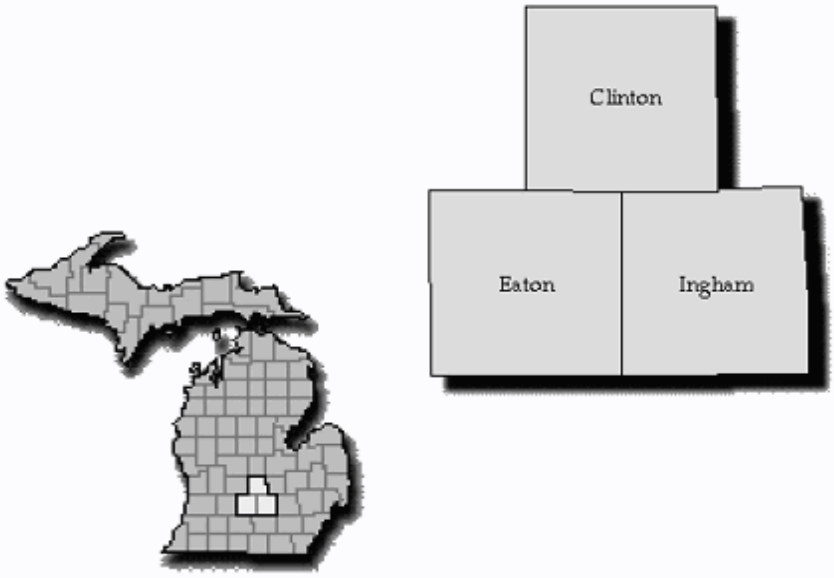
FY 2017 - 2019
MULTI-YEAR & ANNUAL IMPLEMENTATION PLAN
TRI-COUNTY OFFICE ON AGING 6



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ANNUAL & MULTI YEAR IMPLEMENTATION PLAN

FY 2017-2019

Tri-County Office on Aging **FY 2017**

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County/Local Unit of Govt. Review

The Area Agency on Aging must send a letter, with delivery and signature confirmation, requesting approval of the final Multi-Year Plan (MYP) by no later than June 30, 2016, to the chairperson of each County Board of Commissioners within the PSA requesting their approval by August 1, 2016. For a PSA comprised of a single county or portion of the county, approval of the MYP is to be requested from each local unit of government within the PSA. If the area agency does not receive a response from the county or local unit of government by August 3, 2016, the MYP is deemed passively approved. The area agency must notify their AASA field representative by August 7, 2016, whether their counties or local units of government formally approved, passively approved, or disapproved the MYP. The area agency may use electronic communication, including e-mail and website based documents, as an option for acquiring local government review and approval of the Multi-Year Plan. To employ this option the area agency must:

1. Send a letter through the US Mail, with delivery and signature confirmation, to the chief elected official of each appropriate local government advising them of the availability of the final draft MYP on the area agency's website. Instructions for how to view and print the document must be included.
2. Offer to provide a printed copy of the MYP via US Mail or an electronic copy via e-mail if requested.
3. Be available to discuss the MYP with local government officials, if requested.
4. Request email notification from the local unit of government of their approval of the MYP, or their related concerns.

Describe the efforts made to distribute the MYP to, and gain support from, the appropriate county and/or local units of government.

The Tri-County Office on Aging Administrative Board (Tri-County Aging Consortium) is made up of representatives from five local units of government: Clinton, Eaton & Ingham counties, and the cities of Lansing & East Lansing. TCOA Advisory Council older adult members are appointed by their respective local units of government. Both the Advisory Council and Board review, recommend approval of and approve the Multi-Year Plan (MYP).

TCOA sent a letter and a copy of the 2017-2019 MYP to local units of Government via certified mail and signature confirmation by June 30, 2016 requesting approval of the MYP no later than August 1, 2016. The letter will state that if a response is not received by August 3, 2016, it will then be considered passively approved.

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Plan Highlights

The purpose of the Plan Highlights is to provide a succinct description of the priorities set by the area agency for the use of Older Americans Act and State funding during FY 2017-2019. Please note there are separate text boxes for the responses to each item. The Plan Highlights must include the following:

1. A brief history of the area agency and respective PSA that provides a context for the MYP. It is appropriate to include the area agency's vision and/or mission statements in this section.
2. A summary of the area agency's service population evaluation from the Scope of Services section.
3. A summary of services to be provided under the plan, which includes identification of the five service categories receiving the most funds, and the five service categories with the greatest number of anticipated participants.
4. Highlights of planned program development objectives.
5. A description of planned special projects and partnerships.
6. A description of specific management initiatives the area agency plans to undertake to achieve increased efficiency in service delivery, including any relevant certifications or accreditations the area agency has received or is pursuing.
7. A description of how the area agency's strategy for developing non-formula resources, including utilization of volunteers, will support implementation of the MYP and help address the increased service demand.
8. Highlights of strategic planning activities.

1. A brief history of the area agency and respective PSA that provides a context for the MYP. It is appropriate to include the area agency's vision and/or mission statements in this section.

Tri-County Office on Aging (TCOA) is the Area Agency on Aging for Region 6 serving Clinton, Eaton and Ingham Counties. The Consortium is a regional Administrative Board governing TCOA and consists of elected officials representing the three counties and the cities of Lansing and East Lansing. The Consortium was established in 1974 through a regional cooperative agreement under the Michigan Urban Cooperation Act of 1967. TCOA was designated the Area Agency on Aging through the Michigan Aging and Adult Services Agency as a response to the 1973 amendments of the federal Older Americans Act. TCOA's mission is to promote and preserve the independence and dignity of the aging population. This mission is at the core of all programs and services the agency provides in its service area and the foundation of the agency's 2017-2019 Multi-Year Plan. This plan was created using the input of local seniors and persons with disabilities, staff members and members of the agency's Advisory Council and Administrative Board.

2. A summary of the area agency's service population evaluation from the Scope of Services section.

In 2004, the Tri-Counting Aging Consortium Charter was amended to include adults with disabilities in addition to older adults as a target population. Although the funds through the Older Americans Act and the Older Michiganians Act are directed to persons over age 60, TCOA has administered the Michigan Medicaid Home

and Community Based Services Waiver to the Aged and Disabled since 1992 and was one of the first three pioneer agencies for the Waiver.

Between the 2000 national census and the 2014 national census estimate, the three counties that make up TCOA's service area have seen a significant increase in the 60 and older population. In 2000 the tri-county population of adults age 60 and older was 59,807. In 2014 this population had grown to 85,737, just over 18% of the total tri-county population. This is an increase of over 25,000 seniors. TCOA has continued prioritizing services to focus on serving individuals considered high risk and needing the most assistance.

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

Proposed services to be provided under the area plan include Supportive Services, Congregate Meals, Home Delivered Meals, Caregiver Supports, Preventative Health, Elder Abuse Prevention, Access Services, In-Home Services, Respite Care, Ombudsman Services and work to secure a Community For a Lifetime in the tri-county area. The priorities identified in this Plan were developed with input from consumers, Board Members, Advisory Council and a team of staff members including directors from various departments. The Multi-Year Plan proposes to provide a blueprint for what TCOA intends to accomplish over the next three years.

Five Service Categories Receiving the Most Funds:

1. Home Delivered Meals (Meals on Wheels)
2. Congregate Meals (Senior Dining Sites)
3. Personal Care
4. Care Management
5. Homemaking

Five Service Categories with the Greatest Number of Anticipated Participants:

1. Outreach
2. Home Delivered Meals (Meals on Wheels)
3. Congregate Meals (Senior Dining Sites)
4. Information and Assistance
5. Legal Assistance

4. Highlights of planned Program Development Objectives.

With the hopes that more communities in the tri-county area will conduct an aging-friendly community assessment and apply for recognition to Aging and Adult Services Agency as a Communities For a Lifetime (CFL), TCOA would like to work to secure the City of Lansing as a recognized CFL by September 2019 and increase the number of CFLs in TCOA's Planning and Service Area.

In order to ensure older adults have access to information and services to improve their ability to make an educated decision regarding their independence, TCOA hopes to improve access to programs and services for underserved populations, expand housing assistance to increase access to community housing options, provide information about benefits and help people solve problems with health benefit programs and related insurance products, improve transportation options and usability, focusing on TCOA's consumer demographic needs, increase access to kinship care services in the tri-county area, work to advance community integration and

outreach efforts and work to advance advocacy efforts in the tri-county area.

By continuing to expand access to evidence-based disease prevention programs in the tri-county area, providing access to healthy and affordable meals to nutritionally at risk older adults, reducing unnecessary re-admittance to hospitals for high-risk adults and exploring opportunity to assist community members in securing a Senior Millage for vital unmet needs, TCOA is hoping to improve access to health, wellness and nutrition supports.

Raising awareness of domestic abuse, physical and sexual abuse and financial exploitation occurring in the older adult population and how to better respond to these situations will help the community and TCOA to protect older adults from abuse and exploitation.

With the hopes to better support individuals with dementia living in the community, as well as their caregivers, TCOA would like to work to expand access to programs and services available for individuals with Alzheimer's Disease and other forms of dementia who are residing in the community, as well as their formal and informal caregivers.

5. A description of planned special projects and partnerships.

* AARP - Partner with AARP to advance efforts to help people live easily and comfortably in their homes and communities as they age. As a result of the partnership, TCOA hopes aid in the recognition of the City of Lansing as an Age-Friendly Community by September 2019.

* Capital Area Collaborative for Care Transitions: Attend meetings with this cross-provider collaborative to reduce unnecessary hospital readmissions. Work with local hospitals, health plans and community providers on the Capital Area Community-Based Care Transitions Program to reduce hospital readmissions for high-risk Medicare beneficiaries by 20%.

* Medicare/Medicaid Assistance Program – Continue to partner with Capital Area Community Services and Disability Network Capital Area to provide MMAP services in the tri-county area. Recruit and train new MMAP volunteers including using social media and outreach to obtain new volunteers to keep up with growing demand from the changing health care system.

* Evidence-based programs – Strengthen partnerships with health plans, physician groups and community organizations to expand implementation of evidence-based programs.

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

TCOA is continually searching out methods to improve efficiency and save money. Some ways the agency is working on improving efficiency include:

* Careful shopping of all agency purchases and holding off on non-essential purchases
* Negotiating better contract with vendors
* Continue with lower cost IT service provider
* Migration to internal file servers
* Convert telephones lines to fiber connection

Although TCOA is not intentionally seeking the various accreditations, in FY 2015 TCOA worked through an outside vendor to promote and provide Matter of Balance and Personal Action Toward Health classes. The program also moved forward with the Medicare application process and securing a dietitian in order for TCOA to become accredited.

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

Each year over 1,600 individuals volunteer with TCOA and contribute over 43,000 hours of service. These hours are the equivalent of over 28 full time employees. TCOA's Meals on Wheels program could not run without the generosity of these volunteers. The local Medicare/Medicaid Assistance Program also is a beneficiary of many of these service hours and was able to assist over 2,300 tri-county residents last year because of this support. Finally, TCOA supplements its state and local funding with grant writing and fundraising activities throughout the year. New fund development staff will build on the success of FY 2016 by continuing to identify and explore additional funding opportunities. These activities help to pay for additional client services and office supplies and equipment that the agency could not otherwise afford.

8. Highlights of strategic planning activities.

Strategic planning and prioritizing is essential in continuing to provide quality, person-centered programs and services in an efficient and effective way. All strategies to reduce agency expenditures are explored while reducing services, primarily in-home supports, would be the last avenue. TCOA prides itself on putting the client's need above all else and recognizes that seniors are aging in place, want to be more active, and are using or wanting to use technology more. The agency hopes to always be relevant and timely with technology upgrades and implementations. Contingency plans are continually reviewed and revised as new challenges and opportunities arise throughout the year. TCOA will utilize community partnerships and interactions with the Advisory Council and county Human Service Collaborations/Interagency councils to continually gather input and feedback as the agency moves forward with considering new ideas and proposed new initiatives.

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Public Hearings

The area agency must employ a strategy for gaining MYP input directly from the following: the planned service population of older adults, caregivers and persons with disabilities, elected officials, partners, providers and the general public. The strategy should involve multiple methods and may include a series of input sessions, use of social media, online surveys, etc.

At least two public hearings on the FY 2017-2019 MYP must be held in the PSA. The hearings must be held in an accessible facility. Persons need not be present at the hearings in order to provide testimony: e-mail and written testimony must be accepted for at least a thirty (30) day period beginning when the summary of the MYP is made available.

The area agency must post a notice of the public hearing(s) in a manner that can reasonably be expected to inform the general public about the hearing(s). Acceptable posting methods include, but are not limited to: paid notice in at least one newspaper or newsletter with broad circulation throughout the PSA; presentation on the area agency's website, along with communication via e-mail and social media referring to the notice; press releases and public service announcements; and a mailed notice to area agency partners, service provider agencies, Native American organizations, older adult organizations and local units of government. The public hearing notice should be available at least thirty (30) days in advance of the scheduled hearing. This notice must indicate the availability of a summary of the MYP at least fifteen (15) days prior to the hearing, and information on how to obtain the summary. All components of the MYP should be available for the public hearings.

Complete the chart below regarding your public hearings. Include the date, time, number of attendees and the location and accessibility of each public hearing. Please scan any written testimony (including e-mails received) as a PDF and upload on this tab. A narrative description of the public input strategy and hearings is also required. Please describe the strategy/approach employed to encourage public attendance and testimony on the MYP. Describe all methods used to gain public input and the resultant impact on the MYP.

Date	Location	Time	Is Barrier Free	No. of Attendees
05/12/2016	Tri-County Office on Aging	01:00 PM	Yes	20
05/23/2016	Delta Township Enrichment Ce	11:00 AM	Yes	3

Narrative:

TCOA initiated a needs assessment process in February, and through a series of community forums and surveys has gathered information on how the agency can better serve older adults in the community. Press releases regarding the dates, times and locations of the community forums were communicated with local news organizations.

A needs assessment survey focusing on individuals 55 and older, as well as persons with disabilities, was

distributed during February, March and April 2016. Over 150 responses to this survey were received. Reviewing the results of this survey it was clear that the 2017-2019 multi-year plan needed to focus on a few key areas.

The data from the Needs Assessment Surveys showed the vast majority of respondents were over 60 years old, retired, living with a spouse/partner or alone. From the respondents tallies, the top 5 services most critical to seniors over the next three years are Caregiver Supports, Chore Services, Senior Centers, Home Delivered Meals, and Food/Nutrition Programs. Respondents expressed the desire for greater access to information and Adult Day Care. Well over half of the respondents were in favor of a Senior Millage. More respondents are unable to access basic needs without their own car than those who can access basic needs without their own car. Most respondents did not experience a barrier to receiving services, however those who did experience barriers reported unable to find information, cost or other reasons as to why they were unable to receive a service. Most respondents expressed interest in Alzheimer's/Dementia education or Exercise/Fitness classes if they were offered for free in the tri-county area. Most felt there needed to be more options for safe, accessible and affordable housing option in the tri-county area such as Assisted Living Facilities, Independent Living Facilities including affordable housing that is non-subsidized, Subsidized Housing for those under 62 with disabilities and also for seniors, as well as Retirement Villages or Communities. Cost and availability were the top barriers listed in finding safe and affordable housing in the tri-county area.

The Tri-County Office on Aging also dedicated a significant portion of the needs assessment to caregiving. The organization understands that non-professional caregivers caring for family and friends play a very important role in keeping individuals safe and happy in the community. These individuals also can give a unique perspective on what they need to continue caregiving and what the person they are caring for needs. 32 caregivers completed the needs assessment survey. The data from the Needs Assessment Surveys showed the vast majority of respondents are either an adult child caring for a parent or a spouse/partner. Caregivers were often responsible for assisting their care recipient with multiple activities of daily living and errands, as well as providing companionship and social interaction. Just over half of the care recipients were reported as having Alzheimer's or Dementia. Respondents expressed the desire for greater access to information and Adult Day Care services.

In addition to conducting two needs assessment surveys, 16 Community Forums were held across the tri-county area; 10 in Ingham County, including one in Spanish, 3 in Clinton County and 3 in Eaton County. From these forums it was obvious that across the three counties, transportation and the lack of information or access to information were the two most prominent barriers to getting programs and services. All locations mentioned public transportation is their main source of travel, however, the experience is not enjoyable as the service is not user-friendly. Most locations would like to have increased access, with little to no cost, to exercise/fitness classes. Residents in Ingham County expressed a need for little to no cost chore service providers. Most attendees did not feel their community was age friendly. A majority of respondents were in close proximity to healthy foods, but only for part of the year or had little to no access to transportation to get to the healthy food. Many locations expressed great interest in participating in games, puzzles and community outings or events. Also identified is a lack of Spanish Speaking senior centers in the tri-county area.

Finally, two public hearings were held to solicit input on the MYP draft objectives. The public hearings were announced at TCOA's Advisory Council and Administrative Board April meetings and posted on TCOA's

website, Facebook page and also posted in community newspapers. One public hearing was held at the main offices for the Tri-County Office on Aging in Lansing, MI. This hearing was held on May 12, 2016 at 1:00 P.M. prior to the monthly Tri-County Office on Aging Advisory Council meeting. The second public hearing was held at the Delta Township Enrichment Center on May 23, 2016 at 11:00 A.M. Great interest was shown toward the Medicare Medicaid Assistance Program (MMAP) and attendees at the Delta Township Enrichment Center expressed interest in hosting opening enrollment at their location. A suggestion for exploration of community efforts included intergenerational playgrounds. Individuals in attendance were pleased to see the inclusion of Evidence Based Disease Programs and continuation of a health and wellness initiative in the area plan. Attendees also agreed transportation needs are obvious at the local level.

No written comments were received on the MYP before, during, or in the 30 day period after our public hearings.

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Scope of Services

The number of potentially eligible older adults who could approach the area agency's coordinated service system are increasing because of the age wave explosion. Additionally, the quantity and intensity of services that the area agency and its providers are expected to arrange, coordinate and provide for new and existing service populations are increasing. There is an exponentially growing target population of the "old-old" (85-100 +) who often present with complex problems, social and economic needs and multiple chronic conditions. They require more supports coordination and care management staff time to assess, provide service options, monitor progress, re-assess and advocate for the persons served and their caregivers. Area agency partnerships with the medical and broader range of long term care service providers will be essential to help address these escalating service demands with a collective and cohesive community response.

A number of these older individuals with complex needs also have some form of dementia. The prevalence of dementia among those 85 and older is estimated at 25-50%. The National Family Caregiving Program (Title III E funding) establishes "*Caregivers of older individuals with Alzheimer's disease"* as a priority service population. Area agencies, contracted providers and the broader community partners need to continually improve their abilities to offer dementia-capable services to optimally support persons with dementia and their caregivers.

Enhanced information and referral systems via ADRCs, 211 Systems, and other outreach efforts are bringing more potential customers to area agencies and providers. With emerging service demand challenges it is essential that the area agency carefully evaluates the potential, priority, targeted and unmet needs of its service population(s) to form the basis for an effective PSA Scope of Services and Planned Services Array strategy. Provide a response to the following service population evaluation questions to document service population(s) needs as a basis for the area agency's strategy for its regional Scope of Services.

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

Between the 2000 national census and the 2014 national census estimate, the three counties that make up TCOA's service area have seen a significant increase in the 60 and older population. In 2000, the tri-county population of adults age 60 and older was 59,807. In 2014, this population had grown to 85,737, over 18% of the total tri-county population. This is an increase of over 25,000 seniors. TCOA has continued prioritizing services to focus on serving individuals considered high risk and needing the most assistance.

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

There are currently several areas of need that have been identified by Tri-County Office on Aging within the

agency's service area. First, there is a need for programs that specialize in serving minority and non-English speaking populations. Currently, there is a community center in Lansing that focuses on serving the Spanish-speaking, Hispanic population in the area. However, this organization alone is not enough to meet the needs of other minority and non-English speaking groups in the area.

Second, there is a need for improved transportation services within the tri-county area. It was identified that this is especially needed for individuals who are seeking transportation that crosses the county borders. Multiple individuals, as well as the needs assessment data and community forum responses, identified that crossing the county lines to seek programs and services, including routine medical assistance, can be very cumbersome and time consuming to coordinate and individuals limit their activities due to this burden.

Finally, there is an increasing need for services to serve individuals with middle and late stage Alzheimer's disease and dementia. At this time, no adult day services programs serve these high-needs individuals, except the PACE Program. Serving this population would not only ensure that the individuals participating in programs have adequate and safe care, it would also significantly assist the family and friends who are acting as caregivers. Relieving the stress associated with care giving will help to ease caregiver burn-out and allow for more individuals to remain living in the community.

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

In the Region 6 planning and service area (Clinton, Eaton and Ingham counties) several populations have been identified as being underserved. These populations include racial minorities, non-English speaking individuals, and caregivers caring for individuals with Alzheimer's disease or dementia.

In order to better serve racial minorities and non-English speaking individuals, TCOA would like to facilitate connections with culturally and/or linguistically specific community based organizations. It is also the agency's desire to work to resolve cultural competency issues impacting underserved local seniors and persons with disabilities, including non-English speaking and Lesbian, Gay, Bisexual and Transgender individuals. In order to help improve access to health, wellness and nutrition supports, TCOA will seek out community organizations that serve minorities and underserved populations as partners to offer these programs to otherwise overlooked individuals. Additionally, efforts will be focused on expanding SAVVY/Creating Confident Caregivers training to reach more caregivers of minority populations.

In order to better serve non-professional caregivers who are caring for loved ones with Alzheimer's Disease and dementia, TCOA would like to work to expand access to programs and services available for individuals with Alzheimer's Disease and other forms of dementia who are residing in the community, as well as their formal and informal caregivers. During FY 2017-2019, TCOA would like to maintain the Resource Directory for Caregivers with an emphasis on dementia supports in partnership with other community organizations. Opportunities for persons with dementia to receive personal music therapy will be explored as well as partnering with AASA and AAAAM to secure funding for evidence-based programs relating to dementia.

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

Although TCOA has no formal protocols, informal conversations held by the I&A Specialist and Options Counselor parallel many of the protocol topics in the ACL/AoA *Dementia Capability Quality Assurance Assessment Tool* and could be developed into formal protocols. TCOA has piloted an assessment tool, AD-8, and there are hopes to implement this or a similar tool in the future. Through the conversations previously mentioned, caregivers often self-identify. TCOA currently has two (2) Master Trainers that did receive formal training on dementia. In addition, some employees choose to participate in continuing education classes/seminars related to dementia care. Regarding component #3 in the Assessment Tool, TCOA does have dementia specific service providers; however, TCOA cannot endorse one provider over another. There is a list of all providers available to clients and some providers on that list provide dementia-specific care. Some areas for improvement would be training more staff on dementia and/or cognitive impairments and also creating a systematic process to inform staff/support coordinators of providers related to dementia care. The need for caregiver supports is growing. TCOA is open to implementing processes to help accommodate this on-going need.

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

Every request that is made to TCOA is addressed using a person-centered process. Staff members listen to individuals and their expressed needs and wants and work to find a way to fulfill them. Not every service needed or requested can be funded or provided by TCOA. In order to better support individuals, TCOA has an active I&A program and Community Resource Directory that can help connect individuals with the programs and services requested. Additionally, TCOA staff work closely with staff members in other organizations and agencies to more efficiently utilize resources and cross-refer between programs. Finally, when a person is looking for more in-depth assistance, TCOA employs an Options Counselor that is available to work with the individual, and the support persons of their choice, to create a person-centered plan.

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

Strategic planning and prioritizing is essential in continuing to provide quality person-centered programs and services in an efficient and effective way. This means prioritizing services to the most vulnerable individuals who are at-risk of institutional placement. This could involve shifting funds from one program to another, where allowable. All strategies to reduce agency expenditures are explored while reducing services, primarily in-home supports, is the last avenue. This requires creative and strategic planning, which can be daunting, but is preferable to reducing consumer services. Contingency plans are continually reviewed and revised as new challenges and opportunities arise throughout the year.

MDHHS requires the use of their priority system for individuals on the waiting list for MI-Choice services. For the Care Management program, potential clients are put on a waiting list by order in which they contacted the agency if they do not meet any of the criteria set forth in the MDHHS system. Individuals on the waiting lists

have the opportunity to have Personal Emergency Response Systems (PERS) provided to them. Additionally, individuals on waiting lists for in-home services receive a call quarterly from TCOA staff to monitor changes in health status and needs. Referrals are made to the local PACE Program (Community Care of Michigan) and to DHHS Home Help Program.

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

TCOA tries to focus on individuals who are most vulnerable. Some are at risk for nursing facility placement or may have a social or economic need. Some examples include those who are low-income or live in a rural area. The intake specialist works with Information & Assistance (I&A) to assist those to be found ineligible for Care Management. They offer I&A on community resources and alternatives to the Care Management program. As with other I&A situations the individuals are referred to other programs and services as appropriate and Options Counseling based on the approved ADRC standards.

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

The Advisory Council is very supportive of current prioritization methods and service strategies as detailed above. There are no recommendations or concerns from the Advisory Council in regards to these matters at this time.

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

TCOA is proactive in reaching out in the community with information, education and prevention methods. Efforts include Options Counseling, Information and Assistance, MMAP and Evidence Based Programs. Options Counseling offers older adults and their caregivers assistance in planning to meet their long term supports and service needs before or as they arise for individuals to remain in the community as they age. Information & Assistance staff provide information on topics related to older adults and persons with disabilities, such as in-home services, community resources, and housing information, and directs callers to appropriate agency programs. This information can aid in the preparation of services for aging adults.

Michigan Medicare/Medicaid Assistance Program counselors can help individuals understand Medicare & Medicaid, enroll in Medicare prescription drug coverage, review supplemental insurance needs, apply for Medicare Savings programs, identify and report fraud and abuse or scams, and explore long term care insurance.

Evidence-based programs include Advanced Care Planning, Personal Action Toward Health (PATH), Diabetic Personal Action Toward Health (D-PATH), Matter of Balance (MOB), SAVVY/Creating Confident Caregivers, Care Transitions and Medical Nutrition Therapy. Advanced Care Planning discussions are intended to provide, enhance, and improve end-of-life health care through practice, education, evaluation, research, and consultation specifically related to advance care planning, ethics, and medical humanities, including the Investigational Review Board. PATH is a self-management program for persons with chronic disease to help them take control of their own disease process using the Stanford Model. D-PATH is an accredited self-management program to help diabetic persons take control of their own disease process using the Stanford Model. MOB is a structured group intervention proven to help older adults reduce their risk of falling and assist in working to overcome the fear of falling. SAVVY/Creating Confident Caregivers is a six-week education series for caregivers of persons with dementia. Content focuses on understanding the disease, caregiver self-care to prevent burnout and providing structure and support for the person with dementia. Respite care is provided. Care Transitions is a social work program aimed at decreasing unnecessary hospital admissions by addressing the psycho-social determinants of health care. Medical Nutrition Therapy (MNT) is defined as the use of specific nutrition services to treat an illness, injury, or condition and involves two phases: 1) assessment of the nutritional status of the client and 2) treatment, which includes nutrition therapy, counseling, and the use of specialized nutrition supplements. Evidence exists demonstrating that MNT can improve clinical outcomes while possibly decreasing the cost of managing diabetes to Medicare.

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Planned Service Array

Complete the 2017-2019 MYP Planned Service Array form for your PSA. Indicate the appropriate placement for each AASA service category and regional service definition. Unless noted otherwise, services are understood to be available PSA-wide. There is a required narrative related to the Planned Service Array in the following section. The narrative should describe the area agency's rationale/strategy for selecting the services funded under the MYP in contrast to services funded by other resources within the PSA, especially for services not available PSA-wide.

	Access	In-Home	Community
Provided by Area Agency	• Care Management • Case Coordination and Support • Information and Assistance • Outreach • Transportation	• Home Delivered Meals	• Congregate Meals • Disease Prevention/Health Promotion • Caregiver Education, Support and Training
Contracted by Area Agency	• Information and Assistance • Transportation	• Chore • Home Care Assistance • Home Injury Control • Homemaking • Home Health Aide • Medication Management • Personal Care • Assistive Devices & Technologies • Respite Care	• Adult Day Services • Disease Prevention/Health Promotion • Home Repair • Legal Assistance • Long-term Care Ombudsman/Advocacy • Programs for Prevention of Elder Abuse, Neglect, and Exploitation • Counseling Services • Kinship Support Services
Participant Private Pay	• Transportation	• Chore • Home Care Assistance • Home Injury Control • Homemaking • Home Delivered Meals • Home Health Aide • Medication Management • Personal Care • Assistive Devices & Technologies • Respite Care	• Adult Day Services • Nutrition Counseling • Nutrition Education • Health Screening • Assistance to the Hearing Impaired and Deaf • Home Repair • Legal Assistance • Vision Services

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Funded by Other Sources	• Disaster Advocacy and Outreach Program	• Friendly Reassurance	• Disease Prevention/Health Promotion • Assistance to the Hearing Impaired and Deaf • Home Repair • Legal Assistance • Senior Center Operations • Senior Center Staffing • Programs for Prevention of Elder Abuse, Neglect, and Exploitation • Kinship Support Services

* Not PSA-wide

Planned Service Array Narrative

Describe the area agency's rationale/strategy for selecting the services funded under the Multi-Year Plan in contrast to the services funded by other resources within the PSA, especially for services not available PSA wide.

The Planned Services Array diagram serves as a snapshot of how programs and services will be provided in Region 6. However, the array does not explain the reasoning for why programs and services are formatted in such a manner. There are several unique characteristics about TCOA's region that shape the way programs and services are made available.

There are no programs or services funded by local millages because there are no senior millages in Clinton, Eaton or Ingham Counties at this time. Because TCOA is legally a consortium of the counties and the Cities of Lansing and East Lansing each of these municipalities contribute consortium dues to the agency that help meet match requirements and cover some administration costs. Most programs and services are available in the service area via contracts to service providers. Additionally, many of these programs are also available via private pay to individuals who are able to afford accessing these services on their own.

TCOA directly provides both Home Delivered Meals and Congregate Meals. This is due to the fact that no organization has responded to the Request For Proposal process for these programs that occurs every three years. Due to this the Michigan Office of Services to the Aging (now Aging and Adult Services Agency/AASA) asked TCOA to assume this role in 1976 and the agency has done so since this time. However, TCOA does continue to solicit for proposals regularly to provide this service.

TCOA directly provides Creating Confident Caregivers classes in the service area. Several years ago TCOA had a grant from the Michigan Office of Services to the Aging (now AASA) to directly provide these classes. When the grant expired the demand for the program continued and TCOA received permission to continue providing these classes directly.

TCOA does not actively fund disaster advocacy and outreach programs in the service area because each county, as well as the City of Lansing, have active emergency management groups that receive funding from other sources and TCOA participates in.

There are several senior centers in the region, however, these programs are funded through sources outside of TCOA. In-home services that are being "Contracted by the Area Agency", along with Home Repair and Counseling Services are provided under the umbrella of Community Living Supports Services which is a regional service definition in this plan.

Services funded under the multi-year plan are intended to help prevent or delay the onset of Nursing Home eligibility. Services funded by other resources are intended for those with higher levels of care, including those Nursing Home eligible. As always, TCOA strives to maintain access to services that allow PSA residents to remain as independent as possible.

Strategic Planning

Strategic Planning is essential to the success of any area agency on aging in order to carry out its mission, remain viable and capable of being customer sensitive, demonstrate positive outcomes for persons served, and meet programmatic and financial requirements of the payer (AASA). All area agencies are engaged in some level of strategic planning, especially given the changing and competitive environment that is emerging in the aging and long-term-care services network. Provide responses below to the following strategic planning considerations for the area agency's MYP.

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

Strategic planning and prioritizing is essential in continuing to provide quality person-centered programs and services in an efficient and effective way.
Agency strengths include providing person-centered supports, over 40 years of service, being a leader in advocacy at the local and state/regional levels, participating as a pilot for new programs (AASA and Medicaid), longevity of leadership, recognized as the Govenor's prosperity region due to regional cooperation, debt bond due to expire in 2017 and continued efforts to reduce expenses. TCOA also prides itself on putting the client's need above all else, being fiscally responsible and secure, executing effective advocacy, and providing a viable pension for employees. Clients feel well-served due to TCOA's customer service, being able to talk to a live person instead of a recording, timely responses from staff and good follow-up.

Agency weaknesses or areas for improvement include increased access to info, service access for non-English speaking populations, expanded caregiver supports/services, user-friendly website, and enriched media relations. The community forum participants voiced many are unaware of services available through TCOA due to lack of access to information. This also translates to lack of visibility in community. Clients may feel unsatisfied due to continued wait lists for specific programs and services. Quality assurance surveys have been completed by existing clients and one factor mentioned that made them feel dissatisfied was the need for more service hours.

Agency opportunities that have been identified include creating a Community Health Worker/Resource Navigator position, collaboration with physician groups, Michigan Transportation Connection, Refugee Services and Development Center, etc., improve outcome reports, and explore the opportunity to assist community members in securing a Senior Millage for the tri-county area. Trends that have been identified include the senior population explosion due to aging baby boomer constituents. TCOA has also recognized that seniors are aging in place, want to be more active, and are using or wanting to use technology more. Additionally, the minimum wage increase promotes a more stable workforce and alludes to easier staff recruitment. Same sex marriage has offered and will continue to offer the opportunity for education and training staff.

Agency threats or obstacles include lack of user-friendly transportation, funding received in relation to demand and the expansion of managed integrated care would threaten the MI Choice Medicaid Waiver, locally Project Choices. The quality standards or specifications for your job, products or services that are

changing include the minimum wage increase causing a strain on funding and budget, as well as an interest in increased HIPAA compliance and educating staff and providers on best practices.

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

The implementation of the new Medicare/Medicaid integrated health system, Mi HealthLink, could potentially cause a huge reduction in services for the agency due to the loss of the Waiver. This could include staff reduction and client reduction while increasing the demand and output of services like Information and Assistance and Evidence Based Programs, including Care Transitions. Health plans could theoretically buy services through the agency and would allow TCOA to develop a relationship with MI Health Link and contractors. The AAA association is working on enhancing collaboration and contractual arrangments with integrated care organizations.

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

As previously explained, strategic planning and prioritizing is essential in continuing to provide quality person-centered programs and services in an efficient and effective way. All strategies to reduce agency expenditures would be explored while reducing services, primarily in-home supports, would be the last avenue. A 10% reduction in funding from AASA could result in shifting funds from one program to another, where allowable. The Nutrition program through TCOA could require a reduction in operations and the possibility of contracting or partnering with outside vendors. Additionally, employees would not receive a cost of living wage adjustments, as has been done in the past. Contingency plans are continually reviewed and revised as new challenges and opportunities arise throughout the year.

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

TCOA recently became Medicare certified to secure reimbursement for D-PATH and other Medicare covered services. In FY 2015, TCOA worked through an outside vendor to promote and provide Matter of Balance and Personal Action Toward Health classes. TCOA also possesses the American Association of Diabetes Educators (AADE) certification allowing the agency to bill Medicare for diabetes self-management programs.

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

TCOA recognizes the need for technological assimilations into programs, services, operations and client relations. Some things TCOA will continue and improve upon are offering the Quality Assurance and Quality Improvement surveys electronically and the use of electronic records and databases in the field allowing the agency to be more HIPAA compliant and efficient. Some areas that TCOA hopes to explore and evolve are outcome reports from existing databases such as NAPIS, MICIS and I&A databases. The agency hopes to always be relevant and timely with technology upgrades and implementations.

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Regional Service Definitions

If the area agency is proposing to fund a service category that is not included in the Operating Standards for Service Programs, then information about the proposed service category must be included under this section. Enter the service name, identify the service category and fund source, include unit of service, minimum standards, and rationale for why activities cannot be funded under an existing service definition.

Service Name/Definition

Crisis Services for the Elderly - Assistance paying for such things as a utility bill, prescription medications and emergency shelter with a maximum of $200 spent per unduplicated client each fiscal year.

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

This program is designed to assist individuals in facing non-medical emergencies, specifically prescription, shelter and utility crises. Assistance is limited to a maximum $200 per person per fiscal year and individuals never directly receive money. This program serves as a vital role in helping to keep individuals living in the community and does not fit with any current AASA service definitions. During the 2015 fiscal year, over 600 individuals were served by this program.

Service Category	Fund Source			Unit of Service
☐ Access	☑ Title III PartB	☐ Title III PartD	☐ Title III PartE	One unit equals one individual served.
☐ In-Home	☐ Title VII	☐ State Alternative Care	☐ State Access	
☑ Community	☑ State In-home	☐ State Respite		
	☑ Other Fundraising			

Minimum Standards

1. This service will provide assistance to individuals sixty years of age and older living in Clinton, Eaton or Ingham counties.
2. Program staff shall assess each request for assistance through the Crisis Services for the Elderly process by obtaining name, address, phone number, utility bill information and other resources the individual has approached for assistance.
3. The program shall maintain linkages with Information and Assistance programs, utility companies, local Department of Human Services and other local agencies that provide assistance for utilities.
4. The program shall develop a network of community resources to refer individuals to when other needs are identified.
5. Program staff shall be knowledgeable of community resources and have the ability to share information in a manner which empowers individuals and/or their family.

Service Name/Definition

Community Living Services (CLS) - CLS facilitate an individuals independence and promote reasonable participation in the community. CLS can be provided in the participant's residence or in community settings as necessary in order to meet support and services needed sufficient to meet nursing facility level of care needs.

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

This service provision will facilitate the seamless delivery of supports and services to clients regardless of the payment source being used.

Service Category	Fund Source			Unit of Service
☑ Access ☐ In-Home ☐ Community	☑ Title III PartB ☐ Title VII ☐ State In-home ☐ Other _____	☐ Title III PartD ☐ State Alternative Care ☐ State Respite	☐ Title III PartE ☐ State Access	Comprehensive Community Support Services - per

Minimum Standards

Traditional Service:

1. Each direct service provider must have written policies & procedures compatible with General Operating Standards for Waiver Agents & Contracted Direct Service Providers, & minimally, Section A of General Operating Standards for MI Choice Waiver Service Providers.
2. Community Living Services (CLS) include:

a. Assisting, reminding, cueing, observing, guiding &/or training in the following activities: (i) meal prep; (ii) laundry; (iii) routine, seasonal, & heavy household care & maintenance; (iv) activities of daily living such as bathing, eating, dressing & personal hygiene &, (v) shopping for food & other necessities of daily living.

b. Assistance, support, &/or guidance with: (i) money management; (ii) non-medical care (not requiring nursing/physician intervention); (iii) social participation, relationship maintenance, & building community networks to reduce personal isolation; (iv) transportation (excluding to & from medical appointments) to & from participant's residence & community activities; (v) participation in regular community activities incidental to meeting individual's community living preferences; (vi) attendance at medical appointments, (vii) procuring goods & services necessary for home & community living.

c. Reminding, cueing, observing &/or monitoring of medication administration.

d. Staff assistance with preserving the health & safety of the individual in order that he/she may reside & be supported in the most integrated independent community setting.

3. When transportation incidental to provision of CLS is included, the Area Agency on Aging (AAA) shall not also authorize it as a separate service for participant. The Medicaid state plan covers transportation to medical appointments through Department of Health and Human Services & AAA shall not authorize the same as a component of CLS.
4. CLS excludes costs associated with room & board.
5. AAA shall authorize CLS when necessary to prevent institutionalization of participant served.
6. AAA cannot provide CLS where service duplicates services available under Medicaid state plan, through MI Choice waiver, or elsewhere. When more than one service is included in participant's plan of care, AAA must clearly distinguish services by unique hours & units approved.
7. Individuals providing CLS must be at least 18 years of age, have the ability to communicate effectively both orally & in writing & follow instructions.
8. Members of a participant's family, excluding participant's spouse, may provide CLS to participant.
9. Family members who provide CLS must meet same standards as providers who are unrelated to individual.
10. AAA &/or provider agency must train each worker to properly perform each task required for each participant before service delivery. Supervisor must assure each worker can competently & confidently

perform every task assigned for each participant served.
11. When CLS services provided to participant include tasks specified in 2.a.i, 2.a.ii, 2.a.iii, 2.a.v, 2.b.i, 2.b.iii, 2.b.v, 2.b.vi, 2.b.vii, or 2.d above, individual furnishing CLS must have previous relevant experience or training & skills in housekeeping, household management, good health practices, observation, reporting, & recording information. Also, skills, knowledge, &/or experience with food prep, safe food handling procedures, & reporting & identifying abuse & neglect are highly desirable.
12. When CLS services provided to participant include tasks specified in 2.a.iv, 2.b.ii, 2.c & 2.d above, direct service providers furnishing CLS must also:
a. Be supervised by a registered nurse (RN) licensed to practice nursing in the State of Michigan. At the state's discretion, other qualified individuals may supervise CLS providers. Supervisor shall be available to direct care worker at all times worker is furnishing CLS services.
b. Develop in-service training plans & assure all workers providing CLS services are confident & competent in the following areas before delivering CLS services to program participants, as applicable to needs of that participant: safety, body mechanics, & food prep including safe & sanitary food handling procedures.
c. Provide an RN to individually train & supervise CLS workers who perform high-level, non-invasive tasks such as maintenance of catheters, feeding tubes, minor dressing changes, & wound care for each participant who requires such care. Supervising RN must assure each workers confidence & competence in performance of each task required.
d. Be trained in first aid & cardio-pulmonary resuscitation.
e. It is strongly recommended that each worker delivering CLS services complete a certified nursing assistance training course.
13. Each direct service provider who chooses to allow staff to assist participants with self-medication, as described in 2.c above, shall establish written procedures governing assistance given. These procedures shall be reviewed by a consulting pharmacist, physician, or RN & shall include, at a minimum:
a. The staff authorized to assist participant & under what conditions such assistance may take place. This must include a review of the type of medication participant takes & its impact upon participant.
b. Verification of prescription medications & their dosages. Participant shall maintain all medications in their original, labeled containers.
c. Instructions for entering medication information in participant files.
d. A clear statement of participant's & participant's family's responsibility regarding medications taken by participant & the provision for informing participant & participant's family for provider's procedures & responsibilities regarding assisted self-administration of medications.
14. When CLS services provided to participant include transportation described in 2.b.iv & 3 above, following standards apply:
a. AAA may not use funding to purchase or lease vehicles for providing transportation services to participants.
b. Vehicle and driver must be appropriately licensed by Secretary of State. Provider must cover all vehicles used with liability insurance.
c. All paid drivers for transportation providers supported entirely or in part by CLS funds shall be physically capable & willing to assist persons requiring help to & from & to get in & out of vehicles. Provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
d. Provider shall train all paid drivers for transportation programs supported entirely or in part by CLS funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
e. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Self-Determination:
1. When authorizing CLS for participants choosing self-determination option, AAA's must comply with items 2-6 of Minimum Standards for Traditional Service Delivery specified above.
2. Each chosen provider must minimally comply with Section C of General Operating Standards for MI Choice Waiver Service Providers.
3. Each chosen provider furnishing transportation as a component of this service must have a valid Michigan driver's license.
4. When CLS services provided to participant include tasks specified in 2.a.i, 2.a.ii, 2.a.iii, 2.a.v, 2.b.iii, 2.b.v, 2.b.vi, 2.b.vii, or 2.d above, worker furnishing CLS must have previous relevant experience or training & skills in housekeeping, household management, good health practices observation, reporting, & recording information. Also, skills knowledge, &/or experience with food prep, safe food handling procedures, & reporting & identifying abuse & neglect are highly desirable.
5. When CLS services provided to participant include tasks specified in 2.a.iv, 2.b.ii, 2.c & 2.d above, worker furnishing CLS must also be trained in CPR. This training may be waived when providing services to a participant with a Do Not Resuscitate order.

Service Name/Definition

Care Transitions Program - The Care Transitions program provides assistance to people who are likely to readmit to the hospital and work to reduce the hospital readmission rate in the PSA.

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

The Care Transitions program provides assistance to people who are likely to readmit to the hospital. The most important aspect of the Care Transitions Program is it is community-based. Through Care Transitions, clients and their families learn of the various services and supports that are available through a person centered process which honors a person's preferences enabling them to have a successful discharge to home.

Service Category	Fund Source			Unit of Service
☐ Access	☑ Title III PartB	☐ Title III PartD	☐ Title III PartE	Each unit equals one individual served.
☑ In-Home	☐ Title VII	☐ State Alternative Care	☐ State Access	
☐ Community	☑ State In-home	☐ State Respite		
	☐ Other _____			

Minimum Standards

The Care Transitions Program is administered by the Tri-County Office on Aging, the Area Agency on Aging (AAA) for Clinton, Eaton, and Ingham Counties and the cities of Lansing and East Lansing. The Care Transitions Program adheres to the guidelines and protocols of the MI Choice Waiver program set forth by MDCH for the purpose of service providers.
Staff within the Care Transitions Program consists of the following:
Care Transitions Social Workers are Master level social workers who, through a person centered process, complete a comprehensive assessment and develop person centered plans with clients and their allies. The Care Transitions social worker, with client direction, establish the provider, frequency, duration and schedule of services, advocate, maintain contact, conduct formal assessments of clients and follow-up and monitor the services to ensure quality, effectiveness and adherence to the person centered plan. Care Transitions social

workers work alone, however, the entire Care Transitions team, including, the fully licensed supervisor are available to confer on cases when needed.

Social Worker Supervisor is responsible for the clinical and administrative supervision of the Care Transitions social workers by providing direction, consultation and monitoring the quality and quantity of their overall case load.

Program Manager is responsible for the overall quality and function of the program. They conduct quality assurance activities, manage billing and finance activities, promote the program, seek out additional payor sources and provide general oversight and supervision of the Social Work Supervisor.

In order to be eligible for the Care Transitions program, clients must be at high risk for a hospital readmission. High risk may include: Acute myocardial infarction, Congestive heart failure, Pneumonia, Chronic obstructive pulmonary disease, Post total hip/total joint surgery, Post coronary artery by-pass surgery, History of multiple admissions, Length of stay greater than normal for their diagnosis, Persons in need palliative care, Persons with socio-economic needs, Persons with 2 or more co-morbidities.

Care Transitions is predicated on abiding by the client's wishes in regard to their choice of lifestyle and provision of services. Sometimes these choices are at odds with the community, service providers, caregivers, family and friends. Care Transitions social workers may need to advocate on behalf of the client or their legal representative by promoting the honoring of a client's preferences in the following manner:

• Contacting service providers to discuss concerns with front line personnel, intermediate supervisors and management.

• Contacting caregivers, family and/or friends to relay a client's wishes and discuss the situation.

• Contacting the client's physician, skilled nurse, social worker, physical therapist, speech therapist, etc. to discuss concerns.

• Facilitating the inclusion of any or all of the above in the person centered process. This could include participation in a planning meeting or by providing information about the preferences of the client.

Additional Services Provided by Care Transitions social workers – Care Transitions social workers can provide the following direct interventions, as necessary:

• Crisis Intervention – Providing immediate and brief intervention for specific emotional, physical and/or environmental problems when formal or informal resources are not immediately available.

• Family Conferences – To address conflicts in relationships which threaten the client's continued independence or cause the client undue stress.

• Gap Filling – Efforts to find resources for crucial identified needs previously unmet by existing formal and informal systems.

• Public Benefit Programs – Obtain all the public benefits the client is entitled to.

• Emotional Supports – Help clients and families enhance coping abilities as they adjust to illness, physical decline, loss of functioning and other stresses.

• Coordination- Assist the client navigate through the many silos of health care.

Services are arranged to assist the participant to remain in the community and avoid re-hospitalization. The Care Transitions intervention includes a 72 hour post discharge home visit (telephonic if necessary), short term case management involvement, completed bio-psycho-social assessments designed to mitigate risks of re-hospitalization, notification of the primary care physician regarding admission/discharge dates and follow-up appointment schedules, linkage to community resources, health literacy assessment and education and Advanced Care Planning discussion.

Services could include coordinating arranged services (including services the participant purchases or receives through supports), services with third party liability, and services purchased through the Care

Transitions Program. Care Transitions social workers are responsible for arranging all services paid through the Care Transitions Program that are identified through the person centered planning process (reference Care Planning Policy) and approved by the participant. Information and support is available to help participants make informed selections regarding services options and choose among qualified providers. Participants must approve all services including provider, scope and type. If appropriate, staff can assists the participant in arranging privately paid services.

Purchase of services through the Care Transitions Program: After services are agreed upon with the participant, through the Person Centered Process, the Care Transitions social workers will coordinate the initiation of all purchased services once the participant is determined eligible and enrolls in the Care Transitions program. Services are based on client need. Services could include: Community living services, Transportation (both private and congregate), Home delivered meals, Medication co-pay, Durable medical equipment, Medication reconciliation by a skilled agency, Medication set up and delivery, Other services as deemed necessary to prevent re-hospitalization.

The Services Coordinator is available to assist in arranging services when needed. Services should be started at the direction of the participant.

1. The Care Transitions social workers will complete the basic assessment in the database for all home care services and MOW. Health and welfare risks are communicated to the provider through e-mail communication which accompanies the assessment.
2. When the provider has been determined, the completed assessment and e-mail are sent to the agency by the Care Transitions social workers using encrypted e-mail.
3. The Care Transitions social workers save the SA in the Care Transitions folder under the participant's last name in the client folder.
4. All other services will be initiated by the Care Transitions social workers via phone contact with the appropriate provider and confirmed by a SA. Health and welfare risks are communicated to the provider through encrypted e-mail.
5. Calls will be made to the participant two weeks after the start of services to ensure the start and appropriate implementation of the service.

The service authorization is a written description of services, sent to a provider following a verbal referral. The purpose of the service authorization is to show the cost, type of service, day(s) service is to be rendered, frequency, duration and description of tasks (if applicable). Service authorizations must be completed when a service is started, changed or temporarily/permanently discontinued.

Care Transitions program staff will always consider the participant's health, safety, welfare and diverse cultural backgrounds during the assessment, reassessment, development of a person centered plan, and throughout the service delivery. It is the role of program staff to link and coordinate the delivery of supports honoring the preferences, desires and needs of the participant while considering quality of care, quality of life and cost-effective utilization of services.

Cases will be kept open in accordance with the contracting agency. Typically clients will be served for 30 days. Case closure will be documented in the client chart. Cases can be extended passed the closure date for extenuating circumstances. Paid services will not be continued, however, if support and coordination needs persist past the closure date, continuing Care Transitions social workers oversight may occur with the approval of the supervisor.

All information received from or about a client, whether oral or written is considered confidential, including records derived from those communications. A client voluntarily signs, at assessment, a form indicating consent to participate in the Care Transitions Program and permission to release information for a period of

45 days, unless otherwise noted. Release of confidential information is permitted without client consent when the Care Transitions social worker is legally bound to report suspected abuse, neglect or endangerment to the Adult Protective Services (APS) unit of DHS (Adult Protective Services Act P.A. 223 of 1983). Care Transitions social workers should consult with a supervisor before making an APS referral.

Access Services

Some access services may be provided to older adults directly through the area agency without a service provision request. These services include: Care Management, Case Coordination and Support, Disaster Advocacy and Outreach Programs, Information and Assistance, Outreach, and MATF/State Caregiver Support funded Transportation. If the area agency is planning to provide any of the above noted access services directly during FY 2017-2019, complete this section.

Select from the list of access services the area agency plans to provide directly during FY 2017-2019 and provide the information requested. Also specify the planned goals and activities that will be undertaken to provide the service in the appropriate text box for each service category.

Direct Service Budget details for FY 2017 are to be included under the appropriate tab in the Area Plan Grant Budget. The funding identified in this tab should correspond to the funding (Federal OAA Title III or VII and State funds) identified in the Area Plan Grant Budget, Direct Service Budget details. The Area Plan Grant Budget uploaded and saved in AMPS must include Direct Service Budget details.

Case Coordination and Support

Starting Date	10/01/2016	Ending Date	09/30/2017
Total of Federal Dollars	$4.086.00	Total of State Dollars	$15.301.00

Geographic area to be served

Clinton, Eaton and Ingham counties.

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

Goals for the program, including timeline and expected outcome:
Provide Case Coordination and Support services to a minimum of 75 clients in Region 6 from 10/01/16 through 9/30/17.
Conduct assessments for all new clients and reassessments every 6 months for a minimum of 75 clients from 10/01/16 through 9/30/17.
Secure and monitor appropriate in-home services from 10/01/16 through 9/30/17.
Refer clients to other services as needed from 10/01/16 through 9/30/17.
Adhere to all minimum standards from 10/01/16 through 9/30/17.
Expected Outcome: Individuals not eligible for Home and Community Based Waiver (MI Choice) will have services to assist them in remaining in the community, if funding allows. There will be a seamless system for older adults going from Case Coordination and Support to Care Management/ Project Choices.

Outreach

Starting Date	10/01/2016	Ending Date	09/30/2017
Total of Federal Dollars	$23,817.00	Total of State Dollars	$27,105.00

Geographic area to be served

Clinton, Eaton and Ingham counties

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

Goals for the program, including timeline and expected outcome:
Provide outreach services to a minimum of 1000 individuals sixty years of age and older living in Clinton, Eaton and Ingham counties from 10/01/16 through 9/30/17.
Provide a minimum of 24 presentations to senior, caregiver or community groups regarding agency services, averaging two per month, from 10/01/16 through 9/30/17.
Participate in a minimum of 10 planning meetings regarding disaster preparedness from 10/01/16 through 9/30/17.
Participate in a minimum of 6 health and information fairs in the community from 10/01/16 through 9/30/17.
Expected Outcome: Greater community awareness of TCOA resources for older adults, their family members and agencies that assist older adults and persons with disabilities.
TCOA will be more prepared to assist the community in case of emergency and/or disaster.
Older adults with utility or prescription crises will have access to assistance with paying utility bills by hearing about the Crisis Services for the Elderly program.
Kinship caregivers will be better equipped to handle caregiving responsibilities because of access to self-care resources and information on avoiding burnout.

Information and Assistance

Starting Date	10/01/2016	Ending Date	09/30/2017
Total of Federal Dollars	$25,490.00	Total of State Dollars	$26,155.00

Geographic area to be served

Clinton, Eaton and Ingham counties.

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

Goals for the program, including timeline and expected outcome:
Provide Information and Assistance services throughout Clinton, Eaton and Ingham Counties.
Provide I&A services to a minimum of 2,000 older adults, family members or community members each fiscal year.
Secure signed contracts for general I&A services that were selected through a Request for Proposal process.
Monitor I&A contracts with service providers for compliance, including person centered thinking, annually.
Monitor the number of individuals assisted through I&A, including individuals who are considered minority, each quarter.
Provide Caregiver I&A services to a minimum of 500 caregivers each fiscal year.
Refer caregivers to identified services through a person centered process.
Adhere to all AASA minimum standards.
Expected Outcome:
There will be a more informed population through Information and Assistance services available in Clinton, Eaton and Ingham counties.
Caregivers will seek needed assistance to reduce the stress associated with their caregiving role.

Care Management

Starting Date	10/01/2016	Ending Date	09/30/2017
Total of Federal Dollars	$0.00	Total of State Dollars	$215,913.00

Geographic area to be served

Clinton, Eaton and Ingham counties.

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

Goals for the program, including timeline and expected outcome:
Care Management will be provided in Clinton, Eaton and Ingham Counties.
Provide Care Management services to a minimum of 130 clients in Region 6 from 10/01/16 through 9/30/17.
Conduct a minimum of 100 initial assessments from 10/01/16 through 9/30/17.
Develop a minimum of 80 care plans from 10/01/16 through 9/30/17.
Conduct reassessments every 3 months on all active clients or every 6 months if a client is on maintenance from 10/01/16 through 9/30/17.
Arrange and monitor services as needed from 10/01/16 through 9/30/17.
Transition eligible Care Management clients to the MI Choice program as funding allows from 10/01/6 through 9/30/17.
Comply with all minimum standards and quality assurances from 10/01/16 through 9/30/17.

Expected Outcome: A minimum of 130 individuals will be able to remain in their own home. Individuals not eligible for Home and Community Based Waiver (MI Choice) will have services to assist them in remaining in the community, if funding allows. There will be a seamless system for older adults going from Case Coordination and Support to Care Management/ Project Choices.

Number of client pre-screenings:	Current Year:	500	Planned Next Year:	500
Number of initial client assesments:	Current Year:	100	Planned Next Year:	100
Number of initial client care plans:	Current Year:	80	Planned Next Year:	80
Total number of clients (carry over plus new):	Current Year:	130	Planned Next Year:	130
Staff to client ratio (Active and maintenance per Full time care	Current Year:	38	Planned Next Year:	38

Direct Service Request

It is expected that in-home services, community services, and nutrition services will be provided under contracts with community-based service providers. When appropriate, a service provision request may be approved by the MIchigan Commission on Services to the Aging. Direct service provision is defined as "providing a service directly to a senior, such as preparing meals, doing chore services, or working with seniors in an adult day setting". Direct service provision by the area agency may be appropriate when in the judgment of AASA: (A) provision is necessary to assure an adequate supply; (B) the service is directly related to the area agency's administrative functions; or, (C) a service can be provided by the area agency more economically than any available contractor, and with comparable quality. Area agencies that request to provide an in-home service, community service, and/or a nutrition service must complete this section for each service category.

Select the service from the list and enter the requested information pertaining to basis, justification, and public hearing discussion for any Direct Service Request for FY 2017-2019. Specify the planned goals and activities that will be undertaken to provide the service in the appropriate text box for each service category. Direct Service Budget details for FY 2017 are to be included under the appropriate tab in the Area Plan Grant Budget. The funding identified in this tab should correspond to the funding (Federal OAA Title III or VII and State funds) identified in the Area Plan Grant Budget, Direct Service Budget details. The Area Plan Grant Budget uploaded and saved in AMPS must include Direct Service Budget details.

Please skip this section if the area agency is not planning to provide any in-home, community, or nutrition services directly during FY 2017-2019.

Disease Prevention/Health Promotion

Total of Federal Dollars $40,921.00 Total of State Dollars

Geographic Area Served Ingham, Eaton and Clinton Counties

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

Diabetes Personal Action Toward Health (D-PATH) is an accredited self-management program to help diabetic persons take control of their own disease process using the Stanford Model. Matter of Balance (MOB) is a structured group intervention proven to help older adults reduce their risk of falling and assist in overcoming the fear of falling. D-PATH informs class participants through diabetes education and disease management strategies and MOB helps class participants to view falls as controllable, set realistic goals for increasing activity and increase balance through exercise in order to promote and preserve independence and dignity.

Goals:
-Continue to expand access to evidence-based disease prevention programs in the tri-county area.
-To help older adults and persons with disabilities function as independently as possible.

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-To provide support to families assisting aging and disabled relatives.
-To increase awareness of Diabetes Self-Management and fall prevention strategies.
-To enable clients to take charge of their health and healthcare through interactive education, self-management coaching and empowerment.
-To provide current evidence-based education in an open and conducive environment.

Planned Activities:
- Work with the Area Agencies on Aging Association of Michigan as well as location providers to increase the number of Matter of Balance and D-PATH classes offered in the tri-county area.
-Seek out community partners and train new Coaches, Lay Leaders and Master Trainers for these programs.
-Seek out community organizations that serve minorities and underserved populations as partners to offer these programs to otherwise overlooked individuals.
-Serve 75 people in the tri-county area per year providing initial Diabetes Self-Management Training.
-Serve 150 people in the tri-county area per year providing Matter of Balance classes.
-Hold 12 D-PATH classes a year.
-Hold 20 Matter of Balance classes a year.
-Serve 65 people in the tri-county area per year providing Medical Nutrition Therapy

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

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

Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.
In the fall of 2014 the Area Agencies on Aging Association of Michigan was awarded a two-year grant from the Michigan Health Endowment Fund for the purpose of expanding the availability of two evidence based programs, Matter of Balance (MOB) and Diabetes-PATH (D-PATH). As the grant will end in the fall of 2016, TCOA is taking steps to help continue these important offerings. The agency has received a Medicare provider number and will be developing a billing plan. Additional efforts included hiring a full time Registered Dietician to oversee the programs in November 2015. Supplementary funding sources, including the possibility of expanding to Medicaid and other health plans for reimbursement, will also be explored.

Describe the discussion, if any, at the public hearings related to this request. Include the date of the hearing(s).
No discussion on the topic of D-PATH or Matter of Balance occurred at a Public Hearing.

Congregate Meals

Total of Federal Dollars $527,381.00 Total of State Dollars $9.081.00

Geographic Area Served Clinton, Eaton and Ingham Counties

Planned goals and activities that will be undertaken to provide the service in the appropriate text box for each service category.
List each goal of the program, including timeline and expected outcome of the program.
GOAL: Provide a minimum of 82,500 hot, nutritious meals to a minimum of 1,400 seniors at Senior Dining Sites from 10/01/16 through 9/30/2017.
EXPECTED OUTCOME: 1,350 older adults will be provided with 1/3 of their minimum daily nutritional requirements and have an opportunity to socialize with their peers.
Work plan including activities and expected outcome.
Prepare, distribute, arrange and oversee the serving of Senior Dining Site meals.
Provide a minimum of 300 congregate meals through the Senior Dine Card program targeting low-income and rural older adults.
Conduct a minimum of 6 nutrition council meetings.
Comply with all minimum standards.

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

Although all of the above provisions are applicable to some degree, provisions (A) and (C) are the most accurate and applicable to the Congregate Meals program.

Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.
Tri-County Office on Aging (TCOA) has actively sought other providers to administer the Congregate Nutrition Program by putting out a Request for Proposal for providing this service every three years and no one has answered the requests. Aging and Adult Services Agency asked TCOA to assume the Congregate Nutrition

Program, therefore, TCOA has assumed the role. This provision is necessary to assure an adequate supply of congregate meals in Region 6.

Describe the discussion, if any, at the public hearings related to this request. Include the date of the hearing(s).
No discussion on the topic of Congregate Meals occurred at a Public Hearing.

Home Delivered Meals

Total of Federal Dollars	$533,589.00	Total of State Dollars	$398,209.00

Geographic Area Served Clinton, Eaton and Ingham Counties

Planned goals and activities that will be undertaken to provide the service in the appropriate text box for each service category.
Each goal of the program, including the timeline and expected outcome of the program.
GOAL: Provide a minimum of 467,500 well balanced, nutritious meals to a minimum of 2,200 older adults who qualify for Meals on Wheels from 10/1/2016 through 9/30/2017.
EXPECTED OUTCOME: Meals on Wheels participants will receive 1/3 of their daily nutritional minimum requirements and have at least a 75% satisfaction rate with the food.
Work plan including activities and expected outcome.
Assess/reassess Meals on Wheels participants to assure they qualify for Meals on Wheels and that they are receiving the meal options of their choice.
Prepare and offer a hot meal 5 days per week
Prepare and offer frozen meals available 7 days per week for those who choose that option and qualify.
Prepare and make available a cold sack evening meal available 7 days per week, for those who choose that option and qualify.
Recruit and maintain a volunteer pool adequate to deliver meals throughout the tri-county region.
Conduct a minimum of 4 Nutrition Council meetings each fiscal year.
Comply with all minimum standards.

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

Although all of the above provisions are applicable to some degree, provisions (A) and (C) are the most accurate and applicable to the Home Delivered Meals program.

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Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.

TCOA has been providing Home Delivered Meals since 1976. To date, Home Delivered Meals has never had a waiting list, we receive local donations and other in-kind supports to help maintain this program. TCOA has actively sought out other providers by putting out a Request for Proposal for this program every three years and no one has answered the request. Michigan Aging and Adult Services Agency asked TCOA to assume the Home Delivered Meals program, therefore, TCOA has assumed the role. This provision is necessary to assure an adequate supply of home delivered meals in Region 6.

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

No discussion on the topic of Home Delivered Meals occurred at a Public Hearing.

Creating Confident Caregivers

Total of Federal Dollars $6,883.00 Total of State Dollars $0.00

Geographic Area Served Clinton, Eaton and Ingham Counties

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

Each goal of the program, including the timeline and expected outcome of the program.

Goal: Recruit and train at least one additional trainer.

Activities: Communicating with local organizations such as the Alzheimer's Association to reach individuals who would be interested in becoming a CCC trainer.

Provide at least 5 Creating Confident Caregivers classes to at least 40 caregivers in PSA 6 in FY 2016-17.

Activities: Attend local events and promote CCC program.

Activities: Staff members will organize, publicize and teach the Creating Confident Caregivers classes to non-professional caregivers in the planning and service area.

Work plan including activities and expected outcome.

Region 6 AAA began providing Creating Confident Caregivers classes under a statewide grant since 2008. Currently, the agency has two Creating Confident Caregivers Trainers capable of teaching classes. Both are Master Trainers. Since the statewide grant expired on September 30, 2012, TCOA plans to continue to provide these classes using Title IIIE funding in FY 2017.

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

The Creating Confident Caregivers curriculum is one of the most popular evidence based disease prevention programs in the planning and service area. This program meets the needs of a population of caregivers that no other evidence based disease prevention program in the area does. The direct provision of this service is necessary to assure that there is an adequate supply of this program in PSA 6 during FY 2017.

Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.
Region 6 AAA has been providing Creating Confident Caregivers classes under a statewide grant since 2008. Currently, the agency has two Creating Confident Caregivers Master Trainers and efforts to recruit additional trainers are being explored for the upcoming fiscal year, particularly in the minority populations. TCOA would like to continue to provide these classes using Title IIIB funding in FY 2017.

Describe the discussion, if any, at the public hearings related to this request. Include the date of the hearing(s).
No discussion on the topic of Creating Confident Caregivers occurred at a Public Hearing.

Regional Service Request

It is expected that regionally-defined services will be provided under contracts with community-based service providers. When appropriate, a regional direct service provision request may be approved by the Michigan Commission on Services to the Aging. Regional direct service provision by the area agency may be appropriate when in the judgment of AASA: (A) provision is necessary to assure an adequate supply; (B) the service is directly related to the area agency's administrative functions; or, (C) a service can be provided by the area agency more economically than any available contractor, and with comparable quality.

Area agencies that request to provide a regional service must complete this tab for each service category. Enter the regional service name in the box and click "Add." The regional service name will appear in the dialog box on left after screen refresh. Select the link for the newly-added regional service and enter the information requested pertaining to basis, justification, and public hearing discussion for a regional service request for FY 2017-2019. Also specify the planned goals and activities that will be undertaken to provide the service in the appropriate text box for each service category. Regional Service Budget details for FY 2017 are to be included under the appropriate tab in the Area Plan Grant Budget. The funding identified in this tab should correspond to the funding (Federal OAA Title III or VII and State funds) identified in the Area Plan Grant Budget, Direct Service Budget details. The Area Plan Grant Budget uploaded and saved in AMPS must include Direct Service Budget details.

Please skip this section if the area agency is not planning to provide any regional services directly during FY 2017-2019.

Crisis Services for the Elderly

Total of Federal Dollars $14,324.00 Total of State Dollars $15,000.00

Geographic Area Served Region 6: Clinton, Eaton and Ingham

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

Crisis Services for the Elderly (CSE) is a twenty-four hour hotline for seniors with non-medical emergencies designed to help older adults resolve problems in times of crisis. For this program, a crisis is defined as a situation an older adult encounters that needs an immediate response for which the client sees no clear or obvious resolution. CSE is available to older adults (age 60 and older) in the planning and service area. There is also an energy assistant component to the program which serves seniors in all of the service area who have received a utility shut-off notice, or who heat their homes with deliverable fuel and are in a crisis situation. In the years to come, TCOA expects to see a continued increase in demand and hopes to serve over 600 seniors annually. In order to assist the number of individuals with these urgent needs, the Area Agency needs to continue to provide this service.

1. The goal is to continue to meet the demand for providing this non-medical emergency Clinton, Eaton and Ingham Counties assistance so that older adults can continue to live as independently as possible in the community.

a. Provide support for seniors facing utility shut-offs. One time support of up to $200 per client, per year.
b. Provide support for emergency prescription expenses of up to $200 per client, per year.
c. Provide support for miscellaneous expenses needed to maintain independence in the community.

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

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

Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.
Provision of such services by the Area Agency is necessary to assure an adequate supply of such services. Crisis Services for the Elderly (CSE) is a twenty-four hour hotline for seniors with non-medical emergencies and is designed to help older adults resolve problems in times of crisis. For this program, a crisis is defined as a situation an older adult encounters that needs an immediate response for which the client sees no clear or obvious resolution. CSE is available to older adults in the Greater Lansing area age sixty or older. There is also an energy assistance component to the Crisis program which serves seniors in all of Clinton, Eaton and Ingham counties who have received a utility shut-off notice, or who heat their homes with deliverable fuel and in a crisis situation. In Fiscal Year (FY) 2015, 602 individuals were served by the program. This is an increase of 16% compared to the data provided in the MYP for fiscal years 2014-2016. An average of 37.75% of the individuals served in FY 2015 were minority. It is projected that this program will continue to grow and serve more seniors as the need grows. In order to assist the number of individuals with these urgent needs, the Area Agency needs to continue to provide this service.

Describe the discussion, if any, at the public hearings related to this request. Include the date of the hearing(s).
No discussion was offered by the public on this service provision at the public hearings.

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Community Living Services

Total of Federal Dollars $56,735.00 Total of State Dollars

Geographic Area Served Region 6: Clinton, Eaton and Ingham

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

1. To assist appropriate individuals, preserving their health and safety in order that he/she may reside and be supported in the most integrated independent community setting.
2. Assist participants to and from community activities to allow client participation in regular community activities incidental to meeting the individual's community living preferences.
a. Waiver program staff to schedule appointments and fund non-emergency medical transportation for waiver clients.

Section 307(a)(8) of the Older Americans Act provides that services will not be provided directly by an Area Agency on Aging unless, in the judgment of the State agency, it is necessary due to one or more of the three provisions described below. Please select the basis for the services provision request (more than one may be selected).

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

(B) Such services are directly related to the Area Agency's administrative functions.

(C) Such services can be provided more economically and with comparable quality by the Area Agency.

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

Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.

CLS facilitate an individual's independence and promote reasonable participation in the community. CLS can be provided in the participant's residence or in community settings as necessary in order to meet support and service needs for clients who meet nursing facility level of care. This helps to ensure that older adults and persons with disabilities are able to stay in their own homes, should they choose, instead of residing in nursing facilities. This saves the state money and improves the quality of life for the individuals served.

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

No discussion was offered by the public on this service provision at the public hearings.

Care Transitions

Total of Federal Dollars $1,000.00 Total of State Dollars

Geographic Area Served Clinton, Eaton and Ingham Counties

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

1. To decrease the 30 day hospital readmission rate.

Planned Activities:

·Maintaining an open dialogue with clients and their supports so that preferences can be honored to the greatest degree possible.

·Seeking ways to support and assist caregivers without replacing them.

·Assist the client navigating the silos of healthcare.

·Advocating on behalf of clients to assure that they are receiving the services and benefits to which they are entitled.

·Linking clients with their preferred services and programs that support independent living.

Monitoring of the service providers to assure that services are being delivered properly.

2. Expand the number of hospitals and other community partners participating in the Care Transitions Program.

Planned Activities:

·Continue to provide outreach to hospitals and community partners highlighting the benefits of the Care Transitions Program to their at-risk clients.

Section 307(a)(8) of the Older Americans Act provides that services will not be provided directly by an Area Agency on Aging unless, in the judgment of the State agency, it is necessary due to one or more of the three provisions described below. Please select the basis for the services provision request (more than one may be selected).

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

(B) Such services are directly related to the Area Agency's administrative functions.

(C) Such services can be provided more economically and with comparable quality by the Area Agency.

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

Provide a detailed justification for the service provision request. The justification should address pertinent factors that may include: a cost analysis; needs assessment; a description of the area agency's efforts to secure services from an available provider of such services; or a description of the area agency's efforts to develop additional capacity among existing providers of such services. If the service is considered part of administrative activity, describe the rationale and authority for such a determination.

The Care Transitions Program is a short term care management program playing a key role in the mission and goals of the Tri-County Office on Aging (TCOA). TCOA has been providing care management services since 1985. The Care Transitions program provides assistance to people who are likely to readmit to the hospital. The purpose of the Care Transitions Program is to offer services not covered under the typical discharge planning protocol to enable persons to navigate the health care system, gain knowledge of their health status

and address long term care needs which will help decrease hospital readmissions. The most important aspect of the Care Transitions Program is it is community-based and Care Transition Social Workers are connected with participants in the hospital and follow them for 30 days after discharge. Through Care Transitions, clients and their families learn of the various services and supports that are available through a person centered process which honors a person's preferences.

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

No specific discussion on the Care Transitions Direct Service Program occured at the Public Hearings.

Program Development Objectives

Please provide information for all program development goals and objectives that will be actively addressed during the MYP.

New Required Goal/Objective: There is a new priority program development goal/objective area that is required. This is a goal that centers on aging network, public, municipal and private partnerships to assess the aging-friendliness of communities to make them Communities for a Lifetime (CFL) and help them to retain and attract residents of all ages so the communities can thrive and have access to goods, services and opportunities for quality living across the lifespan:

CFL Goal: More communities in the PSA will conduct an aging-friendly community assessment and apply for recognition to AASA as a CFL.

The Minimum Objective: One new community in the PSA will receive recognition as a CFL by 9/30/19.

For technical assistance with developing CFL objectives, narratives, timelines, planned activities and expected outcomes, contact the AASA Lead staff for the CFL Program, Dan Doezema at doezemad@michigan.gov, or 231-929-2531.

The area agency must enter each program development goal in the appropriate text box. It is acceptable, though not required, if some of the area agency's program development goals correspond to AASA's State Plan Goals. There is an entry box to identify which, if any, State Plan Goals correlate with the entered goal. A narrative for each program development goal should be entered in the appropriate text box. Enter objectives related to each program development goal in the appropriate text box. There are also text boxes for the timeline, planned activities and expected outcomes for each objective. (See Document Library for additional instructions on completing the Program Development section.)

Area Agency on Aging Goal

A. More communities in the tri-county area will conduct an aging-friendly community assessment and apply for recognition to Aging and Adult Services Agency as a Communities For a Lifetime (CFL).
State Goal Match: 1, 3, 5

NARRATIVE

TCOA's mission to promote and preserve the independence and dignity of the aging population aligns with the desire to have at least one community in the PSA to receive recognition as a CFL. TCOA hopes to retain and attract residents, particularly seniors, to assist the communities to thrive and have access to goods, services and opportunities for quality living across the lifespan.

OBJECTIVES

1. Work to secure a community in the tri-county area as a recognized CFL by September 2019, such as the City of Lansing.
Timeline: 10/01/2016 to 09/30/2019

Activities
·Partner with AARP to advance efforts to help people live easily and comfortably in their homes and communities as they age.

Conduct an aging-friendly community assessment for the City of Lansing and apply for recognition to Aging and Adult Services Agency as a CFL.

Expected Outcome
City of Lansing will be recognized as a Communities for a Lifetime and help them to retain and attract residents of all ages so the communities can thrive and have access to goods, services and opportunities for quality living across the lifespan.

2. Increase the number of CFL's in TCOA's Planning and Service Area.
Timeline: 10/01/2016 to 09/30/2019

Activities
Explore other communities in the tri-county area that may be willing to align their efforts with the qualifications and requirements to become a CFL.

Expected Outcome
Additional communities in the tri-county area will work to align their efforts with the qualifications and requirements to become a CFL and potentially complete the assessment to be recognized as a CFL.

B. Ensure older adults have access to information and services to improve their ability to make an educated decision regarding their independence.
State Goal Match: 2, 3, 4, 5, 6

NARRATIVE

TCOA holds the independence and dignity of the aging population to high regard and hopes to improve the ability for local residents to access information. Feedback from the needs assessments and community forums will help the agency get information about available programs and services to the target population and their families and caregivers through the preferred avenues expressed by the attendees of those events, as well as additional methods implemented by the agency.

OBJECTIVES

1. Improve access to programs and services for underserved populations.
Timeline: 10/01/2016 to 09/30/2019

Activities
·Secure services of a Community Health Worker/Resource Navigator.

Facilitate connections with culturally and/or linguistically specific community based organizations.

Provide access to assistance with MMAP and other public benefits.

Connect with medical community, physician organizations, and health plans.

Connect with neighborhood organizations.

Promote cultural competency issues impacting underserved local seniors and persons with disabilities, including non-English speaking and Lesbian, Gay, Bisexual and Transgender individuals.

Expected Outcome
Tri-county residents will have greater access to available information and services.

2. Expand housing assistance to increase access to community housing options.
Timeline: 10/01/2016 to 09/30/2017

Activities
·Create/distribute directory of all senior housing, low income and accessible housing options in the tri-county area.

Convene/facilitate regular meetings for Managers of Senior Complexes and Landlords.

Create/distribute directory of Private Landlords

Expected Outcome
Tri-county residents will have increased access to community housing options.

3. Provide information about benefits and help people solve problems with health benefit programs and related insurance products.
Timeline: 10/01/2016 to 09/30/2019

Activities
·Recruit and train new MMAP volunteers.

Utilize traditional and social media to outreach and obtain new volunteers.

Expected Outcome
Tri-county residents will be more informed about health benefit programs and insurance products.

4. Improve transportation options and usability, focusing on TCOA's consumer demographic needs.
Timeline: 10/01/2016 to 09/30/2019

Activities
·Waiver program staff to schedule appointments and fund non-emergency medical transportation for waiver clients.

Maintain supply of bus passes on hand for non-waiver clients.

Promote Michigan Transportation Connection partnership.

Expected Outcome
Tri-county residents will have improved access to transportation options.

5. Increase access to kinship care services in the tri-county area.
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   Strengthen partnership with Kinship Care Coalition

   Expected Outcome
   Tri-county residents will have increased access to kinship care services.

6. Work to advance community integration and outreach efforts. (also fits agency Goals C, D and E)
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   ·Expand public awareness and education efforts.

   Maintain Long Term Care Collaborative/Aging and Disability Resource Center partnership.

   Develop TCOA Newsletter and communication materials.

   Expand partnerships with doctors' offices, physician groups, health plans and community based organizations.

   Expected Outcome
   There will be increased community partnerships and collaboration efforts that will benefit tri-county residents.

7. Work to advance advocacy efforts in the tri-county area.
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   ·Have local seniors represent the tri-county area on the Michigan Senior Advocates Council to advocate for older Michiganians.

   Continue to have Tri-County Office on Aging staff and Advisory Council representation on the planning committee for Older Michiganians Day.

   Encourage Advisory Council members and other local advocates to meet with local state legislators to advocate on issues impacting older adults and persons with disabilities as identified in the Older Michiganians Day Platform.

Expected Outcome
Advocacy efforts will improve existing avenues and provide new opportunities for tri-county residents' opinions and concerns to be heard at the local, state and federal levels.

C. Improve access to health, wellness and nutrition supports.
State Goal Match: 3, 5

NARRATIVE

The needs assessments conducted in early 2016 indicated a great deal of interest in fitness and wellness classes in the tri-county area. Evidence-based disease prevention programs will help to fill this local need. This may also assist in retaining and attracting residents so the communities can thrive across the lifespan.

OBJECTIVES

1. Continue to expand access to evidence-based disease prevention programs in the tri-county area.
Timeline: 10/01/2016 to 09/30/2019

Activities
·Work with the Area Agencies on Aging Association of Michigan as well as location providers to increase the number of Enhanced Fitness, A Matter of Balance (MOB), Personal Action Toward Health (PATH), Diabetes PATH (D-PATH) and Creating Confident Caregivers (CCC/SAVVY) classes offered in the tri-county area.

Explore alternative and additional fund sources available to expand and sustain evidence-based programs.

Seek out community partners and train new Coaches, Lay Leaders and Master Trainers for these programs.

Seek out community organizations that serve minorities and underserved populations as partners to offer these programs to otherwise overlooked individuals.

Maintain Medicare certification and explore the possibility of expanding to Medicaid and other health plans for reimbursement.

Work to provide oral health programs in partnership with nutrition and dental organizations.

Expected Outcome
Tri-county residents will have greater access to evidence-based disease prevention programs in the agency's PSA.

2. Provide access to healthy and affordable meals to nutritionally at risk older adults.
Timeline: 10/01/2016 to 09/30/2019

Activities
·Continue and work to expand Project Fresh.

Explore expansion of frozen food pantry to improve participant choice and variety.

Explore additional funding sources.

Expected Outcome
Tri-county residents who are older adults nutritionally at risk will have increased access to healthy and affordable meals.

3. Reduce unnecessary re-admittance to hospitals for high-risk adults.
Timeline: 10/01/2016 to 09/30/2019

Activities
·Expand partnership to more hospitals for the Care Transitions Program.

Work to expand reimbursement sources to Medicare Advantage Plans, Medicaid and private insurances.

Sustain Advanced Care Planning training.

Expected Outcome
Unnecessary re-admittance to hospitals will be reduced and the Care Transitions Program will expand hospital partnerships.

4. Explore the opportunity to assist tri-county community members in securing a Senior Millage for vital unmet needs.
Timeline: 10/01/2016 to 09/30/2019

Activities
Support possible millage planning committee, including providing data and information to inform campaign.

Expected Outcome
Ingham, Eaton and Clinton counties will each secure a Senior Millage for additional funding for vital unmet needs.

D. Protect older adults from abuse and exploitation.
State Goal Match: 5, 3, 2, 6

NARRATIVE

TCOA's mission to "promote and preserve the independence and dignity of the aging population." Protecting the health and safety of older adults and persons with disabilities is of the highest importance to

TCOA. This agency goal is directly tied to the agency's mission.

OBJECTIVES

1. Raise awareness of domestic abuse, physical and sexual abuse and financial exploitation occurring in the older adult population and how to better respond to these situations.
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   ·Continue to participate in the Ingham County Coordinated Community Response team.

   Explore funding for domestic and sexual violence prevention and response.

   Continue to participate in county vulnerable adult networks in the tri-county area.

   Utilize social media to assist in publicizing information about current scams and fraud occurrences that are being reported locally.

   Expected Outcome
   Awareness of domestic abuse, physical abuse, sexual abuse and financial exploitation will be increased and tri-county residents will be better equipped to respond to and potentially prevent these situations.

E. Support individuals with dementia living in the community, as well as their caregivers.
State Goal Match: 3, 5, 6, 1

NARRATIVE

The 2016 needs assessments and community forums indicated interest in expanding services to support individuals with dementia living in the community, as well as their caregivers.

OBJECTIVES

1. Work to expand access to programs and services available for individuals with Alzheimer's Disease and other forms of dementia who are residing in the community, as well as their formal and informal caregivers.
   Timeline: 10/01/2016 to 09/30/2019

   Activities
   ·Expand SAVVY/Creating Confident Caregivers training to reach more caregivers of minority populations.

   Maintain the Resource Directory for Caregivers with an emphasis on dementia supports in partnership with other community organizations.

   Create opportunities for persons with dementia to receive personal music therapy.

   Partner with AASA and AAAAM to secure funding for Evidence-Based Programs relating to dementia.

Expected Outcome
There will be a decreased rate of caregiver burn-out in the tri-county area and persons with dementia will have increased access to programs and services specific to their disease.

Advocacy Strategy

Describe the area agency's comprehensive advocacy strategy for FY 2017-2019. Describe how the agency's advocacy efforts will improve the quality of life of older adults within the PSA.

The Tri-County Office on Aging (TCOA) advocates for seniors and persons with disabilities to help assure that they can live as independently as possible. The second goal of TCOA's mission statement, "to promote and preserve the independence and dignity of the aging population," is to advocate for adequate resources and sound public policy.

Advocacy is done on the national, state and local levels. TCOA's membership in the Area Agencies on Aging Association of Michigan (AAAAM) and the National Association of Area Agencies on Aging (N4A) provides timely information on important issues and bills being discussed and voted on in the National and State Legislatures. Through the AAAAM, TCOA has participated in efforts to promote the MI Choice Program, locally known as Project Choices, in Region 6 and state-wide. Many agencies, programs and individuals in Region 6 are also on the statewide coalition in support of MI Choice.

The TCOA Advisory Council appoints three representatives to the Michigan Senior Advocates Council (MSAC). The MSAC representatives report to the Advisory Council at their monthly meetings on proposed legislation and issues being worked on. The Advisory Council's opinion is also sought and at times a resolution is passed in support of an issue. Typical concerns of this group are health coverage (Medicare & Medicaid), income (Social Security, Supplemental Security Income and pension security) elder abuse and public utility costs and regulation. One local senior is a representative to the Michigan Aging and Adult Services Agency Advisory Council. The local State Advisory Council member attends the State Advisory Council meetings and reports to the TCOA Advisory Council.

When the TCOA Advisory Council membership has a concern, they seek out more information and may support an issue through a resolution or write a letter expressing their opinion. This information is then shared with the appropriate individual(s) or organizations. Periodically, information on how to advocate as an individual is provided, this includes data on current topics, tips on advocacy, pertinent statistics and names and addresses of National and State elected officials. The Advisory Council members are encouraged to personally express their ideas and to encourage other groups they are involved with to do the same.

TCOA is actively involved in Older Michiganians Day at the state capital. Seniors are encouraged to let elected officials know their opinion on an issue with tips on advocacy and how to contact elected officials with names, e-mail addresses and phone numbers provided.

Partnerships with the disability community have also strengthened through collaboration with Disability Network Capital Area, formerly Capital Area Center for Independent Living. Along with Disability Network Capital Area, the executive director of TCOA is a part of the Olmstead Coalition to advocate for seniors and persons with disabilities.

The Tri-County Aging Consortium Board is kept informed of national and state issues and also expresses their concern or support on issues. Because they are all elected officials or their appointees, these individuals are

advocates at their respective unit of government in support of older adults.

Leveraged Partnerships

Describe the area agency's strategy for FY 2017-2019 to partner with providers of services funded by other resources, as indicated in the Planned Service Array. Complete each dialog box below.

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

a. Commissions Councils and Departments on Aging.
b. Health Care Organizations/Systems (e.g. hospitals, health plans, Federally Qualified Health Centers)
c. Public Health.
d. Mental Health.
e. Community Action Agencies.
f. Centers for Independent Living.
g. Other

In addition to the Long Term Care Collaborative (LTCC) and ADRC-Capital Area partnerships, TCOA has numerous local partnerships and collaboratives to identify the needs and wants of community members. Many of these groups include the membership of Community Action Agencies; Clinton Eaton and Ingham Community Mental Health, and Disability Network Capital Area (formerly known as Capital Area Center for Independent Living/CACIL).

TCOA is planning to continue partnership with Capital Area Collaborative for Care Transitions to reduce unnecessary re-admittance to hospitals for high-risk adults. TCOA directly provides care transitions services to individuals admitted into the hospital using agency staff. This program was funded through the Center for Medicare/Medicaid Services using money provided by Section 3026 of the Patient Protection Affordable Care Act (ACA) and has since secured funding through a private hospital contract.

In 2017-2019, TCOA will continue to work with collaborative members to expand the Capital Area Community-Based Care Transitions Program. The goal is to collaborate with other organizations/agencies to reduce hospital readmission rates for high risk patients in the tri-county area and to work with people in the hospital and out of the hospital to provide intervention tools to empower patients.

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

TCOA, in partnership with the region's Long Term Care (LTC) Collaborative, formally voted to develop an Aging & Disability Resource Center locally. The LTC Collaborative was formed in 1999 with membership including TCOA, Disability Network Capital Area (formerly Capital Area Center for Independent Living/CACIL), CEI Community Mental Health, Sparrow Specialty Hospital, Ingham County Medical Care Facility, Lansing Community College, Ingham County Health Department, Department of Human Services, home health care agencies, and MPRO. This body keeps the membership informed of activity in the area of LTC and works on special projects. The ADRC partnership within the public service area started as a way of utilizing existing long term care resources to develop a "No Wrong Door" model for LTC supports and services. The ADRC model recognizes that all stakeholders function as equal partners. Tri-County Office on Aging staff connected with the local Center for Independent Living and discussed ways of building an effective partnership with each other as

well as other partners in the Community. There is currently no funding for the ADRC, however; TCOA and partners continue to meet bi-monthly as part of the Long Term Care Collaborative whose efforts align with the ADRC.

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

One of TCOA's goals for FY 2017-2019 is to continue to expand access to evidence-based disease prevention programs in the tri-county area. To help accomplish this goal, TCOA is hoping to explore alternative and additional fund sources available to *develop,* expand and *sustain* evidence-based programs, as well as, maintain Medicare certification and explore the possibility of expanding to Medicaid and other health plans for reimbursement. TCOA will also try to seek out community partners and train new Coaches, Lay Leaders and Master Trainers for these programs and community organizations that serve minorities and underserved populations as partners to *build capacity* and offer these programs to otherwise overlooked individuals. Partnering with AAAAM and location providers to increase the number of Enhanced Fitness, A Matter of Balance and Personal Action Toward Health classes offered in the tri-county area will also be explored. Other evidence-based programs that the agency is interested in developing are oral health programs in partnership with nutrition and dental organizations. As mentioned above, TCOA is planning to continue the partnership with Capital Area Collaborative for Care Transitions to reduce unnecessary re-admittance to hospitals for high-risk adults. Expanding partnerships to more hospitals, investigating the ability to expand reimbursement to Medicare Advantage Plans, Medicaid and private insurances and sustaining Advanced Care Planning trainings are all activities that may help the re-admittance rates from rising. Additionally, TCOA plans to work to expand access to programs and services available for individuals with Alzheimer's Disease and other forms of dementia who are residing in the community, as well as their formal and informal caregivers, by expanding SAVVY/Creating Confident Caregivers. In order to accomplish this, the agency hopes to partner with AASA and AAAAM to secure funding for evidence-based programs relating to dementia.

Community Focal Points

Please review the listing of Community Focal Points for your PSA and update as necessary. Please specifically note whether or not updates have been made. Describe the rationale and method used to assess the ability to be a community focal point including the definition of community. Explain the process by which community focal points are selected.

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

The Tri-County Office on Aging defines a community as a specific geographical location where persons live within a larger society and share a common interest; or a group of persons sharing a common cultural background. In the tri-county area, those living in a designated geographical boundary within an area will be identified as living in the same community. For example, an older person living within the geographical boundaries of St. Johns in Clinton County will share the same community and identify with the Information and Assistance (I&A) offices as well as the Clinton County Senior Citizens Drop-In Center in St. Johns. A cultural center in the community where persons of similar heritage congregate and/or access services is also identified as a focal point. The Tri-County Aging Consortium Administrative Board is made up of County Commissioners from Clinton (2), Eaton (3) and Ingham (3) Counties and Lansing (4) and East Lansing (1) City Council members or their designee (See Appendix B). Also, the aforementioned local units of government appoint the senior members of the Advisory Council and this Board approves agency representatives. The Administrative Board is charged with the responsibility of overseeing the functions of the Tri-County Office on Aging and is responsible for all phases of the Area Plan. This includes the identification of Community Focal Points in the region. The Advisory Council reviews documents and makes recommendations to the Board. With the consensus of the Administrative Board, Advisory Council, senior citizens and Tri-County Office on Aging staff, community focal points are to be identified as the I&A Offices (senior citizens offices) senior centers in each county, and TCOA. The senior community identifies their local senior centers, senior citizens offices and/or community centers as a place to go to receive information and/or services for senior citizens in their respective communities. In the Tri-County Area, there are two focal points identified in Clinton County; four in Eaton County; four in Ingham County other than the cities of Lansing and East Lansing; and three in the City of Lansing and one in the City of East Lansing.

In addition to the I&A Offices located in each county and Tri-County Office on Aging, several senior/community centers are identified as focal points. The seniors in the community meet at senior/community centers for various reasons and identify them as a place to go if they need additional services and/or information about senior citizen resources. The agency is particularly sensitive to the needs of minorities in the community and identified three centers where the majority of participants are from minority ethnic/cultural backgrounds. For those focal points, the definition is an ethnic/cultural boundary where persons sharing similar cultural backgrounds gather.

The rationale used for defining a community is based on the input from staff and senior citizens in the region. In terms of identifying a community, staff has taken into consideration certain factors such as geographical area; where people go to buy groceries, shop for clothing, receive medical care and attend religious services; and where seniors go to ask for information/assistance. Also, community includes where seniors of a specific ethnic/cultural background gather and/or go to receive information/assistance.

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

Name:	Capital Area Community Services Clinton County Service Center
Address:	1001 S. Oakland, St. Johns, MI 48879
Website:	www.cacs-inc.org
Telephone Number:	(989) 224-7998
Contact Person:	Pauline Baert
Service Boundaries:	N: Gratiot Rd., S: Sheridan Rd., W: Hubbardston Rd. (Lebanon Twp.) (Clintonia Rd., Dallas, Westphalia, Eagle Twpl.), E: Meridian Rd.
No. of persons within boundary:	7515
Services Provided:	

Name:	Capital Area Community Services Eaton County Service Center
Address:	1370 N. Clinton, Charlotte, MI 48813
Website:	www.cacs-inc.org
Telephone Number:	(517) 543-5465
Contact Person:	Jeff Keener or Jewell Snipes
Service Boundaries:	N: Eaton Hwy., S: Baseline Hwy., W: Hager Rd., E: Waverly Rd.
No. of persons within boundary:	12667
Services Provided:	

Name:	Capital Area Community Services Rural Ingham Service Center
Address:	218 East Maple Street Mason, MI 48854
Website:	www.cacs-inc.org
Telephone Number:	517-676-1081
Contact Person:	Marina Poroshin
Service Boundaries:	S: Baseline Rd., St. State Rd., W: Waverly Rd., E: Herrington Rd./Locke Twp, Wallace/LeRoy Twp. Kane (White Oak and Stockbridge (twp)
No. of persons within boundary:	13773
Services Provided:	

Name:	Cristo Rey Comm. Center
Address:	1717 N. High St. , Lansing, MI 48906
Website:	www.cristoreycommunity.org
Telephone Number:	(517) 372-4700
Contact Person:	Joe Garcia

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Service Boundaries:	Tri-County Focal for Seniors of Hispanic Origin in Clinton, Eaton, Ingham Co.
No. of persons within boundary:	902
Services Provided:	

Name:	Delta 39ers Senior Center
Address:	4538 Elizabeth, Lansing, MI 48917
Website:	www.deltami.gov/parks/deltawaverly39sprogram.htm
Telephone Number:	(517) 484-5600
Contact Person:	Tammy Opdyke-Mejia
Service Boundaries:	N: Eaton Hwy, W: Royston Rd, E: Waverley Rd, S: Davis Hwy
No. of persons within boundary:	3949
Services Provided:	

Name:	Eaton Area Senior Center
Address:	804 S. Cochran, Charlotte, MI 48813
Website:	
Telephone Number:	(517) 541-2934
Contact Person:	Cindy Miller
Service Boundaries:	All of Eaton County
No. of persons within boundary:	23284
Services Provided:	

Name:	Letts Community Center
Address:	1220 W. Kalamazoo, Lansing, MI 48915
Website:	www.lansingmi.gov/letts_community_center
Telephone Number:	(517)483-4311
Contact Person:	Jodi Ackerman
Service Boundaries:	City of Lansing
No. of persons within boundary:	18526
Services Provided:	

Name:	Meridian Senior Center
Address:	Chppewa Middle School, 4000 N. Okemos Rd. Okemos, MI 48864
Website:	
Telephone Number:	(517)706-5045
Contact Person:	Cherie Wisdom
Service Boundaries:	N: Ingham County Line, S: Jolly Rd., W: Abbott/Hagadorn/Timberland/College, e: Meridian Rd.

No. of persons within boundary:	4306
Services Provided:	

Name:	Prime Time, East Lansing
Address:	819 Abbott Rd., E. Lansing, MI 48823
Website:	www.elprimetime.org
Telephone Number:	(517) 337-1113
Contact Person:	Kelly Arndt
Service Boundaries:	N: 2 Miles N. of Lake Lansing Rd., S: Mt. Hope/Forest/Bennett, W: US 127/Collins, E: Abbott/Hagadorn/College
No. of persons within boundary:	3015
Services Provided:	

Name:	Rocking Chair Deserters-Eaton Rapids Senior Center
Address:	201 Grand, Eaton Rapids, MI 48827
Website:	
Telephone Number:	(517) 663-2335
Contact Person:	Deb Malewski
Service Boundaries:	N: Davis Hwy. /Kinsel Hwy, S. Baseline Hwy., W: Five Point-Curtis, E: Waverly Road
No. of persons within boundary:	4886
Services Provided:	

Name:	Sam Corey Senior Center
Address:	2108 N. Cedar, Holt, MI 48842
Website:	
Telephone Number:	(517) 268-0096
Contact Person:	Mark Jenks
Service Boundaries:	N: Jolly, Willoughby and I-96, S:Nichols Rd., W: Waverly Rd., E: College Rd.
No. of persons within boundary:	2400
Services Provided:	

Name:	Tri-County Office on Aging
Address:	5303 S. Cedar St., Lansing, MI 48911
Website:	www.tcoa.org
Telephone Number:	(517) 887-1440
Contact Person:	Deb Arendsen
Service Boundaries:	Clinton, Eaton and Ingham Counties
No. of persons within boundary:	85737

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Services Provided:

Name:	Williamston Senior Center
Address:	201 School St., Williamston, MI 48895
Website:	www.williamstonseniorcenter.com
Telephone Number:	(517) 655-5173
Contact Person:	Nancy Williams
Service Boundaries:	N: Milton Rd., W: Meridian Rd., E: Wallace Rd
No. of persons within boundary:	3980

Services Provided:

Other Grants and Initiatives

Use this section to identify other grants and/or initiatives that your are agency is participating in with AASA and/or other partners. Grants and/or initiatives to be included in this section may include, but not be limited to the following:

- **Tailored Caregiver Assessment and Referral (TCARE)**
- **Creating Confident Caregivers (CCC)**
- **Chronic Disease Self-management Programs, such as PATH**
- **Building Training...Building Quality**
- **Powerful Tools for Caregivers**
- **PREVNT Grant**
- **Programs supporting persons with dementia**
- **Medicare Medicaid Assistance Program (MMAP)**
- **MI Health Link (MHL)**

Describe other grants and/or initiatives the area agency is participating in with AASA or other partners. Describe how these grants and other initiatives will improve the quality of life of older adults within the PSA. Further, describe how these other grants and initiatives reinforce the area agency's planned program development efforts for FY 2017-2019.

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

TCOA received notification of a grant award for FY 2017 from the Lansing Rotary Foundation for funding to maintain a supply of shelf stable meals for distribution to Meals on Wheels (MOW) clients during or in advance of weather related events and other emergencies such as power outages. A shelf stable meal has several food items in one container that, when combined, constitute a complete meal. Each container is packaged with food from the following food groups to offer a well-balanced meal option: bread or bread alternative, vegetables, fruit, dairy and meat or meat alternative. TCOA attempts to purchase and maintain a supply of these meals to address any anticipated barrier to meal delivery for those most vulnerable among us.

In the fall of 2014 the Area Agencies on Aging Association of Michigan was awarded a two-year grant from the Michigan Health Endowment Fund for the purpose of expanding the availability of two evidence based programs, Matter of Balance (MOB) and Diabetes-PATH (D-PATH). As the grant will be ending in the fall of 2016, TCOA is taking steps to help continue these important offerings. The agency has received a Medicare provider number and will be developing a billing plan. Additional efforts included hiring a full time Registered Dietician to oversee the programs in November 2015. Supplementary funding sources will also be explored in the next three fiscal years.

Through a partnership with Capital Area Community Services, Michigan Medicare/Medicaid Assistance Program (MMAP) counselors can help to understand Medicare & Medicaid, enroll in Medicare prescription drug coverage, review supplemental insurance needs, apply for Medicare Savings programs, identify and report fraud and abuse or scams, and explore long term care insurance. AASA sends federal MMAP funding directly to MMAP Central who in turn sends a portion to TCOA. AASA may also send TCOA directly a small

amount of MIPPA-ADRC funds.

Care Transitions is a social work program aimed at decreasing unnecessary hospital admissions by addressing the psycho-social determinants of health care. TCOA directly provides care transitions services to individuals admitted into the hospital using agency staff. This program was funded through the Center for Medicare/Medicaid Services using money provided by Section 3026 of the Patient Protection Affordable Care Act (ACA) and has since secured funding through a private hospital contract.

SAVVY/Creating Confident Caregivers (CCC) is a six-week education series for caregivers of persons with dementia. Content focuses on understanding the disease, caregiver self-care to prevent burnout and providing structure and support for the person with dementia. Respite care is provided. SAVVY/CCC is currently funded through Title III-B funds.

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

TCOA Nutrition Program/MOW makes a significant, positive difference and serves some of the area's most vulnerable individuals through home delivered meals and congregate dining sites. Considering the weather emergencies experienced in recent years, MOW clients have benefited greatly by receiving these crucial shelf stable meals in lieu of the hot meals. By arranging to provide food to them in advance, TCOA ensures that the recipient will have food available to get them through the emergency, even without power.

Continuing MOB and D-PATH will serve to greatly expand the number of older adults who will have increased knowledge of how to manage their fear of falling and/or disease. Research has shown that individuals who complete the D-PATH course have a much higher success rate with managing their Type 2 Diabetes. Not only does this improve the quality of life for the individual and their loved ones, it also helps to keep a large number of seniors living independently which is beneficial to the community as a whole. Accidental falls among seniors are considered to be a major cause of injuries, hospitalizations and nursing facility institutionalization in the United States. Research has shown that MOB classes have a significant impact in reducing an individual's risk of falling along with the fear of falling. This can greatly improve the quality of life for class participants long after the course has been completed.

The Medicare/Medicaid Assistance Program (MMAP) provides free health benefits counseling services to Medicare beneficiaries, those who are 65 years of age or older and those who are Medicare eligible due to a disability, and their families. MMAP provides timely, objective and accurate information as well as support to Michigan beneficiaries so they can make informed decisions about their health care. Information and assistance is provided in the areas of Medicare, Medicaid, Medicare Prescription Drug Coverage, Medicare Advantage plans (health plans), Medicare supplemental insurance, Medicare Savings Programs, identification and report of Medicare and Medicaid fraud/abuse and scams and exploration of long term care insurance options. MMAP Counselors are not connected with any insurance company and are not licensed to sell insurance. The MMAP program in the tri-county area continues to serve more people each year than the previous.

The Care Transitions program seeks to intervene and correct possible triggers for hospital readmissions by encouraging a community to come together and work together to improve quality, reduce cost, and improve patient experience. Care transition services will be used to effectively manage Medicare patients' transitions

and improve their quality of care. The program hopes to reduce hospital readmissions for high-risk Medicare beneficiaries by 20%.

SAVVY/CCC provides persons caring for a loved one with dementia in their home with information, skills and attitudes to manage stress and increase effective caregiving skills. Two-hour sessions, led by dementia-care specialists, are held once each week for six weeks. This program utilizes the research-based Savvy Caregiver Program.

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

Prior to the Michigan Health Endowment Fund, Matter of Balance classes were being funded through Federal Title IIID funding. Now that those funding streams have ceased, the receipt of money through Medicare reimbursement, and potentially other insurances, will allow TCOA to work with the Area Agencies on Aging Association of Michigan as well as location providers to increase the number of evidenced-based program classes offered in the tri-county area. Additional efforts that the initiative reinforces are seeking out community partners and train new Coaches, Lay Leaders and Master Trainers for these program and seeking out community organizations that serve minorities and underserved populations as partners to offer these programs to otherwise overlooked individuals.

The implementation and expansion of shelf stable meals as a result of the grant award for FY 2017 from the Lansing Rotary Foundation will help TCOA in partnership with MOWs to improve access to health, wellness and nutrition supports. Access to healthy and affordable meals to nutritionally at risk older adults will also be increased.

Promoting MMAP supports the agency's goal to ensure older adults have access to information and services to improve their ability to make an educated decision regarding their independence. Working to achieve this goal with and through MMAP will also improve access to programs and services for underserved populations. Outreach and volunteer recruitment/management are two important aspects of MMAP. Advertisements, such as television, radio, printed materials and flyers, outreach at health fairs, group presentations to the public and outside agencies and word of mouth are the main forms of outreach used in the tri-county area. TCOA's website and Facebook page have also been utilized for outreach.

Appendices

Appendices A through F are presented in the list below. Select the appendix from the list on the left. Provide all requested information for each selected appendix.

A. Policy Board membership
B. Advisory Council membership
C. Proposal selection criteria
D. Cash-in-lieu-of-commodity agreement
E. Waiver of minimum percentage of a priority service category
F. Request to transfer funds

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APPENDIX A

Board of Directors Membership

	Asian/Pacific Islander	African American	Native American/ Alaskan	Hispanic Origin	Persons with Disabilities	Female	Total Membership
Membership Demographics	0	2	0	1	0	6	12
Aged 60 and Over	0	1	0	0	0	3	12

Board Member Name	Geographic Area	Affiliation	Elected Official	Appointed	Community Representative
Kathie Dunbar	Lansing	Lansing City Council	Yes		
Joan Jackson-Johnson	Lansing	Appointee Lansing City Council		Yes	
Chris Swope	Lansing	Lansing City Council	Yes		
Mark Meadows	East Lansing	Mayor East Lansing	Yes		
Howard Spence	Eaton County	Commissioner	Yes		
Blake Mulder	Eaton County	Commissioner	Yes		
Barbara Rogers	Eaton County	Commissioner	Yes		
Kara Hope	Ingham County	Commissioner	Yes		
Carol Koenig	Ingham County	Commissioner	Yes		
Bryan Crenshaw	Ingham County	Commissioner	Yes		
Anne Hill	Clinton County	Commissioner	Yes		
Ken Mitchell	Clinton County	Commissioner	Yes		

APPENDIX B

Advisory Board Membership

	Asian/ Pacific Islander	African American	Native American/A laskan	Hispanic Origin	Persons with Disabilities	Female	Total Membership
Membership Demographics	0	2	0	0	1	21	24
Aged 60 and Over	0	1	0	0	1	11	24

Board Member Name	Geographic Area	Affiliation
Bud (Felix) Fliss	East Lansing	East Lansing
Carol Halsey	Eaton County	Eaton County
Martha Yoder	Eaton County	Eaton County
Penny Gardner	Lansing	Lansing
Emly Horne	Lansing	Lansing
Mary Estes	Lansing	Lansing
Dawn Sargent	Tri-County	Community Mental Health Older Adult Services
Laurie Parker	Tri-County	Disability Network Capital Area
Kelly Neve	Tri-County	Clinton/Eaton County, DHHS
Linda Keilman	Tri-County	MSU, College of Nursing
JJ Jackson	Tri-County	CATA
Chad Johnson	Tri-County	JWR
Phyllis Monroe	Tri-County	Tri-County Nutrition Council
Gary Pollitz	Tri-County	Senior Alliance for Education
Tina Gross/Toby Powell	Tri-County	Sparrow Specialty Hospital
Karen Truszkowski	Tri-County	Sixty Plus Elderlaw Clinic
Jennifer Sexton	Tri-County	McLaren Orthopedic Hospital GEMS Unit

Janet Clark	Tri-County	Senior Companion Program
Ruth Voisinet	Clinton County	Clinton County
Eileen Heideman	Clinton County	Clinton County
Susann Baker	Ingham County	Ingham County
Jane Wallin	Ingham County	Ingham County
June Morse	Ingham County	Ingham County
Robyn Ford	Tri-County	Social Security Administration

APPENDIX C

Proposal Selection Criteria

Date criteria approved by Area Agency on Aging Board:	05/16/2016

Outline new or changed criteria that will be used to select providers:

No new or changed criteria was proposed.

APPENDIX D

Agreement for Receipt of Supplemental Cash-In-Lieu of Commodity Payments for the Nutrition Program for the Elderly

The above identified agency, (hereinafter referred to as the GRANTEE), under contract with the Aging and Adult Services Agency (AASA), affirms that its contractor(s) have secured local funding for additional meals for senior citizens which is not included in the current fiscal year (see above) application and contract as approved by the GRANTEE.

Estimated number of meals these funds will be used to produce is:	**550,000**

These meals are administered by the contractor(s) as part of the Nutrition Program for the Elderly, and the meals served are in compliance with all State and Federal requirements applicable to Title III, Part C of the Older Americans Act of 1965, as amended.

Therefore, the GRANTEE agrees to report monthly on a separate AASA Financial Status Report the number of meals served utilizing the local funds, and in consideration of these meals will receive separate reimbursement at the authorized per meal level cash-in-lieu of United States Department of Agriculture commodities, to the extent that these funds are available to AASA.

The GRANTEE also affirms that the cash-in-lieu reimbursement will be used exclusively to purchase domestic agricultural products, and will provide separate accounting for receipt of these funds.