MEALS ON WHEELS: MORE THAN A MEAL

Creatiing an innovative and responsive system to deliver
critical nutrition and social interaction
to vulnerable, isolated adults
in the Jefferson Managed Care Service Area.

ABSTRACT

Meals on Wheels America and Meals on Wheels Texas recognize a need to assure more eligible recipients are identified and served through a robust business plan and innovative practices. The following report details an analysis by home delivered meals (aka Meals on Wheels) providers, with the assistance of a consultant, in the Jefferson Managed Care Service Area, to consider how they may collaborate to accomplish these goals.

This report is funded by a grant from Meals on Wheels America to Meals on Wheels Texas. The report is part of analysis and preparation for the development of a pilot project in two regions of Texas designated for services from Managed Care Organizations (MCOs): the Bexar Managed Care Service Area, centered around Bexar County, Texas, and the Jefferson Managed Care Service Area, near Jefferson County, Texas.

This report is the property of Meals on Wheels Texas and Nutrition and Services for Seniors, the lead agency for the project in the Jefferson Managed Care Service Area. The report should not be shared without the permission of:

Elaine Shellenberger
Executive Director
Nutrition and Services for Seniors
4590 Concord
Beaumont TX, 77703
Phone: 409-892-4455
Fax: 409-892-0443
elaine@seniormeals.org

This report was prepared by Martha Spinks, Ph.D., consulting with Meals on Wheels Texas.
Dr. Spinks can be contacted at:
419 Stonewood
San Antonio, TX 78216
210.499.5175/210.364.6474
marthakspinks@gmail.com

Table of Contents

SUMMARY OF THE MEETING HELD JANUARY 22, 2016: 4

POINTS OF DISCUSSION 4

INVITEES 5

PILOT PROJECT 7

THE BUSINESS PLAN 7

A. Goal 7
B. Management Plan 7
C. Operating Plan 8
D. Marketing Plan 8
E. Funding Plan 9
F. Return on Investment/Social Return on Investment 9

Environmental Considerations for Expanding the Client Base in the Jefferson Managed Care Service Area 10

SWOT Analysis 13

STRENGTHS 13
WEAKNESSES 13
OPPORTUNITIES 14
THREATS 14

FOLLOW UP 15

FORMALIZE AN AGREEMENT 15
TO DO LIST PREPARATORY TO THE NEXT MEETING 16

APPENDICES 17

APPENDIX A. Invitation/Agenda Emailed to Jefferson Managed Care Service Area Providers 18
APPENDIX B. Bexar and Jefferson Managed Care Services Areas, by Counties and Places 19
APPENDIX C. Kronkosky Foundation Research Brief: Meals on Wheels 21
APPENDIX D. Proposed Flow Chart, Operation and Management of the Jefferson Managed Care Service Area 26
APPENDIX E. Proposed Community Coalition Charter 27
APPENDIX F. Draft Agreement between Fiduciary Agent and Coalition Members 30
APPENDIX G. Organizational Capacity Self Assessment & Collaborative Solutions Tool 32
APPENDIX H. Dual Eligible Medicaid Enrollment, by County 42
APPENDIX I. Medicare-Medicaid Recipients, by County 43
APPENDIX J. Age, Disability and Poverty Index by County 44
APPENDIX K. Area 2014 Census Population Characteristics for Age 60+, by County, with Comparison to State of Texas 50
APPENDIX L. Selected Economic Characteristics_14_5YR_DPO3.xls 51

SUMMARY OF THE MEETING HELD JANUARY 22, 2016:

FOCUS GROUP

Facilitated by Meals on Wheels Texas (Facilitator: Martha Spinks, Ph.D., MSW, Consultant)
for Regional Home Delivered Meals Providers

Concerning a Pilot Project to Improve Coverage in Unserved or Underserved Areas

Hosted by Holly Anderson, Director, Area Agency on Aging
Deep East Texas Council of Governments (DETCOG), Jasper, Texas

POINTS OF DISCUSSION

- Identify **challenges** to Meals on Wheels programs
- Identify **opportunities** presented by the challenges/current environment
- Make a **formal commitment to collaboration**
- Develop a **business plan**

GOAL FOR THE PILOT PROJECT (Broadly defined by the attendees at the end of the meeting and subject to edits or amendments by collaborating agencies):

Through a collaborative effort among regional home delivered meals providers, develop a cooperative business plan that closes the gaps in areas not currently served, or are underserved, by individual programs.

PROPOSED NEXT STEPS:

1. Facilitator will use content from the focus group meeting to draft a charter agreement and business plan outline for the group to review and make comment.
2. Following group input by email, group will determine whether to have a telephone conference and/or meeting to finalize draft business plan and charter.
3. Collaborating agencies will sign a charter, designate a Fiduciary Agent, and approve a business plan by March 2016.
4. With formalization of the relationship among collaborative members, the Jefferson Managed Care Service Area will operationalize to contract with one or more Managed Care Organizations (MCO) to provide Meals on Wheels/Home Delivered Meals to eligible adults in the designated region. (See Appendix B for a map of the pilot regions.)

INVITEES

Name	Mailing Address	City/Town	Zip Code	Email Address	Phone	Attending Meeting
Virgil Allen	P.O. Box 415	Coldspring	77331	sjseniorcitizens@yahoo.com	936.653.4175	Y
Barbara Hayes	602 E. Church Street, Ste 145	Livingston	77351	healthcare@livingston.net	936.327.6830	N
Frank Ivory	340 F Hwy 75 North	Huntsville	77320	seniorhuntsville@yahoo.com	936.295.6151	N
Bobbie Brodnax	109 West Water St	Jasper	75951	bobbiebrodnax@gmail.com	438.27280	Y
Maxine Morris	P.O. Box 1095	Cleveland	77328 - 1095	seniorteens@sbcglobal.net	281.592.1174	Y
Linda Hughes	103 North 5th St.	Orange	77631	lindaa@gtbizclass.com	409.886.2186	Y
Sandy Vaughn		Newton	75966	sandyvaughn@etxss.org	409.379.8083	Y
Vicki Smith	PO Box 3607	Victoria	77904	vickismith@cacv.us	361.578.2989	N
Y-Etta McBride	PO Box 683	Anahuac	77514	yetta@seniorcitizenprojectcc.org	409.267.3559	N
Elaine Shellenberger	4590 Concord	Beaumont	77703	elaine@seniormeals.org	409.892.4455	Y
Holly Anderson	210 Premier Dr.	Jasper	75951	handerson@detcog.com	409.384.5704	Y
Barbara Wilson	P.O. Box 1095	Cleveland	77328	seniorteens@sbcglobal.net	936.509.6350	Y
Tammy Blank	621 Harris	Nacogdoches	75964	tammyblank1@suddenlinemail.com	936.509.6350	Y
Rayfield Jefferson	P.O. Box 415	Coldspring	77331	sjseniorcitizens@yahoo.com	936.653.4175	Y
*Mitch McMillon	409 N. Fletcher	Jasper	75951	mitchmcmillom@sbcglobal.net	409.384.3701	Y
Bobbie Stott	210 Premier Dr.	Jasper	75951	b.stott@detcog.com	409.384.5704 ext 5303	Y
Donna Sprouse	210 Premier Dr.	Jasper	75951	donna.sprouse@detcog.com	409.384.5704	Y
*Kasie Kroll	340-F Hwy 75 North	Huntsville	77321	seniormeals60@att.net	936.291.2868	N
*Charles Lee	PO Box 1008	Groveton	75845	grovetonsrcenter@windstream.net	936.642.1541	N
*Katie Jones	PO Box 1008	Groveton	75845	grovetonsrcenter@windstream.net	936.642.1541	N
*Deacon Glenda Hardin	2041 Trinity Ave.	Liberty	77575	admin@saintstephensliberty.org	936.336.3762	N

*Not included in email invitation for January 22, 2016 meeting. They should be added to list of invitees.

ATTENDEES SIGNING COMMITMENT TO COLLABORATE with Meals On Wheels Texas and Other Local Home Delivered Meals Providers to Develop a Business Plan:

Agency	Representative	Phone	Email
East Texas Support Services, Inc.	Bobbie Broadnax	409.382.7280	bobbirbroadnaz@gmail.com
San Augustine County	Bridgette Brown, for Judge Sayme Johnson	936.201.3951	BBROWNloavesandfishes@gmail.com
Senior Citizens of San Jacinto County	Rayfield Jefferson	936.653.4175	sjseniorcenter@yahoo.com
Nacogdoches County Senior Center	Tammy Blank	936.569.6350	Tammyblank1@suddenlinkmail.com
Orange County	Linda Hughes	409.886.2186	lindaa@qtbizclass.com
Nutrition and Services for Seniors, Beaumont, TX	Elaine Shellenberger	409.892.4455	elaine@seniormeals.org

Note: This is a nonbinding commitment based on the initial meeting of the group of potential collaborators. Others who did not sign or did not attend the meeting on January 22, 2016, have an opportunity to commit to the project by signing the proposed charter.

PILOT PROJECT

1. The first hour of the meeting was a presentation from the facilitator about the **pilot project** led by Meals on Wheels Association of Texas, funded by Meals on Wheels of America. Meals on Wheels America and Meals on Wheels Texas recognize a need to expand services to assure more eligible recipients are identified and served. The challenges of reaching more eligible recipients will require collaboration among providers to develop a business plan that allows the various home delivered meals programs to identify
   A. their respective strengths
   B. ways in which the programs can align their strengths and help each other to—
      i. create efficiencies that result in more clients being served
      ii. sustain individual HDM programs
      iii. sustain the traditional model of a local HDM program that delivers "more than a meal" by engaging in frequent face-to-face contact with clients
      iv. collaborate to develop innovative solutions that address the barriers described in items i-iii above

2. Attendees were given summary statistics from an online survey that was completed by them in November and December. The results were used to lead a discussion about the characteristics and capacity of the programs collectively.

3. The facilitator discussed the outline of a business plan:
   A. Goal
   B. Operating Plan
   C. Management Plan
   D. Funding Plan
   E. Return on Investment/Social Return on Investment

THE BUSINESS PLAN

4. Attendees began discussions on the business plan as follows:
   A. **Goal**
   "Through a collaborative effort among regional home delivered meals providers, develop a cooperative business plan that closes the gaps in areas not currently served, or that are underserved, by individual programs."

   B. Management Plan
      1) Designate all parties to the agreement as a coalition and advisory committee to the coalition
      2) Designate a leader for the group, who, at a minimum, will
         a. Be a point of contact for members of the coalition
         b. Be a point of contact for business partners or potential business partners

c. Organize, at minimum, routine quarterly meetings
d. Call other meetings as needed
e. Be on the alert for funding opportunities
f. Organize work groups or identify specialists within the group who can write grants, negotiate contracts, etc.

3) Formalize an agreement to collaborate and implement a business plan and regional operating network (See Appendix E for draft charter.)
4) Review types collaborative arrangements, including, but not limited to:
    a. Consider organizing a voluntary coalition, and the criteria for membership.
    b. Consider the efficacy of organizing as a 501(c)(3)
    c. Per DETCOG AAA staff, consider approaching the regional coalition of Area Agencies on Aging to discuss expanding the membership of that existing organization to home delivered meals providers. (Per suggestion from DETCOG AAA staff.)
5) Designate a Fiduciary Agent for the collaborative. (See Appendix F for draft of Fiduciary Agent agreement.)

C. Operating Plan

1) See Appendix D for schematic of proposed operating procedure
2) Identify allies of the home delivered meals programs
3) Share information
4) Share good ideas
5) Standardize core programs to the degree possible, with the understanding that agencies vary to some degree in their resources as well as their additive programs and will continue to do so
6) Create a formal agreement among area home delivered meals providers to act as a collaborative to contract with MCOs and address other mutual interests
7) Create a more coordinated and reliable information and referral system for clients and providers
8) Join and/or work with the regional coalition of Area Agencies on Aging
9) Develop partnerships among home delivered meals providers to assist each other to fill respective gaps

D. **Marketing Plan**

1) Use the current threat from new competitors as an opportunity to revive marketing materials and develop a consistent strategy that individual HDM providers can share, e.g.,
    a. Write a business case for the superiority of local HDM programs that all HDM providers use in print materials, presentations, contacts with officials, community leaders, DADS, etc.
    b. Design a marketing strategy for core services offered by all providers that results in
        i. A brochure, posters and other print materials shared by all providers

ii. A scripted presentation that all members can use in contacts with officials, the media, and potential business partners

c. Not discussed, but facilitator recommends:

i. A standardized style in logos, colors, print, signage etc. (Consider using the new Meals on Wheels America logo and colors.)

ii. A press kit that represents the coalition as an extensive network across the region

iii. Contacts with media outlets using the press kit, asking for regional coverage of the coalition

iv. A dedicated website to promote all regional HDM programs (See example at www.callarideforseniors.org) to supporters as well as consumers.

v. Sample letters to use in contacts with officials, businesses, volunteers, etc.

vi. A map for who, by position or title, to contact in each local community

vii. Schedule meetings with all county and state officials, community leaders, community volunteers and businesses to tell them about HDM and the role it plays in the health of the community and containment of health crises and health costs, as well as the potential threat to traditional HDM.

E. Funding Plan

1) Attendees are tentatively willing to discuss the possibility of consolidating administrative activities, which may include appointing a Fiduciary Agent from within the agencies that are members of the collaborative.
2) Attendees discussed the possible benefit of collaboration would be the ability to contract with MCOs and and others to generate additional revenue

F. **Return on Investment/Social Return on Investment**

1) Return on Investment (ROI)

a. Efficiencies of scale resulting from consolidating administration and management of several HDM providers for contracting, billing, reporting, etc.

b. Efficiencies from realigning service areas and referring clients between providers within the service area to allow more flexibility based on capacity and geographic reach of collaborating HDM programs

c. Savings to individuals, insurance companies and local health care systems through early identification of client health risks that

i. Prevents recidivism/readmission of recently discharged individuals, for which health care systems now are penalized under the Affordable Care Act

ii. Prevents or delays client morbidity and mortality, prompting health care treatment at an earlier or non-emergency and less expensive stage

   d. Leverages relationships in the community to provide additional social service support or intervention that prevents morbidity and mortality
   e. Increase in unit rates through collaborative efforts of local HDM providers and local officials to leverage political influence at the state level
   f. Increase in funding sources through agreements with Managed Care Organizations, health care systems and others
   g. Potential for Medicaid reimbursements for other program services, e.g., care transitions, adult day care, transportation to medical appointments
2) Social Return on Investment (SROI)
   a. Strengthens the social safety net for consumers by keeping a local program in place that
      i. Provides social interaction to isolated clients almost daily, which has been documented to improve mental health
      ii. Insures frequent face-to-face observation and comparison of client status over time
      iii. Notifies family caregivers, health care providers, adult protective services or others of concerns
      iv. Has detailed knowledge of the whole person, e.g., secondary health or social problems, relationships, isolation, or change in status that may prompt or prevent decompensation and may be unknown to family caregivers, health care providers or public safety officials
      v. Can leverage relationships in the community to provide additional formal and informal resources or intervention with at-risk clients who are unserved or underserved by social services or health care systems
   b. Makes HDM a component of broader public health consciousness of the local community, rather than isolating it as a commercial enterprise
   c. Educates local agencies, officials, businesses and individuals about HDM and the value and impacts accruing to the community from local HDM providers, compared to commercial providers

Environmental Considerations for Expanding the Client Base in the Jefferson Managed Care Service Area

1. For the purposes of this report, the term Home Delivered Meals (HDM) refers to all programs that deliver meals to adults in their homes. HDM is the term used by the major funder of most of these programs, the federal Older Americans Act. Meals on Wheels often is used interchangeably with HDM, but for the purposes of this report, MOW is used to refer to Meals on Wheels Texas (MOWT), an association of HDM providers from across the State of Texas, or to organizations that are members of MOWT. MOWT is the recipient of a grant from Meals on Wheels America for the purpose of developing coalitions among HDM providers—not just MOWT members.

2. Attendees at the focus group in this largely rural area participated in a SWOT analysis, which provides important insights into the environment in which they have operated for decades. The SWOT analysis is provided below.
3. The majority of directors of HDM programs in this area have at least 10 years of experience, and many have 20 or more years of experience managing and sustaining their current programs.
4. These directors have significant experience fundraising and habitually overmatch the OAA grant, as do most of the HDM programs throughout Texas. A brief prepared by the Kronkosky Foundation at Appendix C describes the MOW program in the Bexar Managed Care Service Area, yet is instructive about MOW programs more generally, and is fitting as a general description of the Jefferson Managed Care Service Area.
5. See Appendix B for a map of the areas that will be the sites of the pilot projects. While San Antonio and Beaumont are sizable municipalities, for much of the Jefferson and Bexar Managed Care Service Areas, the map shows large geographical expanses with few major highways and a limited number of towns or villages, suggesting the distances that HDM providers may be required to drive to reach many rural clients. Geography is a key challenge to expanding the number of clients served.
6. The HDM programs were established nearly 40 years ago when the federal Older Americans Act (OAA) added funding for nutrition services for people 60 and older. OAA funding is awarded to states, and in Texas those funds are passed to Area Agencies on Aging in 28 designated regions that manage most of the federal and state funding for people 60 and older. In addition to nutritional funding, the OAA also provides case management, information and referral, benefits counseling, income support, family caregiver support, and other related social services programs.
7. The OAA requires providers to put up matching funds, which the HDM programs solicit from the state, other government agencies, and charitable and civic organizations, adding as much as much as 40%-60% to the total program funding. HDM typically have substantial volunteer support, the recruitment and management of which adds further in-kind contributions from the providers. (See Appendix C for more detail on the impact of the nonprofit providers.)
8. Conversations with members of Meals on Wheels Texas indicated that MOW providers have difficulty estimating how many eligible participants reside in their areas and what percentage of eligible clients are not served. For this reason, Appendices H through L have been included for the convenience of HDM providers in the Jefferson Managed Care Service Area so they can extrapolate the number of eligible clients who are 60 and older, and also consider the numbers and categories of new clients that might be offered to them by contracts with a Managed Care Organizations, which provide community-based services to Medicaid-eligible adults under its Star+Plus contract with the State of Texas.
9. Contracting with Managed Care Organizations or others could expand HDMs' traditional client base from people 60 and over to anyone 18 and older who meets qualifications for community-based services.
10. Star+Plus is a Medicaid Managed Care program of the Texas Health and Human Services Commission (HHSC) for adults who are not receiving Medicare. The term "Managed Care" means the State of Texas hires managed care organizations (MCOs) to manage recipients' health care, including community-based services, such as HDM, that prevent admission or readmission to hospitals and long term care facilities. Those eligible for Star+Plus include:

- Individuals who do NOT have Medicare coverage AND
- Individuals with Intellectual or Developmental Disabilities (IDD), who receive services in an intermediate care facility,
- Individuals with an Intellectual Disability or Related Conditions (ICD-IID),
- Or Individuals with one or more of the following IDD Waivers:

    - Community Living Assistance and Support Service (CLASS)
    - Deaf Blind and Multiple Disabilities (DBMD)
    - Home and Community-based Services (HCS)
    - Texas Home Living (TxHmL)[1]

11. The pilot project and the data in this report were prompted by recent changes to the way the Older Americans Act nutrition program has operated for the past 40 years. The State of Texas has been approached by commercial providers claiming that they can reach isolated seniors and meet the goal of the State to assure HDM are provided to all seniors in Texas, regardless of location. While HDM providers have provided exceptional service, reaching all isolated seniors in the vast, open areas of Texas has always been a challenge for nonprofit HDM, due to limitations in infrastructure and funding.

12. The commercial providers have contacted state legislators and Texas' Department of Aging and Disability Services (DADS) for their support in changing the Texas Administrative Code (TAC) to allow them to compete with nonprofit HDM providers.

13. To date, the commercial providers have made inroads in two areas: 1) some Area Agencies on Aging have contracted with commercial providers to deliver meals to seniors for emergencies and/or routine needs, and 2) Managed Care Organizations, charged by the State of Texas Star+Plus program to provide community-based services to Medicaid recipients, have contracted with both commercial and nonprofit HDM providers to provide nutrition services to their clients.

14. The Meals on Wheels Association of America has identified commercial providers as a threat to the traditional Meals on Wheels providers nationally. As a result, MOWA awarded MOWT a $10,000 grant to develop two pilot projects in Texas between November 2015 and August 2016 to test whether HDM providers can collaborate to create and operationalize a business plan that will make them better able to maximize their reach to isolated seniors, serving more seniors in more diverse ways, to meet the goal of the State to serve every eligible senior, wherever they may be.

---

[1] - For more detail see http://www.starplustx.com/#sthash.0bWe5nz0.dpuf
For MCOs assigned to each county and contact information for those MCOs, see http://www.starplustx.com/Counties.)
For more information on community-based services funded by Texas Department of Aging and Disability Services, go to http://www.dads.state.tx.us/providers/.)

SWOT Analysis

STRENGTHS

1. The majority of HDM are prepared fresh daily, without additives/preservatives
2. HDM has firsthand knowledge of clients in detail, e.g., day to day comparison of physical and cognitive function, preferences, support systems, families, social history, level of isolation, idiosyncrasies that could put them at risk
3. HDM staff have trusted face-to-face relationships with clients who may not respond to people they don't know
4. HDM integrates many other services with meal delivery, e.g., Senior Companions, Adult Day Care, Senior Centers, Congregate Meals, Special Events
5. HDM staff recognize barriers to nutrition, particularly for chilled or frozen meals, such as
    a. Lack of electricity
    b. Lack of refrigeration
    c. Lack of cooking/heating devices
    d. Lack of physical or cognitive ability to receive, store, or prepare meals
6. HDM supports the mission of Area Agencies on Aging by daily observing clients most at risk
7. HDM has the capacity to provide client tracking to MCOs
8. Recognition of MOW and/or local HDM provider agencies as a trusted brand
9. HDM staff and volunteers possess
    a. First hand knowledge of the environment and people
    b. Decades of experience by staff
    c. Personal connections at the local level with
        i. Clients
        ii. Family caregivers
        iii. Community members
        iv. Government officials
        v. Businesses
        vi. Civic organizations
        vii. Religious organizations
        viii. Educational institutions
10. Volunteers offset expenses of traditional HDM programs
11. HDM programs raise funds to match and sometimes exceed government nutrition funding
12. HDM programs receive financial contributions from local governments and agencies to supplement government nutrition funding

WEAKNESSES

1. Limited funding
2. Lack of staff
3. Lack of volunteers
4. Lack of time
5. Reliance on declining government funding

6. Overtaxed local donors, especially in smaller communities, which have fewer charitable or civic organizations or philanthropists
7. Managing the transition gap from oldest old aging out of HDM or dying while to trying to engage Boomers. (This may result in a short term dip in demand services that will increase as Boomers become older.)
8. Need to improve marketing
9. Lack of media exposure in rural areas
10. Need to identify all people who need help
11. HDM staff aging out, i.e., staff stay with HDM program for many years, often till retirement; limited funds prevent hiring new staff for overlap and training; substantial institutional knowledge is lost
12. DADS policies prevent (or make difficult) collaboration/client sharing/gap coverage. Example: individual assigned to one service area that cannot reach far enough to assist could be assisted by HDM in another area, but assignment and funding rules prevent assistance
13. SPURS/Harmony system is problematic for both HDM providers and AAAs

OPPORTUNITIES

1. Requests from commercial providers to provide a higher rate for meal delivery has opened a discussion at state level that was not encouraged in the past
2. Requests from commercial providers to change Texas Administrative Code (TAC) to allow them more flexibility may produce more flexibility for traditional HDM programs
3. The pilot project can be used to mount a well integrated, well defined marketing campaign that helps providers engage stakeholders, including MCOs, consumers, other helping agencies, officials, and businesses

THREATS

1. Requests from commercial providers to change Texas Administrative Code (TAC) to allow them more flexibility could give them advantages in competing with HDM programs
2. Commercial competitors with substantial financial, marketing and political resources could pose a threat to continuing traditional HDM programs
3. The long term effect of competition from commercial providers could be that 1) HDM programs could not sustain the competition, and 2) with the demise of HDM programs commercial providers would raise rates with the eventual result that 3) fewer clients would be served than are currently served, because 4) the program becomes more expensive
4. With drop-ship services and more flexible funding, commercial providers can provide meals seven days a week
5. Communication gaps with Managed Care Organizations
    a. Delayed response from MCOs to HDMs' inquiries about clients, including notification of continuation in the health plan
    b. Delayed reimbursement of providers for services
    c. Non-reimbursement when services are provided after client drops health plan without provider's knowledge

6. Lack of knowledge by MCOs re HDMs
7. MCO staff lack knowledge/experience dealing with client population, connecting clients to resources, including HDM
8. Decline in charitable funding
9. Lack of empathy for aging populations among funders
10. Logistics
    a. Rural isolation—delivery of traditional HDM to one person at a great distance from others is not cost effective
    b. Extended service areas beyond ability of HDM staff or volunteers to deliver
    c. Poor country roads—wear and tear on vehicles, poor signage, add to complexity of delivery
    d. Poor 9/11 network in rural areas inhibits communication
    e. Poor information and referral in rural areas
    f. Clients may have limited capacity for self care, e.g.,
        i. following staff instructions
        ii. recognizing whom they can trust
        iii. having utility service
    g. Clients at risk for health crises, self neglect, exploitation

FOLLOW UP

Items that need to be addressed in order to form a collaboration, sign a charter, and create and implement the business plan.

FORMALIZE AN AGREEMENT

1. Review this report of the meeting on January 22, 2016
2. Submit questions and comments to the facilitator and/or Elaine Shellenberger, Executive Director of Nutrition for Seniors and More, whose agency received the grant for this project
3. HDM providers in the Jefferson Health Service Area who wish to proceed with a regional collaboration should
    a. Review the draft charter (Appendix E), provide comments, recommend modifications, and advise the facilitator if the provider is willing to sign the charter
    b. Review the draft Fiduciary Agent Agreement (Appendix F), provide comments, recommend modifications, and advise the facilitator if the provider is willing to sign the charter
    c. Indicate availability for participation on an Advisory Committee that will communicate frequently to implement the operational plan
    d. Be prepared to attend a follow up meeting to finalize details of the collaboration and sign the charter

TO DO LIST PREPARATORY TO THE NEXT MEETING

1. Elaine Shellenberger will forward information to attendees about acquiring a Medicaid number for billing.
2. Individual organizations should complete the Organizational Assessment (See Appendix G) and submit to the facilitator along with the following information:
    a. Identify what each collaborator can contribute to the collaboration
    b. Identify what each collaborator needs from other collaborators
    c. Identify areas where collaborators may need to create a new system or process to make the business plan work
3. Providers with an MCO contract email a copy of the contract to the facilitator, along with contact information for MCO staff person responsible for setting up or managing the contract.
4. Each attendee submit one or more stories, not to exceed 250 words, that illustrate the impact of the HDM program
5. Each attendee submit any information about operations of Mom's Meals or other commercial providers, in their area that can be documented, e.g.,
    a. A client requesting Mom's Meals in place of traditional HDM
    b. A client being reassigned by an MCO from HDM to Mom's Meals
    c. An Area Agency on Aging that is using drop ship providers

APPENDICES

APPENDIX A. Invitation/Agenda Emailed to Jefferson Managed Care Service Area Providers 18

APPENDIX B. Bexar and Jefferson Managed Care Services Areas, by Counties and Places 19

APPENDIX C. Kronkosky Foundation Research Brief: Meals on Wheels 21

APPENDIX D. Proposed Flow Chart, Operation and Management of the Jefferson Managed Care Service Area 26

APPENDIX E. Proposed Community Coalition Charter 27

APPENDIX F. Draft Agreement between Fiduciary Agent and Coalition Members.. 30

APPENDIX G. Organizational Capacity Self Assessment & Collaborative Solutions Tool 32

APPENDIX H. Dual Eligible Medicaid Enrollment, by County 42

APPENDIX I. Medicare-Medicaid Recipients, by County 43

APPENDIX J. Age, Disability and Poverty Index by County 44

APPENDIX K. Area 2014 Census Population Characteristics for Age 60+, by County, with Comparison to State of Texas 50

APPENDIX L. Selected Economic Characteristics_14_5YR_DPO3.xls 51

APPENDIX A. Invitation/Agenda Emailed to Jefferson Managed Care Service Area Providers

Meeting Agenda
Friday, January 22, 2016
10 a.m.-2 p.m.
Meals on Wheels Association of Texas (MOWAT)
&
Home Delivered Meals Providers of the Deep East Texas Area
LOCATION:
Deep East Texas Area Agency on Aging
210 Premier Drive
Jasper, Texas 75951

Executive Directors of area Home Delivered Meals (HDM) Programs are invited to attend a meeting with representatives of Meals on Wheels Association of Texas (MOWAT) on Friday, January 22, 2016, from 10 a.m. to 2 p.m. Lunch will be provided by the meeting host, Deep East Texas Area Agency on Aging. The purpose of this meeting is to discuss building a collaboration among HDM providers to expand and improve HDM services, with a special focus on reaching unserved or underserved areas.

All HDM providers—not just members of MOWAT, and not just recipients of state or federal funding—are strongly encouraged to attend. We are aware that there are HDM programs that are doing important work without these connections, and we would like to know about you and how you might be part of this project.

Several HDM providers that were previously identified received surveys from MOWAT in November and December asking about their capacity, their concerns, and their interest in collaborating to strengthen their organizations and expand services. If you want to know more about the survey, go to https://www.surveymonkey.com/r/attachmentDETCOG to view and/or complete the survey.

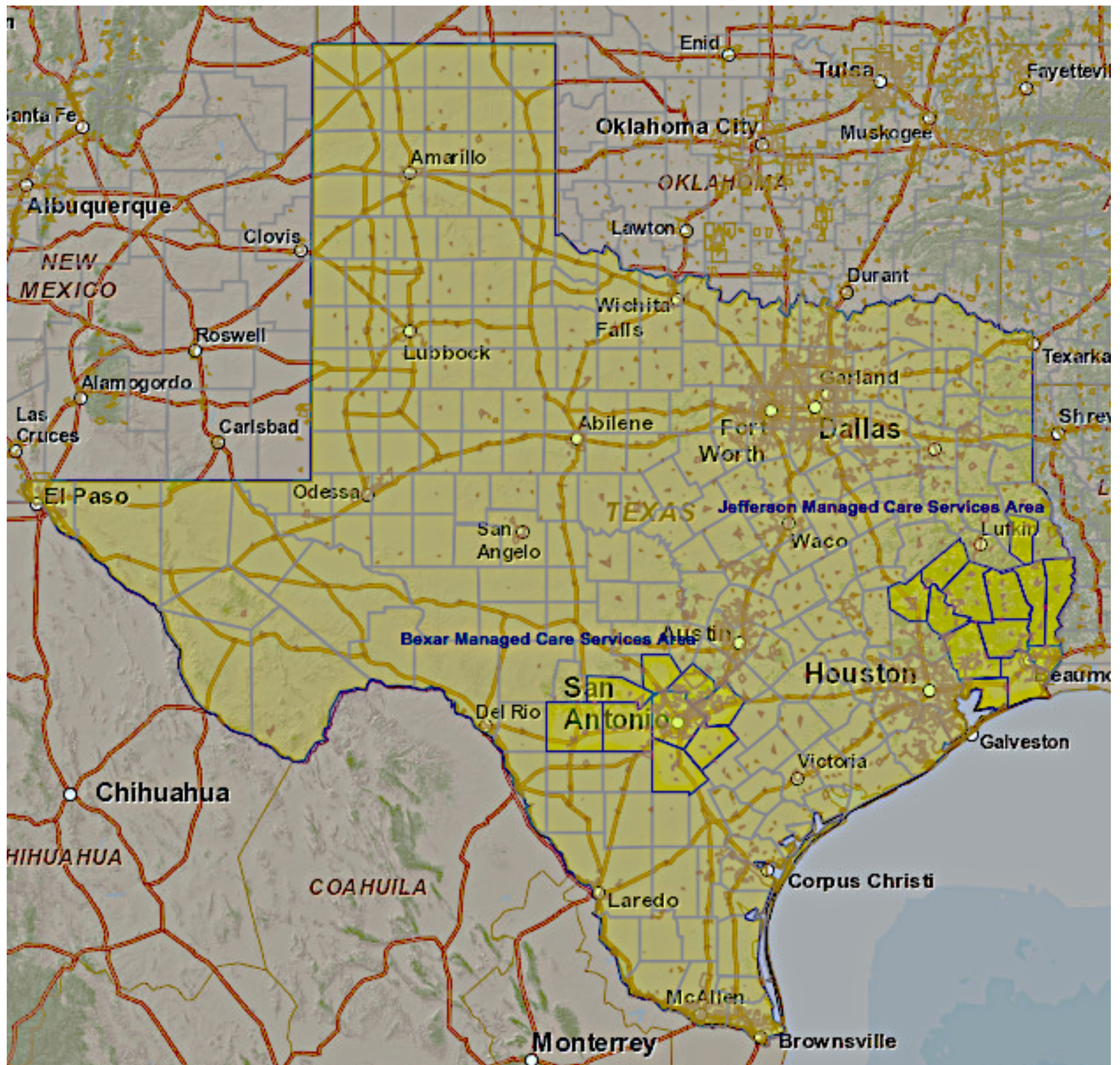
The goals of the meeting are:

1. Discuss MOWAT's pilot project to assist HDM programs in Deep East Texas to create and test a new collaborative business model.
2. Share what has been learned from the MOWAT survey about the Strengths/ Weaknesses/Opportunities/Threats related to the area Home Delivered Meals programs.
3. With the input of HDM providers in attendance, fill in information that the survey may not have captured.
4. With the input of HDM providers in attendance, outline a plan about how HDM providers can collaborate to create a robust program that expands meal services to more consumers and opens new opportunities to providers that will strengthen their operations.
5. Draft a tentative agreement to collaborate and pilot the development and implementation of a new business plan.

If you have questions about the MOWAT pilot project, please feel free to contact Martha Spinks, Ph.D., MSW, at marthakspinks@gmail.com or 210.499.5175.

Holly Anderson, CIRS-A
Director, Area Agency on Aging
Director, 211/Area Information Center
210 Premier Drive
Jasper, Texas 75951
409-384-7614, 409-384-5704, ext 5258 (office)
409-384-6177 (fax)

APPENDIX B. Bexar and Jefferson Managed Care Services Areas, by Counties and Places



Note: San Augustine and Trinity Counties are not normally part of the Jefferson Managed Care Service Area, but have been added for the purposes of the pilot project due to interest from those counties. Uvalde is not normally part of the Bexar Managed Care Service Area, but is being considered for addition to the pilot project.

With the designation of places and major highways in each county, this map illustrates the relative isolation of areas in Texas. See below for the Census Bureau definition of "Places," which are represented on this map.

Geographic Terms and Concepts - Place

Incorporated Places are those reported to the Census Bureau as legally in existence as of January 1, 2010, as reported in the latest Boundary and Annexation Survey (BAS), under the laws of their respective states. An incorporated place is established to provide governmental functions for a concentration of people as opposed to a minor civil division, which generally is created to provide services or administer an area without regard, necessarily, to population. Places always are within a single state or equivalent entity, but may extend across county and county subdivision boundaries. An incorporated place usually is a city, town, village, or borough, but can have other legal descriptions.

Census Designated Places (CDPs) are the statistical counterparts of incorporated places, and are delineated to provide data for settled concentrations of population that are identifiable by name but are not legally incorporated under the laws of the state in which they are located. The boundaries usually are defined in cooperation with local or tribal officials and generally updated prior to each decennial census. These boundaries, which usually coincide with visible features or the boundary of an adjacent incorporated place or another legal entity boundary, have no legal status, nor do these places have officials elected to serve traditional municipal functions. CDP boundaries may change from one decennial census to the next with changes in the settlement pattern; a CDP with the same name as in an earlier census does not necessarily have the same boundary. CDPs must be contained within a single state and may not extend into an incorporated place. There are no population size requirements for CDPs. (Retrieved from https://www.census.gov/geo/reference/gtc/gtc_place.html, February 22, 2016)

APPENDIX C. Kronkosky Foundation Research Brief: Meals on Wheels

Exhibit on following page

Research Brief

Meals on Wheels

JUNE 2015

The Meals on Wheels Association of America is the largest and oldest organization that provides meal services to the needy, particularly to the elderly, homebound, disabled, frail, or at risk. Understanding the need for Meals on Wheels programs first requires an examination of hunger among Americans, particularly senior citizens.

Need for Meals on Wheels:
Hunger among America's seniors
For seniors, many factors contribute to food insecurity, hunger, and nutritional deficiencies, including:

- Cost of food
- Expense for necessary medications
- Inability to locate, purchase, and cook food
- Reduced absorption of nutrients from food
- Less acute sense of taste and smell
- Loss of appetite
- Physical impairments
- Poor general and oral health
- Difficulty chewing and swallowing
- Social Isolation
- Depression

(Go4Life, n.d.; Health in Aging, 2015)

As people age, food insecurity and hunger increase health risks. Research has demonstrated that seniors with low food security experienced more depression, lowered quality of life, and reduced physical performance. In fact, the higher the level of food insecurity, the more issues with pain, general health/functioning, and mental health.

In addition, seniors are more likely to have nutrient deficiencies and obesity (Meals on Wheels Association of America, 2010). Some earlier studies on elderly nutrition (Sharpe, Huston, & Finke, 2003) supported the recent research findings that seniors consumed fewer than the recommended daily allowance for eight nutrients like calcium and vitamin D. When those seniors also had insufficient supplies of food, the nutrient deficiencies were even more pronounced and appeared for multiple vitamins including B12, B6, D, and folic acid (Health in Aging, 2015).

Hunger in Texas
In 2013, 14.3% of all U.S. households experienced food insecurity. In Texas, the food insecurity rate included 18% of all households (Coleman-Jensen, Gregory, and Singh, 2014):

- **2013 Food Insecure Households *(with low or very low food security)***
    - United states – 14.6%
    - Texas - 18%
- **2013 Food Insecure Households *(with very low food security)***
    - United states – 5.7%
    - Texas - 6.3%

(Coleman-Jensen, Gregory, and Singh, 2014)

As of March 2013, Texas was ranked 3rd in the nation for percentage of food insecure persons (Texas Legislative Study Group, 2013), and when only seniors are considered, Texas ranked 5th with 20.26% of seniors facing the threat of hunger in 2013 (Ziliak & Gunderson, 2015). Some research

provides detailed demographic information on Texas senior citizens who are classified as food insecure. Those results appear in the following table. All of the available statistical data and research findings emphasize the need for legislation and programs like Meals on Wheels to enhance the nutritional intake of senior citizens.

Distribution of Food Insecurity in Texas Senior Citizens	
	%
Age	
60-70 years old	51.4
70-80 years old	33.9
Older than 80	14.7
Gender	
Female	61.2
Male	38.8
Ethnicity	
White	70.4
African-American	24.5
Other	5.1
Hispanic	27.2
Education	
Less than high school	52.3
High School	28.8
Some College	15.7
College Degree(s)	3.2
Employment	
Employed	14.2
Unemployed	2.3
Retired	54.5
Disabled	29.0
Income	
< 50% Federal Poverty Line (FPL)	8.9
50%-100% FPL	34.1
100%-200% FPL	26.2
> 200% FPL	12.8
Income not provided	18.0
Location	
Metro	83.2
Non-metro	16.8
Family	
No grandchildren or parent* in home	80.8
Grandchild and parent* in home	9.4
Grandchild in home	9.9
Living Alone	28.9
Homeowner	70.9
* Of the senior in question	
(Ziliak & Gunderson, 2009)	

Beginnings of Senior Nutrition Programs: The Older Americans Act

Some of the initial programs addressing the nutritional and social needs of senior citizens were created by the federal government in 1968. One decade later, Congress funded an elderly nutrition program under Title III of the Older Americans Act (Colello, 2011).

In 2014, the final allocations for the Older Americans Act included $433,809,090 in funding for congregate (group) meals, $214,233,030 towards home-delivered meals, and $144,130,140 for nutrition services incentive program (limited to food purchase). This money is given to state agencies, who then distribute the funds to area agencies, including Meals on Wheels. Texas' share of the funds in 2014 included $27,060,605 for congregate meals, $13,802,428 for home-delivered meals, and $8,842,879 for nutrition services incentive program (Administration on Aging, 2014). Typically, for every dollar of Title III money spent, another $1.70 for congregate meals and $3.35 for home-delivered meals must be raised from other state, local, private, and participant funding (Colello, 2011).

Programs that receive money from the Older Americans Act, including Meals on Wheels, must abide by several requirements. In Texas, these guidelines are outlined by the Texas Department of Aging and Disability Services (DADS). The guidelines include:

- Offer services to people 60 years and older with the greatest social and economic need, especially low income seniors and those who reside in rural areas
- Provide at least one meal a day, five or more days a week (exceptions allowed in rural areas)
- Meal must contribute to 1/3 of the daily dietary allowance
- Safe and sanitary food preparation conditions
- Initial nutritional screening of participants
- Promote intergenerational meal programs

- Offer congregate meals when possible at facilities like senior centers, community centers, schools, and adult day care centers
- Ask participants for voluntary monetary contribution toward the meal (not required if they lack the means)

(Colello, 2011)

The Meals on Wheels Program

The predecessor of Meals on Wheels occurred during World War II when meals were delivered to service members in England. The first Meals on Wheels program in its current form began in Philadelphia during 1954, where "Platter Angels" served hot, nutritious meals to senior shut-ins. Today, a hot lunch is delivered by volunteers at least 5 days a week to seniors either at their home or in a group setting (congregate) such as a senior center (NorthWest Senior & Disability Services, n.d.). There are more than 5,000 Meals on Wheels programs in the United States that are operated by more 2 million volunteers (Meals on Wheels America [MOWA], 2015a).

Meals on Wheels focus is on two participant bases, those who are frail elderly needing long-term support and those who need a short-term intervention (such as rehabilitation from a hospital stay).

A 2009 study reported that the average person receiving home-delivered meals was 75 years or older, garnered an income of $10,000 or less a year, and required assistance with one or more activities of daily living (such as shopping, dressing, bathing, and housework). In addition, the meals provided gave the recipients at least half of their daily food consumption (Colello, 2011).

The mission of Meals on Wheels America is to "empower local community programs to improve the health and quality of life of the seniors they serve" with the vision of "An America in which all seniors live nourished lives with independence and dignity" (MOWA, 2015a). The Meals on Wheels Association of America provides one year of meals to its participants for $1,600. This cost is equivalent to the average cost of one week's stay in a nursing facility (MOWA, 2015b).

Meals on Wheels Close to Home: Bexar and Surrounding Counties

Exclusive Meals on Wheels programs exist in Bandera, Bexar, Comal, and Kendall counties. The scope of the program depends, in part, on the size of the county. The following chart lists the most recent data available:

San Antonio Region Meals on Wheels Program Statistics

County	Meals on Wheels Provider	Year	Meals Delivered	Congregate Meals	Total
Bandera	Silver Sage Corral Senior Activity Center	2014	18,139	6,249	24,388
Bexar	Christian Senior Services	2014	924,146	46,218	970,364
Comal	Comal County Senior Citizens Center	2014	48,099	4,085	52,184
Kendall	Kronkosky Place (Rainbow Senior Center)	2014	45,313	28,900	74,213

(Bandera County Committee on Aging, 2014; Christian Senior Services, 2014; Comal County Senior Citizen's Foundation, 2014; Rainbow Senior Center, 2014)

Beyond Just a Meal: Extra Benefits of Meals on Wheels

In addition to supplementing clients' daily nutrition, Meals on Wheels services provide other direct and indirect benefits:

- *Reduces isolation and provides social interaction and support*. This occurs when the senior eats at group meal sites or through daily interaction with the Meals on Wheels volunteers.
- *Supports seniors with disabilities.* An important study on health risks for seniors (Sharkey, 2002) suggested that difficulty in shopping for food and preparing meals were associated with increasing severity of disability.
- *Lowers the cost of health care.* Poor nutrition increases the risk of disease and therefore the cost of health care, particularly for seniors. "The elderly were the smallest population group at 13 percent of the population and accounted for ... 34 percent of spending in 2010" (Centers for Medicare & Medicaid Services], 2014).

Growing Crisis

The number of seniors experiencing hunger continues to grow at an alarming rate. "Since the onset of the recession in 2007 until 2013, the number of seniors experiencing the threat of hunger has increased by 56%" (Ziliak and Gundersen, 2015, p.2). Surprisingly, the majority of seniors in this position are living with an income above the poverty line. The need for services such as Meals on Wheels can be expected to rise as the number of seniors increases with the aging of the Baby Boom generation.

References

Administration on Aging. (2014). State allocation tables: Title III (2014). Retrieved from http://www.aoa.gov/AoA_programs/OAA/Aging_Network/State_Allocations/docs/T3_2014.pdf

Bandera County Committee on Aging. (2014). *Evaluation report for fiscal year 2014.* Available at the Kronkosky Charitable Foundation office.

Centers for Medicare & Medicaid Services (CMS). (2014). *National Health Expenditure Data Fact Sheet*. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html

Christian Senior Services. (2014). *Evaluation report for fiscal year 2014.* Available at the Kronkosky Charitable Foundation office.

Colello, K. (2011). *Older Americans Act: Title III nutrition services program*. Retrieved from http://nationalaglawcenter.org/wp-content/uploads/assets/crs/RS21202.pdf

Coleman-Jensen, A., Gregory, C., and Singh, A. (2014). *Household food security in the United States in 2013.* Retrieved from http://www.ers.usda.gov/media/1565415/err173.pdf

Comal County Senior Citizen's Foundation. (2014). *Evaluation report for fiscal year ended 2014*. Available at the Kronkosky Charitable Foundation office.

Go4Life. (n.d.). *Overcoming Roadblocks to Healthy Eating*. Retrieved April 15, 2015, from https://go4life.nia.nih.gov/tip-sheets/overcoming-roadblocks-healthy-eating

Health in Aging. (2015). *Nutrition: Unique to Older Adults*. Retrieved from http://www.healthinaging.org/aging-and-health-a-to-z/topic:nutrition/info:unique-to-older-adults/

Meals on Wheels Association of America. (2010). *A brief on: "The Causes, consequences, and future of senior hunger in America" and "Senior hunger in the United States: Differences across states and rural and urban areas."* Retrieved from http://www.nfesh.org/wp-content/uploads/2013/03/Brief+on+Senior+Hunger+2008+and+2009.pdf

Meals on Wheels America (MOWA). (2015a). *Meals on Wheels America*. Retrieved from http://www.mealsonwheelsamerica.org/national

Meals on Wheels America (MOWA). (2015b). *More quick facts about our seniors.* Retrieved from http://www.mealsonwheelsamerica.org/theissue/facts-resources

NorthWest Senior & Disability Services. (n.d.), *History of Meals on Wheels programs*. Retrieved April 15, 2015 from http://www.nwsds.org/content/Senior%20Meals/History%20of%20Meals%20on%20Wheels%20Program.pdf

Rainbow Senior Center. (2014). *Evaluation report for fiscal year ended 2014*. Available at the Kronkosky Charitable Foundation office.

Sharkey, J. R. (2002). The interrelationship of nutritional risk factors, indicators of nutritional risk, and severity of disability among home-delivered meal participants. *The Gerontologist, 42*(7), 373-380. Retrieved from http://gerontologist.gerontologyjournals.org/cgi/content/full/42/3/373?ijkey=30207bce0037b5bfcaa4630c50e7f4b674b08191

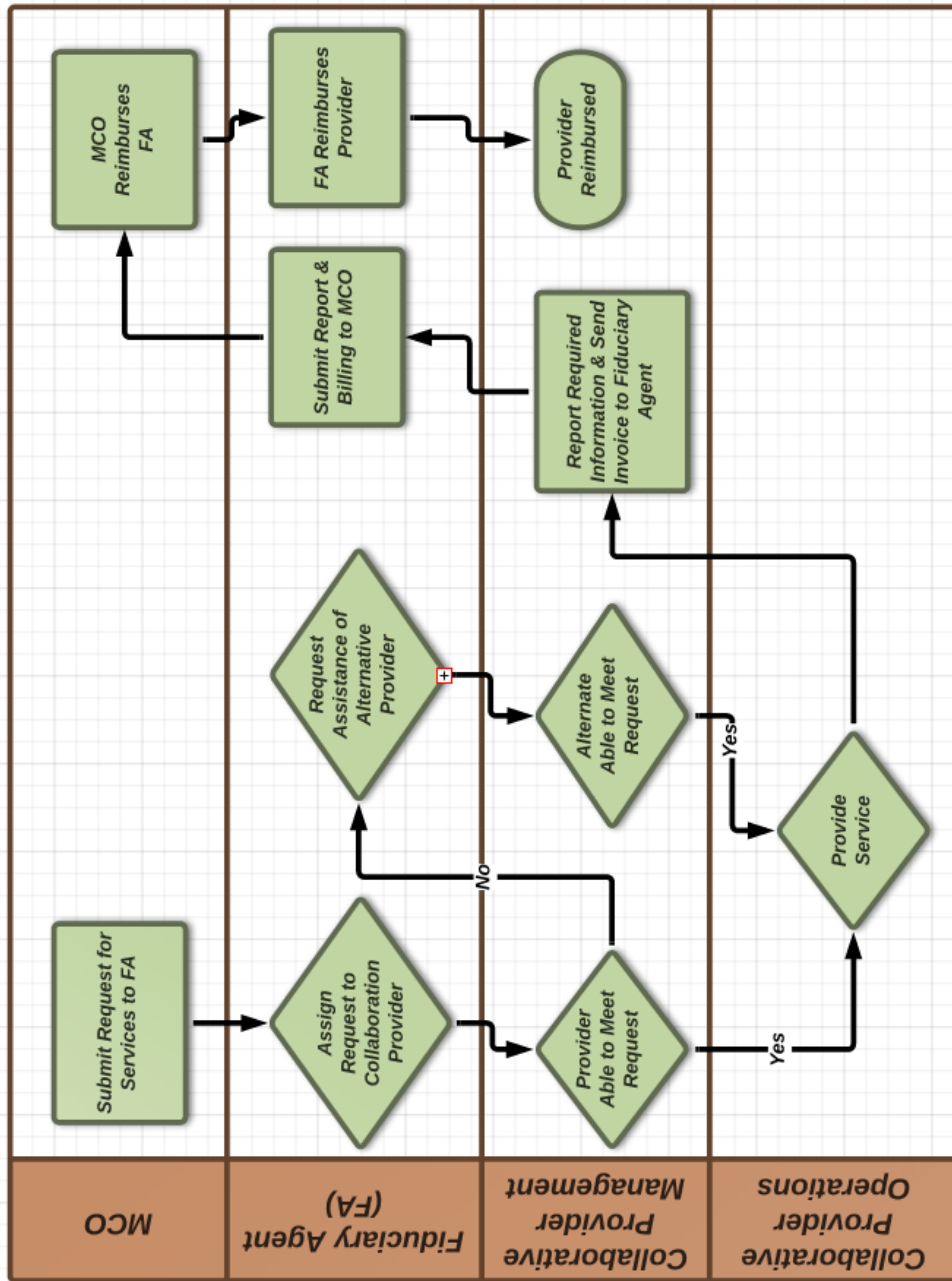
Sharpe, D.L., Huston, S. J., & Finke, M.S. (2003). Factors affecting nutritional adequacy among single elderly women. *Family Economics and Nutrition Review, 15*(1), 74-82. Retrieved from http://pfp.missouri.edu/documents/research/sharpe_factorsaffecting.pdf

Texas Legislative Study Group. (2013). *Texas on the brink*. Retrieved from http://texaslsg.org/

Ziliak, J., & Gundersen, C. (2009). *Senior hunger in the United States: Differences across states and rural and urban areas*. Retrieved from http://www.nfesh.org/wp-content/uploads/2013/03/Senior+Hunger+in+the+United+States+2009.pdf

Ziliak, J. P., Gundersen, C. (2015). *The state of senior hunger in America 2013: An annual report.* Retrieved from http://www.nfesh.org/wp-content/uploads/2014/05/State-of-Senior-Hunger-in-America-2012.pdf

APPENDIX D. Proposed Flow Chart, Operation and Management of the Jefferson Managed Care Service Area



APPENDIX E. Proposed Community Coalition Charter

Article I – Name

The name of this Coalition ("Coalition") shall be <insert name>.

Article II – Mission & Vision

The mission of the <coalition name> is: *Through a collaborative effort among regional home delivered meals providers, develop a cooperative business plan that closes the gaps in areas not currently served, or those that are underserved by individual programs.*

The coalition will strive to increase the number of eligible adults receiving services by 10% in the next 12 months.

Article III – Purpose

1. To build and sustain a community coalition with a focus on the delivery of nutrition services and associated support to vulnerable adults
2. To provide mutual support to coalition members to assure their programs are sustainable and responsive to the needs of eligible adults in their respective communities
3. To develop and operationalize a business plan than identifies opportunities for expansion, improvement and innovation of nutrition programs
4. To collaborate and encourage efforts of organizations with a shared purpose of improving care
5. To advance community engagement that furthers the mission and vision of the Coalition.

Article IV – Participation

Section I – Collaboration

Participation in the <coalition name> is open to organizations and individuals interested in fostering the vision by actively engaging in the planning and work of the Coalition.

Charter members should join in a commitment to:

- Share best practices and knowledge
- Mentor partners and providers
- Request and provide assistance where needed
- Share data and support analyses
- Promote implementation of evidence-based interventions

Participant categories may include:

- Providers of home delivered meals
- Providers of other nutritional services to vulnerable adults (e.g., congregate meals, food banks, government commodities programs, etc.)
- Managed Care Organizations

- Healthcare Providers across the continuum of care
- Provider Associations
- Consumer Advocacy Organizations
- Government Organizations (Department of Agriculture, Municipal Officials, Health Department, Area Agency on Aging, etc.)
- Quality Improvement Organizations
- Educational and Funding Organizations
- Consumers

The <coalition name>, has received a $10,000 grant from Meals on Wheels America to conduct a pilot project demonstrating the ability of <coalition name> to create a regional collaboration that accomplishes the purposes described herein.

Section II – Coalition Participant Responsibilities

Meeting Attendance. Coalition Members agree to attend in person or by teleconference a minimum of 70% of scheduled meetings each year with not more than two (2) consecutive unexcused absences.

Committees. Coalition Members agree to actively participate in committee work, and are expected to volunteer their services for Coalition projects.

Article V – Committees

Section 1. The activities of the Coalition will take place within its committees and all Active Participants are expected to select the committee or committees on which they wish to serve during any given year.

Section 2. The standing committees of the Coalition are:

1. Management Advisory Committee
2. Marketing Committee
3. Education and Communication Committee
4. Technical Support

Other Task Forces may be formed on an ad hoc basis as needed.

Section 3. Committees are chaired by Active Participants, chosen by the Coalition.

Section 4. The term of service for the committee chairs shall be one year.

Section 5. No member shall hold more than one committee chairmanship at a time.

Article VI – Meetings

Section 1. Annual Meeting

There shall be an Annual Meeting of the Coalition, at which time the Coalition will review membership, committee reports, develop annual goals, and conduct other business as appropriate.

Section 2. Regular Meetings
Meetings of the Coalition shall be held at least quarterly. Meetings may take place in person or remotely.

Article VII –Procedural Policies

Section 1. Conflicts

No one may profit financially from membership in the Coalition by sales or solicitation at meetings or workshops. Participants will disclose any actual or potential conflicts of interest to the Active Members.

Section 2. Decision Making

In the spirit of the <coalition name> vision, all Coalition business shall be conducted based on the philosophy of mutual respect. Simple majority rules will apply. Coalition Participants are entitled to one vote per member.

Section 3. Voting

Voting on the business of the Coalition may be conducted by those in attendance at the meeting either in person or by teleconference. Proxy voting via email is permissible.

Charter Members. Signatures below confirm the intent of the signee to participate in the <coalition name> in accordance with the conditions of this charter agreement.

SIGNATURE	ORGANIZATION	DATE

APPENDIX F. Draft Agreement between Fiduciary Agent and Coalition Members

Agreement to Act as Fiduciary Agent
on Behalf of a Principal
of <name of coalition>

This document is an agreement between ________________________________ ("Fiduciary Agent (FA)") and _____________________________ ("Principal"), a member of <name of coalition>. The Fiduciary Agent will be responsible for the solicitation and management of funding awarded to Principal through the <name of coalition>. The Fiduciary Agent is required to act for the benefit of the Principal, with the duties of good faith, trust, confidence, reasonable care and diligence, loyalty, disclosure, accounting, and candor.

A. This duty obligates the FA to act in the best interest of the Principal. Specific duties include:

  1. Administering the project as directed by the Management Advisory Committee of <name of coalition> and respective funders, including organizations awarding grants or contracts to <name of coalition>.
  2. Acting as the point of contact on behalf of <name of coalition> for application, management, reporting and administration of contracts and grants intended to benefit members of the coalition.
  3. Establishing and maintaining accounting systems and financial records to accurately account for invoicing, reporting, and reimbursement from organizations contracting with <name of coalition>.
  4. Monitoring the management and operations of the project are reviewed assessing information gathered from program and financial reports, routine committee meetings, site visits, teleconferences, and other means.
  5. Ensuring that project objectives are met and funds are spent and accounted for properly.
  6. Assuring the FA management systems are sufficient to meet project objectives, comply with award terms and conditions, and account for funds.

B. The duties of the Principal include:

  1. Following the financial management requirements imposed by the FA, who must comply with the requirements that contracting organizations impose on the FA.
  2. Proper accounting and financial recordkeeping and timely reporting to the FA of both performance and financial data and any other information pertinent to the management of the project and reimbursement for services rendered.
  3. Accounting of receipts and expenditures, cash management, maintenance of adequate financial records, and refunding expenditures disallowed by funding organizations.

C. Shared FA and Principal Responsibilities:

  1. FA and Principal will ensure that the requirements, limitations, and regulations pertinent to contracts and grants are applied.
  2. Attention should be directed to the maintenance of current financial data.
  3. Reviewing Financial Operations
    a. FA should be familiar with Principal's financial operations, records, systems, and procedures.
    b. Principal should be familiar with FA's financial operations, records, systems, and procedures.

4. Recording Financial Activities

   a. FA invoices and receipts should be supported by report forms duly filed by the FA. All financial records must validate invoices and receipts related to the respective contract(s).

   b. Principal expenditures should be evidenced by report forms duly filed by the Principal. All financial records must validate expenditures related to the respective contract(s).

5. Audit Requirements - FA must meet, and must ensure that Principal has met, the necessary audit requirements.

6. Reporting Irregularities - FA and Principal shall promptly notify the contracting organization of any illegal acts or irregularities and of proposed and actual actions, if any. Illegal acts and irregularities include conflicts of interest, falsification of records or reports, and misappropriation of funds or other assets.

7. Debarred and Suspended Organizations - FA and Principal must not contract at any level to any party that is debarred or suspended from participation in Federal assistance programs.

8. The FA and Principal must have sufficient insurance, bond or other coverage to protect the FA, the Principal, the <name of coalition> and contracting organizations.

7. Monitoring Project Performance

   a. The FA and Principal have full responsibility for the conduct of the project or activity supported and for the results achieved.

   b. The FA and Principal must monitor the performance of the project and communicate regularly to assure adherence to performance goals, time schedules or other requirements as appropriate to the project or the terms of the agreement.

8. Contracting Organization Responsibilities:

   a. The Contracting Organization role is that of a partner, where the Contracting Organization reimburses the <name of coalition> to carry out the project activities.

   b. A contracting organization should limit involvement between itself, the FA, and Principal in the performance of a project to the minimum necessary to achieve program objectives and to ensure conformance with requirements of the contract.

   c. The FA is the primary point of contact with the Contracting Organization, representing the interests of Principal as individuals and as a collaborative whole, the <name of coalition>.

   d. The FA is responsible for sharing communications from the Contracting Agency with the Principal, and determining with the Principal what is in the best interest of the Principal and the <name of coalition>.

The signatures below constitute an agreement between the Fiduciary Agent and the Principal to the enter into the relationship defined above. This agreement can be cancelled by either party with two weeks notice in writing.

____

Fiduciary Agent Organization Date

____

Principal Organization Date

APPENDIX G. Organizational Capacity Self Assessment & Collaborative Solutions Tool

Use this as a self-assessment tool to determine your organization's organizational capacity and to consider how your agency may contribute to or benefit from the collaborative efforts of other Meals on Wheels or Home Delivered Meals providers. Circle each element that most closely describes your organization. This information will guide conversations among collaborators on how to structure the collaboration to fill gaps in services to clients, and how organizations might collaborate to address areas for improvement. Please complete and return to the consultant by email or postal mail.

	Capacity Elements	**LEVEL ONE**	**LEVEL TWO**	**LEVEL THREE**	**LEVEL FOUR**	**Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.**
1	Staffing Levels	Some positions within and peripheral to organization (e.g., staff, volunteers, board, senior management) are unfilled, inadequately filled, or experience high turnover and/or poor attendance	Critical positions within and peripheral to organization are staffed, though some inappropriately; attendance problems are limited; high turnover is sometimes a challenge	Critical positions within and peripheral to organization are adequately and appropriately staffed; attendance problems are rare; turnover is limited	All positions within and peripheral to organization are adequately and appropriately staffed; attendance problems are extremely rare; turnover is limited; vacancies filled immediately	
2	Skills, Abilities, & Commitment of Volunteers	Volunteers not working up to their potential or ill-equipped for work with organization; may be unreliable or have low commitment	Many volunteers working up to their potential; mostly reliable, loyal, and committed to organization's success	Capable set of individuals that bring required skills to organization; culturally competent, reliable, loyal, and generally committed to organization's success and to	Extremely capable set of individuals that bring complementary skills to organization; culturally competent, reliable, loyal, highly committed to	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
				"making things happen"; work easily with most staff, but do not generally play core roles without staff supervision	organization's success and to "making things happen"; often go beyond call of duty; able to work easily with wide range of staff and play core roles without special supervision	
3	Fundraising	Generally weak fundraising skills and lack of expertise (either internally or accessible externally)	Main fundraising needs covered by some combination of internal skills and expertise, and access to external fundraising assistance (if/when needed)	Fundraising needs adequately covered by well-developed internal fundraising skills; occasional access to some external fundraising expertise (if/when needed)	Highly developed internal fundraising skills and expertise in all funding source types to cover all needs; access to external fundraising expertise for additional extraordinary needs	
4	Board Involvement & Participation in Fundraising	Most members do not recognize fundraising as one of the board's roles and responsibilities; no goals or plans for board-	Members accept that the board has some fundraising responsibilities, but some concerns exist regarding ability of board to be successful in this area; board	Many members embrace fundraising as one of the board's core roles and responsibilities, and participate with fundraising endeavors;	All members embrace fundraising as one of the board's core roles and responsibilities; realistic and appropriate board	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
		driven fundraising activities exist; members do not generally make financial contributions to organization	fundraising activities are limited; some members make a personally significant annual financial contribution to organization based on their individual means	realistic and appropriate board fundraising goals and plans exist; fundraising activities are underway; most members make a personally significant annual financial contribution to organization based on their individual means	fundraising goals and plans in place; board actively fundraises and has achieved measurable progress towards goals; all members make a personally significant annual financial contribution to organization based on their individual means, and some contribute more frequently	
5	Revenue Generation	No internal revenue-generation activities; concepts such as cause-related marketing, fee-for-services, and retailing are neither explored nor pursued	Some internal revenue generation activities, however financial net contribution is marginal; revenue generation activities may distract from programmatic work and often tie up senior management team	Some proven internal revenue generation activities: these activities provide substantial additional funds for program delivery, but occasionally distract from programmatic work and require	Significant internal revenue generation; experienced and skilled in areas such as cause-related marketing, fee-for-services, and retailing; revenue-generating activities support, but don't distract	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
				extensive senior management attention	from, focus on creating social impact	
6	Communications Strategy	No communications plan or articulated communications strategy in place; key messages not defined or articulated; stakeholders not identified; information messages about organization are inconsistent	No communications plan or articulated communications strategy in place, but key messages defined and stakeholders identified; communications to stakeholders are fairly inconsistent	Communications plan and strategy in place; key messages defined and stakeholders identified; communications to stakeholders are generally consistent and coordinated	Communications plan and strategy in place and updated on a frequent basis; stakeholders and their values identified, and communications to each of those stakeholders customized; communications always carry a consistent and powerful message	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
7	Communications & Outreach	No marketing materials, or outdated materials; strictly internally-focused and little to no outreach to stakeholders; any materials that exist are unprofessional in presentation	Loose collection of materials used for marketing; generic documents and not always updated to reflect current programs, activities, and outcomes; materials have a minimal degree of professionalism or consistent look and feel; a few key materials are provided in multiple languages as needed	Packet of marketing materials used on a consistent basis; information contained in the materials is up to date and reflects current programs, activities, and outcomes; materials reasonably professional in presentation and aligned with established standards for font, color, logo placement, etc.; most materials are provided in multiple languages as needed	Packet of marketing materials used consistently and easily updated on a regular basis; materials extremely professional in appearance and appeal to a variety of stakeholders; all materials consistently adhere to established standards for font, color, logo placement, etc.; all materials are provided in multiple languages as needed	
8	Telephone & Fax	Working status, lack of sophistication, or limited number of telephone and fax facilities are an impediment to day-to-day	Adequate basic telephone and fax facilities accessible to most staff; may be moderately reliable or user-friendly, or may lack certain features that would increase	Solid basic telephone and fax facilities accessible to entire staff (in office and out in the field); cater to day-to-day communication needs with	Sophisticated and reliable telephone and fax facilities accessible by all staff (in office and out in the field), includes around-the-clock, individual	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
		effectiveness and efficiency	effectiveness and efficiency (e.g., individual voice-mail), or may not be easily accessible to some staff (e.g., field staff); most frequent users receive training on phone system features	essentially no problems; includes additional features contributing to increased effectiveness and efficiency (e.g., individual, remotely accessible voice-mail); most staff receive training on phone system features	voice-mail; supplemented by additional facilities (e.g., pagers, cell phones) for selected staff; effective and essential in increasing staff effectiveness and efficiency; all staff receive training on phone system features	
9	Computers, Applications, Network, & Email	Limited/no use of computers or other technology in day-to-day activity and/or little or no usage by staff of existing IT infrastructure	Adequately equipped at central level; incomplete/limited infrastructure at locations aside from central offices; equipment sharing may be common; satisfactory use of IT infrastructure by staff; periodic training provided to some staff members	Solid hardware and software infrastructure that contributes to increased efficiency; no or limited sharing of equipment is necessary; regular use of IT infrastructure by staff, though some accessibility challenges for front-line program deliverers may exist; periodic training	State-of-the-art, fully networked computing hardware with comprehensive range of up-to-date software applications; greatly enhances efficiency; all staff have individual computer access and e-mail; high usage level of IT infrastructure by staff; regular training	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
				provided to all staff members	provided to all staff members	
10	Website	No individual website	Basic website containing general information, but little information on current developments; site maintenance is a burden and performed only occasionally	Comprehensive website containing basic information on organization as well as up-to-date latest developments; most information is organization-specific; easy to maintain and regularly maintained	Sophisticated, comprehensive, and interactive website, regularly maintained and kept up to date on latest area and organization developments; praised for its user-friendliness and depth of information; includes links to related organizations and useful resources on topic addressed by organization	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
11	Databases / Management Reporting Systems	No systems for tracking clients, staff volunteers, program outcomes and financial information	Electronic databases and management reporting systems exist in only few areas; systems perform only basic features, are awkward to use, or are used only occasionally by staff	Electronic database and management reporting systems exist in most areas for tracking clients, staff, volunteers, program outcomes, and financial information; commonly used and help increase information sharing and efficiency	Sophisticated, comprehensive electronic database and management reporting systems exist for tracking clients, staff, volunteers, program outcomes, and financial information; widely used and essential in increasing information sharing and efficiency	
12	Buildings & Office Space	Inadequate physical infrastructure, resulting in loss of effectiveness and efficiency (e.g., unfavorable locations for clients and employees, no possibility of confidential discussions, insufficient workspace for individuals, no	Physical infrastructure can be made to work well enough to suit organization's most important and immediate needs; a number of improvements could increase effectiveness and efficiency	Fully adequate physical infrastructure for the current needs of the organization; infrastructure does not impede effectiveness and efficiency; decor partially reflects cultural traditions of constituents	Physical infrastructure well-tailored to organization's current and anticipated future needs; well-designed to enhance organization's effectiveness and efficiency; favorable locations for clients and employees; plentiful space	

	Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
		space for teamwork)			encourages teamwork; layout increases critical interactions among staff; decor clearly reflects and affirms cultural traditions of constituents	
13	Management of Legal & Liability Matters	Legal issues not anticipated; issues addressed individually when they arise; property insurance includes some liability coverage	Legal support resources identified, readily available, and employed on "as needed" basis; major liability exposures managed and insured (including property liability and workers compensation)	Legal support regularly available and consulted in planning; routine legal risk management and occasional review of insurance	Well-developed, effective, and efficient internal legal infrastructure for day-to-day legal work; additional access to general and specialized external expertise to cover peaks and extraordinary cases; continuous legal risk management and regular adjustment of insurance	

Capacity Elements	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	Note here if you can assist or would like to have assistance from a collaborator to strengthen your agency's capacity with an element.
Comments:					

Note: This assessment is adapted from the Marguerite Casey Foundation Organizational Capacity Assessment Tool, self-assessment instrument that helps nonprofits identify capacity strengths and challenges and establish capacity building goals. Retrieved from http://caseygrants.org/resources/org-capacity-assessment/, February 24, 2016.

APPENDIX H. Dual Eligible Medicaid Enrollment, by County

Final Count - Medicaid Enrollment by County - October 2013

	Total Enrollment	Total Enrollment in Children's Medicaid	Total Children Under Age 19 Enrolled in Medicaid	Aged	Disabled & Blind	TANF Adults	TANF Children	Foster Care Children	Pregnant Women	Newborns	Children Age 1-5	Medically Needy
Chambers	3,216	2,326	2,430	170	470	114	354	30	136	215	733	-
Hardin	6,194	3,939	4,189	459	1,219	265	736	43	312	403	1,089	-
Jasper	5,855	3,701	3,983	475	1,223	250	769	38	206	341	1,057	-
Jefferson	40,933	26,501	28,720	2,508	8,698	1,651	4,918	280	1,574	2,259	7,778	1
Liberty	11,827	8,195	8,562	617	1,959	586	1,662	148	469	689	2,249	1
Newton	2,187	1,279	1,384	190	539	104	294	6	73	91	296	2
Orange	11,862	7,588	8,130	558	2,515	690	1,785	128	511	692	2,053	-
Polk	7,415	4,524	4,865	600	1,610	412	1,055	90	269	371	1,161	-
San Augustine	1,642	952	1,008	228	356	58	217	17	48	67	244	-
San Jacinto	4,147	2,692	2,832	250	810	250	653	39	145	209	623	-
Trinity	2,263	1,342	1,451	210	524	103	272	22	84	88	354	-
Tyler	2,838	1,747	1,856	246	607	115	308	66	123	165	461	-
Walker	6,122	4,195	4,468	345	1,098	227	654	118	256	344	1,259	1

Data Source: Texas Health and Human Services Commission. Monthly Medicaid Eligibles File Extract and Texas Medicaid Historical (8-Month) Enrollment File. Table Prepared by: Research and Evaluation Department, Strategic Decision Support, Texas Health and Human Services Commission.

(Retrieved from: http://www.hhsE.state.tx.us/research/MedicaidEnrollment/ME/201212.html)

APPENDIX I. Medicare-Medicaid Recipients, by County

County-Level Dual Status Codes, March 2015

Medicare-Medicaid Enrollee State and County Enrollment Snapshots, Updated Quarterly (March 2015)

County of Beneficiary	Qualified Medicare Beneficiaries (QMB)-only	QMB plus Full Medicaid Benefits	Specified Low-income Medicare Beneficiaries (SLMB)-only	SLMB plus Full Medicaid Benefits	Qualifying Individuals (QI)	Other Dual Full Medicaid Benefit	Qualified Disabled and Working Individuals (QDWI)	Total
CHAMBERS	89	161	59	14	35	53	0	411
HARDIN	276	470	206	48	115	182	0	1297
JASPER	295	519	204	37	116	120	0	1291
JEFFERSON	1864	4083	1025	252	481	868	0	8573
LIBERTY	618	917	343	38	191	161	0	2268
NEWTON	128	276	69	20	40	60	0	593
ORANGE	545	851	348	73	171	249	0	2237
POLK	417	697	257	52	147	153	0	1723
SAN AUGUSTINE	87	210	40	14	31	38	0	420
SAN JACINTO	165	298	98	*	50	43	0	654
TRINITY	140	274	122	19	43	53	0	651
TYLER	174	285	92	21	66	77	0	715
WALKER	268	496	190	20	73	88	0	1135

(Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html, February 27, 2016.)

APPENDIX J. Age, Disability and Poverty Index by County

JEFFERSON MANAGED CARE SERVICE AREA	Chambers County		Hardin County		Jefferson County		Jasper County	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total:	36,155	+/-171	54,652	+/-251	34,797	+/-182	236,106	+/-1,256
Under 18 years:	10,089	+/-145	13,842	+/-93	8,815	+/-121	59,029	+/-273
With a disability:	571	+/-226	770	+/-253	602	+/-223	2,648	+/-443
Income in the past 12-months below poverty level	200	+/-185	214	+/-160	238	+/-147	952	+/-219
Income in the past 12-months at or above poverty level	371	+/-189	556	+/-193	364	+/-150	1,696	+/-400
No disability:	9,518	+/-279	13,072	+/-260	8,213	+/-253	56,381	+/-492
Income in the past 12-months below poverty level	889	+/-401	2,058	+/-438	2,063	+/-503	18,231	+/-1,122
Income in the past 12-months at or above poverty level	8,629	+/-504	11,014	+/-525	6,150	+/-560	38,150	+/-1,048
18 to 64 years:	22,461	+/-171	33,166	+/-125	20,089	+/-169	145,535	+/-1,174
With a disability:	2,838	+/-483	4,786	+/-501	3,695	+/-426	17,820	+/-930
Income in the past 12-months below poverty level	622	+/-193	976	+/-201	780	+/-194	5,104	+/-504
Income in the past 12-months at or above poverty level	2,216	+/-449	3,810	+/-469	2,915	+/-398	12,716	+/-783
No disability:	19,623	+/-498	28,380	+/-489	16,394	+/-454	127,715	+/-1,520
Income in the past 12-months below poverty level	1,778	+/-317	2,671	+/-398	2,518	+/-615	22,062	+/-1,418
Income in the past 12-months at or above poverty level	17,845	+/-594	25,709	+/-611	13,876	+/-675	105,653	+/-1,623
65 years and over:	3,605	+/-123	7,644	+/-177	5,893	+/-144	31,542	+/-279

JEFFERSON MANAGED CARE SERVICE AREA	Chambers County		Hardin County		Jefferson County		Jasper County	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
With a disability:	1,639	+/-170	3,179	+/-315	3,310	+/-308	14,541	+/-534
Income in the past 12-months below poverty level	216	+/-115	328	+/-151	493	+/-144	2,223	+/-300
Income in the past 12-months at or above poverty level	1,423	+/-189	2,851	+/-313	2,817	+/-317	12,318	+/-569
No disability:	1,966	+/-174	4,465	+/-313	2,583	+/-298	17,001	+/-571
Income in the past 12-months below poverty level	242	+/-133	369	+/-146	121	+/-60	1,756	+/-317
Income in the past 12-months at or above poverty level	1,724	+/-198	4,096	+/-314	2,462	+/-301	15,245	+/-531

JEFFERSON MANAGED CARE SERVICE AREA	Liberty County		Newton County		Orange County		Polk County	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total:	70,612	+/-595	13,956	+/-184	81,682	+/-297	41,370	+/-875
Under 18 years:	19,096	+/-98	3,192	+/-35	20,128	+/-174	9,168	+/-122
With a disability:	822	+/-231	228	+/-168	1,355	+/-319	753	+/-219
Income in the past 12-months below poverty level	226	+/-140	36	+/-35	435	+/-197	247	+/-164
Income in the past 12-months at or above poverty level	596	+/-182	192	+/-163	920	+/-268	506	+/-160
No disability:	18,274	+/-263	2,964	+/-178	18,773	+/-365	8,415	+/-263
Income in the past 12-months below poverty level	4,135	+/-651	674	+/-266	3,297	+/-515	2,203	+/-363
Income in the past 12-months at or above poverty level	14,139	+/-681	2,290	+/-297	15,476	+/-595	6,212	+/-438

JEFFERSON MANAGED CARE SERVICE AREA	Liberty County		Newton County		Orange County		Polk County	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
18 to 64 years:	42,567	+/-589	8,335	+/-189	49,958	+/-251	23,630	+/-855
With a disability:	7,325	+/-600	1,429	+/-268	8,046	+/-701	5,294	+/-461
Income in the past 12-months below poverty level	2,150	+/-410	319	+/-138	2,439	+/-429	1,540	+/-356
Income in the past 12-months at or above poverty level	5,175	+/-503	1,110	+/-224	5,607	+/-536	3,754	+/-391
No disability:	35,242	+/-702	6,906	+/-307	41,912	+/-708	18,336	+/-858
Income in the past 12-months below poverty level	5,514	+/-821	884	+/-212	4,892	+/-542	2,745	+/-492
Income in the past 12-months at or above poverty level	29,728	+/-980	6,022	+/-389	37,020	+/-862	15,591	+/-929
65 years and over:	8,949	+/-193	2,429	+/-55	11,596	+/-167	8,572	+/-175
With a disability:	4,681	+/-319	1,238	+/-172	5,059	+/-278	4,258	+/-324
Income in the past 12-months below poverty level	464	+/-126	98	+/-50	548	+/-147	401	+/-133
Income in the past 12-months at or above poverty level	4,217	+/-352	1,140	+/-168	4,511	+/-269	3,857	+/-315
No disability:	4,268	+/-296	1,191	+/-153	6,537	+/-265	4,314	+/-335
Income in the past 12-months below poverty level	445	+/-136	68	+/-49	443	+/-133	312	+/-96
Income in the past 12-months at or above poverty level	3,823	+/-297	1,123	+/-152	6,094	+/-305	4,002	+/-334

JEFFERSON MANAGED CARE SERVICE AREA	San Augustine County		San Jacinto County		Trinity County		Tyler County	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total:	8,554	+/-122	26,659	+/-120	14,330	+/-86	19,040	+/-462

JEFFERSON MANAGED CARE SERVICE AREA	San Augustine County		San Jacinto County		Trinity County		Tyler County	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Under 18 years:	1,732	+/-74	6,215	+/-36	2,874	+/-122	4,024	+/-148
With a disability:	89	+/-47	467	+/-177	112	+/-84	400	+/-112
Income in the past 12-months below poverty level	32	+/-41	259	+/-142	71	+/-63	197	+/-114
Income in the past 12-months at or above poverty level	57	+/-46	208	+/-120	41	+/-45	203	+/-75
No disability:	1,643	+/-74	5,748	+/-179	2,762	+/-135	3,624	+/-189
Income in the past 12-months below poverty level	636	+/-283	1,433	+/-355	659	+/-230	765	+/-208
Income in the past 12-months at or above poverty level	1,007	+/-271	4,315	+/-398	2,103	+/-267	2,859	+/-289
18 to 64 years:	4,847	+/-98	15,588	+/-137	7,848	+/-183	10,818	+/-421
With a disability:	1,258	+/-308	2,351	+/-409	1,975	+/-319	2,090	+/-266
Income in the past 12-months below poverty level	493	+/-205	841	+/-239	409	+/-159	731	+/-211
Income in the past 12-months at or above poverty level	765	+/-214	1,510	+/-368	1,566	+/-309	1,359	+/-219
No disability:	3,589	+/-318	13,237	+/-399	5,873	+/-380	8,728	+/-441
Income in the past 12-months below poverty level	531	+/-201	2,295	+/-489	771	+/-252	862	+/-235
Income in the past 12-months at or above poverty level	3,058	+/-306	10,942	+/-603	5,102	+/-448	7,866	+/-446
65 years and over:	1,975	+/-95	4,856	+/-131	3,608	+/-144	4,198	+/-97
With a disability:	924	+/-164	2,086	+/-223	1,507	+/-194	1,943	+/-241
Income in the past 12-months below poverty level	169	+/-69	328	+/-153	198	+/-89	290	+/-94

JEFFERSON MANAGED CARE SERVICE AREA	San Augustine County		San Jacinto County		Trinity County		Tyler County	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Income in the past 12-months at or above poverty level	755	+/-172	1,758	+/-267	1,309	+/-196	1,653	+/-221
No disability:	1,051	+/-159	2,770	+/-255	2,101	+/-210	2,255	+/-245
Income in the past 12-months below poverty level	170	+/-83	220	+/-96	191	+/-103	172	+/-76
Income in the past 12-months at or above poverty level	881	+/-168	2,550	+/-250	1,910	+/-203	2,083	+/-244

JEFFERSON MANAGED CARE SERVICE AREA	Walker County	
	Estimate	Margin of Error
Total:	47,998	+/-1,577
Under 18 years:	10,707	+/-151
With a disability:	458	+/-200
Income in the past 12-months below poverty level	223	+/-134
Income in the past 12-months at or above poverty level	235	+/-145
No disability:	10,249	+/-245
Income in the past 12-months below poverty level	3,005	+/-550
Income in the past 12-months at or above poverty level	7,244	+/-631
18 to 64 years:	30,496	+/-1,559
With a disability:	2,648	+/-392
Income in the past 12-months below poverty level	930	+/-246
Income in the past 12-months at or above poverty level	1,718	+/-331
No disability:	27,848	+/-1,533

JEFFERSON MANAGED CARE SERVICE AREA	Walker County	
	Estimate	Margin of Error
Income in the past 12-months below poverty level	7,403	+/-719
Income in the past 12-months at or above poverty level	20,445	+/-1,239
65 years and over:	6,795	+/-234
With a disability:	2,001	+/-256
Income in the past 12-months below poverty level	164	+/-87
Income in the past 12-months at or above poverty level	1,837	+/-248
No disability:	4,794	+/-279
Income in the past 12-months below poverty level	461	+/-186
Income in the past 12-months at or above poverty level	4,333	+/-290

APPENDIX K. Area 2014 Census Population Characteristics for Age 60+, by County, with Comparison to State of Texas

Exhibit Follows on Next Pages, K.1-K.25

State of Texas……K.1
Hardin County……K.4
Jasper County……K.7
Jefferson County………K.10
Liberty County……K.13
Orange County……K.16
Polk County………K.19
San Jacinto County……K.22
Walker County……K.25

APPENDIX L. Selected Economic Characteristics_14_5YR_DPO3.xls

Note: Due to limited population size, identical Census Bureau data for 2014 Census Population Characteristics Age 60+ is not available for the following counties: Chambers, Newton, San Augustine, Trinity, and Tyler. Similar, but not identical, data for those counties are available in the series. For consistency, all 12 counties plus the state of Texas are included in the following series.

Exhibit Follows on Next Pages, L.1-L.14

State of Texas L.1
Chambers County L.2
Hardin County..L.3
Jasper County...L.4
Jefferson County...L.5
Liberty County..L.6
Newton County...L.7
Orange County..L.8
Polk County...L.9
San Augustine...L.10
San Jacinto County..L.11
Trinity..L.12
Tyler..L.13
Walker County...L.14

…