AoA Aging State Plan 2015-2018 Public Hearing

March 10, 2014 **11 a.m. – 2 p.m.** **Vincennes, IN**

All attendees, please sign in.

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Vincennes Public Hearing, March 10, 2014

Karen Gilliland – Welcome and Introductions

Since we are a small and comfortable group – Generations is in the house! I'm very grateful to Generations for making the arrangements for us. If you don't mind, let's go around and introduce ourselves. I'm going to ask Lynn to start.

Lauren Holscher, Generations
Brian Hurt, Generations
Stacey Kahre, Generations
Cindy Holloway
Judy Stempler, Advisory board member, Generations
Lora Hewith, Help at Home
Carol Smith, Help at Home
Noble Stallons, retired advocate, Generations board member, CoA, AARP legislative team
Mike Weber, CEO of Riverwalk Communities, Evansville, IN (AL, ADS)
Jill Cecil, Senior Family Services, Washington, IN
Jessica Fulcher, Home Instead Senior Care
Dennis Gunther, VP Business Development Home Instead Senior Care, Board member SWIRCA
Alma Kramer, Healthy Aging Coordinator, Generations
Jane Hall, Generations
Sister Kathy Bilskie, Good Samaritan
Gloria Wetnight, West Central Indiana, Area 7

******** Karen Gilliland introduction of State Plan ********

Michael Weber: One of the things that you point out in here, which we're finding just by way of definition, as I said earlier, we're Assisted Living and Adult Day Care with 113 AL units and licensed for 64 ADC, but we're primarily MA waiver which is a little unusual for most ALs and adult day care. We've been doing this since 2006, and what I've seen in the evolution of our residents is that we're dealing with a lot more mental health issues than we are with physical health issues, particularly, and we're looking at people who are not 75 – 80 years old, but more 45-55 years of age, dealing with different disabilities. And I was sort of interested to see or very interested to see that collaboration with Division of Mental Health because I think that's a problem for us. We can deal with their physical needs, but it becomes awfully difficult to deal with the mental health needs. What we've done on our own is collaborate with a number of

different local agencies. We have psychologists that come in three days a week now, and _____ and they're doing treatments. It's actually helped stabilize our group. We also have a psychiatrist from the Southwestern Behavioral Health - used to be Southwestern Mental Health - - that comes in every Thursday and has a pretty good case load as well. She's also instituted some genetic testing, which helps us understand how drug interactions effect people, and we've had some rather interesting successes there. But that was something that we kind of pulled together ourselves. In doing that...you know, from that standpoint, the collaboration you have with the mental health Division. Most…some of it's just attention-seeking, as simple as that, to some pretty serious bi-polar to all kinds of psychotic issues. Anyway, I got the plan; I didn't get a chance to read it in detail. I apologize for that, but I was curious what thoughts you had maybe on mental health integration.

Karen Gilliland: Well, it's something we have identified, just like maybe you all have, is that we have a situation pop up and we can't find an immediate answer. We have a CM or supervisor calling, "What do we do with this individual?" There's no one that will take them, I think, is the most common thing we hear. Or, we've got them in a safe environment but then they won't take their meds. And then it just unravels. A number of them kind of came to the forefront the last couple of weeks and one of the things I think is exciting about our new Director's attitude and the Secretary's attitude is that she's very much and I'll say she for either one of them, are very much moving away from a "silo" effect under the Family and Social Services support. Yes, we're going to be the Division of Aging, but trying to break down some of these, that this is the Division of Mental Health, this is Division of Disability and Rehabilitative Services, this is Medicaid. Because the reality is that all of those populations are aging and we can't afford to say, you know, you belong over there. It is going to be a major communication issue and goal for us. There are a lot of players, but I think what you're saying is a perfect example of how we've got to kind of take our services, take our programs, take our mindsets across all this continuum. People have needs and they don't always fit in the nice "grandma that's 85 and easy to care for." They just don't. And that's part of why we want to bring APS closer into the fold because they get a lot of those contacts. And sometimes they're not the victim, the mentally ill aren't the victim; they're the perpetrator of the abuse to parents or other individuals. That is one of our goals is to try to get a continuum of service coordination across the players under the Family and Social Service Administration. And I thank you for those comments because that helps us reinforce that.

Dennis Gunther (Home Instead): The goal #5; I'm glad to see they're focusing some on the APS working, trying to strengthen that. I know from our perspective, we have individuals in the home

working, and several times report to APS that there is abuse going on. We have one particular one that even SWIRCA's been involved in and knows the abuse is there, and the APS officer comes out and speaks to the woman with her abuser, which is her son standing right beside her. And she says, "No, I'm fine, you know, everything's fine." And then as soon as APS leaves and the son leaves, she's begging the caregivers to do something for her. So I'm glad to see goal #5, that you're going to be working on that at the State level.

Karen: Thank you. Yes. I've heard a number of situations like that and the challenge always is determining is this person able to make their own choices? If they are, then we do tend to back off. But if they're not, if they're being coerced, then that needs to be looked at much more stringently than we have in the past, perhaps. Laura?

Laura: I have multiple comments.

Karen: Oh, good!

Laura: And I have already prepared them for Lynn.

Karen: Oh, wonderful!

Laura: So you want me to just go ahead and start?

Karen: Certainly. Feel free! If you go off-script, let us know!

Laura: I'll try not to go off-script. But just...thank you, Lynn. You've done a good job. I mean, I'm sure it was hard to put all this together, and it was easy to read and easy to follow, so you did a good job. That wasn't in the script.

Karen: Put that in the notes, Lynn!

Laura: (see typed notes)

Karen: Thank you very much, Laura. Michael?

Michael: Karen, I want to build upon Dennis. We've seen a lot more of financial abuse and financial exploitation. More recently, we can track it pretty easily. Whenever someone comes in and says, "Oh, jeez, I think we're going to discharge my aunt because she's going to come and

live with me." _____ they've figured out that their aunt gets a nice check, or even a small check. Doesn't matter.

Karen: Doesn't matter, anymore.

Michael: I agree with you that also with the APS, it's difficult to follow up; it's difficult to do and goes nowhere so sometimes we don't even call. We just know it happens. We follow up a little bit more on the Medicare side of things with the financial abuse, but still it's rather difficult. So I concur, that's very important for them to _____ and help people out because they are helpless in that respect. In that their checks gone and they have nothing to live on. Secondly, the Money Follows the Person, which I think most people don't have a real grasp for. In southwestern Indiana, I have talked to Juman about this. Juman Bruce. Is that the person that's handling that, is covering a big area. I don't see it...us as getting a lot of traction on MFP, particularly the ALs; it doesn't cover everything necessarily, but we may actually probably refer more people to them than they refer to us. So, I've talked with Barbara Cash about that at CareStar too, in fact, when they took over the contract in summer; late summer. So, that was one just...whether more staffing is needed. Probably part of it is education on the program. I was in the skilled nursing home business for many, many years, and I can assure you that they are not motivated to discharge their residents at all, even with _____ cuts. So it's still heads and beds and they're getting reimbursement for it. What we do find, quite often, is that when we get a referral, it's not a referral we want. The facility is dumping. So we have to be careful in our assessment, as well. And I'm sure even Generations sees some of that from time to time because of behavioral issues or whatever it may be. We call them high-maintenance clients. And, last but not the least, I am a recovering CPA and I dealt with finance most of my life. One of things that I've talked with your predecessor and Faith and all, about, and I've talked to SWIRCA many times about is the level of reimbursement.

Karen: Are you talking here about MA waiver?

Michael: Medicaid Waiver. Sorry. I know...I'm pretty sure from what Rhonda Zuber told me at SWIRCA, they haven't had an rate increase since July of 2008. Now I understand we just got one January 1, of 2%, but we talked about _____ like the APS funding and so forth. As a provider, and I'm sure it is with Generations as well, as costs are going up, and that's a problem. I can't seem to get a lot of attention on that, but it is something that is critically important, is funding for those services.

Karen: Other comments?

Judy Stempler: I didn't come over to speak, because I'm probably the only non-professional in the group. And I came to listen, but I was encouraged to hear you talk about your mother, and the fact that you were trying...from out of state to find services for her, and she didn't fit into these various buckets. And, I thought about this a good deal; it's one of these "d'ruther,"..."I'd rather," it be this way kind of things, you know? And I don't look for you to accomplish anything of this sort in your next four year Plan. In fact, if you even attempted what I am thinking, probably it

would just throw a total clinker into it. But, I would like to see Medicaid and Medicare talk to each other a little more, and cooperate with each other a little more.

Karen: I'm getting a lot of nodding heads!

Judy: I'm in a position to be slowly evolving into a caretaker. My husband has Parkinson's. For 58 years he provided for me, and I intend to keep him at home and provide for him for the rest of his life if I possibly can. He is having particularly some mental health issues that are common with this condition. He was diagnosed 7 years ago. But I can see myself evolving into a total caregiver, which is a position that of course, I'm just feeling my way into. I'm not real comfortable with this. He's always provided for me. When I think about where services - helpful services - might come from when the need arises, as the need arises. Even though I've served on the Advisory board for Generations for a while and I know the services that they provide, my...we're going to fall into those buckets you talked about your mother not fitting. And, for that reason, I can see where it might be beneficial for the country as a whole, particularly senior citizens as a whole, if some of these services overlapped into these bucket areas you were talking about. With...because, personally, when I think about the services that Generations and these funded programs cover, and I don't begrudge them. I think they're wonderful. I just am totally, totally, sincerely for our country, thankful for these services. But, I really don't know where to turn, personally.

Karen: And that is the thing, that I think we recognize -- Generations recognizes, there are so many people that are like you...not sure which way to turn. And I will tell you, you do need to talk to Generations, because they can help you figure out what you need to be working towards and working for, so you're not all alone. One of the things that Sister and I were talking about is that, when you become the caregiver in a situation like you are taking on, you become very tunnel vision, and it's hard to find time to figure out things. We're just busy doing the laundry, or doing this, or filling the pill container, or whatever it is. You need to get a case manager in to help you figure that out and it may just be little things right now, but then you'll have that connection when maybe things change so that you know that you can connect with them again to catch up with the changes you experience yourself, because you need to watch out for yourself, and with the changes your husband is going to experience. One of the things that I didn't say and I had it written on my iPad and everyone told me I shouldn't go old school and use my papers, but I missed it when I was doing my iPad notes, is that "no wrong door" is the concept the Administration for Community Living uses sometimes for an Aged and Disability Resource Center or the Area Agency on Aging, that there's not a wrong door there, you didn't go in the wrong door. Go in the door physically, or by the phone, or by e-mail. They will help you figure out the pieces that exist in your community, whether there are programs or not. So, little pieces. Little pieces may be of great relief to you just for some help with the...nobody understands Medicare and Medicaid. Putting them together. Worked in Medicare for years, I work in Medicaid now. Nobody does it. And we always say, "Gee, if we didn't have this background, how would we figure things out?" Well, that's the truth for everybody and so, make that call or physically stop in because they will help you find some of the little pieces that can help you now even though you don't fit in those buckets. Did I say that right for you all? Yup? Okay. "Cause I

knew they wouldn't say no. That is the concept of an Area Agency on Aging, is helping you identify what's out there, whether it's a program, whether it's a service, or just a resource to connect with.

Karen: Noble?

Noble: If I remember correctly, one of the objectives that I read someplace, the State's intention is to develop a State Plan for supporting caregivers. Did you have a timeline for that? How's it going to roll out?

Karen: Well, that has been one that we've had in the past, and we are re-committing ourselves to helping to drive and coordinate statewide efforts. The thing's that's embarrassing to me is that if we say it at the state level, it sounds like it's new and re-designed and re-developed, and I will bet you money that every area agency has a program for caregivers that we just don't have in our sense of what's out there, where we can refer people to. We're as guilty as any of the networks of not recognizing our own local resources. Generations has caregiver support.

Noble: Programming and support are not synonymous.

Karen: Right. Programming and support are not synonymous. We are going to be looking for grants to expand, to develop. There aren't a lot of resources out there but I think one of the things we feel strongly about is getting attention, pulling together a statewide awareness of what's out there, what's not out there, where the gaps are, has got to be the first step. One of the things...now I'm going to put Lynn on the spot. She just got this title of Director of Grants last Friday. That's one of her roles, to see if we can't get more aggressive in finding resources, not just looking at the state network, regional network we fit into, but broader than that. We do have some area agencies; Ft. Wayne is one where they have been actively involved in training for caregiver support, so that their staff are going out. I can't speak to all the different ones, but we need to look at best practices, what's working out there, and what we can replicate.

Noble: How much flexibility will the area agencies have? And I know some have been working the last few years to introduce a culture of person-centered orientation...person-centered focus. How much flexibility will they have to carry that out to the caregiver? Or, will that be up to them to find the resources to do that?

Karen: A little bit of both. We want to build in some flexibility in the resources that we have now. And that is...that's the challenge. We have people right now on waiting lists and it's hard to say well, we're going to change our service priorities and our direction when all the resources that we have now are being used now. And we've got people waiting in the wings. But, one of the things with the CHOICE bill that we are going to be doing is setting up, up to four pilot projects in the state, of looking at person-centered planning, community living options, of looking at, okay, can we tweak this? Can we find some models to play with that might be able to have some flexibility, because one of the things that's absolutely true is that you can't take services away from people that are using them and are dependent on it now. But we can start gradually trying to change our model, so there is more focus on the self-direction, consumer-driven choices. Not everybody needs a home-delivered meal and as Laura mentioned, that may

be a critical part...program part, when they're coming out of the hospital, but re-determining do they want them to continue, or do we just continue because they fit into that bucket for a while? So we may have to re-think where we put our priority, but we have to safeguard the people we have now. And that's the challenge, because as everybody knows...there aren't big...I'm using buckets a lot...there aren't big buckets of money being dumped on Indiana.

Noble: Karen, the last year there was a piece of legislation that introduced the concept of a tax deduction for caregivers. Caregivers don't need a tax deduction; they need support. And, I don't recall who sponsored that piece of legislation, but they have their heads in the wrong place.

Karen: Suzanne Crouch.

Noble: And so, at the state level, whoever your advocates are at the legislative and the General Assembly, we need to change that focus from tax deduction because many times, you get the tax deduction, it's the caregiver that winds up in the nursing home and not the client. So, that's not a solution.

Karen: No, it's not.

Noble: Of course, I've been on that stump for a while, and not had much success. So maybe you folks can continue it, and next year when we have a longer session, we'll refocus that piece of legislation to actually what's needed.

Karen: That would be excellent. I think I can speak for the new administration, that they are open to a lot of new topics to be brought to the forefront, not just with the federal funds, but also with the state resources. Knowing that maybe there aren't more resources, but re-thinking what we advocate for, and who we advocate with.

Noble: Can you tell me a little more about this Community Living transition? Which agency was it that changed their focus?

Karen: Area 12 is the one that did it on their own with their own local resources from fundraising. Area 12 is southeastern Indiana. See, again, my alphabet soup and buzzwords. Area 12 is down on the Ohio River and borders Cincinnati area; very rural. Madison is probably the biggest city in that area. They tried this model using their own resources. Then Area 2, which is South Bend, St. Joe County, and all the counties that surround it have received a grant to do this program of Community Living, and looking at small incremental needs that can be addressed early before they balloon into an injury that might require hospitalization, which might lead to nursing home placement. The example, mine, is of the light bulb. They talk about an individual who needed a washer and dryer moved from the basement to the main floor. That's all that person needed. But the risk of not going up and down those stairs when they're a fall risk - significant. Or someone that had a base built for their recliner so they could get themselves up easier than at an awkward angle. Those are little things but they can be very significant in keeping an injury from happening. It's a foot in the door, if you will, to look at what are those consumer's needs? Not providing a whole range of service, but meeting that small need where it is so you're available to be contacted as needs change, that the case manager is actively following

up at a set amount of time to see what's going on with that consumer. So rather than running in with a number of services when someone has diminished in their capacity to care for themselves, try to identify some people that are just now beginning to be at risk and providing smaller support systems, like your husband may be a perfect example.

Noble: How have they evaluated that cultural shift? Has it been a positive experience?

Karen: It has been a positive experience as far as a culture shift. It has not been yet proven to be a positive experience financially, to be honest. So it will take a lot more refinement. That's why we're going to do four pilot projects with the resources from the CHOICE program.

Noble: How are you going to get the resources out of the $47.6m?

Karen: That is a good question. That's probably the million dollar question because I don't see them having resources at this point in time. So they may be designing the model this year and going back to the legislature next year to get the resources to actually implement it.

Gloria Wetnight: I notice _____ comments. I notice there's a section on health and wellness in the original draft, but then in the breakout piece, there wasn't a whole lot about health and wellness. And I know we take care of those folks that aren't as healthy, but in our agency, we're really trying to push the health and wellness part. And I know we have very limited funds, so we try to find other grants. I didn't know if the State had any perspective of _____ don't we have _____ preventive health dollars that are very limited. And we do a lot of CDSM classes (Chronic Disease Self-Management), and we do a lot of Matter of Balance classes that we have found very successful. We've been subcontracting with a lot of groups in our area that use some evidence-based programming with smoking cessation, diabetes management, which has helped stretch our dollars, but you know, if we can get some of these folks, we're getting ready to do a big health and fitness fair in May. If we can look at the folks that are younger, so that they could be healthier before they get to the point is our focus is that we're outside of the box. We're not just an Area Agency on Aging, which is hard for us to get around that name sometimes in our community to provide certain services but you know, I think the health and wellness piece is very important to our community then those people we have in our community so we can get those folks who are younger. All of us are aging at a level, but there's just some of those folks that need some of those services I think that if they go. We've seen a lot of people. I'm a master trainer of Chronic Disease Self-Management. We've had folks with mental health conditions come to our classes as well as people with chronic health conditions and they seem to be very successful in taking the information that we share and applying it to their lives, and a lot of them have made contacts in that group and they stay connected. That's very beneficial.

Karen: That piece is important also, as we talk about potential isolation as we age. But you raise some very good points, and that is still something that we do want to continue to look at resources for and the support with the OAA funding, because that is also a part of the Community Living piece of trying to provide the smaller services that may have a big impact down the road in delaying a fall, delaying another kind of injury or illness like a heart attack. You don't necessarily see the end result immediately but you see the improvement in the health

and the networking with the individuals to be a participant in the community, which is part of what we found is that people don't feel connected to their community. Any comments on any of that? Because I know it's still...it is in there. We have not refined it or expanded on it, but those comments are excellent.

Noble: Karen, I think Gloria has hit on an important point as far as health and wellness. There are three other areas. If the culture shift is going to move from eligibility to needs. The other two areas that are important are the basic needs of food, clothing, and shelter, with housing being integral to living in place and aging in place, along with the social connectedness you talked about, which brings up transportation. The mental and physical health that's been spoken about, which brings up mobility support, all of these things with health and wellness being the foundation. All of these things are needed for independence and if mobility isn't there, which is the basis for health and wellness, is exercise and nutrition. If it isn't there, then the community-based care is not going to work. So, the cultural shift is going to require dollars. Huge dollars. And that's one of the reasons I asked about the federal agency that changed its title to Community Living. Is their long-term focus moving in that direction?

Karen: Absolutely. Absolutely. Keeping communities connected; keeping the people in those communities connected. Having the services in the continuum. But you're right - some of it is planning and some of it's wishing because we all recognize there are a lot of us aging and want to be as independent as possible and have as many options available to us but they do take money. They either take our own personal resources, and most people do not plan well for retirement. Or they take government resources and we all know the government is not in a position to continue to fund at the level the population is going to need. So it's going to hit a critical mass.

Noble: One last thought. Is we need to look more closely at becoming a business model. I'm not sure becoming a business model is compatible with client-centered care. Yes, we need to be stewards of our finances, but client-centered care is predicated on their level of independence, mobility, and all of the dots that we connected here today.

Karen: And when we say a business model, what we're talking about, is positioning the area agency on aging network to be the place to go, regardless if you're on Medicaid; regardless if you're private-pay; if you're on managed care plan, we want to position the area agencies on aging to be that entity. So, they may develop a business model of private-pay case management for those persons who really need to have some of the care planning done but are not going to be Medicaid-eligible; are not going to...the daughter that lives in Seattle might be very willing to pay Generations to be the case manager for her mother that lives in Knox County. That would be a good model. What we don't want, is to see, with the managed care that is coming, with Medicaid and with Medicare, we don't want to see a whole new system _____ of a for-profit case management entity, when we have experts in the state already doing it -- every area agency on aging. We're encouraging the area agencies to be that model for private-pay, for public funds, and that's going to take a little bit of a shift in their operations so that they can be assured that they're competing well with the managed care entities, and that they know how they're going to cost-price out their services.

Noble: So we're not looking at a cookie-cutter approach that says one fits all.

Karen: Well, it depends somewhat on what our funding sources say in that regard. Not the state and federal funds of the OAA, but some of the other funding sources that are driving managed care. When we say no cookie-cutter approach, I think that's the uniqueness of area agencies on aging. They meet local needs. But I think across the bases, we've got to have some of the same key services operating regardless of where they are. Case management being one of them. We need to know there's consistency in all parts of the state to be able to market these services to managed care, to market it to the daughter that lives in Seattle. Have I pontificated enough? Any closing comments? Debbie, do you have any comments you want to make?

Debbie: Um, yes, real quick, I would just address Noble a little bit on the idea of the cookie-cutter approach. We don't want it to be a cookie-cutter approach for the client, for the individual that we're serving. But we do want there to be norms and standardizations regarding the services they might utilize so that the quality of care they receive, no matter which pieces they need to pull from, there's some uniformity and consistency there. And I think the other piece of a business kind of model that we sometimes talk about, is having ways of measuring our success. And we don't have that right now, and so that's a big focus of this Plan, and particularly Goal #1, and in working with the AAAs in trying to figure out what are our performance measures? What can we point to tell people we're succeeding? The stories about individual people and individual successes work great in small groups and they get the attention of donors sometimes, and you might even get a legislator who'll really buy on to a cause, because they really feel that story; they connect with that person. When they get behind closed doors and they're writing a budget, they don't remember the stories anymore. They don't want to see stories; they want to see numbers and data. And they want to have those measures: what is the impact of these dollars on people's lives? What am I going to buy with this dollar I'm going to devote toward HCBS? And quite frankly, we do not have a good way of telling them that. And so that, you know, is a big part of what the State Plan is, it's a big part of what my job is over the next year even, is to figure out what are we measuring, are we measuring it correctly, what does it tell us about the impact of our services? So then, we're not cookie-cutter, but we've got to get business-like enough that we know what works and what doesn't. And right now, I don't think we know that very well. And so we need to get to that point where we're measuring and looking at things in a more business-like or scientific even, kind of approach to things so that we can figure out okay, what works. And then when we figure out what works, do we have the organizational skills, the leadership skills to then go and replicate it at other places around the state. So I think that's a huge part of what we're trying to accomplish, particularly in Goal #1 of this Plan, but really in the whole Plan, whether it's caregiver stuff...anything like that. It's first, let's go look. What are we doing for caregivers? What's the uniqueness of each AAA in the caregiver services they provide? Let's figure out how to measure them. Figure out which ones work, and then how do we take it and put it in a little package so that everybody can benefit from it. And not just this county or that county that happens to have the program. So, I would add that.

Karen: Thank you, Debbie. Yes, Dennis?

Dennis: I just had one last thing I wanted to add. I realize that by no means are our processes in the state perfect or anywhere where they need to be. However, being...taking care of my father who was diagnosed with Alzheimer's living in Kentucky, who passed away about six years ago. I can tell you that the communication that I see going on through places like Generations, SWIRCA, and the other agencies here in Indiana are far above what I dealt with from Kentucky and dealing with it was horrible. And I knew what I was doing, and I was just amazed that I could not get anywhere. And I don't know how older individuals in those states even function. So, I realize we have a long way to go in Indiana, but I think we're far above...farther down the line than a lot of the states that I've dealt with so, I applaud you guys for your hard work.

Karen: Thank you. Thank you very much. I'm afraid all of us experience from doing, from being caregivers, and it doesn't matter what your background is and your own work experience. That's when you start to see how things don't always connect well when you're trying to get services in place or trying to get a need met and that's what we're wanting to look for in the future is having some uniformity of knowing where you go to get what you need to help coordinate, just to get the information would be beneficial. Well, I want to thank you all for coming. We didn't quite know what to expect, or we didn't quite know how much time to allow for this. But I think this has been a great exchange of information. I really thank you all for doing it. And it's not over. I really do want to encourage you to go to the website and put in comments as you think of things. We do have a flyer back there to direct you to our website. I know most of us brought business cards if you want to e-mail us with comments. You can turn comments into Generations; they'll pass them along. It's to be a collaborative process. Thank you.

Laura Holscher
Vincennes, 3/10/14

Division of Aging State Plan 2015-2018
Public Hearing
March 10, 2014

P1: Executive Summary –First Paragraph

- Identify Options Counseling, In-Home Assessment, Case Management, Care Transitions and Healthy Aging/Prevention services explicitly as part of "comprehensive, coordinated community-based systems"

P3: Context –Third Paragraph

- Identify Options Counseling, Health Aging/Prevention and Care Transitions explicitly as part of the AAAs role in the continuum of care.
- The word accredited could be misleading. The assumption could be that all ADRC's are accredited by AIRS and that is not accurate.

P10: Objective 1.2

- Add as additional strategies the establishment of Options Counseling as a stand-alone billable service (needs to stand alone outside of PAS), and expansion of the CLP model of needs-based assessment, resource counseling, care planning and service delivery to additional AAAs.
- Also, on page 9, global budgeting and data management are identified by the SCAN Foundation as possible solutions, but there are no objectives that address these two issues.

P10: Performance measure

- For average expenditure per unit of service - care planning and case management are the same thing. If the intent is that they are not the same then it should be average care plan cost.

P13: First heading

- Should read *A person-centered approach requires strong AAA's instead of ADRC.* The ADRC , like options counseling and case management is a function of the AAA.

P15: Strategy

- Requirement to provide face-to-face assessments and options counseling prior to delivery of in-home services can be counterproductive for some services, ie., home delivered which hospitals and nursing facilities rely upon prior to discharging patients. We can support the requirement to provide face-to-face assessments and options counseling, but need to have flexibility for some critical services.

P15: Objective 2.2

- In second bullet, specify also POST –Physician Order for Scope of Treatment.

P15: Objective 2.4

- Since there is no explanation of the Indiana Culture Change Coalition, not sure how this is objective is relevant to the goal.

P18: Objective 3.1

- In third bullet, may want to include (or re-write the section) the establishment of a consistent care giver assessment to be implemented by all AAAs. However, this would need to jibe with the needs based assessment mentioned previously.

P22: Objectives in General

- Currently lacking are any objectives related to work with IHCDA regarding further prioritization, planning and funding for elder friendly communities / aging issues in the state's Consolidated Plan or other IHCDA programs and services. Also, same issue re: USDA and rural housing initiatives and community development.
- There are also other advocacy partners to work with they should be identified. E.g., AARP on Complete Streets initiatives.

P22: Objective 4.1

- In second bullet, it is the "Lifelong Indiana Coalition,"and it should probably be explained in the preceding context.

P22: Objective 4.3

- In first bullet may want to include expansion of volunteer programs like, but not limited to RSVP and Foster Grandparents opportunities. Both of these programs have seen significant cuts in recent years and expansion is unlikely.

P26: Last Paragraph

- Would like to see this re-worded to indicate that the AAA's and DA are working together in education and training on data collection.

Respectively submitted by Laura Holscher, Area 13 Agency on Aging.

3/14/14 **AoA Aging State Plan 2015-2018 Public Hearing**

~~March 13~~, 2014 **11 a.m. – 2 p.m.** ~~**Ft. Wayne**~~, **IN**

All attendees, please sign in. Indianapolis

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Indianapolis Public Hearing, March 14, 2014

Karen Gilliland – Welcome and Introductions

June Lyle, AARP

Leslie Nickels, Putnam County

Christy Smiley, Franciscan Alliance

Susan Waschevski, Franciscan Alliance

Doug May, CICOA

Sherry Beck, DA APS

Joe Hemersbach, Area 4

Gail Rothrock, Families First Indiana

Shirley Burris, AFC Provider, and client

Eric Sanders, AFC Provider, and clients

Dennis Bisbecos, Caregiver Homes

******** Karen Gilliland introduction of State Plan ********

Shirley Burris (AFC Provider): I'll start off. When the program first started, we had a meeting at the English Foundation Building.

Karen: Okay.

Shirley: A lot of providers...at that particular time, I was a provider for a foster care services and I got the notice to come and listen to the meeting. At that particular time, the program hadn't really set off like it is today, and I'm talking about 7 years ago. So my name became...and my son's name became, one of the first two people would be calling for placement. And of course, according to the law, you could only have then, maybe two or three in a home. So, I got in at that particular time with Advantage Healthcare Solutions and with CVL, okay? As we went on, developing the program so that the whole thing was to bring people out of the nursing home facilities that didn't need to be in there, and give them a place to live. Give them back what they were losing. And I became a person that ended up being a caregiver for my mom. I put my mom in four different nursing homes, to no avail. They did not treat her right because she had Alzheimer's. So she was in this little Alzheimer's area. Oftentimes we would go there; her head would be down in her food. She would be wheeled to a hallway and there she would sit all day in front of the nurses' station. One of the nursing homes said that, we're going to put her in hospice. I said, no, my mother's not going to hospice. So eventually what happened to me and my family.

I brought my mom home. At that particular time, we had our businesses. Everything had to cease. My mother ended up living years after...when the nursing home wanted to put her in hospice. So naturally, I jumped on it cause I wanted to see that people got a good quality of life no matter what the situation was. So we ended up with two at first. The State had told us; they said they would be going around and they would go into nursing home facilities because we weren't allowed to do it, and they would see that there were people who were in there that didn't want to be there. So we went to the nursing home. We visited these people. We brought them out; we gave them lunch and everything, to see how they would work within our homes. And we ended up with two. So I had two homes at that particular time, so I called the State, and said you know, where are the people at? Cause we waited like maybe two years before we got anybody. It's like, where are the people at? And we were told, market yourself, market yourself at your church. Market yourself here. Market yourself there. And by the grace of God, a friend of mine told me about another company that my client right here had been with for seven years. Said, call this company. When I called, they said we don't have any funding right now. So we waited. One of the houses I had to end up letting go because we didn't get anybody. So, as it went on, the programs...some of the agencies that we....well, a couple of the agencies that we worked with...they were good. Then all of a sudden...they didn't tell us that the program in that agency was only going to last for one year. One year, is all they gave, but they pulled this gentleman out of the nursing home. And they told us that....and just dropped us. So then, we got in with CICOA for...for the gentleman that we have now and they began to work with us on getting him funding so that he would remain in the house. Then we come to the...my son comes to the point where he is a home…household provider. They ended up treating him like he was an agency...with a whole bunch of paperwork and stuff that he needed to do to keep the gentleman that has been with him for five years...and said if you don't get this done, we'll pull him within ten days. If you don't get this part done, we'll pull him within thirty days. So, everybody is not on the same page as far as what does the government really want? When the primary goal for the whole situation is the care for the individuals? Can we give them good care? Can we put them back into the community? Can they be safe? You know, can they go on trips? Can they go to the movies...can they do all these things that they should have a right to do? Just because they're aging does not mean that they should not have a right. And a lot of families don't want to take care of their elderly people. They want to put them somewhere so that they can have free time for themselves. But what I'm concerned about mostly is...what about the people? What about them? You know, what about the caregiver? We're seven days a week, twenty-four hours a day, giving care. We...some of them don't offer no respite services. You run up against a situation where if you try to get somebody, you know, we need them to be qualified, so we keep up on our first aid, CPR, and universal precaution...all of that. So that when they get the care when we have to go someplace...because we humans…things are going to happen to us, too. Okay. We may get sick or whatever. Then the State says if you get sick, or you want a little bit of time to yourself, you can go ahead and do that, but we're not going to pay you. So there's no respite option for the caregiver. And you don't want the caregivers to get burned out. You want these people to have a good quality of life, you know. But you don't know where to go or who to connect with, you know. Or how is this coming about? But yet, the State is constantly changing rules in the middle

of nowhere, and most of the time we don't know the rules are being changed until the last minute. Then we have to figure out what is this? We have paperwork that we have to do. We've got daily reports we have to do. We have laundry.

Eric Sanders (2nd AFC Provider): What she's saying is under different agencies like Advantage Healthcare Solutions, and you got CICOA, and you have Community _____ Living. There's different rules for different clients. This guy, he's my client. This guy, he's my client, okay? For example, I'm forced to buy commercial insurance for this client. This client does not have to have that commercial insurance? Why, when it's the same service? But under different agencies, there's different rules. And if you don't comply to these rules immediately, there's a threat on losing your client. This is a human being. He should not have to be shuffled through the system on account of the paperwork.

Karen Gilliland: Let me address that just briefly, and I do appreciate your comment. And I do understand from your end, it is very confusing. So, if the rest of you will kind of back up and give him a little bit of background. I'm probably the person that required that of you. I thought I knew your name and you probably know mine. One of the things I can say is, we learn as we go along, too. And most of the funding that we're talking about in your situation, comes from Medicaid waiver...Medicaid and federal funding. We, as the State of Indiana...Hi, Peter! We got dinged, if you will, a couple of years back, because we hadn't put the requirement up front for you, so you would know you were going to have to have that insurance, or that you know that you were going to have all these pieces in place. Eager to get programs started and, to be honest also, there wasn't a lot of direction back then from the federal government on all of the pieces that did need to be in place. It was rather open-ended, and then it became tighter and tighter, and we weren't in compliance. And you're right, we did have to say to you, yes, you do need commercial liability insurance. But it's because if something were to happen, you would be at risk at losing your own home. And the Insurance Commissioner came down on us for not having required that. I will be the first to admit that we are in the midst of all kinds of bureaucracy, and I know on the side of providers, but even more so on the side of the person you're caring for...it doesn't always make sense. I'd be glad to sit down and talk to you some more about some of the requirements, but we have _____ anything ____ for providers to live up to, that we aren't being told ourselves by the source of the money. So for us to get the money to pass on, we're going to jump through those hoops. I think that's probably the best answer I can give you.

Eric: Why do you think certain agencies are not aware of this insurance because _____ for this _____, he has no _____.

Karen G: That really worries me...

Eric: ...and it's the same service...

Karen G: ...and it's the same service. That really worries me because that means we're out of compliance right here and now. So I do need to talk to you about that.

Shirley: And even CICOA...they didn't even know what he was talking about and said that they were doing theirs...

Eric: I have _____ about a week or so ago, and I'm just required to come up with a list of things I wasn't in compliance with...provide quality assurance _____ manual, operations manual. When the case manager comes over for _____, she has these forms with her as she's doing her interview with my mother. My case manager comes over, she has nothing. Only thing she has is to make sure he's satisfied with where he's at. But all this other stuff...HIPAA compliance and everything, it was foreign to me because in the beginning, I never did the administrative part of it. This was my mom and my sister-in-law, but when he had to be placed under my care, just me alone, it was foreign to me like I said. So now it's a learning process for me, but my thing is, this man should not have to be shuffled through the system...

Karen G: No, it should not be the individual that is receiving services...

Eric: ...it should not be like that _____ you do this, or else. Because this is a learning process and it's never going to stop. So I think all _____ change, but the main focus is, is this man happy? And he is, and if he leaves my home, it's going to be traumatic.

Karen G: Why don't you and I get together and we can talk about some of those issues in detail, and see if we can give you a hand?

Eric: Alright.

Karen G: Other questions? Okay, Susan.

Susan Waschevski: We actually have testimony we were just going to read.

Karen G: That's fine.

Susan: We have some extra copies. So...I'll just read it...if that's okay! First, thank you for the opportunity to submit testimony regarding the Indiana State Plan for Aging. We appreciate the challenges identified within the draft plan as consumers, caregivers and providers struggle to create what I think we all want – a high-quality, person-centered system of care for older adults and persons with disabilities. We are pleased to partner with the Family and Social Services Administration (FSSA) and Centers for Medicare & Medicaid Services (CMS) to provide solutions to these challenges through the Program of All-Inclusive Care for the Elderly (PACE) and the Pioneer Accountable Care Organization (ACO).

PACE is a Medicare program for older adults and people over the age of 55 living with disabilities. This program provides community-based care and services to people who otherwise need nursing home level of care. PACE was created as a way to provide consumers, their family, caregivers, and professional health care providers flexibility to meet health care needs and to help consumers continue living in the community. An interdisciplinary team of professionals will provide the coordinated care. These professionals are also experts in working with older people. They will work together with consumers and family (if appropriate) to develop the most effective plan of care. PACE provides all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs,

doctor care, therapy, transportation, home care, check ups, hospital visits, and even nursing home stays whenever necessary.

PACE supports caregivers with caregiver training, support groups and respite to help families keep their loved ones in the community.

Participation in PACE is voluntary and available to eligible individuals across the financial spectrum. Individuals who qualify for Medicare, all Medicare-covered services are paid for by Medicare. Individuals who also qualify for Medicaid, will pay nothing for the long-term portion of the PACE benefit. Individuals who do not qualify for Medicaid will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE there is never a deductible or copayment for any drug, service, or care approved by the PACE team.

We are pleased that FSSA is offering PACE as an additional service option through the Balancing Incentive Program and request that PACE be included in the Aging State Plan as an additional service option.

Accountable Care Organizations, or ACOs, are entities that agree to be responsible for the quality, cost, and overall care of a defined population. ACOs consist of groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated, high-quality care to Medicare patients.

Accountable Care Organizations were largely popularized by the Affordable Care Act

- Called for testing of a Medicare ACO program via the newly-created Centers for Medicare and Medicaid Innovation (Pioneer ACO program)
- Created the Medicare Shared Savings Program (MSSP) ACO program, which became a permanent part of Medicare
- Program has continued to grow since inception in 2012; there are now 366 Medicare ACOs across the country

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

The overarching goal of an ACO is to achieve the "Triple Aim:" Better population health, higher-quality care, lower costs of care.

ACO's aim is to deliver better healthcare by improving quality and reducing costs across the care continuum.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves.

As of January, 2014, Franciscan Alliance Accountable Care Organizations serve more than 110,000 Medicare beneficiaries throughout the state, including, blind, disabled, and dual-eligible beneficiaries.

Karen: Thank you. Any questions? Other comments?

June Lyle: June Lyle with AARP, and we have written comments as well but just wanted to briefly say that we see a lot of common ground with the draft Aging Plan in terms of the overall goal of serving more Hoosiers in their homes and communities which is something that AARP supports very much. And we know that 90% of our members say that that's a top priority for them. Would also like to mention that we think the focus on caregiving and livable communities is right on target with where Indiana needs to go and are top priorities for AARP as well so we look forward to working on those issues together. And I've got some more detailed comments in here that I'll submit in written form but really appreciate the opportunity to share our comments today.

Karen G: Thank you, June.

Shirley Burris (AFC Provider): Another question I would like to ask is, the Medicaid Waiver. We've been trying to change his one level of care for my son's client. And the list is so _____ that it takes years before you know, we can get that changed, and I want to know how soon, because the level of care that he's on now, it really needs to be taken down _____ to a Level 3.

Karen G: A Level 3?

Shirley: Getting that changed is something we have not been able to do.

Karen G: Okay. That's your program that needs to be at the Level 3? We can put that as a part of our discussion with the other issues that you have because you will have to have additional services and supports in the home to meet his needs at a Level 3. But we can talk about what those are and what it would take for you to be able to do that, if that's agreeable. We want to be sure that the people we are serving in the community are in the appropriate setting for their needs, and as the needs change, then we have to be sure that setting still meets those needs, and that there's not an increased risk to the individual - this gentleman, but also to you, as the provider…because we need to make sure that we have those pieces in place _____ document that you can't _____, but we can talk about that and we can talk about some of those forms that you need _____. Let me give you my card right now, so we can talk and set up an appointment.

Karen: Sherry, did you have a comment? No? Peter.

Peter Bisbecos: Peter Bisbecos, with Caregiver Homes of Indiana. We'll be filing written comments but wanted to appear today and give you in-person support for the Plan that you've put out there, in particular Goal #3 dealing with caregivers. As you all know, we provide structured family caregiving, which is a new service to the Waiver. It is different than the standard

Medicaid in-home services. We help people stay in their homes. We provide support both to the consumer and to the caregiver individually _____, and we're now serving 20 people in Indiana. First ones to do it, so it's starting to grow quickly. And we're seeing it work the same way it does in Massachusetts. We're in four states; over 2,000 people in total. And we're starting to see people stay in their homes....you know, continue to live in their homes. Stress reduction amongst caregiver and consumer, and it's working as it has elsewhere. As the people who are traditionally staff continue to age and retire like the rest of the population, as the aging population grows obviously, more options rather than less are going to be necessary, continue to be _____. We think this service is one that will continue to help support caregivers, and we encourage you to look at other things that would be supportive to caregivers in the community. So we want to thank you for your thoughtfulness and flexibility in adopting this service, and we look forward to working with you. _____.

Karen: Thank you. Doug?

Doug May: Doug May, with CICOA, and I'd like to also really commend the thoughtfulness of this Plan, of the approach you're taking to building on partnerships, expanding the networks, having a Plan that really looks at person-centered types of outcomes, we feel is very important. I know that CICOA will be providing some formal, written testimony, as well as the Indiana Association of Area Agencies on Aging, about the Plan and some of the details. One thing I did want to note, and in going through the Plan, that both our board of directors has commented on in the form of a resolution. In fact, Peter here, is on that Board and, I think that there's one piece that may have had unintended consequences within the Plan, and that relates to the objective to promote the requirement to provide face-to-face assessments and Options counseling with AAAs before delivery of in-home services. And we believe very much that it is very important to have in-home -- anyone receiving services -- have that face-to-face in-home assessment for services. But a concern we have had in trying to do that in relationship to HDMs is the problem that it actually causes a delay of service for some of the people who are the most vulnerable. (1:18:28) And to illustrate that, I think, the best way that people can relate to is that in the past, both the social worker at a hospital, say it's St. Francis...may call for an ADRC, and refer that person for the Home Delivered Meals because let's say, Mrs. Smith is going to go home on Tuesday. Our objective, once we get the basic information from that social worker that shows that person is eligible is to be able to get that meal within three business days of that referral. And by all means, we would be triaging with both the caregiver if there was one as well as the social worker and other people who have concerns, to make sure that we're assessing other needs that the individual would have. But having a policy that requires before – if we can't trust that social worker – let me back up a little, to have given us an appropriate referral, we have a real concern. And in practice, that is rarely been the case. The social worker from a hospital or other organization is not giving an inappropriate referral. They look at the requirements, and we do as well. So what we would prefer, at least in the case of meals, is a system that works to allow the service to begin, and then have follow-up with the care manager, the Options Counselor for the face-to-face assessment. And I think that, the system that we have now, if we have a delay in service, is not good for the consumer...is not really person-centered. And also then reflects

poorly unintentionally on us and on the State at that point for having a rather bureaucratic process in place. But again, I think the overall Plan and what you have here is an excellent document and something we want to work with you in developing, and we appreciate that you're building upon the networks that are in existence.

Karen: Thank you, Doug. Yes?

Gail Rothrock: Thank you. I'm Gail Rothrock from Families First. We're a social service organization here in Indianapolis and for many decades, we have provided in-home non-medical support for older adults and those with disabilities. I was pleased to see particularly, but overall, the Plan I think, is very strong...and particularly pleased with the Goal #5 related to _____ older adults who are vulnerable because that is one aspect of our service that is in greatest need, particularly where financial exploitation is _____. And I was interested, yet not surprised, to hear your statistic about the huge increase in financial exploitation reports, and our referrals bear that out. What's unfortunate is that, with that increase, there's not an increase in services to respond to those issues. And our frustration is, when we get a call about that kind of situation, we have a waiting list well in excess of a year. Our staffing has decreased by 25% in the past year because of funding constraints. The services that we provide to protect those older adults who want to stay in their homes, but be safe from that kind of exploitation is…it's reimbursed thanks to our friends at CICOA to some degree. But the amount that we're able to capture in revenue compared to the intensive effort that's required to keep that person safe is a drop in the bucket. And so…our program, while these statistics are exploding…our program is shrinking, and I would like to work with the State on some way to reverse that trend. We stand ready to try to help you achieve that goal, but we've got to have some more support from the State to make that possible.

Karen: That's a very good point, and we do recognize that. We haven't found those buckets of money back over here, but it's a very valid point. We know that the resources are tight, and the demand is great.

Joe Hemersbach: Well, I'm Joe Hemersbach and I'm going to speak...I think I'm going to speak as a private citizen at this point.

Karen: Okay.

Joe: I have been associated with aging services in Indiana since 1985. For 18 years of those, I was associated with Adult Protective Services; I ran that unit in Lafayette, to cover that region. My point is, I want to support some help to Adult Protective Services. This is a cause…endangered adults is a cause…that is a cause that is dear to my heart, and I see it needs some support. And my suggestion is three things at least. One is an increase in the number of APS investigators has got to be done in order to meet the challenges out there. Two, I think that there needs to be some investigation of what to do with at-risk adults...you know, we don't have public guardianships in Indiana. We have a form of a public guardianship, but it's not inclusive in my mind and, that's a big problem in our state. But that won't solve the issue of at-risk adults, and I think, you know...we have CHINS, which is relatively easy to implement in the legal sense

for children but, what can you do with adults who clearly get themselves in trouble and getting exploited? There's more ways of getting exploited now...then I…I get myself exploited, you know, just getting on the Internet. So how can an older adult who has grown up with paper checkbooks survive in this kind of _____? So I think there needs to be an investigation on how to deal with at-risk adults, something that can be all-inclusive, for all citizens. And the last thing is, I think that there needs to be standardization APS units made in both practice and both in measurement of outcomes and the impact on community. When I ran APS, we were accredited by the National Accreditation…Council on Accreditation, and that does provide standards. You don't have to follow those standards, particularly. There are other standards out there, but there really should be some standardization, not asking that everything be _____, but I think that there has to be some reasonable expectation as to what activities when an investigation is done and what those activities are defined as and when they should be done and measured and kept as a statewide measurement because we really can't say what...how many investigations truly are done because they're defined differently from unit to unit. I also think that outcomes have to be measured. Because we really don't know if APS is effective or not. I think it is, but nobody's really looking and saying, "you've gone out and you've done 5,000 investigations." So what? If the person still dies; if the person's still abused; you haven't done anything. So what is the outcome of your investigation and your intervention? And I think APS does a really great job of investigation, but intervention is something that hasn't been defined. And I hear...continually hear APS investigators say, "We don't like case management. That's social service stuff, but then they go out and do case management. So, that needs to be defined, and what the interventions are, _____ and then again, measure the impact on the community, measure the impact on the person, and make it person-centered, and the victim _____.

Karen: Good point. Any other comments?

Shirley Burris (AFC Provider): I would like to see ____ laws put in place for situations...more people should get a good feel about what is going on, if the caregiver just _____ the clients, and I know _____ I have had to do with my company. There's still a lot of abuse and neglect going on, not only just in the home but in different institutions…that you're not going to get the bad guy all the time and I guarantee that the bad guys are very few but it's very significant, where as the ones that are doing their job correctly...but we are all put into this mold of being bad guys. That's the way I feel, you know. So you come up with the rules and you come up with visits...surprise visits...and putting nurses in place to see if these people are being taken care of. See what I'm saying? So to be able to catch that person who is abusing the system or whatever, I would like to see something that would really be in place as far as the care is concerned so that we all don't have to suffer for what the bad guy is doing. Cause you'll always have them, no matter how hard you try, you'll probably won't ever eliminate them because some people's hearts are not right and they're never going to be right. And somehow they can get into the system...you know what I'm saying?

Karen: I do!

Shirley: So...whenever there are laws or things that are going to be put in place, I would like to see the State work a lot with the caregivers themselves, you know, instead of different...so many different agencies and organizations and people that are coming together like we are today. This is really a good thing because then we get a chance to see and hear what's going on. And the caregivers...we should have more caregivers to the meetings to explain what they do on a day-to-day basis as far as taking care of the individuals are concerned, and what are some of our options that we could use without someone saying over here, "yes, you can do that," and someone over here saying, "you can't." Because they need...I feel like...my client that I have...he's like my family. He's a part of me. He doesn't have any family. He has no one that cares about what he does. So I have a job. He's been diagnosed as paranoid schizo, but over the seven years, you would not believe the progress he has made in order for him to be in my home. How we have to work with him every day...on their good days and on their bad days, we have to be there for them. To take them to the doctor's appointment; to make sure they have a good quality of life. The caregivers need to have a say-so before the State jumps up and makes up a lot of rules and then the rules follow the agencies and then the agencies put it on us. And really, the whole source of know whether or not something is working is dealing with us. We're the people that are there every day, that could give you a report every day on what our clients are doing. We submit it to somebody else, they submit it to somebody else, and they submit it to somebody else.

Eric (AFC Provider): At the same time, these guys are feeling the effects of that because he'll ask me, "what's going to happen to me if you don't get this paperwork correct?" So, my question really is, _____ when I call...I believe it was Tanya Downing. She had no clue of what I needed _____ with the State. And to me, she should know. But her definition of "we're not responsible for that." We're responsible for making sure he's happy. But at the same time, if I'm not in compliance, he's not going to be happy.

Karen: That's a very good point.

Doug May: Just want to say, we'll be happy to work with you and with Karen to figure out what may have not gone correctly with this.

Eric: It's really simple because I've had to ask, because I'm sure I know what they're asking, but they're telling me it's got to be in a certain format.

Karen: I think if we sit down...I remember you jumped through a lot of hoops but you got your insurance in place. I do remember that. So we can work our way through these other hoops.

Eric: And insurance is another thing. Okay? You say, get this insurance. Okay, where do I go? Nobody really actually explained to me what it was. I had to call other providers to find out where to go.

Karen: And that's a good point. That was a long drawn out process that we could not find insurance companies that understood what Adult Family Care was. You're absolutely right. But we knew we needed to protect you, protect us, and protect the federal government, but that was a strange animal to everyone. Are there any other comments? Well, we'll draw this part to a close, but again please feel free. We've got more than a month for comments to come in before we

finalize it to go to Secretary Minott, the head of Family and Social Services Administration, and from there it will go to the governor. And so there is time for you to share input, ideas, thoughts, concerns across the board. I like some suggestions that have come out of here today. Maybe some things we can do to streamline this...take advantage of another opportunity that we may not have put in the Plan but should have. Maybe we need to rethink some things, but this is just the beginning framework so we want that input. Thank you very much.

Clough, Lynn

From: Dennis Frick [dennis.frick@ilsi.net]
Sent: Friday, March 14, 2014 10:37 AM
To: Clough, Lynn
Subject: Comments on DoA State Plan 2015-2018

I am writing to provide comments on the Draft State Plan. I applaud the Division on circulating the Draft Plan and giving an opportunity to provide comments. I am the Director of the Senior Law Project of Indiana Legal Services, Inc. We receive grants from Areas 6, 8, and 9 to provide legal assistance to older adults, and we receive grants in Areas 6 and 8 to provide ombudsman services to residents, and their family members, of nursing homes and assisted living facilities. We have seen a substantial increase in requests for our services, and we receive many referrals from the ADRCs in our areas. The CASOA survey shows 42% of older adults identified needs for financial and legal assistance. Page 7, Draft Report.

The Draft Report did a good job of identifying systems objectives. I write to suggest that more emphasis should be given to providing needed assistance directly to older adults. For example, under Goal 2 on strengthening self-determination, I applaud Objective 2.2's strategy of increasing awareness of advance planning through education. I suggest that additional direct assistance to Hoosiers to complete forms would be useful. This is something our office does through our legal assistance project, but it is difficult to meet the current need. National Public Radio has reported on Lacrosse, Wisconsin where 96% of people who die have advance directives, thanks to community efforts to educate and assist persons to do this planning. Exploring and supporting the implementation of projects like this in Indiana would be useful.

Under Goal 5 on strengthening systems for advocacy and protection for older adults, there is a reference to education, but there is no other reference to providing direct assistance to older adults. Our office provides legal representation to older adults who are the subject of abuse or exploitation in those cases where the older adult is able to seek assistance. Empowering older adults through advocacy is important. More emphasis should be given to increasing funding to provide direct services to older adults to defend against and fight back against abuse and exploitation.

Thank you for the opportunity to comment, and thanks to the Division for its service to older adults.

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AARP®
Real Possibilities

AARP comments
re: Division of Aging State Plan 2015-2018

March 14, 2014

AARP appreciates the opportunity to provide comment on the Division of Aging State Plan 2015-2018 Draft dated Feb. 20, 2014.

AARP is a nonprofit, nonpartisan organization, with a membership of more than 830,000 in Indiana that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families. In Indiana, AARP's priorities include: supporting Indiana's 1.3 million family caregivers; increasing the retirement security of Hoosiers 50+; making Indiana communities more livable for people of all ages; and empowering Hoosiers to protect themselves and their families from fraud and identity theft.

As the largest membership organization in the state for older Hoosiers, AARP finds much common ground with the priorities outlined in the Division's draft State Plan. In particular, we applaud the Division's overarching vision to "re-define long-term care for consumers and providers by focusing on coordinated, community-based systems." Surveys of AARP members in Indiana find that a vast majority – 90% -- want to be able to age in their homes and communities. Ensuring that Indiana communities are livable for older adults and people of all ages, and that Indiana's long-term care programs are designed to empower Hoosiers to continue to receive the care they need at home and in the community, will be critical in helping Hoosiers achieve that almost universal goal.

In addition, in its draft State Plan, the Division has identified a number of priority areas that are consistent with AARP's priorities and the needs that AARP has identified in Indiana's older adult population.

There is a great deal of opportunity for collaboration in the Division's key goal areas, including supporting family caregivers and preparing Indiana communities for growing older adult populations. AARP looks forward to working with the Division in achieving these mutual goals.

More detailed comments on each of the five Goals identified in the State Plan are as follows:

Goal 1: Enhance the capacity of the provider network to provide quality care programming while ensuring responsible stewardship of public monies.

- AARP supports this goal, and the recognition that the Area Agency on Aging network is critical to quality, effective, person-centered delivery of long-term care in Indiana.
- AARP would like to see more explicit reference to the importance of the home and community based care programs administered by the Division -- especially the Medicaid waiver and CHOICE programs -- in providing quality long-term care to Hoosiers in the appropriate setting. We believe that continued management of the A&D waiver to minimize or eliminate waiting lists, and effective use of CHOICE to maximize the number of people who can be served, could also be strategies identified by the Division under this Goal, under Goal 2, or both. In addition, we would encourage more explicit reference to how the Division will utilize Money Follows the Person, the Balancing Incentive Program, and other specific programs/tools to continue to expand HCBS in Indiana.

Goal 2: Strengthen the rights of Hoosiers to self-determination in their long-term services and supports, regardless of their position on the financial spectrum.

- AARP supports this goal, especially the emphasis on person-centered care.
- While the Division has a special responsibility to older Hoosiers of limited means, AARP agrees that, as the ADRC experience has demonstrated, the long-term care system works best when it is open and responsive to people of all incomes. We feel this is an appropriate focus for the Division.
- AARP believes that the Division should explore expansion of self-directed care options to encourage the goals of self-determination and empowerment.

- While we strongly support the goal of educating Hoosiers on the continuum of long-term care services and supports, AARP's efforts at the national level have shown how challenging it can be implement a successful long-term care education program. AARP stands ready to work with the Division on these efforts, but recommends careful analysis of best practices before moving forward with a program in Indiana.

Goal 3: Create a statewide focus on the needs of family caregivers.

- AARP strongly supports this goal and applauds its inclusion in the State Plan.
- Based on the Caregiver Connection events AARP has hosted around the state, we believe there is a large set of unmet family caregiver needs in Indiana. Accordingly, we strongly endorse the Division's proposed strategy of assessing the current state of Hoosier caregivers and researching caregiver's true needs. We believe that the aging community and policy makers need more complete information on the experience of family caregivers and what their needs might be.
- AARP also encourages the Division to explore larger public policy solutions in support of this goal, including but not limited to, establishment of a state tax credit for family caregivers, requiring that adequate hospital discharge instructions be given to family caregivers, and improving state-funded respite options for family caregivers.

Goal 4: Assess and facilitate community readiness for a growing older population on a statewide basis.

- AARP strongly supports this goal and applauds its inclusion in the State Plan.
- The Division appropriately recognizes that community readiness is a critical factor in enabling people to age in place, and that community readiness includes both social/civic and physical characteristics.
- We appreciate the Division's commitment to continuing participation in the Lifelong Indiana Coalition, of which AARP is a leading organization, which is taking a collective impact approach to making Indiana communities more age- and ability-friendly for people of all ages. The ongoing involvement of the Division will be critical to the Lifelong Indiana Coalition's success.

Goal 5: Strengthen statewide systems for advocacy and protection for older adults.

- AARP supports this goal.
- AARP believes that Indiana would benefit from a comprehensive review of the existing programs to prevent and prosecute elder abuse in Indiana, and whether those programs are adequate to meet the needs of vulnerable older Hoosiers.
- In addition to the Strategies outlined in the State Plan, AARP recommends that the Division convene stakeholders to determine: 1) what is the true extent and nature of elder abuse in Indiana; 2) what changes to existing laws could help law enforcement better prevent and prosecute elder abuse; and 3) what changes to APS in terms of policies or staffing could help Indiana better prevent and prosecute elder abuse.

In conclusion, AARP believes there is much common ground in the goals and strategies identified by the Division in its Draft State Plan. As always, we look forward to continued collaboration in improving Indiana's long-term care system, with an emphasis on person-centered, community-based options.

Respectfully submitted,

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St. Francis Health Network

Comments regarding the Indiana Family and Social Services Administration Division of Aging State Plan
March 14, 2014

Thank you for the opportunity to submit testimony regarding the Indiana State Plan for Aging. We appreciate the challenges identified within the draft plan as consumers, caregivers and providers struggle to create a high-quality, person-centered system of care for older adults and persons with disabilities. We are pleased to partner with the Family and Social Services Administration (FSSA) and Centers for Medicare & Medicaid Services (CMS) to provide solutions to these challenges through the Program of All-Inclusive Care for the Elderly (PACE) and our Pioneer Accountable Care Organization (ACO).

PACE

PACE is a Medicare program for older adults and people over age 55 living with disabilities. This program provides community-based care and services to people who otherwise need nursing home level of care. PACE was created as a way to provide consumers, their family, caregivers, and professional health care providers flexibility to meet health care needs and to help consumers continue living in the community. An interdisciplinary team of professionals will provide the coordinated care. These professionals are also experts in working with older people. They will work together with consumers and family (if appropriate) to develop the most effective plan of care. PACE provides all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs, doctor care, therapy, transportation, home care, check ups, hospital visits, and even nursing home stays whenever necessary.

PACE supports caregivers with caregiver training, support groups and respite care to help families keep their loved ones in the community.

Participation in PACE is voluntary and available to eligible individuals across the financial spectrum. Individuals who qualify for Medicare, all Medicare-covered services are paid for by Medicare. Individuals who also qualify for Medicaid, will pay nothing for the long-term care portion of the PACE benefit. Individuals who do not qualify for Medicaid will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE there is never a deductible or copayment for any drug, service, or care approved by the PACE team.

We are pleased that FSSA is offering PACE as an additional service option through the Balancing Incentive Program and request that PACE be included in the Aging State Plan as an additional service option.

ACO

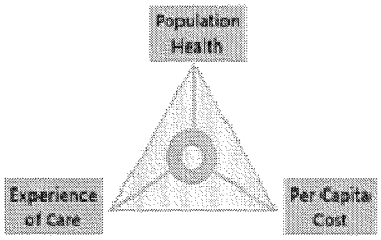
Accountable Care Organizations (ACOs) are entities that agree to be responsible for the quality, cost, and overall care of a defined population. ACOs consist of groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated, high quality care to Medicare patients.

Accountable Care Organizations, or ACOs, were largely popularized by the Affordable Care Act

- Called for testing of a Medicare ACO program via the newly-created Centers for Medicare and Medicaid Innovation (Pioneer ACO program)
- Created the Medicare Shared Savings Program (MSSP) ACO program, which became a permanent part of Medicare
- Program has continued to grow since inception in 2012: there are now 366 Medicare ACOs across the country

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

The overarching goal of an ACO is to achieve the "Triple Aim".



-Better population health
-Higher-quality care
-Lower costs of care

ACO's aim is to deliver *better healthcare* by improving quality and reducing costs across the care continuum.

When an ACO succeeds ~~both~~ in both delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves.

As of January, 2014, Franciscan Alliance Accountable Care Organizations serve more than 110,000 Medicare beneficiaries throughout the state, including blind, disabled, and dual-eligible beneficiaries

3/18/14

DA's State Public Hearing - Ft Wayne

Chris Renner

Sharon Tester - Adams Co. Council on Aging

Susan Steele - Turnstone

Lila Pufahl - Turnstone

BECKY WEIMERSKIRCH - CTN

Jill M Huston, Heritage Pointe

Chad Boxell, Heritage Pointe

Kristin Folkerts - AIHS

Debbie Blackstar - Extendicare

Chris Forucci - Aging + In-Home Services

Dorcas Maples - CHOICE Board

KEITH HUFFMAN - Aging & In-Home Serv

Katrina Stevens - Sunshine Home Healthcare

Elizabeth Eckenberger - Sunshine Home Health Care

Sandra Leslie - Sunshine Home Health Care

Denise Arbuckle - Sunshine Home Health Care

Carol Dudley - Interim Healthcare

Eddie Brock - Philips LIFELINE

David M. Warnecke - Trinity Home Health Care, Inc.

Kristen Wallace - FAAAA

Ft. Wayne Public Hearing, 3/18/14

Yonda Snyder: My name is Yonda Snyder and I am in the Division of Aging in the Family and Social Services Administration, and I am very excited to see such a large turnout for our public hearing today on our State Aging Plan. I'll keep my remarks very brief and very general, and turn it over to the people who really know this material inside and out, that I'm lucky enough to work with on a day-to-day basis. But just tell you...some of you were here for the previous presentation on the CASOA study. And it was information from that study as well as many of the programs that have been explored in the state of Indiana over the last couple of years, that really informed the development of this survey. We have approached this very much in a sense of a strategic planning process. I actually stepped into this role the first week of January. I had a couple of months of transition and that's when I learned that, oh my goodness, we have to do a new four-year State Aging Plan. There's no better way to learn something than to be able to sort of plunge in to this, and it was a really good opportunity for me to begin to learn the challenges and opportunities that we face as a State, and also begin to sort of chart out a vision for where we want to point the Division of Aging, and that's really what this State Plan is all about. So I'm going to introduce Karen Gilliland, who is the Deputy Director for Programs, Policies, and Planning in the Division of Aging, and she will actually talk more specifically about the Plan itself. The Plan can be found on our website, which is as in.gov/fssa/da. We, of course, are happy to take comments today but additional comments can be submitted via the web link as well. So, I'm eager to hear what everybody has to say. Thank you.

Karen G: Thank you, Yonda.

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Karen G: Those are our five broad-based goals. I've talked enough. What we want to hear now is what are the issues you're concerned about across the state of Indiana, up here in Area 3, or anything in general that you'd like to share with us today. Again, you're welcome to share your comments today; you're welcome to go to our website and add comments, or e-mail us any comments before the end of April. Thank you very much. Are there any comments? You want to start us out? And please introduce yourself, Connie.

Connie Benton-Wolff: First of all, we're happy to have one of the State's hearings here in the Ft. Wayne area, so that we have an opportunity to provide input to the State. I'm Connie Benton-Wolff, President and CEO of Aging and In-Home Services of Northeast Indiana. We are the area agency on aging, representing area 3 planning and service area. Also with me today is Keith Huffman, who is our board chair, who is back here. And our region is home to over 10% of Indiana's 60+ population. And we touched the lives of over 50,000 older adults, individuals with disabilities, and family caregivers last year. We're privileged to have the Indiana Division on Aging in our area today, for one of the three hearings that have been scheduled to receive input on the State Plan. So we're very happy to have an opportunity for our residents to be able to speak. Aging and In-Home Services has had an opportunity to participate with the State Division on Aging in conducting the statewide community needs assessment for older adults, that has

guided much of the development of this annual Plan document. We would like to congratulate the Division on Aging for its forethought and for its vision in guiding the development of a fully-coordinated state view of the needs of older adults, while at the same time preserving for each of us as regions, to identify special needs from our areas. We think that having this consistent data available to all of us will guide the development and funding of services and our activities to create more livable communities for all ages, and to highlight those areas where, region by region, we need to focus our limited resources to be of the greatest value. In our limited time today, Aging and In-Home Services would like to focus its testimony on the first two goals noted in the Division on Aging State Plan for 2015 - 2018.

The first goal we would like to address is State's goal #1: Enhancing the capacity of the provider network to provide quality programming. Three years ago, our board of directors adopted a strategic organizational priority to focus our efforts on creating a new business model. That new model prioritized the need for a system dedicated to creating a coordinated care system, that integrated health and social services for our clients. Our organization has seen the impact on our clients when health and social service systems operated in parallel worlds with little or no crossover or communication. Clients were most at risk as they faced transitions from care setting to care setting. It was not unusual for physicians, discharge planners from hospitals or nursing homes, and care managers, to not communicate in a fashion that would enhance or improve the care of the individual and facilitate their independent living. Through our Aging and Disability Resource Center, we approached Parkview Health Systems to determine their willingness to join hands and a pilot Care Transitions program serving Allen County. They too, were witnessing the importance of a more integrated model for their patients, and so enthusiastically linked with us to see what we could achieve. The pilot was successful and became the foundation for an expanded program that is now funded by the Centers for Medicare and Medicaid services. The Community Care Transitions program that we support is now in eleven hospitals and 22 counties of northern and eastern Indiana, and we are seeing results. The State Division on Aging notes in its Plan, the benefits of working toward a model of care for older Hoosiers that bridges health and social services. We highly support these efforts and we're very pleased to see recognition of this need in the State Plan.

In our learning mode, as we have worked in partnership first with Parkview, and now with CMS, Aging and In-Home has recognized that there are several barriers that must be overcome for the Aging Network to truly work in tandem with these other systems. First, we must become much more sophisticated in the arena of data management. If we're serious about building an integrated care model, we must invest in our own infrastructure related to data collection and transmission. And we must add to our systems, the specialized expertise that allows us to accomplish this goal. This is an investment that we would like to see the State make a high priority. In addition to this priority, individual AAAs must work to become more business-oriented, drive down their costs to be competitive while enhancing performance standards. This challenge will call for leadership and new skill development in our network. At Aging and In-Home Services, we're excited to be a part of this movement. We are very proud of our providers and we stand ready to adapt and

assist the State in any way that accelerates this change required so that we can participate in this new environment of performance-based reimbursement.

Aging and In-Home Services also believe that there are opportunities for further enhancement for the Aging and Disability Resource Center, family caregiver, and nutrition programs, currently funded by our traditional Older Americans Act and state funding sources, to play an even greater role in this new business model. An investment in pilots which continues the movement to evidence-based programming that would best utilize the limited resources we have to serve the growing population would be a very worthwhile investment by the State at this juncture. With the right support, we have a unique opportunity to build on the foundation already established in Indiana to create a new model of person-centered care with expanded funding sources that is so needed by our State and across the country.

The final area Aging and In-Home would like to address with our testimony is the opportunity that we believe is available to create more academic partnerships that will lead to applied research with a focus on community and home-based care for elders. As we think about State Plan Goal #2, to strengthen the rights of Hoosiers to self-determine, to make long-term services and support decisions regardless of the financial spectrum, we need to acknowledge that many of our home and community-based service programs are operating on the original models outlined in the Older Americans Act legislation that was crafted in the early 70s. While much has been learned that has extended the life expectancy of older adults, not as much research has focused on how to extend their independent living through home and community-based social services and social supports. Aging and In-Home has developed recent partnerships with several universities including Northwestern University's College of Medicine, Manchester College of Pharmacy, the University of Iowa College of Nursing and School of Social Work, and we are participating with the Administration for Community Living in Washington, DC, in a thought leaders group related to creating linkages to solidify community-based and academic partnerships. Along with these efforts, Indiana's passing of the Physicians' Order for Scope of Treatment (POST) adds weight to the wishes of patients and their families at end of life. Our Aging and In-Home Services Board Chair Keith Huffman, was instrumental in the advocacy which led to this important legislation. We also believe that advance planning for home and community-based services is part of the key that is necessary for us to really extend independent living, choice, and that sense of self-direction that we know our clients so richly deserve and want. So clearly, to accomplish these goals for the State, and making Indiana a great place to grow up and grow old will take all of us working together. And we are anxious from Area 3 to work hand in hand with the State to make this happen.

Karen G: Thank you very much, Connie. Other comments? Questions? Kristen, do you have comments?

Kristen LaEace: Good morning, everybody. My name is Kristen LaEace. I'm CEO of the Indiana Association of Area Agencies on Aging. We are the trade association that represents all 16 of the area agencies on aging around the state. I'm very pleased to be able to be here in Ft. Wayne. It's great to always travel out of Indianapolis and actually meet people doing all the hard work. I

think we'll go through our comments. I think they're a little more...I would say granular....so it may be a little boring. Connie has some great concepts, and I appreciate that, so we'll just kind of step through some of our specific comments to each component of the Plan.

First of all, we want to thank Yonda and the rest of the Division of Aging staff for their preparation for the draft State Plan on Aging. It's obviously the product of many hours of research and consideration of lots of documents. These include the CASOA survey, there was a Health Management Associates' study of the CHOICE program, Community Living Program final report, reporting on statewide Care Transitions initiatives; there was a study by FSSA of managed care for the aged, blind, and disabled population, and many other documents that I know the Division of Aging has considered. So we are very much welcoming the scope and ambition of the Plan, especially given the increasing challenges and opportunities we face as a state in serving the critical long-term services and supports for older adults and people with disabilities. We've also recognized that the Division of Aging has considered the comments, suggestions, and documents that we have submitted thus far as an Association, and we feel that those are very much in evidence thus far in the goals, objectives, and strategies proposed by the Plan. Just in terms of the comments that we're providing. A number of area agency executives and myself went through the Plan and prepared these comments, and we would invite any questions from the Division or members of the public as to the content of our comments.

On page 1, the Executive Summary, first paragraph. We would like to see Options Counseling, In-Home Assessment, Case Management, Care Transitions and Healthy Aging/Prevention services explicitly identified as part of "comprehensive, coordinated community-based systems" of care. And I think Karen spoke very well to this in her preparatory comments.

On page 3 of the Plan, Context, third paragraph. We would like again, to see Options Counseling, Healthy Aging/Prevention and Care Transitions services explicitly identified as part of the AAAs' role in the continuum of care. We also note that the word accredited is used regarding the ADRCS. We would suggest using a different word because that could suggest that all ADRCs are accredited by the Association of Information and Referral Services which is not the case across the state.

On page 10, Objective 1.2. We would like to see explicitly identified an addition of additional strategies the establishment of Options Counseling as a stand-alone billable service, and this kind of goes along with some of the things we've been talking about related to Pre-Admission Screening restructuring, which I believe is also identified in the State Plan, and expansion of the CLP model of needs-based assessment, resource counseling, care planning, and service delivery to additional AAAs. And Karen did mention this is part of the pilot programs related to HB 1391 that passed. We're concerned about the description of the evaluation of nutrition services suggestive that they are not currently person-centered or cost-effective. We would want to suggest rewording to something more proactive such as "Assess existing nutrition programs to highlight best practices in person-centered care and cost-effectiveness." Just so that we're highlighting...that we know that there are cost-effective and person-centered programs out there, so let's take a look at what's happening across the state. And finally, on page 9 in the Plan, global

budgeting and data management are identified by the SCAN Foundation as possible solutions, but we don't see any objectives that address these two issues, and this is certainly something we have talked about a long time with the Division, even prior to the current staff configuration, of global budgeting that seeks to make sure money truly follows the person whether it's in a nursing home setting or a community-based setting, as well as the data management issues which Connie addressed in her comments.

On page 10, Objective 1.3. In the second strategy, we think it would be helpful to expand on "medical community" to explicitly identify the places that elders engage in health care systems, including things like primary care physician's offices, gerontologists and other specialists, nursing facilities, dentists, hospital and emergency rooms, health clinics, etc. There's a list there.

On page 10, Objective 1.4. There's a lot of discussion about building the capacity of the provider network. We just want there to be a more explicit definition of the providers that are intended as the result of this goal. And further, If nursing facilities are included as part of this objective, the plan may want to explicitly engage the nursing facility leadership collaboratives and culture change coalitions, and/or identify learnings from these initiatives that can be applied to other providers.

On page 10, for performance measures. The average expenditure per unit of service regarding care planning and case management are the same thing in terms of how we're reading the Plan and how things currently operate. If that's not the intent of the Plan, then it should be average care plan cost that's identified in this Plan.

On page 12, there is a lot of discussion of person-centered care, but it's specifically within the context of nursing facility settings. And so we want to hopefully expand that discussion to include other home and community-based service settings.

On page 13, we want to clarify that the ADRCs...clarifying some language that we recognize the ADRCs are a program component of the area agencies on aging. So we want to highlight the role of the AAA first, rather than separating out the ADRC as a separate entity. There's a little bit of confusion there.

On page 15 in the strategies, we've noted that the requirement to provide face-to-face assessments and options counseling prior to delivery of in-home services in the way we're currently configured to do things, can be counterproductive for some services. So for example, home-delivered meals in which hospitals and NFs rely upon prior to discharging patients. So we can support the requirement to provide face-to-face assessments at options counseling, but we need to have some flexibility to provide these kinds of critical services so that we can assure some level of support prior to us being able to actually get out there and do the in-home assessment.

Page 15, Objective 2.2, which deals with advance directives, we recommend that you specifically identify POST – Physician Order for Scope of Treatment, as one of the options.

Objective 2.4 on page 15. There is...we couldn't find...or didn't see an explanation of the Indiana Culture Change Coalition in the particular objective, so we would hope there would be some expansion on that discussion so we can see how the objective relates to the goal.

On page 18, Goal 3, We....and this relates to caregiver issues...we would want to consider the establishment of a consistent caregiver assessment to be implemented across the AAA system, but there's also discussion of the move to do a needs-based assessment so we would want to make sure that any movement in that regard to a caregiver assessment also fits within the needs based assessment movement.

Page 18, Objective 3.1. One idea about caregiving coalitions are discussed, the Plan may want to consider the establishment of a certification program for caregiving mentors. In the third bullet, we may want to include or rewrite the section...oh, this is a repeat. I'm sorry about that. Again, related to the consistent caregiver assessment being implemented across all AAAs. And we note that there have been perennial but yet unsuccessful to date efforts in the Indiana General Assembly to create a caregiver or dependent care tax credit. And we would recommend a strategy...the addition of a strategy, that seeks to educate legislators on caregiver issues, either related to the creation of a caregiver tax credit explicitly or other caregiver issues that would require legislative initiative. So we feel like the legislature isn't as up to speed on caregiver issues and we hope we can work with the Division of Aging to improve that.

Page 18, Objective 3.3. We would recommend an additional strategy either in this objective or above, in other objectives of the goal statement, regarding the creation and dissemination of written caregiving resources that caregivers can access without participating in a formal training program. There's a lot of discussion in the Plan about formal training programs that could be implemented within the caregiving coalitions and within the AAAs but we want to make sure that the people like you mentioned...who aren't...don't want to participate in a formal program, there are resources available.

Page 22; this is the goal related to getting communities ready for the expanded aging population. We noted that there are currently lacking any objectives related to working with Indiana Housing and Community Development Authority (IHCDA) regarding further prioritization, planning, and funding for elder friendly communities and/or aging issues in the states's Consolidated Plan or other IHCDA programs and services. And we would also recommend that the USDA and their rural housing initiatives and community development initiatives be added as an objective in that plan. We also note that there are lacking any objectives or strategies that highlight concrete changes that could affect the system of community services which is described on the top of page 21. So there's a discussion in the Plan about the kinds of community services that need to be in place, but we're just trying to push the Plan a little bit to identify some concrete changes. So these could include the adoption of visitability standards in urban planning and zoning and building codes, things like requirements regarding the construction of sidewalks, local ordinances that encourage (or at least do not prohibit) shared housing among elders, and many more. In addition, there might be an objective or strategy that seeks to provide education on these types of incentives and solutions to municipal and county elected officials, planners, and other

staff. So across the state, people aren't necessarily aware of all these kinds of things that they can do. And finally, we would also encourage the Plan to identify some of the other partners that are working in this area including the AARP on their Complete Streets initiatives, and there are many more.

Page 22, Objective 4.1. We're just making the technical change regarding the "Lifelong Indiana Coalition," which is a statewide effort regarding community readiness, but we also know that we might want to explain the Coalition in the preceding context discussion.

Page 22, Objective 4.3. And this has to do with elder engagement in their communities. In the first bullet, the Plan may also want to include expansion of volunteer programs similar to RSVP and Foster Grandparents, which are mentioned in the Plan. Both of these programs have seen significant cuts in recent years and are currently proposed for additional cuts at the federal level, and so their expansion is therefore, is unlikely. So we don't want to rely just on those two programs. We would also recommend the addition of a strategy that seeks to outreach to and educate local community leadership on the value and benefits of engaging older adult volunteers. So targets for this kind of outreach may include mayors, city and town councils, county commissioners, chambers of commerce, United Ways, county-based leadership development programs, etc. There's a lot of discussion about volunteering in elder engagement in the community but we also recognize a lot of elders seek to continue their employment and so we would recommend the addition of a strategy that would seek to build partnerships with the Department of Workforce Development, Senior Community Service Employment Program providers (such as Goodwill Industries), local Workforce Investment Boards, and regarding the value and benefits of employing older adults, and supporting older adults in staying in, or re-entering, the workforce.

Page 24, Goal 5. We may want to consider objectives or strategies that specify certain types of coordination among AAAs, local police, and APS staff, such as the identification of persons that have frequent interaction with the police, and information development and sharing on persons at risk including photographs to aid in identification, patterns of behavior, key family contacts, etc. So this kind of pushes a little bit some of the comments Karen made about Ombudsmen, APS, local police, AAAs, working together to secure safety and justice for older adults.

And finally we would request that in the last paragraph on page 26, that the paragraph be re-worded to indicate that the AAAs and DA are working together in education and training on data collection.

So, that's kind of a lot more detail and I recognize that if you haven't gone through the Plan with a fine-tooth comb some of these may be coming a little bit...you're kind of like, "well, what's that all about?" So I wanted to see perhaps if you had any questions about any of these particular comments. I know that the State Division on Aging will...this is a good document for them, but it's not necessarily a good document if you haven't gone through the entire Plan. Any questions or comments?

Question: Is the goal of the Association to have data retention within the AAAs?

Kristen: Yes, I will say yes. Let me expand a little bit on data management issues. As Connie alluded to in her testimony. Kind of this brave new world of what's happening in long-term services and supports, in medical care management, integration of the medical side with the long-term services and supports side. And the need for AAAs to change their business models. To engage in that brave new world, we need a lot more robust ability to collect and analyze data. And currently as a network, we don't have that because the legacy system that is provided by the Family and Social Services Administration that we have to use didn't contemplate any of this when it was put in place...how many years ago? Ten, fifteen, twenty? Before we were born! So, we've constantly tried to work with the Division and FSSA and been a really big partner in pushing any kind of effort to enhance data collection, data management, etc. For us to be able to document outcomes that Karen alluded to in her comments, we need to have that more robust data collection management capability because the current system just doesn't help us do that very well.

Question: And I agree with that, but I guess my question is more of...is it the goal of the AAAs...I mean, it's not only someone needs to retain all the data for these individuals, not only a health record but a social service record...the...what are they using? I mean, we have people that move from place to place so is it your association's goal to have that data retention within the AAAs so that no matter where I am in the state of Indiana, somebody -- whether it's a long-term care provider, an elder law attorney...somebody can gather all that data and look at all the data that an individual creates in these types of situations?

Kristin: So more robust data collection, yes, than we are currently capable of collecting. The other thing is that currently, when consumers move from area agency to area agency, the agencies have access to that data, so that piece of it already exists. One AAA can...if a client transfers to another part of the state, that data follows the consumer already. But what you're talking about is a more robust set of data and yes, we want to move in that direction...

Karen G: Within the HIPAA guidelines...

Kristen: Yes. And that really has to be, in our opinion, led by FSSA and the Division of Aging. It's not something that the trade association will come in and create a data management system, but we have to work within...

Karen G: Within partnership…

Question: And is that one of the goals stated in the Plan for FSSA?

Karen G: Well, it is. It is one that we have been aware of for some time and recognize the need for. It would be up to FSSA because our system does go across many platforms of...aging, developmentally disabled, mental illness population groups, so it will be led by FSSA as opposed to the Division of Aging itself.

Yonda: And that is actually part of the FSSA strategic plan and included in that is a systemic upgrade of both the case management system as well as we're building a division within the broadly speaking IT division of FSSA, specifically around data analytics. And one of the goals

that we have realized within FSSA is the extent to which FSSA has...this is a new opportunity that we're really focusing on. Eliminating...to your point about all of the different ways people can enter the system. Now, many of those may be outside of our purview, but the ones that are within the FSSA purview for example, MA and care coordination alongside the social services, you know. We believe that will be achievable under the strategic plan.

Karen: Do we have other comments on the State Plan? You do not need to have prepared written comments. We are very glad to have any comments shared today or later, but are there others that would like to speak? Not hearing any others...all right. Thank you!

Keith Huffman: My name is Keith Huffman and I'm the Chair of Aging and In-Home Services right now. Not a very high paying job. I'm also Chair of the Indiana Elder Law section of the Indiana Bar Association. I think what you're doing is wonderful. The Indiana plan to age in place has been very successful. The Medicaid waivers have been tremendous for my clients, for the people that I represent. They've been able to stay at home; they've been able to stay in assisted living facilities. It's been a wonderful program. Are there things we can do better? There are always things we can do better. One of the things that Aging and In-Home services is participating in right now, is a program called *Respecting Wishes*. This is out of the Gunderson healthcare system in Wisconsin. And its' a three-step plan. The first step is for folks 50 years or older to make sure they have an advance directive, and to make sure they've had a conversation with their health care proxy to tell them what it is they want or don't want for future health care. The next step is people age 70. Those people have some kind of chronic medical condition. We want to identify that they have an advance directive; they've had the conversation with the person they've named to make decisions if they can't make it, and we also have their advance directive in the medical record.

And then the final step is for folks who have a chronically ill or medically fragile condition and they're in the last year of life. And we're going to want to make sure we've had the conversation with them. We have the documents in place, and make sure EMS on board and know what those things are, so we can make a decision to respect whatever kind of care they want in the future. And we're not here talking about trying to restrict the care they get, but we're trying to figure out what that care is. We also want to make sure that the family's been involved, so they know what it is Mom or Dad wants in their final days. And so I think, really, it's going to be important for the Division of Aging to make sure that we have these documents available to people. And it's also going to be important that all the hospitals have some type of uniform way that we get these things into the electronic medical records going forward and into the future. If you go into the hospitals in our area, every hospital has a different policy about how that advance directive gets admitted into the medical record, where it's put in the medical record, and how we access it in the medical record. And so it's going to be important going forward when we have these electronic medical records that will follow us around the United States, that we somehow have some type of uniform way to make the determination in Indiana how we're going to make sure that we educate people about healthcare decisions and respect that. I would also say that as far as your partners and FSSA, the Medicaid Waiver program is a wonderful program, but the case workers need to be trained on how the budgeting works and the rules of eligibility are. You can't go into

any one of the different sections that you have in Indiana right now, and get uniform results. And that can be very discouraging for people who are trying to access the waiver system.

I would also say you ought to take a look back at your residential-based assistance group program. That is for people who are...need to be in assisted living. They don't meet nursing home level of care so they can't qualify for the waiver, but they don't have enough assets to live on their own, or enough income to live on their own. So the old residential-based assistance program can be very invaluable for a lot of different individuals and I would encourage you to look at that so people can age in place as much as possible. And I'd also like you to look into the Self-Directed Attendant Care program. That can be a very, very good program to a lot of people that age in place but we have hardly anyone enrolled in that program in Indiana at all right now. I would venture to say there are probably less than a thousand people receiving services under that program. And those are my comments, and thank you very much. Now I'm not going to ask for questions, because I don't know the answers!

Karen G: It's enough to throw the questions out…you don't have to come up with the answers, too.

Question: Has FSSA looked at implementing the PACE program again in this Plan, or not at all in this Plan?

Karen: It isn't specifically detailed in the Plan, but the model is one we are very interested in.

Question: Can I make a comment of making sure that that specifically is in this Plan?

Karen: You certainly may. That's fine. That's exactly what we want to hear of input. Any other comments or questions? Please!

Question: I'm interested in knowing about caregivers, whether they're family-type or an agency-provided caregivers. Is there going to be specific guidelines for training that they're going to have to meet?

Karen: Are you talking paid caregivers? Okay. Yes, caregivers do have to meet specific training requirements whether it's family caregivers that are being paid, or agency caregivers. Absolutely.

Question: So is there going to be...is there already a list of requirements forthcoming?

Karen: Yes. For agency caregivers, for most of our programs require a license from the state the department of health. If they're serving more than six clients. Individually, they would still have to meet the requirements that are detailed under the waiver program of the training that they've had, TB tests, and other criteria. Then, as an individual caregiver with the area agency, they generally adopt those same standards from the waiver standards, so that we're sure that they meet the same criteria, which also includes a criminal background check, and I'm kind of missing a few pieces in my brain right now...but just as if they were employed with an agency. Same standards.

Generally when you have a hearing like this and it looks like nobody's going to speak up, as soon as you say we'll adjourn, people do think, well wait a minute, I did have a question! So I want to make sure that we don't cut anybody short, because that was a very good question, too. Any other concerns or things you always wondered about, like why is it done this way or that way? Well, I do thank you for coming, listening, thinking, and it's not too late to send us an e-mail. I don't think we've put out our business cards yet, but we certainly will. The website again, is www.in.gov/fssa/da. The State Plan's there on a link on the left-hand side as is a whole lot of other information that we really encourage you to visit..read about...think about...and see what all is out there for older adults in our state and the network and the links to each of the AAAs is there. Thank you!

INDIANA ASSOCIATION OF AREA AGENCIES ON AGING
leadership. advocacy. access.

March 18, 2014

Ms. Yonda Snyder
Director, Division of Aging
Indiana Family and Social Services Administration
402 W Washington Street
RM W454
Indianapolis, IN 46204

Dear Yonda,

Many thanks to you and your staff for your preparation of the draft 2015-2018 State Plan on Aging.

This draft plan is obviously the product of many hours of research and consideration of documents such as the statewide CASOA survey, the Health Management Associates study of the CHOICE Program, the Community Living Program final report, reporting on the statewide Care Transitions initiatives and the ABD Managed Care Task Force Report, among many others. Its scope and ambition are welcome given the increasing challenges and opportunities we face as a state in serving the critical long-term services and supports needs of older adults and people with disabilities.

We appreciate your consideration of the comments, suggestions and documents that the Indiana Association of Area Agencies on Aging (IAAAA) has submitted thus far which is very much in evidence in the goals, objective and strategies proposed by the plan.

A number of Area Agency on Aging executives and I contributed to the attached comments. The full IAAAA Board of Directors vetted and approved the comments at its March 14, 2014 meeting.

Please contact me at klaeace@iaaaa.org / 317.205.9201 for any needed follow-up.
We look forward to our continued partnership as you finalize the elements of the plan and engage its many stakeholders in its implementation.

Most Sincerely,

Kristen S. LaEace, MBA, CAE
CEO

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Indiana Assocation of Area Agencies on Aging

Comments to the Draft State Plan on Aging 2015-2018

Approved March 18, 2014

P1: Executive Summary –First Paragraph

- Identify Options Counseling, In-Home Assessment, Case Management, Care Transitions and Healthy Aging/Prevention services explicitly as part of "comprehensive, coordinated community-based systems"

P3: Context –Third Paragraph

- Identify Options Counseling, Health Aging/Prevention and Care Transitions explicitly as part of the AAAs role in the continuum of care.
- The word accredited could be misleading. The assumption could be that all ADRC's are accredited by AIRS and that is not accurate.

P10: Objective 1.2

- Please add as additional strategies the establishment of Options Counseling as a stand-alone billable service (needs to stand alone outside of PAS), and expansion of the CLP model of needs-based assessment, resource counseling, care planning and service delivery to additional AAAs.
- The description of the evaluation of nutrition services suggests they are not currently person-centered or cost-effective. We would suggest rewording to something such as "Assess existing nutrition programs to highlight best practices in person-centered care and cost-effectiveness."
- Also, on page 9, global budgeting and data management are identified by the SCAN Foundation as possible solutions, but there are no objectives that address these two issues.

P10: Objective 1.3

- In the second strategy, it may be helpful to expand on "medical community" to explicitly identify the places that elders engage the health care system, including primary care physician's offices, gerontologists and other specialists, nursing facilities, assisted living, adult day centers, optometrists, ophthalmologists, dentists, hospitals and emergency rooms, health clinics, urgent care centers, mental health centers and support groups.

P10: Objective 1.4

- It is unclear as to what types of providers are the focuses on this objective.
- If nursing facilities are included as part of this objective, the plan may want to explicitly engage the nursing facility leadership collaboratives and culture change coalitions, and/or identify learnings from these initiatives that can be applied to other providers.

P10: Performance measure

- For average expenditure per unit of service -- care planning and case management are the same thing. If the intent is that they are not the same then it should be average care plan cost.

Indiana Assocation of Area Agencies on Aging

Comments to the Draft State Plan on Aging 2015-2018

Approved March 18, 2014

P12: Person-Centered Care

- The definition and description of person-centered care should be expanded beyond just the nursing facility setting to include other home and community-based settings.

P13: First heading

- This should read *"A person-centered approach requires strong AAA's"* rather than "ADRCs." The ADRC, like options counseling and case management is a function of the AAA.

P15: Strategy

- The requirement to provide face-to-face assessments and options counseling prior to delivery of in-home services can be counterproductive for some services, i.e., home delivered which hospitals and nursing facilities rely upon prior to discharging patients. We can support the requirement to provide face---to---face assessments and options counseling, but need to have flexibility for some critical services.

P15: Objective 2.2

- In the second bullet, specify also POST –Physician Order for Scope of Treatment.

P15: Objective 2.4

- Since there is no explanation of the Indiana Culture Change Coalition, it is unclear how this objective is relevant to the goal.

P18: Goal 3

- In the third bullet, the plan may want to include (or rewrite the section) the establishment of a consistent care giver assessment to be implemented by all AAAs. However, this would need to fit with the needs based assessment mentioned previously.

P18: Objective 3.1

- As part of the creation of caregiving coalitions, the plan may want to consider the establishment of a certification program for caregiving mentors.
- In the third bullet, the plan may want to include (or rewrite the section) the establishment of a consistent care giver assessment to be implemented by all AAAs. However, this would need to fit with the needs based assessment mentioned previously.
- There have been perennial (yet to date unsuccessful) efforts in the Indiana General Assembly to create a caregiver/dependent care tax credit. We would recommend a strategy that seeks to educate legislators on caregiver issues, either related to the creation of a tax credit or other caregiver issues that would require legislative initiative.

P18: Objective 3.3

- We recommend an additional strategy either in this objective or above regarding the creation and dissemination of written caregiving resources that caregivers can access without participation in formal training programs.

P22: Objectives in General

- Currently lacking are any objectives related to work with IHCDA regarding further prioritization, planning and funding for elder friendly communities / aging issues in the state's Consolidated Plan or other IHCDA programs and services. Also, same issue re: USDA and rural housing initiatives and community development.
- Currently lacking are also any objectives or strategies that highlight concrete changes that could effect the system of community services described on the top of page 21. These may include the adoption of visitability standards in urban planning and zoning and building codes, requirements regarding the construction of sidewalks, local ordinances that encourage (or do not prohibit) shared housing among unrelated elders, and many more.
- In follow-up to the above suggestion, there might be an objective or strategy that seeks to provide education on these types of interventions and solutions to municipal and county elected officials, planners and other staff.
- There are also other advocacy partners to work with that could be explicitly identified such as AARP on Complete Streets initiatives.

P22: Objective 4.1

- In second bullet, it is the "Lifelong Indiana Coalition," and it should probably be explained in the preceding context.

P22: Objective 4.3

- In the first bullet, the plan may want to also include expansion of volunteer programs similar to RSVP and Foster Grandparents. Both of these programs have seen significant cuts in recent years, are currently proposed for additional cuts at the federal level, and their expansion, therefore, is unlikely.
- We recommend the addition of a strategy that seeks to outreach to and educate local community leadership on the value and benefits on engaging older adult volunteers. Targets for outreach may include mayors, city and town councils, county commissioners, chambers of commerce, United Ways, leadership development programs, etc.
- We also recommend the addition of a strategy that would seek to build partnerships with the Department of Workforce Development, Senior Community Service Employment Program providers (such as Goodwill Industries), the local Workforce Investment Boards (such as EmployIndy) regarding the value and benefits of employing older adults, and supporting older adults in staying in, or re-entering, the workforce.

P24: Goal 5

- The plan may want to consider objectives or strategies that specify certain types of coordination among AAAs, local police and APS staff, such as the identification of persons that have frequent interaction with the police, and information development and sharing on persons at risk including photographs to aid in identification, patterns of behavior, key family contacts, etc.

P26: Last Paragraph

- We request that this paragraph to be re-worded to indicate that the AAA's and DA are working together in education and training on data collection.

March 25, 2014

The Indiana Division of Aging
402 W. Washington Street IGCS, Rm. W-454
Indianapolis, IN 46207-7083

Dear Members:

Hendricks County Senior Services is a nonprofit agency located in Danville, Indiana. Hendricks County Senior Services believes that older adults have the right to live with independence and dignity, in the home of their choice, for as long as possible. To that end, the agency provides a wide range of supportive services. This year, the agency will serve more than 5,000 older adults, caregivers and people from Hendricks County.

Thank you for the opportunity to comment on The Indiana Division of Aging State Plan 2015-2018. I appreciate the global and local perspective that the State has taken in the development of its plan. I value the information provided by the CASOA survey and commend the members for making decisions based on the findings from the survey.

Page 1 and 2: The Division of Aging is correct to recognize the value and prominence of its core Older Americans Act Programs, particularly the nutrition and family caregiver programs. The local agencies provide a tremendous support to older adults through funds from the Older Americans Act. The local agencies perform critical work that helps keep seniors living independently, including in-home services provided through the Aged and Disabled Waiver.

Page 5 and 6: The report notes that 60% of respondents had problems with not knowing what services were available and that the most commonly cited mental health issues included feeling bored, depressed and confused. It is our belief that the lack of information and some of the mental health issues could be addressed through the use of senior centers.

The CASOA report indicates that less than 2 in 10 respondents have used a senior center in the community. Surveys conducted each year by Hendricks County Senior Services indicate that seniors believe their participation in our programs help them decrease isolation, increase their wellbeing, and help them live with greater independence. A public awareness campaign **(Objective 1.5)** that directs people to their local senior center would have a significant impact on the ability of the provider care network to provide programming that helps older adults and caregivers navigate the complex system of aging services.

The report also notes that the greatest needs for older adults in Indiana are in the areas of civic engagement and physical health (**page 7**). *Significant needs exist within finding meaningful activities, mental health, financial and legal assistance, social engagement, recreation and basic necessities.*

Local senior centers are the perfect location to provide this type of assistance. Yet, Older Americans Act funds are not available to operate the senior centers and, unfortunately, other public and private funders have not been interested in providing support for these kinds of activities. Our agency has been successful at partnering with other organizations to meet the needs of older adults. However, additional funds are critical as the senior population grows and as our oldest-seniors continue to need additional support.

Page 15: Hendricks County Senior Services recognizes the importance of face-to-face meetings as in-home services are arranged. Our agency meets face-to-face with each potential client prior to the start of any services. I am concerned that the Division of Aging strategy (Objective 2.1) to require a face-to-face assessment and options counseling with the AAA before the delivery of in-home services could slow down the delivery of services or cause people not to receive services. I would recommend that the State consider an option in crisis/higher level situations that waive the requirement of a face-to-face meeting prior to the delivery of service. In those cases, the face-to-face meeting could be scheduled within a week of the start of services. Until recently, our clients in need of home delivered meals were not served as quickly as possible because of the State requirement for face-to-face meetings prior to meal delivery. This was a disservice to clients who needed immediate help.

Page 22: The example noted in Objective 4.3/Strategy 2 is concerning for several reasons. It is true that multi-generational activities are important to many older adults. However, establishing meal sites at schools is likely to not be the best approach for the following reasons: schools and their parking lots are not designed to be senior-friendly (e.g. low toilets, limited handicap parking, large and expansive facilities, noisy, etc); schools are an unfamiliar setting; schools are not staffed to support senior programs and senior centers do not have enough staff to work off-site; children can expose older adults to illness; and transportation can be difficult to arrange. One important value of the congregate meal sites provided at senior centers is the opportunity for seniors to engage and socialize and to build relationships that extend beyond the walls of the senior center. Aging can be a lonely process and it is critical for older adults to form friendships with one another. Perhaps a more appropriate example of a multi-generational activity is to promote the Foster Grandparent program or a senior/youth mentoring program. Our agency has long-time partnerships with many local public and private schools whose students provide on-site special event activities such as a spaghetti dinner and BINGO, a Wii bowling tournament, and holiday programs.

Lastly, I appreciate the focus on elder abuse and public safety workforce trainings **(page 23)**. It is our experience that Adult Protective Services is overwhelmed and under-resourced. In addition, many older adults are fearful to report abuse because of their love for the family member who is abusing them. It would be beneficial to provide training to the front line worker at senior centers who can help identify cases of elder abuse, recognize the warning signs, speak with seniors about their options, and understand the situations that should be reported to APS. It is important to note that the Indiana Criminal Justice Institute does not include any resources for elder abuse on its website. This agency could be an important partner in efforts to serve seniors who are abused by their loved ones and caregivers.

Sincerely,

Marina Keers

Marina Keers
Executive Director

Comments

Clough, Lynn

MH/Aging

From: Kristen LaEace [KLaEace@iaaaa.org]
Sent: Friday, March 28, 2014 6:28 PM
To: Koors, Rebecca L (Becky); Orion Bell
Cc: Snyder, Yonda; Clough, Lynn; Gilliland, Karen; Pierson, Debbie (FSSA); Filler, Karen S
Subject: RE: DA State Plan -- mental health & aging

Hello Lynn and Karen,

At the Mental Health and Aging Conference this past Monday, I was struck by the two goals the "Atlanta Team" of FSSA staff had developed a year ago around mental health and aging. The FSSA staff presenting at the conference commented on how the goals had been vetted through the new administration and had its full support. So, it seemed that if these were goals that had to do with aging, they should be included in the State Plan on Aging given it is the Division's strategic plan.

The two goals the Atlanta Team developed are:

- Elevate awareness of older adults who at-risk for mental health and substance abuse issues. This was in response to the recognition that there is a lack of identification of mental health and substance abuse among older adults as well as a need for cross-training of providers.
- Reduce the suicide rate among older adults. This was in response to Indiana's higher than average rate of suicide among older adults.

In response to the two goals, following were some ideas that came out of the discussion during the conference sessions. We didn't talk about priorities for the ideas, or whether they even flow logically in a theory of change around the two goals.

- Indiana has developed a Suicide Prevention Plan. Apparently, older adults were identified as a subpopulation, but there wasn't extensive work proposed. There is an opportunity to revise that section of the Suicide Prevention Plan to make it more robust.
- For legislators who consider themselves expert on mental health issues and expert on aging, there is an opportunity to hold a joint education session for them specifically on mental health and aging.
- There is an opportunity to develop an educational session for AAA staff on mental health and aging issues.
- There is an opportunity to look at standardized mental health screenings that could be implemented across all AAAs.
- There is an opportunity to do research on how many nursing facility residents have mental health issues, both now, and at the time of admission. Apparently, level of care screenings and diagnoses can downplay mental health issues that lie at the root of medical and ADL needs. There are incentives to highlight the medical and ADL needs that result from the mental health problems as the primary diagnoses so that someone can achieve level of care to gain nursing facility admission, especially if there aren't other alternatives for housing and supportive services given the gaps in the service continuum.
- There are opportunities to address the gap that exists for services for older adults with SMI when they have needs but can't meet waiver or nursing home level of care, especially if those needs are ultimately mitigated through successful management and treatment of the SMI.
- There is an opportunity to look at how the prevention, recognition, treatment and management of mental health issues could be built into the state's CDSMP and other healthy aging programming. There is a model in NY that trained a variety of workers (health aging prevention, case managers, options counselors, etc.) to conduct brief mental health and substance abuse screenings, and to follow-up with a "light" non-clinical intervention. This model helps to put something in place for people in light of the shortages of mental health practitioners.

For more background on the development of these goals and the work of the Atlanta Team for inclusion in the State Plan, you will want to connect with Becky.

Hope this is helpful,

Kristen

-----Original Message-----
From: Koors, Rebecca L (Becky) [mailto:Rebecca.Koors@fssa.in.gov]
Sent: Friday, March 28, 2014 8:54 AM
To: Orion Bell; Kristen LaEace
Cc: Koors, Rebecca L (Becky); Snyder, Yonda; Clough, Lynn; Gilliland, Karen; Pierson, Debbie (FSSA); Filler, Karen S
Subject: DA State Plan -- mental health & aging

Good morning Orion and Kristen -
Just wanted to followup with you regarding the DA state plan and our conversation as a result of the mental health & aging conference/coalition session earlier this week.
If you would please provide your recommendations/suggestions to Karen Gilliland & to Lynn Clough for review and potentially incorporation into the state plan.
Thanks,
Becky

Becky Koors
Assistant Director, Long Term Care Operations Division of Aging
402 West Washington Street, P.O. Box 7083 MS 21, Room W454 Indianapolis, Indiana 46207-7083 office - 317-232-4355 fax - 317-232-7867

-----Original Message-----
From: Clough, Lynn
Sent: Wednesday, March 26, 2014 10:15 AM
To: Koors, Rebecca L (Becky); Gilliland, Karen
Cc: Filler, Karen S; Snyder, Yonda; Pierson, Debbie (FSSA)
Subject: RE: DA State Plan

Thanks, Becky! That's a good question. It has not come up in the public hearings held around the state, nor in any submitted comments regarding the State Plan. We should probably find out what Kristen and Orion have in mind regarding a collaboration between Aging and Mental Health. I'd be happy to e-mail them, or would you prefer to do that since you're a member of the Coalition? Just let me know!

****

Lynn Clough, MA
Special Projects Manager, Long-Term Care Operations Division of Aging Indiana Family and Social Services Administration
402 W. Washington Street, Room W454
Indianapolis, IN 46207-7083
317.234.3112
lynn.clough@fssa.in.gov

-----Original Message-----
From: Koors, Rebecca L (Becky)
Sent: Tuesday, March 25, 2014 5:48 PM
To: Gilliland, Karen; Clough, Lynn
Cc: Koors, Rebecca L (Becky); Filler, Karen S; Snyder, Yonda
Subject: DA State Plan

Hi Karen and Lynn -

I attended the Mental Health & Aging Conference yesterday. During the Mental Health and Aging Coalition session, Kristen/Orion asked the following question:

~~Does the current/pending DA State Plan include any language regarding Aging and Mental Health and / or any collaboration between the two groups ?

As you may recall, staff from DA & DMHA are members of the Mental Health and Aging Coalition group as is I4A, Area 8 (currently Orion is the chair of the coalition) as well as other mental health providers and aging providers/trade associations. And so at the Mental Health & Aging Coalition session, the above referenced question came up and I was not sure of the answer. I asked Kristen and Orion if that question has come up during any of the public hearing meetings and they were not sure.
And so, I am passing the question over to you! :-)

We can chat more if you would like.

Thanks,
Becky

Becky Koors
Assistant Director, Long Term Care Operations Division of Aging
402 West Washington Street, P.O. Box 7083 MS 21, Room W454 Indianapolis, Indiana 46207-7083 office - 317-232-4355 fax - 317-232-7867

caregiver homes

March 31, 2014

Yonda Snyder
Director, Division of Aging
Indiana Family & Social Services Administration
402 W. Washington Street, Room W454
Indianapolis, IN 46204

Dear Director Snyder,

On behalf of Caregiver Homes of Indiana, I want to express our support for the Division of Aging's proposed State Plan for 2015 through 2018. We appreciate the opportunity to provide these comments which are focused on Goal 3, "Create a statewide focus on the needs of family caregivers".
Caregiver Homes of Indiana supports elder Hoosiers and their caregivers as a family unit through Structured Family Caregiving (SFC). The Division's decision in 2013 to allow Structured Family Caregiving (SFC) as a service, to individuals eligible through the Aged and Disabled Waiver, is yielding positive results for elders and their caregivers. Through our organization and our sister organizations in Massachusetts, Rhode Island and Ohio, we provide this service to over 2,000 elders and adults with disabilities in 5 states.

Because of the work that we do in homes every day, we wholeheartedly endorse Goal 3. Structured Family Caregiving improves satisfaction and outcomes for elders and their caregivers and saves money for the state and federal government. We see the benefits on a daily basis as families and friends provide services and supports to elders in their homes. We see the relief in caregivers' faces as we help them to understand and address unfamiliar issues. We see elders living their lives with as much independence and dignity as their health allows.

As family caregivers have become a critical part of the workforce caring for elders, addressing the needs of those caregivers will have an immediate and positive impact on the other challenges identified in the Plan. For example:

- In Goal 1, the Plan identifies the fragmentation of services as a challenge for elders. Educating and supporting family caregivers to engage in care coordination alongside professional health care providers will improve service delivery and health outcomes for elders.

- In Goal 2, the Plan details the State's intent to ensure that elders' rights to self-determination are honored. A concerned caregiver, personally invested in an elder's well-being, can play a major role in ensuring that an elder's rights are respected and honored.

caregiver homes

- In Goal 4, the Plan focuses on assessing and facilitating community readiness for a rapidly aging population; this can certainly be enhanced by well-informed caregivers. As the COSOA findings listed on page 6 of the Plan indicate, 6 in 10 older Hoosiers say they are caregivers providing between 8 to 11 hours of care per week. Who could be more motivated to improve their communities than those who will need them in their foreseeable futures?

- Finally, we want to express support and appreciation for the Division's ongoing efforts to improve data collection across systems. As system resources are increasingly strained by the aging of the baby boom generation, the Division's ability to use data to identify those with the greatest need will be increasingly important.

Caregiving has great rewards and costs. The rewards come from helping someone live independently, with dignity, and with the best quality of life possible. Caregiving also has costs that include stress, physical injury, and lost employment opportunities. Without appropriate professional supports, new caregivers don't know what to expect, how to make a home safe, or how best to face a variety of other challenges. Supporting family caregivers will have an immediate positive impact on the lives of Hoosier elders, and will improve the effectiveness of systemic reforms. Indiana's decision to allow Structured Family Caregiving as a Waiver service is helping Hoosiers enjoy the rewards of caregiving, while addressing some of the associated costs.

Finding new ways to support caregivers in their important work should be a high priority. We appreciate that you have made it such a prominent part of this State Plan. If you would like further information, or we can help the Division to meet State Plan goals, please feel free to contact me at 317-515-6335 or at pbisbecos@caregiverhomes.com.

Sincerely,

Peter A. Bisbecos
State Director
Caregiver Homes of Indiana

Clear Choice Adult Day Service Inc.

Caring for your loved one with compassion, integrity and excellence

March 18, 2014

Is there a more ethical way for the referral system? Real Services area on aging in the St Joseph County and surrounding area is the referral and funding for elderly and disable. Since Real Service has merged with Milton House also an Adult day services program and it is now one entity it does not seem ethical for Real Service to have the authority to do assessment for level of care and placement for adult day program.

For example a client has been assessed at a facility as a level one client has all necessary documents, physical and TB client attended ADS program for three weeks as private pay. He client niece found that it was hard to pay. I referred her to Real Services, in turn real service assessed client as a level 3. what rights do the ADS program have?

Thanks

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