

9. Each program shall establish linkages with agencies providing long-term care support services within the program area (e.g., in-home services providers, case coordination and support programs, HCBS/ED waiver programs).

10. Programs shall ensure staff is available to assist in disaster management activities coordinated by the local emergency operations center as necessary to protect the health and safety of CM clients.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Access Services

SERVICE NAME	Case Coordination and Support
SERVICE NUMBER	A-2
SERVICE CATEGORY	Access
SERVICE DEFINITION	The provision of a comprehensive assessment of persons aged 60 and over with a complementing role of brokering existing community services and enhancing informal support systems when feasible. Case Coordination and Support (CCS) includes the assessment and reassessment of individual needs, development and monitoring of a service plan, identification of and communication with appropriate community agencies to arrange for services, evaluation of the effectiveness and benefit of services provided, and assignment of a single individual as the caseworker for each client.
UNIT OF SERVICE	Provision of one hour of component CCS functions.
COMPONENT FUNCTIONS	Intake, assessment, reassessment, development of service plan, arrangement for each service.

Minimum Standards

1. Each CCS program must have uniform intake procedures and maintain consistent records. Intake may be conducted over the telephone. Intake records for each potential client must include at a minimum:

   a. Individual's name, address and telephone number
   b. Individual's age or birth date
   c. Physician's name, address and telephone number
   d. Name, address, and phone number of person, other than spouse or relative with whom individual resides, to contact in case of emergency
   e. Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems
   f. Perceived supportive service needs as expressed by individual or his/her representatives.
   g. Race (optional)
   h. Gender (optional)
   i. An estimate of whether or not the individual has an income at or below the poverty level for intake and reporting purposes and at or below 125% of poverty level for referral purposes.

2. If intake indicates a single service need on a one-time or infrequent basis, the individual should be provided information and assistance services. When intake suggests ongoing and/or multiple service needs, a comprehensive individual assessment of need shall be performed within ten working days of intake. If intake suggests ongoing or multiple complex service needs at a level beyond the scope of the CCS program, a referral shall be made to the CM program. All assessments and reassessments shall be conducted in person. Each assessment shall provide as much of the following information as is possible to determine:

Note: caseworkers must attempt to acquire each item of information listed below, but must also recognize and accept the client's right to refuse to provide requested items.

a. Basic Information

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

b. Functional Status

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

c. Supporting Resources

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

d. Need Identification

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

Each client shall be reassessed every six months, or as needed to determine the results of implementation of the service plan. If reassessment determines the client's identified needs have been adequately addressed, the case shall be closed.

3. A service plan shall be developed for each person determined eligible and in need of CCS. The service plan shall be developed in cooperation with and be approved by the client, client's guardian or designated representative. The service plan shall contain at a minimum:

   a. A statement of the client's problems, needs, strengths, and resources.
   b. Statement of the goals and objectives for meeting identified needs.
   c. Description of methods and/or approaches to be used in addressing needs.
   d. Identification of services and the respective time frames they are to be obtained/provided from other community agencies.
   e. Treatment orders of qualified health professional, when applicable.

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

4. Each program shall maintain comprehensive and complete case files which include at a minimum:

   a. Details of client's referral to CCS program.
   b. Intake records.
   c. Comprehensive individual assessment and reassessments.
   d. Service plan (with notation of any revisions).
   e. Listing of all contacts (dates) with clients (including units of service per client).
   f. Case notes in response to all client or family contacts (telephone or personal).
   g. Listing of all contacts with service providers on behalf of client.
   h. Comments verifying client's receipt of services from other providers and whether service adequately addressed client need.
   i. Record of all release of information about the client, signed release of information form, and all case files shall be kept confidential in controlled access files. Each program shall use a standardized release of information form which is time limited and specific as to the information being released.

5. Each case file must be assigned status in one of the following categories:

   a. Open. From initial referral or reassessment of inactive case through current activity in implementing a service plan.
   b. Closed. Client decides to discontinue service, client needs have been met, another program or agency has assumed responsibility for client, client unable to be served and referral of case is not possible, or client's death.

6. Each program shall maintain a current listing of isolated older persons, with active case files, which can be made readily available to agencies providing emergency services in the event of a disaster.

7. Each program shall employ caseworkers who have a minimum of a bachelor's degree in a human service field or who by training or experience have the ability to effectively determine an older

person's needs and match those needs with appropriate services. If the program does not employ an individual with an appropriate bachelor's degree, access to such an individual in the community shall be arranged for purposes of technical support and/or consultation. Clients with identified unmet health needs (physical and/or mental) shall be referred to an appropriate health care agency. Only one caseworker may be currently assigned to each individual case.

8. Each CCS program shall provide, as supporting services, information and assistance, and outreach. However, it is not required that such service provision be reported to OSA.

9. Program staff shall receive in-service training at least twice each fiscal year which is specifically designed to increase their knowledge and understanding of the program and clients, and to improve their skills for tasks performed in the provision of service. An individualized in-service training plan should be developed for a staff person, when performance evaluations indicate a need.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Access Services

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

Minimum Standards

1. Each agency or organization providing services to the aging to be funded or reimbursed under this service definition must have a "mission" defined in an adopted annex of the local emergency preparedness plan prepared under the provisions of the Michigan Emergency Management Act, as amended.

2. Each AAA, or local provider of aging services, must have identified alternative approaches for both responding to a disaster and undertaking appropriate activities to assist victims recover from a disaster, depending upon the resources and structures available. The same functions cited as allowable service components are performed, but the responsibility may be assigned to individuals employed by other agencies and organizations instead of hiring persons by the AAA or contracted service provider.

3. All disaster advocacy and outreach activities shall be under the supervision of an individual who has the educational and work experience necessary to help advocates determine when individuals need assistance beyond the scope of their capabilities. A team concept is acceptable.

Allowable Service Components

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Access Services

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

Minimum Standards

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

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

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

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

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

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

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

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Access Services

SERVICE NAME	Outreach
SERVICE NUMBER	A-5
SERVICE CATEGORY	Access
SERVICE DEFINITION	Efforts to identify and contact isolated older persons and/or older persons in greatest social and economic need, who may have service needs, and assisting them in gaining access to appropriate services. Outreach does not include comprehensive assessment of need, development of a service plan, or arranging for service provision.
UNIT OF SERVICE	One hour of outreach service including identification and contact of isolated older persons, assistance in their gaining access to needed services, and follow up.

Minimum Standard

1. Each program shall have a uniform intake procedure which identifies and documents client needs. Persons who appear to have multiple needs shall be referred to a case coordination and support or care management program, where available.

2. Each program shall establish linkages with I&A programs in the project area and be able to assist clients in gaining access to available services, as necessary.

3. A follow-up contact shall be made on an annual basis with at least 15 percent of individuals served to determine whether needed services have been received.

4. Each program located in areas where non-English or limited English speaking older persons are concentrated shall have bilingual personnel available. Such interpreters do not have to be paid staff persons.

5. Each program shall specify annually how it intends to satisfy the service needs of low-income minority individuals in its respective service area.

6. Each program, to the maximum extent feasible, shall provide services to low-income minority individuals in accordance with their need for such services.

7. Each program must meet the specific objectives established by the AAA for providing services to low income minority individuals within the planning and service area.

8. Each program shall identify those eligible for assistance with a special emphasis on older individuals:

   a. Residing in rural areas.
   b. With greatest economic need (with particular attention to low-income minority individuals).
   c. With greatest social need (with particular attention to low-income minority individuals).
   d. With severe disabilities.
   e. Who are Native Americans.
   f. With limited English speaking ability.
   g. With Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals).

9. Each program shall make efforts to inform the older individuals identified in Minimum Standard 8., and the caretakers of such individuals, of the availability of assistance.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Access Services

SERVICE NAME	Transportation
SERVICE NUMBER	A-6
SERVICE CATEGORY	Access
SERVICE DEFINITION	Centrally organized services for transportation of older persons to and from community facilities in order to receive support services, reduce isolation, and otherwise promote independent living.
UNIT OF SERVICE	One, one-way trip per person, or one educational session.

Minimum Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

B. GENERAL REQUIREMENTS FOR IN-HOME SERVICE PROGRAMS

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

1. Service from Other Resources

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

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

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

2. Individual Assessment of Need

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

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

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

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

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

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

Assessors must attempt to acquire each item of information listed below, but must also recognize, and accept, the client's right to refuse to provide requested items. Changes in any item should be specifically noted during reassessments. Assessments must be documented in writing, signed and dated.

Minimum information to be gathered by assessments:

a. Basic Information

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

b. Functional Status

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

c. Support Resources

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

d. Client Satisfaction (at reassessment)

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

3. Service Plan

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

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

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

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

4. In-home Supervision

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

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

5. Client Records

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

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

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

6. In-Service Training

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Chore
SERVICE NUMBER	B-1
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Non-continuous household maintenance tasks intended to increase the safety of the individual(s) living at the residence. Allowable tasks are limited to the following: • replacing fuses, light bulbs, electrical plugs, and frayed cords • replacing door locks and window catches • replacing/repairing pipes • replacing faucet washers or faucets • installing safety equipment • installing screens and storm windows • installing weather stripping around doors • caulking windows • repairing furniture • installing window shades and curtain rods • cleaning appliances • cleaning and securing carpets and rugs • washing walls and windows, scrubbing floors • cleaning attics and basements to remove fire and health hazards • pest control • grass cutting and leaf raking • clearing walkways of ice, snow and leaves • trimming overhanging tree branches
UNIT OF SERVICE	One hour spent performing allowable chore tasks.

Minimum Standards

1. Funds awarded for chore service programs may be used to purchase materials and disposable supplies used to complete the chore tasks to increase the safety of the individual. No more than $200 may be spent on materials for any one household per year. Equipment or tools used to perform chore tasks may be purchased or rented with funds awarded up to an amount equal to 10% of the total grant funds.

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

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

Minimum Standards

1. Each program must have written eligibility criteria.

2. All workers performing home care assistance services must be trained by a qualified person and must be tested for each task to be performed prior to being assigned to a client. The supervisor must approve tasks to be performed by each worker. Completion of a recognized nurses aide training course by each worker is strongly recommended.

3. Individuals employed as home care assistance workers must have previous relevant experience or training and skills in assisting with personal care needs, housekeeping, household management, good health practices, observation, and recording and reporting client information.

4. Semi-annual in-service training is required for all home care assistance workers. Required topics include safety, sanitation, emergency procedures, body mechanics, universal precautions, and household management.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Home Injury Control
SERVICE NUMBER	B-3
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Providing adaptations to the home environment of an older adult in order to prevent or minimize the occurrence of injuries. Home injury control does not include any structural or restorative home repair, chore or homemaker activities. Allowable tasks include installation or maintenance of: • enhanced lighting • ramps for improved and/or barrier-free access • bathroom chairs and grab bars • non-slip treatments • vision or hearing adaptive devices • stairway and/or hallway handrails • smoke and/or gas alarms
UNIT OF SERVICE	Installation or maintenance of one safety device in an older adult's residence.

Minimum Standards

1. Prior to initiating service, each program must determine whether a potential client is eligible to receive services available through a program supported by other funding sources, particularly programs funded through the Social Security Act. If it appears that an individual can be served through other resources, an appropriate referral should be made.

2. Each program must develop working relationships with chore, homemaker, home care assistance and home repair service providers, as available within the program area, to ensure effective coordination of efforts.

3. Each program must utilize a home environment assessment tool to formally evaluate the circumstances and needs of each client. The program may utilize the MI Choice assessment for initiating service if the client is referred by either a care management or HCBS/ED program.

4. Each program must maintain a record of safety improvements made at each residence including dates, tasks performed, materials used and cost.

5. All safety devices installed must conform to local building codes and meet respective UL® safety standards.

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Homemaking
SERVICE NUMBER	B-4
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Performance of routine household tasks to maintain an adequate living environment for older individuals with functional limitations. Homemaking does not include provision of chore or personal care tasks. Allowable homemaking tasks are limited to one or more of the following: • laundry • ironing • meal preparation • shopping for necessities (including groceries) and errand running • light housekeeping tasks (dusting, vacuuming, mopping floors, cleaning bathroom and kitchen, making beds, maintaining safe environment) • observing, reporting, and recording any change in client's condition and home environment Note: Social/emotional support of client may be offered in conjunction with other allowable tasks.
UNIT OF SERVICE	One hour spent performing allowable homemaking activities.

Minimum Standards

1. Each program must have written eligibility criteria.

2. Individuals employed as homemakers must have previous relevant experience or training and skills in housekeeping, household management, meal preparation, good health practices, observation, reporting and recording information.

3. Required in-service training topics include safety, sanitation, household management, nutrition and meal preparation.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Home Delivered Meals
SERVICE NUMBER	B-5
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	The provision of nutritious meals to homebound older persons.
UNIT OF SERVICE	One meal served to an eligible participant.

Minimum Standards

1. Each program must have written eligibility criteria which places emphasis on serving older persons in greatest need and includes, at a minimum:

   a. That to be eligible a person must be 60 years of age or older, or be the spouse of a person 60 years of age or older, or be an individual with disabilities who resides in a non-institutional household with a person eligible for and receiving home delivered meals.
   b. That to be eligible a person must be homebound; i.e., does not leave his/her home under normal circumstances.
   c. That to be eligible a person must be unable to participate in the congregate nutrition program because of physical or emotional difficulties.
   d. That to be eligible a person must be unable to obtain food or prepare complete meals.
   e. That there is no adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
   f. That the person's special dietary needs can be appropriately met by the program, i.e., the meals available would not jeopardize the health of the individual.
   g. That to be eligible a person must be able to feed himself/herself.
   h. That to be eligible a person must agree to be home when meals are delivered, or contact the program when absence is unavoidable.
   i. That the spouse, regardless of age, or unpaid caregiver (if 60 years of age or older) of an eligible client, or any individual with disabilities residing with an eligible client, may receive a home delivered meal if the assessment indicates receipt of the meal is in the best interest of the client.

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

   Eligibility criteria shall be distributed to all potential referring agencies or organizations and be available to the general public upon request.

2. Each home delivered meal program shall demonstrate cooperation with congregate and other home delivered meal programs in the program area. If the same provider operates both a congregate and a home delivered meals program for an area, it must be able to demonstrate effective utilization of existing congregate meal sites and personnel for the home delivered meal program.

3. Each program may provide up to three meals per day to an eligible client based on need as determined by the assessment. Providers are expected to set the level of meal service for an individual with consideration given to the availability of support from family and friends and changes in the participant's status or condition.

4. Each home delivered meals provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances for older adults (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Meals shall be available at least five days per week.

5. The program may also make liquid meals available to program participants when ordered by a physician. The regional dietitian must approve all liquid meal products to be used by the program. The program shall provide instruction to the participant, and/or the participant's caregiver and participant's family in the proper care and handling of liquid meals.

   When liquid meals are used to supplement a participant's diet, the physician's order must be renewed every six months.

   When liquid meals are the participant's sole source of nutrition, the following requirements must also be met:

   a. Diet orders shall include client weight and be explicit as to required nutritional content;
   b. Diet orders must be renewed, by a physician, every three months; and,
   c. The care plan for participants receiving liquid meals shall be developed in consultation with the participant's physician.

6. The program shall verify and maintain records that indicate each client receiving frozen meals has, and maintains, the ability to handle frozen meals.

7. Each program shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. Staff and volunteers shall be trained on procedures to be followed in the event of severe weather or natural disasters and the county emergency plan.

8. Each program must complete a prioritizing pre-screen for each individual placed on a waiting list for home delivered meals.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Home Health Aide
SERVICE NUMBER	B-6
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Performance of health-oriented services prescribed for an individual by a physician which may include: assistance with activities of daily living (ADL), assisting with a prescribed exercise regimen, supervising the individual's adherence to prescribed medication and/or special diets, changing non-sterile dressing, taking blood pressure, and other health monitoring activities.
UNIT OF SERVICE	One hour spent performing home health aide activities.

Minimum Standards

1. Each program must have written eligibility criteria that includes determination that the health related needs of the individual can be adequately addressed in the home.

2. After each home health aide client is reassessed, progress must be reported to the client's physician with a request for renewal of orders for the service plan.

3. In determining which providers will be selected for home health aide services, preference is to be given to certified home health agencies or agencies corporately related to a certified home health agency.

4. All aides performing home health aide services must be directly supervised by an RN. Each aide must have completed a home health aide or nurse aide training curriculum approved by the AAA and be trained for each task to be performed. The supervising nurse must approve tasks to be performed by each aide. An RN must be available for advice and consultation by telephone or otherwise at all times aides are providing service.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Medication Management
SERVICE NUMBER	B-7
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Direct assistance in managing the use of both prescription and over the counter (OTC) medication. Allowable program components include: • Face-to-face review of client's prescription and OTC medication regimen. • Regular set-up of medication regimen (Rx pills, Rx injectables, and OTC medications). • Monitoring compliance with medication regimen. • Cueing via home visit or telephone call. • Communicating with referral sources (physicians, family members, primary care givers, etc.) regarding compliance with medication regimen. • Family, caregiver and client education and training.
UNIT OF SERVICE	Each 15 minutes (.25 hours) of component activities performed.

Minimum Standards

1. Each program shall employ a registered nurse (RN) who supervises program staff and is available to staff when they are in a client's home or making telephone reminder calls. Each program shall employ program staff who are appropriately licensed, certified, trained, oriented, and supervised.

2. The supervising nurse shall review and evaluate the medication management care plan and the complete medication regimen, including prescription and OTC medications, dietary supplements and herbal remedies, with each client and appropriate caregiver.

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

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

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

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

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

4. The program shall maintain an individual medication log, for each client that contains the following information:
   - Each medication being taken;
   - The dosage for each medication;
   - Label instructions for use for each medication;
   - Level of service provided and initials of person providing service; and,
   - Date and time for each time services are provided.

5. The program shall report any change in a client's condition to the client's physician(s) immediately.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Personal Care
SERVICE NUMBER	B-8
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Provision of in-home assistance with activities of daily living (ADL) for an individual including assistance with bathing, dressing, grooming, toileting, transferring, eating, and ambulation. Personal care does not include health oriented services as specified for Home Health Aide Services.
UNIT OF SERVICE	One hour spent performing personal care activities.

Minimum Standards

1. Each program must have written eligibility criteria.

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Personal Emergency Response System (PERS)
SERVICE NUMBER	B-9
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	A service system utilizing electronic devices designed to monitor client safety and provide access to emergency crisis intervention for medical or environmental emergencies through the provision of a communication connection system.
UNIT OF SERVICE	One month of monitoring a client and each occurrence of equipment installation.
SERVICE DESCRIPTION	Personal Emergency Response Systems (PERS) are electronic devices which enable certain high risk individuals to secure help in the event of an emergency. The system may involve a portable "help" button to allow for client mobility. The system is connected to a client's telephone and programmed to signal a response center once the "help" button is activated. PERS services are limited to individuals who live alone or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and/or would otherwise require extensive routine supervision.

Minimum Standards

1. Equipment used must be approved by the Federal Communication Commission and must meet UL® safety standards specifications for Home Health Signaling Equipment.

2. Response center must be staffed 24 hours/day, 365 days/year with trained personnel. Response center will provide accommodations for persons with limited English proficiency.

3. Response center must maintain the monitoring capacity to respond to all incoming emergency signals.

4. Response center must be able to accept multiple signals simultaneously. Calls must not be disconnected for call-back or put in a first call, first serve basis.

5. Provider will furnish each responder with written instructions and provide training as appropriate.

6. Provider will verify responder and contact names semi-annually to assure current and continued participation.

7. Provider will assure at least monthly testing of the PERS unit to assure continued functioning.

8. Provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct clients and caregivers in the use of the devices, as well as to provide for performance checks.

9. Provider will maintain individual client records that include the following:

   a. Service order.
   b. Record of service delivery, including documentation of delivery and installation of equipment, client/caregiver orientation, and monthly testing.
   c. List of emergency responders.
   d. Case log documenting client and responder contacts.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Respite Care
SERVICE NUMBER	B-10
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Provision of companionship, supervision and/or assistance with activities of daily living for persons with mental or physical disabilities and frail elder persons in the absence of the primary care giver(s). Respite care may be provided at locations other than the client's residence.
UNIT OF SERVICE	Each hour of respite care provided.

Minimum Standards

1. Each program must establish written eligibility criteria that includes at a minimum:

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

2. Respite care services include:

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

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

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

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

In-Home Services

SERVICE NAME	Friendly Reassurance
SERVICE NUMBER	B-11
SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Making regular contact, through either telephone or in-home visits, with homebound older persons to assure their well being and safety and to provide companionship and social interaction.
UNIT OF SERVICE	Each contact with a homebound older person.

Minimum Standards

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

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

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

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

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

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

SERVICE NAME	Adult Day Services
SERVICE NUMBER	C-1
SERVICE CATEGORY	Community
SERVICE DEFINITION	Daytime care of any part of a day, but less than 24 hour care, for functionally and/or cognitively impaired elderly persons provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the client's home.
UNIT OF SERVICE	One hour of care provided per client.

Minimum Standard

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

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

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

   a. The individual's name, address and telephone number.
   b. The individual's age or birth date.
   c. Physician's name, address and telephone number.
   d. The name, address and telephone number of the person to contact in case of emergency.
   e. Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems.
   f. Perceived supportive service needs as expressed by the individual.
   g. Race and gender (Optional)
   h. An estimate of whether or not the individual has an income at or below the poverty level.

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

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

a. Basic Information

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

b. Functional Status

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

c. Supporting Resources

(1) Physician's name, address and telephone number
(2) Pharmacist's name, address and telephone number
(3) Services currently receiving or received in the past
(4) Extent of family and/or informal support network
(5) Hospitalization history
(6) Medical/health insurance information
(7) Long-term care insurance information
(8) Clergy name, address and telephone number

d. Need Identification

(1) Client perceived
(2) Caregiver perceived
(3) Assessor perceived
(4) Determination of whether individual is eligible for program

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

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

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

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

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

a. Details of client's referral to adult day service program.
b. Intake records.
c. Assessment of individual need or copy of assessment (and reassessments) from referring program.
d. Service plan (with notation of any revisions).
e. Listing of client contacts and attendance.
f. Progress notes in response to observations (at least monthly).
g. Notation of all medications taken on premises (including 1. the medication, 2. the dosage, 3. the date and time, 4. initials of staff person who assisted, and, 5. comments.
h. Notation of basic and optional services provided to the client
i. Notation of any and all release of information about the client, signed release of information form, and all client files shall be kept confidential in controlled access files. Each program shall use a standard release of information form that is time-limited and specific as to the information being released.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Each service center shall have the following furnishings:

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

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Dementia Adult Day Care
SERVICE NUMBER	C-2
SERVICE CATEGORY	Community
SERVICE DEFINITION	Daytime care of any part of the day, but less than 24 hours care, for older persons with dementia provided through a structured program of social and rehabilitative and/or maintenance services in a supportive or group setting other than the client's home. These standards are in addition to OSA Adult Day Services Standards.
UNIT OF SERVICE	One hour.

Minimum Standards

1. The Dementia Adult Day Care (DADC) program shall be accessible. This means the center is to be located within a convenient distance of clients' homes. The DADC should provide or arrange for transportation, if possible. All drivers and vehicles shall be appropriately licensed and insured. Each program shall develop standards regarding criteria for safe driving records of persons responsible for providing transportation. Drivers shall make every effort to provide physical assistance to persons requiring help in and out of vehicles and buildings and be trained to respond to medical emergencies.

2. All DADC participants shall have a physical exam within six months of program admission. Staff shall establish a care plan objective to work with families to obtain a current medical evaluation. The physician's written authorization and recommendations for activity participation, medication and diet shall be obtained within one month of entering DADC.

3. The program shall demonstrate evidence of outreach services to non-enrolled families through home visits, follow-up phone calls and dissemination of printed materials that clearly describe services provided by the program.

4. The program shall demonstrate evidence of providing opportunities for care givers to discuss concerns, feelings, physical care and stress management techniques via case consultation, care conferences or supportive counseling.

5. The program shall demonstrate evidence of providing care giver information and education about dementia or to assist care givers in obtaining it through referral to local self-help organizations, or dementia resource libraries regarding:

   a. Diagnosis, stages/progression of dementia conditions, aspects of Alzheimer's disease that lead to forgetfulness, misperceptions or misidentification of objects or people.
   b. Task breakdown, verbal/nonverbal communication approaches and emphasis upon areas of strength and remaining capacity.
   c. Financial, legal and placement planning considerations.

6. The program shall demonstrate awareness of and referral to other support services as needed, such as family support groups of the Alzheimer's Association, Parkinson's and Huntington's Disease Foundations; in-home, congregate and overnight respite; home-based nursing and personal care services; benefit entitlement programs; and brain autopsy services.

7. The program shall have clear provisions for ensuring the availability of crisis response services for persons with dementia and their families. If this service is not provided directly by the host agency, there is evidence of a formal arrangement with the local community mental health board or center to provide the service.

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

      (1) Illness or death of the primary care giver.
      (2) Suicidal ideation of the care giver or person with dementia.
      (3) Abusive behavior of the person with dementia or care giver; neglect or exploitation as defined by the Michigan Department of Human Services.
      (4) Adverse incident during the delivery of service.

8. DADC program staff shall be trained in crisis procedures.

   a. Staff shall notify the program supervisor of any physical or behavioral changes in a program participant or care giver that may warrant further evaluation or medical attention. Staff shall advise the care giver to seek professional consultation or medical attention for the identified concern.

9. The DADC program shall have a policy to address potential waiting lists. The program supervisor is responsible for monitoring service usage on a weekly basis and contacting families bi-monthly that may be on a waiting list, to apprize them of their status. The program shall demonstrate efforts to provide case consultation to such families to assist care givers in developing a provisional plan of care and refer them to other appropriate services, as available.

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

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

    a. Persons with a diagnosis of Alzheimer's disease or other type of dementia. Other persons who display symptoms of dementia yet have not undergone a diagnostic evaluation may be

considered for admission with the provision that written confirmation of diagnosis by a physician shall be obtained within 90 days of admission. Persons with dementia shall constitute the majority of participants.

b. Persons demonstrating significant impairments in cognition, communication and personal care activities of daily living that may require one or more of the following:

(1) Modifications in environmental cues, communication approach and task breakdown to enhance comprehension and participation in identified activities.
(2) Supervision to maintain personal safety.
(3) Hands-on assistance to perform activities of toileting, grooming, hygiene and bathing.

c. Person is responsive to redirection and other supportive verbal interventions when angry, anxious, lost or upset.
d. Person does not have an acute medical illness.
e. Person is free of communicable respiratory disease and hepatitis.
f. Client's family understands and is willing to comply with program policies related to participation in service planning, communication of status changes or planned absences, and payment of fees.

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

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

12. The DADC program shall meet the following requirements:

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

13. The program shall arrange to use program consultants, as necessary, such as medical and mental health professionals, environmental specialists and other therapists. DADC programs shall work toward developing the following as necessary:

    a. RN (or LPN under RN supervision) to provide physical health and support services a minimum of four hours/month.
    b. Social worker or certified counselor to coordinate and provide counseling and linkage for a minimum of four hours/month.
    c. Arrangements to access cognitive and psychiatric specialists to evaluate difficult behaviors and to develop alternative interventions for care givers to try.
    d. Arrangements to access physical, speech and occupational therapies.

14. The DADC programs shall have a minimum staff/volunteer/student participant ratio of 1:3. At least one staff shall be on site at all times when participants are in attendance.

15. All persons responsible for transporting clients shall have a valid driver's license or chauffeur's license, as required by the Michigan Secretary of State; a safe driving record with not more than three points; and training with valid certification in first aid and CPR.

16. All DADC programs shall have a formal staff development program.

    a. All staff shall complete an initial training program that includes content in the following areas:

        (1) Normal aging vs. Alzheimer's disease and related conditions
        (2) Impact of Alzheimer's disease and related disorders upon the person with dementia and family care givers
        (3) Communication enhancement techniques
        (4) Assessment and management of difficult behaviors
        (5) Physical care techniques related to activities of daily living
        (6) Emergency response procedures
        (7) Access to assessment, care giver information and education
        (8) Access to information and referral to other community services
        (9) Therapeutic 1:1 and small group activities
        (10) Environmental modification and home safety
        (11) Adult protective services law
        (12) Recipient rights.

    b. All personnel shall attend, at a minimum, two in-service training programs per year after completing the initial training program above.
    c. All personnel shall be required to participate in staff meetings, individual and group supervisory conferences, as scheduled, to develop their knowledge and expertise.

17. All DADC programs shall have specific training for volunteers and students:

    a. This training should include:

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Congregate Meals
SERVICE NUMBER	C-3
SERVICE CATEGORY	Community
SERVICE DEFINITION	The provision of nutritious meals to older individuals in congregate settings.
UNIT OF SERVICE	Each meal served to an eligible participant.

Minimum Standards

1. Each program shall have written eligibility criteria that places emphasis on serving older individuals in greatest need and includes, at a minimum:

   a. That to be eligible a person must be 60 years of age or older, or be the spouse of a person 60 years of age or older.
   b. Whether, at the provider's discretion, individuals with disabilities who have not attained 60 years of age but who reside in housing facilities occupied primarily by the elderly at which congregate nutrition services are provided, may receive such services.
   c. Whether, at the provider's discretion, non-senior individuals with disabilities who reside in a non-institutional household with and accompany an eligible older individual are eligible to participate on the same basis as elderly participants.
   d. Whether, at the provider's discretion, a non-senior volunteer who directly supports meal site and/or food service operations may be provided a meal. Such meals may be provided only after all eligible participants have been served and meals are available. A fee is not required for non-senior volunteer meals and such meals are to be included in NAPIS meal counts.

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

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

4. Each congregate meal site shall be able to document:

   a. That it is operated within an accessible facility. Accessibility is defined as a participant with a disability being able to enter the facility, use the rest room, and receive service that is at least equal in quality to that received by able-bodied participants. Documentation from a local building official or licensed architect is preferred. A program may also conduct accessibility assessments of its meal sites when utilizing written guidelines approved by the respective AAA.

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

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

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

6. Each site shall serve meals at least three days per week with a minimum annual average of 25 eligible participants per serving day. If the service provider also operates a home delivered meals program, home delivered meals sent from a site may be counted towards the 25 meals per day service level. Waivers to this requirement may be granted by the respective AAA only when the following can be demonstrated:

   a. Two facilities must be utilized to effectively serve a defined geographic area for three days per week.
   b. Due to a rural or isolated location, it is not possible to operate a meal site three days per week.
   c. Seventy-five percent or more of participants at a meal site with less than 25 participants per day are in great economic or social need. Such meal sites must operate at least three days per week.

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

8. When a meal site is to be permanently closed, the following procedures shall be followed:

   a. The program shall notify the respective AAA in writing of the intent to close a meal site.
   b. The program shall present a rationale for closing the meal site which is based on lack of attendance, inability to meet minimum standards and/or other requirements, loss of resources, or other justifiable reason.

c. The respective AAA shall review the rationale and determine that all options for keeping the site open or being relocated have been exhausted. If there remains a need for service in the area that was served by the meal site, efforts should be made to develop a new meal site and/or assist participants to attend another existing meal site.
d. The respective AAA shall approve in writing the closing of all meal sites operating with funds awarded from OSA and notify OSA of all meal site closings. If a meal site to be closed is located in an area where low-income and/or minority persons constitute 25% or more of the population, or if low-income and/or minority persons constituted more than 25% of meal participants served over the past 12 months, OSA must also approve in writing the closing of the meal site.
e. The program shall notify participants at a meal site to be closed of the intent to close the site at least 30 days prior to the last day of meal service.

9. Each program shall document that appropriate preparation has taken place at each meal site for procedures to be followed in case of an emergency including:

   a. An annual fire drill.
   b. Staff and volunteers shall be trained on procedures to be followed in the event of a severe weather storm or natural disaster and the county emergency plan.
   c. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency.

10. Each program shall have written agreements with the owners of all leased facilities used as meal sites. Written agreements are recommended for donated facilities, but not required. The agreements shall address at a minimum:

   a. Responsibility for care and maintenance of facility, specifically including restrooms, equipment, kitchen, storage areas and areas of common use.
   b. Responsibility for snow removal.
   c. Agreement on utility costs.
   d. Responsibility for safety inspections.
   e. Responsibility for appropriate licensing by the Public Health Department.
   f. Responsibility for insurance coverage.
   g. Security procedures.
   h. Other issues as desired or required.

11. A program may enter into an agreement with an organization operating a congregate meal site in order for that organization to receive NSIP funding for meals served to persons aged 60 and over, upon approval of the respective AAA. Any meal site receiving only NSIP funding must operate in compliance with all federal requirements and state operating standards pertaining to the congregate meal program and assure the availability of adequate resources to finance the operation of the meal site without charge to program participants. The program shall have a written agreement with each organization operating NSIP-only meal sites. This agreement shall be either OSA's standardized "Agreement for Receipt of Supplemental NSIP Cash Payment" or one that contains the same components.

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

13. Each program shall make available, upon request, food containers and utensils for participants who are blind or have disabilities.

14. Congregate meal programs receiving funds through OSA may not contribute to, provide staff time, or otherwise support potluck dining activities.

15. Each program shall have a project council, comprised of program participants, to advise program administrators about services being provided. Program staff shall not be members of the project council.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Nutrition Counseling
SERVICE NUMBER	C-4
SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of individualized advice and guidance to individuals, who are at nutritional risk because of health and/or nutritional history, dietary intake, medications use or chronic illness, about options and methods for improving their nutritional status.
UNIT OF SERVICE	One hour of advice and guidance.

Minimum Standards

1. Nutrition counseling services shall be performed by a registered dietitian.

2. Each program shall conduct an individual assessment of need for each client which includes at a minimum: nutritional history; both chronic and acute health problems; and, a listing of all prescription and over the counter medications being taken including vitamin and mineral supplements and any herbal treatments being used.

3. Each program shall develop a nutritional care plan for each client based on the individual assessment of need that includes at a minimum:

   a. A statement of the client's problems, needs, strengths, and resources.
   b. Specific goals and objectives for the client.
   c. Descriptions of methods and approaches to be used.
   d. Identification of other community resources currently being utilized by the client.
   e. Current treatment orders, if any, from client's physician including special diets and orders for liquid nutrition supplements.

4. Each program shall be able and prepared to offer services in a variety of settings including the client's residence as well as community-based settings.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Nutrition Education
SERVICE NUMBER	C-5
SERVICE CATEGORY	Community
SERVICE DEFINITION	An educational program which promotes better health by providing culturally sensitive nutrition information (which may also address physical fitness and related health issues) and instruction to participants, and/or care givers, in group or individual settings.
UNIT OF SERVICE	One educational session.

Minimum Standards

1. Nutrition education services shall be provided by, or be supervised by, a registered dietician or an individual with comparable expertise.

2. Each program shall establish linkages with local sources of information that meet the standards for accuracy and reliability as set by the American Dietetic Association. Programs may incorporate the purchase of fresh produce as a component of nutrition education services.

3. Nutrition education sessions shall be conducted at senior centers and congregate meal sites, to the extent feasible.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

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

Minimum Standards

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

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

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

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Health Screening
SERVICE NUMBER	C-7
SERVICE CATEGORY	Community
SERVICE DEFINITION	A systematic screening of an older individual's health status, supervised by a registered nurse, in order to identify and/or monitor actual and potential health problems and to determine if referral for medical intervention is indicated.
UNIT OF SERVICE	One complete health screening for each client, including referral and follow-up. Should not exceed one time per year per client.

Minimum Standards

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

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

   a. Basic Information (may be completed by client)

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

   b. Health History (can be completed by client)

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

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

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

(2) Mental and social status.

(3) Abnormal signs or symptoms observed by the RN and reported by client.

(4) Review of results of screening tests.

(5) Vision
- a. Date of last eye exam
- b. Condition of glasses
- c. Age of glasses
- d. Able to read
- e. Able to drive

(6) Hearing
- a. Date of last hearing exam
- b. Does the assessor have to shout
- c. Does the client read lips

(7) Hearing Appliance Used
- a. Condition of hearing aid
- b. Check for wax in ears

(8) Dental
- a. Date of last dental exam
- b. Condition of dental hygiene

2. Each program shall offer or otherwise provide for the following annual screening tests or procedures (a client may choose not to participate in one or more tests):
   - a. Vital signs-temperature, pulse, respiration and blood pressure.
   - b. Hemoglobin or hematocrit
   - c. Stool sample for blood detection
   - d. Height and weight
   - e. Breast exam or instruction in breast exam
   - f. Urine test
   - g. Tuberculosis skin test
   - h. Influenza immunization
   - i. Referral for mammogram and pap test as appropriate
   - j. Pneumonia vaccine
   - k. Information on prostate exams
   - l. Referral for dental exams if needed

3. Each program may offer the following annual screening tests or procedures:

   a. Tetanus and diphtheria immunizations

b. Random plasma glucose if venous blood draws are done in a non-fasting state or fasting plasma glucose if venous blood draws are done in a fasting state
c. Blood chemistry
d. Hearing test
e. Vision test
f. Glaucoma test
g. Yearly urinalysis and serum cretin

4. All health screening tests and immunizations shall be done under the on-site supervision of a registered nurse.

5. The program shall be able to offer basic health information in response to screening results and to make referrals for medical intervention as indicated.

6. A follow-up contact with the client shall be made on referrals for medical intervention within 30 days. If the client chooses not to seek medical intervention, an appropriate notation shall be made on his/her screening records. Follow-up shall be made on all annual screens.

7. Each program shall maintain complete records for each client screening including at a minimum:

a. The annual physical, social and psychological assessment
b. Results of tests
c. Immunizations received
d. Notes in response to follow-up client contact.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

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

Minimum Standards

1. Each program shall have staff who are fluent in American Sign Language and other communication modes suitable to the deaf and hearing impaired.

2. Each program shall establish linkages with other local and state-wide programs offering services to the hearing impaired and have knowledge of the deaf community culture.

3. Each program shall make services available throughout the geographic target area. Service providers must identify sites where services will be delivered and develop a schedule for site-specific service delivery.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

SERVICE NAME	Home Repair
SERVICE NUMBER	C-9
SERVICE CATEGORY	Community
SERVICE DEFINITION	Permanent improvement to an older person's home to prevent or remedy a sub-standard condition or safety hazard. Home Repair Service offers permanent restoration and/or renovation to extend the life of the home and may involve structural changes. Home repair does not involve making aesthetic improvements to a home, temporary repairs, chore or home maintenance that must be repeated. Allowable home repair tasks include: • roof repair/replacement • siding repair/replacement • door and window repair/replacement • foundation repair/replacement • floor repair/replacement • interior wall repair • plumbing and drain repair/replacement • insulating/weatherization (including water heater wrap, low-flow shower head, socket sealers, draft stoppers and door sweeps) • stair and exterior step repair/replacement • heating system repair/replacement • ensuring safe and adequate water supply • electrical wiring repair/replacement • obtaining building permits • painting to prevent deterioration in conjunction with repairs
UNIT OF SERVICE	Performance of one hour of allowable home repair tasks.

Minimum Standards

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

3. Each program shall develop working relationships with weatherization, chore and housing assistance service providers, as available, in the program area to ensure effective coordination of efforts.

4. Funds awarded for home repair service may be used for labor costs and to purchase materials used to complete the home repair tasks to prevent or remedy a sub-standard condition or safety hazard. The program shall establish a limit on the amount to be spent on any one house in a 12-month period. Equipment or tools needed to perform home repair tasks may be purchased or rented with funds from OSA up to an amount equal to 10% of total grant funds.

5. Each program shall maintain a record of homes repaired including dates, tasks performed, materials used and cost.

6. The program shall check each home to be repaired for compliance with local building codes. No repairs may be made to a condemned structure.

7. Each program shall utilize a job completion procedure which includes:

   a. Verification that work is complete and correct.
   b. Verification by a local building inspector(s) that the work satisfies building codes.
   c. Acknowledgement by the home owner that the work is acceptable, within ten days of completion.

8. The program shall utilize a written agreement with the owner (purchaser) of each home to be repaired which includes at a minimum:

   a. A statement that the home is occupied and is the permanent residence of the owner.
   b. A statement that in the event that the home is sold within two years of completion of work by the program, the owner will reimburse the program the full cost of repairs made to the home.
   c. Specification of the repairs to be made by the program is to be provided.

9. Each program shall establish and utilize written criteria for prioritizing homes to be repaired which address the condition of the home, client need and appropriateness of the requested repairs.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Legal Assistance
SERVICE NUMBER	C-10
SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of legal advice and representation by an attorney (including counseling or other appropriate assistance by a paralegal or law student under the supervision of an attorney), and counseling or representation by a non-lawyer, where permitted by law.
ALLOWABLE SERVICE COMPONENTS	**Intake.** The initial interview to collect demographic data and identification of the client's legal difficulties and questions. **Advice and Counsel**. Where the client is offered an informed opinion, possible course of action and clarifications of his/her rights under the law. **Referral**. If a legal assistance program is unable to assist a client with the course of action that he/she wishes to take, an appropriate referral should be made. Referral may also be necessary when legal services providers observe individual needs which they are unable to resolve, such as income maintenance, social service or health service needs. **Representation.** If the client's problem requires more than advice and counsel and the case is not referred to another source, the program may represent the person in order to achieve a solution to the legal problem. Representation may include legal research, negotiation, preparation of legal documents, correspondence, appearance at administrative hearings or courts of law, and legal appeals where appropriate. **Legal Research**. The gathering of information about laws, rights or interpretation of laws that may be performed at any point after intake has occurred, to resolve an individual's legal problems. Such information will be used to assist providers of legal services in counseling individuals, in representing them in hearings and a court of law, or in negotiations with potential legal adversaries.

ALLOWABLE SERVICE COMPONENTS	**Preparation of Legal Documents**. Writing documents that serve to protect individual rights, such as contracts, wills, or leases, which might later be used in a court of law. **Negotiation.** As the client's representative, program staff may contact other persons concerned with the client's legal problem in order to clarify factual or legal contentions and possibly reach an agreement to settle legal claims. **Legal Education**. Preparation and presentation of programs to inform elderly persons of their rights, the legal system, and alternative courses of legal action.
UNIT OF SERVICE	Provision of one hour of an allowable service component.

Minimum Standards

1. Each legal assistance program shall have an established system for targeting and serving those in greatest social and economic need.

2. Service shall be provided by, supervised by, or have direct contact with an attorney licensed to practice law in the State of Michigan who can perform or supervise any of the components listed above.

3. A paralegal, defined as an individual trained in accredited paralegal courses or in the specific legal service subject areas in which they will be assisting an attorney or law student, with under 30 hours of course work under the supervision and guidance of a licensed attorney, may perform any of the components listed above with the exceptions of representation in court and final review of legal documents. Although a paralegal may represent client at an administrative hearing, representation in court shall be by an attorney. Preparation of legal documents may be assigned to a paralegal. However, all finalized documents shall be reviewed and approved by an attorney.

4. Law students who have completed 30 hours of course work at an accredited law school may perform any of the service components under legal assistance acting under the guidance and supervision of a licensed attorney.

5. The program may support initiative of a class action suit when a large group of seniors are affected by a legal inequity.

6. Each program shall provide at a minimum, advice and counsel, representation and education components.

7. Each program shall demonstrate coordination with local long-term care advocacy programs operating within the project area.

8. When a legal assistance program identifies issues affecting clients which may be remedied by legislative action, such issues shall be brought to the attention of the AAA, Michigan OSA and the Michigan Legal Services legislative branch, as permissible and appropriate.

9. Each program shall provide assurance that it operates in compliance with regulations promulgated under the Older Americans Act as set forth in 45 CFR Section 1321.

10. Each program that is not part of a Legal Services Corporation project grantee shall have a system to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this definition to individuals with the greatest social and economic need.

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

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

13. Each program must give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and discrimination.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Long-Term Care Ombudsman/Advocacy
SERVICE NUMBER	C-11
SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of assistance to residents of long-term care facilities to resolve complaints through problem identification and definition, education regarding rights, provision of information on appropriate rules, and referrals to appropriate community resources. The service also involves assistance to prospective long-term care facility residents and their families regarding placement, financing and other long-term care options. Identification and sharing of best practices in long-term care service delivery, with an emphasis on promotion of the Eden Alternative, is also part of the service. Each program must provide the following elements. **Family Support**. Provision of assistance to elderly persons and their families in understanding, identifying, locating, evaluating and/or obtaining long-term care services. **Complaint Investigation/Advocacy**. Receipt, investigation, verification and attempted resolution of individual complaints from residents or others acting on their behalf regarding any action which may adversely affect the health, safety, welfare and rights of a long-term care facility resident. Complaint resolution processes include negotiation, mediation, and conflict resolution skills. This component also includes activities related to identifying obstacles and deficiencies in long-term care delivery systems and developing recommendations for addressing identified problems. **Community Education**. Provision of information to the public including long-term care facility residents, regarding all aspects of the long-term care system. This component includes formal presentations, agency consultation, activities with the print and electronic media, development of consumer information materials. **Volunteer Support**. Conduct of recruitment, training, supervision, and ongoing support activities related to volunteer advocates assigned to assist residents of identified long-term care facilities.
UNIT OF SERVICE	Each hour of family support, complaint investigation/advocacy, community education or volunteer support activities.

Minimum Standards

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

2. Each entity desiring to be designated as a local Ombudsman must be pre-qualified by the Michigan Office of the State Long Term Care Ombudsman (MOSLTCO) prior to responding to AAA's selection (request for proposal) process. The MOSLTCO will establish written pre-qualification criteria which must be met by each entity. Subsequent to pre-qualification by the MOSLTCO and the award of funds by a local AAA, each designated local Ombudsman program will adhere to program directions, instructions, and guidelines issued by the MOSLTCO in the following areas:

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

3. Each program will use the reporting system, procedures and reporting time frames specified in their contract with the AAA and as determined by OSA and the MOSLTCO.

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

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

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

7. Each program, through leadership provided by the MOSLTCO and in cooperation with the Michigan Guardianship Association, will develop and maintain relationship with public and private guardians.

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

9. Each program must establish or participate in a regional Eden Alternative support group, in cooperation with BEAM (Bringing the Eden Alternative to Michigan).

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

11. Each program must be able to demonstrate working relationships with local offices of the Department of Human Services, local Department of Consumer and Industry Services licensing and survey team, and local county public health agencies.

12. Program staff must be familiar with the complaint resolution processes of the Michigan Department of Consumer Industry Services, Department of Human Services, the Federal Office of Civil Rights, Michigan Peer Review Organization, the Michigan Office of the Attorney General's Health Care Fraud Unit, Social Security Administration and the Federal Office of the Inspector General.

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

14. Each program shall operate in compliance with Long-term Care Ombudsman program instructions, issued by OSA through transmittal letters, as required by federal and state authorizing legislation.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Senior Center Operations
SERVICE NUMBER	C-12
SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of support for the operation of a senior center. A senior center is defined as a community facility where older persons can come together for services and activities which enhance their dignity, support their independence and encourage their involvement in and with the community.
UNIT OF SERVICE	One hour of senior center operation.

Minimum Standards

1. Each senior center shall be certified as an accessible facility. Accessibility is defined as the ability of a person with a disability to enter the facility, use the restroom and receive service that is at least equal in quality to that provided to able-bodied participants.

2. Each senior center shall be open a minimum of three days per week and at least 24 hours per week.

3. Each senior center shall be a meal site for a congregate nutrition program funded through Title III, Part C, of the Older Americans Act.

4. Each senior center shall provide directly or make arrangements for the provision of the following services:

   a. Outreach
   b. Information and assistance
   c. Socialization/recreation
   d. Education
   e. Volunteer opportunities

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

5. Each senior center shall demonstrate that it is in compliance with fire safety standards and applicable Michigan and local public health codes regulating food service establishments.

6. Each senior center shall document that appropriate preparation has taken place for procedures to be followed in case of an emergency including:

   a. An annual fire drill.
   b. Posting and training of staff and regular volunteers on procedures to be followed in the event of severe weather or a natural disaster.

c. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency.

7. Each senior center shall be appropriately incorporated under Michigan law or be operated by an organization which is appropriately incorporated or a local unit of government. Each senior center should seek 501 (c)(3) tax exemption unless prohibited by the nature of its incorporation.

8. Each senior center shall strive to adhere to the Principles for the Operation of Senior Centers as established by the National Institute of Senior Centers.

9. Each senior center shall provide an opportunity for center participants to have input regarding the governance of the center at the policy making level as well as in daily operations.

10. Allowable senior center operational costs are limited to:

    a. Rent
    b. Utilities
    c. Communications
    d. Insurance
    e. Custodial services
    f. Ground maintenance
    g. Supplies

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Senior Center Staffing
SERVICE NUMBER	C-13
SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of funding to support staff positions at a senior center which may include a senior center director, a senior center program coordinator or a senior center specialist.
UNIT OF SERVICE	One hour of staff time worked.

Minimum Standards

1. Each program shall strive to adhere to the Principles for the Operation of Senior Centers as established by the National Institute of Senior Centers.

2. Where the program supports a senior center director position, the person occupying this position shall have the authority to perform administrative functions of the senior center.

3. Where the program supports a senior center program coordinator position, the person occupying this position shall be involved in the development of three or more programs at any given time.

4. Where the program supports a senior center specialist position, the person occupying this position shall oversee the operation of a variety of programs and/or services within the senior center.

5. Allowable senior center staffing costs are limited to:

   a. Wages
   b. Fringes
   c. Travel
   d. Training
   e. Supplies (not to exceed $200 for each position to be used only in support of that position).

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Vision Services
SERVICE NUMBER	C-14
SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of specialized vision services for the visually impaired and older blind persons which include: • orientation and mobility training • rehabilitation for activities of daily living (ADL)* • optometric services to help persons with severe vision loss to utilize remaining vision as effectively as possible • group education on prevention of or adjustment to visual impairment *ADL includes personal hygiene and grooming, meal preparation and kitchen safety, homemaking and leisure pursuits.
UNIT OF SERVICE	One hour of service provided or one group education session.

Minimum Standards

1. Program staff providing rehabilitation training shall have experience and be trained in communication skills including Braille, typing, handwriting, use of recording devices, telephone dialing, manual alphabet and other appropriate skills.

2. Program staff providing orientation and mobility training shall have experience and be trained in techniques, methods, and use of travel aids to visually impaired clients.

3. Optometric services shall be provided by an optometrist that has graduated from an accredited College of Optometry and is licensed to practice optometry in Michigan.

4. The program shall have a coordinator with a minimum of a bachelor degree in Blind Rehabilitation, Occupational Therapy, Rehabilitation Teaching or a related field.

5. Each vision services program shall demonstrate working relationships with other local agencies and organizations offering programs for the blind and with the Commission for the Blind of the Michigan Department of Human Services.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

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

Minimum Standards

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

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

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Counseling Services
SERVICE NUMBER	C-16
SERVICE CATEGORY	Community
SERVICE DEFINITION	Professional counseling services, provided to older adults, and National Family Caregiver Support Program (NFCSP) eligible caregivers, in order to prevent or treat problems that may be related to psychological and/or physiological dysfunction. The program may also establish peer-counseling programs that utilize older adults as volunteer counselors.
UNIT OF SERVICE	Each hour of counseling services (including direct client contact and indirect client support). [Indirect client support means information gathering, maintenance of case records, and supervisory consultation on behalf of the client.]

Minimum Standards

1. Each program shall conduct a comprehensive assessment of each client that addresses social and psychological function.

2. A treatment plan shall be developed for each client based on the comprehensive assessment. The treatment plan shall be developed in cooperation with and be approved by the client, and/or the client's guardian or designated representative. The treatment plan shall contain at a minimum:

   a. A statement of the client's problems, needs, strengths and resources.
   b. A statement of the goals and objectives for meeting identified needs.
   c. A description of the methods and/or approaches to be used.
   d. Identification of services to be obtained/provided from other community agencies.
   e. Treatment orders of qualified health professionals, when applicable.

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

3. The program may provide individual, family and/or group counseling sessions. Family members of clients are eligible for family counseling when appropriate to resolve the problems of the client.

4. The program shall have the flexibility to provide services in a range of settings, appropriate to the client's needs.

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

6. The program may use volunteer peer counselors who are appropriately trained and supervised by paid program staff.

7. The program shall assure that case supervision is available on a weekly basis for each staff counselor. All open cases shall undergo a quarterly case review by the respective staff counselor and appropriate supervisory staff.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Specialized Respite Care
SERVICE NUMBER	C-17
SERVICE CATEGORY	Community
SERVICE DEFINITION	The provision of a brief period of rest or relief from the day-to-day care giving when the community client is either a dependent family member or primary caregiver. Either the dependent family member or the primary caregiver must be 60 years of age or older. Specialized respite services provide short-term, temporary care and supervision to persons in their own homes or in out-of-home settings. Such services must be recommended by multi-purpose collaborative bodies approved by the Human Services Cabinet.
UNIT OF SERVICE	One hour of respite care provided.

Minimum Standards

1. Each program shall establish written eligibility criteria that includes at a minimum:
   a. That clients served shall be either a dependent family member or primary caregiver who is 60 years of age or older.
   b. That clients served shall be dependent family members who require continual supervision in order to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver is in need of relief or otherwise unavailable.
2. Of the funds allocated for Specialized Respite Care, the existing state formula shall be used to determine regional allocations to each county. When there are counties in the region that do not have an approved multi-purpose collaborative body, funds allocated to these counties may be re-directed to other counties at the discretion of the AAA.
3. The AAA shall serve as the fiduciary for Specialized Respite Care funds received from OSA.
4. Upon recommendation of the approved Multi-Purpose Collaborative Body, AAAs shall disburse funds for Specialized Respite Care through grant awards, contractual agreements or direct purchase of service agreements. Specific information for Specialized Respite Care program design shall be developed according to existing standards for Request for Proposals or Request for Bids and in conjunction with the approved multi-purpose collaborative body.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Caregiver Supplemental Services
SERVICE NUMBER	C-18
SERVICE CATEGORY	Community
SERVICE DEFINITION	A program intended to provide goods and services to support caregivers, including kinship caregivers, in response to needs that cannot otherwise be met.
UNIT OF SERVICE	One good or service purchased or each hour of related service provision.

Minimum Standards

1. Each program must maintain linkage with caregiver focal points, as available, within the PSA.

2. Programs may offer Caregiver Supplemental Services to caregivers of any age when the care recipient is aged 60 or over and is unable to perform at least two activities of daily living or requires substantial supervision due to a cognitive or other mental impairment. Programs may offer Caregiver Supplemental Services to individuals aged 60 and over who are kinship caregivers for a child no more than 18 years old.

3. Payments directly to family caregivers are not permitted.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

SERVICE NAME	Kinship Support Services
SERVICE NUMBER	C-19
SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of support services (which include respite care, supplemental and education, support and training services) where an individual aged 60 or over is the primary caregiver for a child no more than 18 years old. Kinship support services may be provided at locations other that the client's residence.
UNIT OF SERVICE	Each hour of support services provided, or each activity session, as appropriate.

Minimum Standards

1. Each program must establish written eligibility criteria that includes at a minimum:
   a. That the child must require support services as a result of the kinship care relationship.
   b. That the kinship caregiver must be a grandparent or relative caregiver who has a legal relationship to the child or is raising the child informally.
2. Each program shall conduct an evaluation of the care-giving situation to ensure that the skills and training of the support services worker to be assigned coincides with the situation. The program may utilize volunteer support services workers.
3. Each program must develop and maintain procedures to protect the safety and well being of the children being served by the program.
4 An emergency notification plan shall be developed for each care recipient and respective caregiver.
5. Supervision must be available to program staff at all times.

MICHIGAN OFFICE OF SERVICES TO THE AGING

Operating Standards For Service Standards

Community

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

Minimum Standards

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

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

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