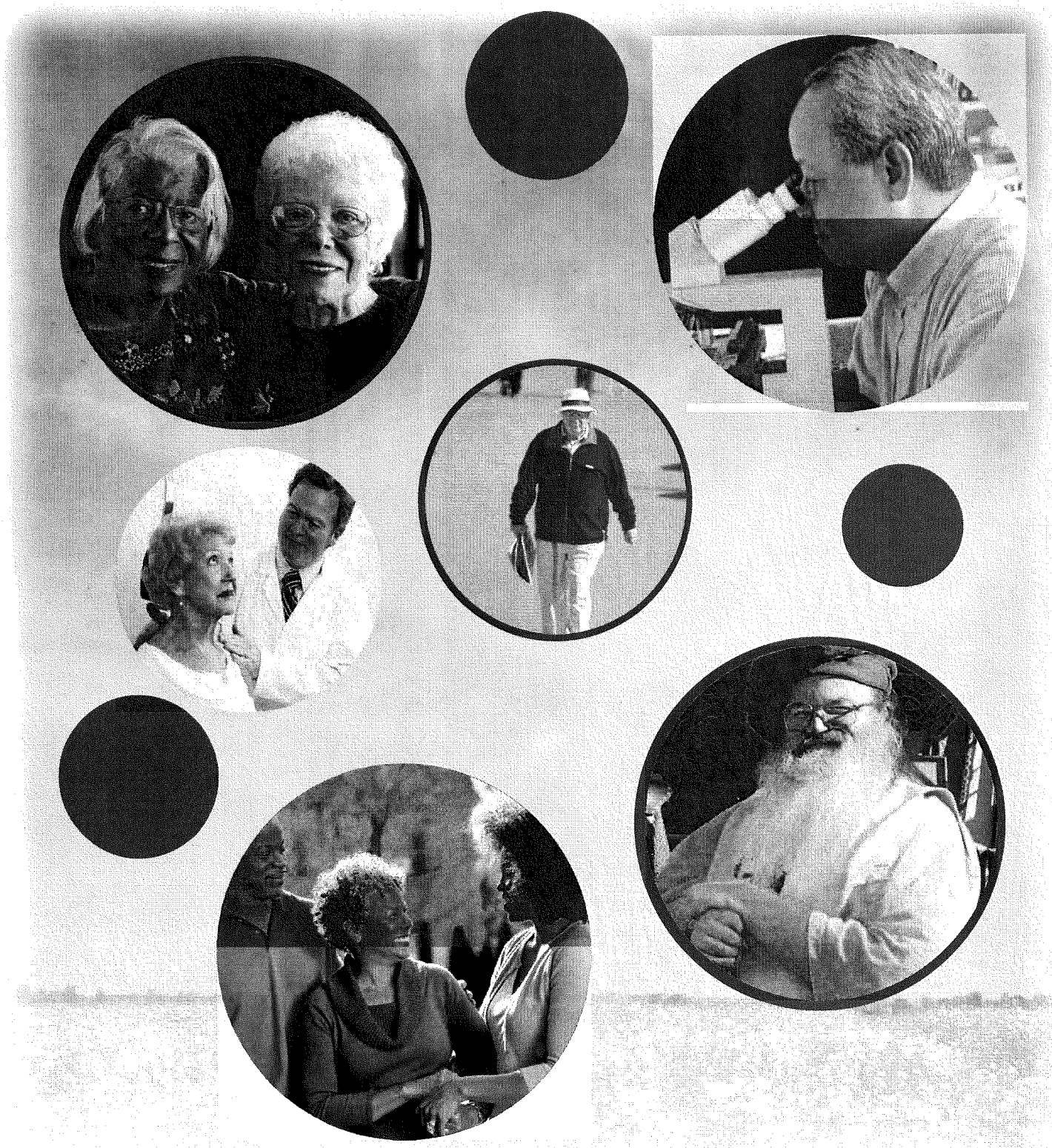

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

Division of Aging

2015-2018

State Plan

STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Michael R. Pence
Governor

June 20, 2014

Mr. Jim Varpness
U.S. Administration on Aging
Chicago Regional Support Group
233 N. Michigan Ave., Suite 790
Chicago, IL 60601

Dear Mr. Varpness,

The purpose of this letter is to officially submit Indiana's State Plan on Aging for 2015-2018, in accordance with the requirements of the Older Americans Act.

Indiana Code 12-10-1-3 & 4, designates the Division of Aging, within the Indiana Family & Social Services Administration (FSSA) as the agency responsible for developing the comprehensive Plan on Aging and administering programs and services for the elderly. The plan has been thoughtfully prepared following a broad analysis and gathering of public input into the needs of Indiana's elderly and disabled.

We look forward to your review and approval of the Plan. Please contact the Director of the Division of Aging, Yonda Snyder (yonda.snyder@fssa.in.gov) , if you have any questions.

Sincerely,

Michael R. Pence
Governor of Indiana

Indiana Division of Aging State Plan 2015 – 2018

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Indiana Division of Aging State Plan 2015 – 2018

Executive Summary

The mission of Indiana's Family and Social Services Administration (FSSA) is to develop, finance, and compassionately administer programs to provide healthcare and other social services to Hoosiers in need in order to enable them to achieve healthy, self-sufficient and productive lives. The Division of Aging (DA), one of several divisions within FSSA, focuses this mission on serving the needs of older Hoosiers. The DA establishes and monitors programs that serve the needs of Indiana seniors. The DA's overarching vision is to re-define long-term care for consumers and providers by focusing on comprehensive, coordinated community-based systems that provide advocacy and protective services; planning, coordination and brokering services; interagency linkage and information sharing; and monitoring and evaluation services. The DA focuses on long-term care supports for the elderly and disabled, and is also responsible for nursing home reimbursement policy and overseeing the Residential Care Assistance Program.

In this proposed State Plan on Aging for 2015-2018, Indiana's Family and Social Services Administration (FSSA), through the DA, has identified the following goals:

- **Goal 1** - Enhance the capacity of the provider network to provide quality care programming while ensuring responsible stewardship of public monies.
- **Goal 2** - Strengthen the rights of Hoosiers to self-determination in their long-term services and supports (LTSS), regardless of their position on the financial spectrum.
- **Goal 3** - Create a statewide focus on the needs of family caregivers.
- **Goal 4** - Assess and facilitate statewide community readiness for a growing older population.
- **Goal 5** - Strengthen statewide systems for advocacy and protection for older adults.

With our State Plan on Aging, the DA intends to improve its operational and policy decision-making based on the needs of all Hoosiers, but particularly those in vulnerable positions. Through improved data analysis and collection methods specified in the Plan, the DA anticipates developing best practices in a variety of long-term care and support services (LTSS) activities. The DA's capacity for documenting its successful methods and practices relates directly to its ability to secure additional funding through grant opportunities and exploring new revenue streams. We have set out to provide a strategic plan designed to address the range of needs experienced by our older citizens and those with disabilities, via the goals, objectives, and strategies outlined here. Enhanced integration of programs and delivery systems, expanded collaborations and partnerships with other organizations and academic institutions, as well as improved community education on existing long-term care and support services will be instrumental to our success in building capacity and ability in Indiana's LTSS network.

In development of this Plan, the DA recognizes the value and prominence of its core Older Americans Act programs, particularly the social services, nutrition, and family caregiver programs. Over the next few years, the DA plans to expand on lessons learned through Administration for Community Living grants, including the Community Living Project, Care Transition programs, and Aging and Disability Resource Center grants. The DA also recognizes the critical importance of continuing to expand opportunities through the Money Follows the Person program, and its two Medicaid Waiver programs: the Traumatic Brain Injury Waiver and the Aged and Disabled Waiver.

As a result of the Balancing Incentives Program and other initiatives, the DA has created strong working relationships with other FSSA divisions, such as the Division of Mental Health and Addiction (DMHA), the Division of Disability and Rehabilitative Services (DDRS), the Division of Family Resources (DFR), and the Office of Medicaid Policy and Planning (OMPP). The DA hopes to build on these relationships as it works to achieve these new goals.

The 2015-2018 State Plan on Aging also acknowledges the critical importance of consumer direction and choice. The DA believes improved education on the availability of various long-term services and support options is critical to ensure Hoosiers are well-informed in the decisions they make. Also essential to preserving consumer choice and direction, is the existence of a robust system of consumer protection and advocacy.

The next pages contain the Context portion of the Plan beginning with a description of the needs assessment survey tool conducted in 2013 by Indiana's sixteen Area Agencies on Aging (AAAs), along with key findings. The following pages include research-based findings that support the stated goals, objectives, strategies, and performance measures we believe will assist us in meeting the needs of our state's residents. This information, along with input of key stakeholders across the state, helped drive the development of the DA's goals, objectives, and planned strategies.

Context

Key staff members of the Division of Aging (DA) reviewed the *Community Assessment Survey for Older Adults*™ evaluative tool (Attachment D) to create this draft Aging State Plan. DA staff also took into account feedback offered throughout the year by the Indiana Association of Area Agency workgroup discussions, and took note of comments and suggestions on a variety of aging topics provided by CHOICE Board and Indiana Commission on Aging members who meet every other month. Draft copies of the State Plan were posted on the Division of Aging (DA) website, and community participation was invited through three public hearings throughout the state. Plan public comments can be found in Attachment E.

The CHOICE Board and Indiana Commission on Aging both provide valuable expertise regarding aging and disability issues. Whereas Indiana established the CHOICE Board by Indiana Code to oversee the CHOICE program, their expertise is valuable for all of DA's programs. Similarly, the Indiana Commission on Aging was created to advise the DA on Older Americans Act (OAA) programs but now encompasses all aging issues.

The DA subcontracts with sixteen Area Agencies on Aging (AAAs) for service delivery and case management. The AAA network was created in Indiana in 1973 to assist state government in meeting the needs of older Hoosiers. Over the years, their role in the continuum of care has expanded from the original OAA programs to include Medicaid HCBS Waivers, the CHOICE program, and designation as Aging and Disability Resource Centers (ADRCs). The AAAs provide the case management and level of care determination functions for Medicaid Waiver, Title III, SSBG, and CHOICE. Some AAAs also provide nutrition, transportation, and other services directly. It should be noted that Indiana has not implemented cost-sharing by service recipients, but accepts consumer contributions as part of program income.

Needs Assessment Results

Results of the 2013 needs assessment conducted by the state demonstrate that Indiana has a number of strengths to offer its older citizens. However, the same needs assessment, or Community Assessment Survey for Older Adults™ (CASOA), which provides statistically valid surveys of the strengths and needs of older adults in communities also uncovered areas Indiana can improve upon for the well-being of Hoosier older adults.

Much of the CASOA survey focused on asking individuals 60 and over to rate their quality of life in a variety of areas. As Kelley-Gillespie notes in her paper on an integrated conceptual model of quality of life, with the unparalleled rapid growth rate of our country's aging population, the term "quality of life" has now become a standard of measure for outcomes associated with long-term care and other aging program services, as well as cost-effectiveness analyses. However, we feel it is important to note that "quality of life" has both objective and subjective elements. The extent to which an individual meets the demands of his surroundings is objective, whereas one's insights into his or her own well-being are very subjective.

The survey was conducted via a questionnaire containing questions related to the life of older residents in the sixteen AAAs within the state of Indiana. Survey participants were asked to rate their overall quality of life, as well as aspects of quality of life in Indiana. They also evaluated characteristics of the community and gave their perceptions of safety. Moreover, the questionnaire assessed the individual needs of older residents and involvement by respondents in the civic and economic life of Indiana.

Overall, survey respondents comprised nearly 70% of adults who had lived in their community for over twenty years; 42% had income of less than $25,000 annually. Over half (54%) of respondents were between the ages of 60 to 69; 24% ages 70 to 74; and 22% 75 or older. The majority (72%) of respondents was fully retired from work; 28% were not retired but expected to retire upon reaching age 70.

Based on the following six community dimensions, the survey results demonstrate the degree to which Hoosier older adults often encounter problems within each element:

- Overall Community Quality
- Community and Belonging
- Community Information
- Productive Activities
- Health and Wellness
- Community Design and Land Use

CASOA Key Findings

Overall Community Quality

Communities that assist older adults to remain or become active community participants enhance quality of life by providing necessary opportunities for recreation, transportation, culture, education, communication, social connection, spiritual enrichment, and the provision of health care. It is worth mentioning that, according to Kelly-Gillespie, the criteria that defines a good quality of life for older adults applies as equally well to people from other age groups.

This section explored how older residents view their community in general, how connected they feel to the community, and how easily they can access information and services offered by the state of Indiana, as well as how likely residents are to recommend and remain in the community. Most of Indiana's older residents gave high ratings to the community as a place to live. Over three-quarters (76%) of older adults said they would recommend their community to others. Over two-thirds (69%) of respondents had lived in their community for more than twenty (20) years, and nearly 9 out of 10 (88%) older adults plan to stay in the area throughout retirement.

Community and Belonging

Older residents of Indiana rated several aspects of belonging, including their sense of community and overall feelings of safety, as well as the extent to which they felt accepted and valued by others. Almost two-thirds (63%) of respondents reported "excellent" or "good" overall feelings of safety. Conversely:

- Between 8% and 14% had experienced safety problems related to being a victim of crime or abuse.
- Slightly less than half (49%) of older residents rated the sense of community as "excellent" or "good;" similar ratings were provided for the community's neighborliness and valuing of older residents.

Community Information

Keeping a large community of older adults informed is not simple, but when residents are aware of attractive, useful, and well-designed programs through planned dissemination of community information, more residents will benefit from participating. However, in Indiana:

- Just over half (55%) of survey respondents reported being somewhat or very informed about services and activities available to older adults.
- About one-third (31%) reported having problems with finding meaningful volunteer work.
- Over half (about 60%) of respondents had problems with not knowing what services were available and feeling as though their voices were not heard in the community.

Productive Activities

Traditional and non-traditional forms of work and maintenance of social ties combine with health and personal characteristics to promote quality of life in later life and contribute to active aging. In this section, the extent of older adults' engagement was examined along with participation in social and leisure programs and their time spent attending or viewing civic meetings, volunteering or providing help to others.

The majority of older residents (59%) rated the recreation opportunities in the community as "excellent" or "good," and about 7 in 10 (73%) felt Indiana had "excellent" or "good" volunteer opportunities. However, the survey revealed that:

- Nearly one-third (31%) reported having problems with finding meaningful volunteer work.
- Less than 2 in 10 (18%) respondents had used a senior center in their community.
- Nearly half (47%) of older adults said they had at least "minor" problems having interesting social events or activities to attend.

- Over half (about 6 in 10 or 60%) of older residents said they were caregivers. Respondents averaged between 8 and 11 hours per week providing care for children, adults, and older adults.
- About one in five older adults in Indiana felt physically (23%), emotionally (26%), or financially (20%) burdened by their caregiving.
- Forty (40%) of respondents rated employment opportunities in their community as "poor;" nearly 1 in 4 (23%) had problems finding opportunities to enroll in skill-building or personal enrichment classes.
- Almost three-quarters (72%) of respondents were fully retired, but nearly 4 in 10 (38%) respondents experienced at least minor problems with having enough money to meet daily expenses.

Health and Wellness

Of all the attributes of aging, health poses the greatest risk and the biggest opportunity for communities to support the independence and contributions of their aging populations. For purposes of this study, this section included not only physical and mental health, but also issues of independent living and health care. Approximately 8 in 10 (82%) rated their overall mental health/emotional well-being as "excellent" or "good." However,

- Older adults reported the most problems with maintaining their physical health (64%), doing heavy or intense housework (61%) and staying physically fit (60%).
- Only about 3 in 10 (34%) older residents felt there was "excellent" or "good" availability of mental health care in Indiana.
- The most commonly cited mental health issues included feeling bored (46%), feeling depressed (40%), and experiencing confusion or forgetfulness (40%).
- The least cited mental health issues included figuring out which medications to take and when (12%), and having friends or family to rely on (27%).
- Around 4 in 10 (40%) respondents reported at least minor problems with having adequate information or dealing with public programs such as Social Security, Medicare, and Medicaid.
- One-third (32%) of respondents reported spending time in a hospital.
- One-third (33%) of older adults had fallen and injured themselves in the twelve months prior to the survey.
- At least 16% of older adults reported at least minor problems with aspects of independent living, including 3 in 10 (36%) who reported having problems with performing regular activities, including walking, eating, and preparing meals.

Community Design and Land Use

The movement in America towards designing more "livable" communities—those with mixed-use neighborhoods, higher-density development, increased connections, shared community spaces and more human-scale design—will become a necessity for communities to age

successfully. Communities that have planned for older adults tend to emphasize access, and promote ease of movement and participation.

Respondents rated the ease of getting to the places they usually have to visit (68%) and ease of car travel (73%) most positively with at least 6 in 10 rating each as "excellent" or "good." On the other hand:

- Only 4 in 10 respondents felt the city had "excellent" or "good" availability of affordable quality housing (43%) and variety of housing options (44%).
- About one-fourth (25%) of older adults experienced problems with having safe and affordable transportation available. Nearly half (43%) of respondents rated the ease of travel by public transportation (bus, rail, on-demand/senior transportation) as "poor."
- Nearly 1 in 5 (18%) older adults experienced problems with having housing to suit their needs, and over 1 in 10 (12%) with having enough food to eat.

Generally, over three-quarters (79%) of respondents rated their overall quality of life as "excellent" or "good."

CASOA summary

In summary, Hoosier older adults reported the lowest prevalence of need in the areas of caregiver burden and safety; however, any existing need may be quite serious for those who are affected. It should be understood that the percent of the population experiencing a problem is not a measure of how difficult a problem is to endure for the people who share it. Some needs or opportunities, though rare as a percent of residents, have a significant impact on residents' quality of life – for example, needing help transferring from bed to wheelchair or having a problem with safety – so it is important to consider both the prevalence of the need or opportunity and its importance in maintaining residents' independence.

Goals, Objectives, and Strategies

Goal #1: Enhance Capacity of Provider Network

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

As reported by the National Coalition on Care Coordination (N3C), over the next fifteen years, one in five Americans will be 65 or older. During that time, health and long-term care services costs will continue to increase. Services currently in place are often a confusing tangle of uneven quality and often duplicated efforts. As a result, many older adults, including the most vulnerable—the frail elderly and those with chronic diseases—do not receive the care they deserve, or are unnecessarily hospitalized or institutionalized. These costs and inefficiencies also exact enormous financial, emotional, and physical tolls on the 34 million family caregivers who provide the bulk of care to the aging.

Meeting this challenge head on requires care coordination—a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following set standards of care.

ADRC Terminology Survey Tool
The ADRC Technical Assistance Exchange created a survey for ADRC grantees to administer and use as a tool to stimulate thought and discussion about the different words and terminology used by partners to refer to themselves, each other, the people they work with, and the services and supports they provide. Language is an essential element of culture; organizations have their own ways of doing business and their own ways of talking about it. People who have professional and personal backgrounds in aging and disability services sometimes use different words to refer to the same thing, or they may use the same words but intend different meanings. Because language is constantly evolving, ADRC partners may not be able to agree on a standard set of words to use, but they should strive for a greater understanding of what words they and their partners prefer to use. ADRCs are encouraged to adapt and use this survey with their partners, advisory boards, and other stakeholders to begin a dialogue about and promote a better understanding of terminology.

Person-centered cost-effective service delivery models
Stakeholders involved with long-term care services and supports (LTSS) have long discussed the fragmentation found throughout care delivery and how a system redesign can improve the "on-the-ground experience of care for vulnerable older adults and persons with disabilities." In an ideal world, the "right providers would engage with individuals at the right time and right place, involving family as appropriate and creating a rational plan of care that puts the person's

preferences, values, and desires first." The SCAN Foundation's Policy Brief No. 7 (September, 2012) describes the following five major obstructions to, and possible solutions for, the generation of a "high-quality, person-centered system of care for older adults and people with disabilities."

1. Administrative oversight of medical care and supportive services often spans multiple agencies, departments, and programs through both formal and informal arrangements, minimizing the capacity for a central decision-making authority." Further, this maze is reflected at the local level where service delivery occurs, resulting in significant confusion and frustration for consumers and their families.
    - Minimize the number of pathways individuals must navigate to receive needed services
2. No payer is singularly responsible for coordinating care or managing overall costs of care; instead, multiple funding silos result in individuals potentially enrolling in multiple, duplicative programs or missing opportunities for more cost-effective services.
    - Traditional public accounting practices allocate resources from multiple funding streams on a program or service basis without acknowledging that people frequently transition between settings and services over time. The integration of funding streams across programs into a single budget can reduce or eliminate funding silos between disparate programs, allow greater investment in programs that more effectively or efficiently deliver care, and target spending in greater alignment with an individual's needs.
3. Multiple medical and LTSS providers assess their clients' needs in a variety of ways, using different rating instruments, with the information used for different purposes, resulting in increased time expenditures for each program, and "assessment fatigue" for the client.
    - Using a "universal assessment" tool can not only be used for service delivery purposes, but for quality measurements that can assist program planners at the state level understand the needs of the population, support allocation of resources, and evaluation purposes.
4. Numerous challenges exist for fragmented information systems organized and contained in departmental or agency silos—just obtaining approvals for data sharing and data use agreements can take months!
    - An integrated information system is essential for effective policy evaluation, resource allocation, and performance monitoring. A person-centered system that drives planning and decision-making is more likely to occur when data are centrally organized, with easy linkage across programs.
5. Traditional measures of the clinical quality of care focus on specific settings of care, i.e., hospital, outpatient, skilled nursing, or even on specific diseases such as diabetes or heart failure. But these are not sufficient to know if the system is working to better need the individual's needs.

- Current quality evaluation efforts should connect with other methods and data sources that capture the person's experience of care. For example, health plan demonstrations of network adequacy should be linked with consumer self-reported experiences such as the ability to get a needed medical appointment within a reasonable timeframe. Further, evaluation of care transitions will be critical; these can determine the successful avoidance of health/activity decline and/or hospital readmissions.

National Core Indicators-Aging & Disabilities

The National Core Indicators-Aging & Disabilities (NCI-AD) is an initiative designed to support states' interest in assessing performance of their programs and delivery systems, and improving services for older adults, individuals with physical disabilities, and caregivers. NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD), Human Services Research Institute (HSRI), and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). Like the developmental disability (DD) service system's National Core Indicators (NCI), NCI-AD's primary aim is to collect and maintain valid and reliable data that give states a broad view of how publicly-funded services impact the quality of life and outcomes of service recipients.

Objectives, Strategies, and Performance Measures

Objective 1.1 Collaborate on strategic planning/AAA culture change to a more business-oriented model to better leverage opportunities for new revenue streams and long-term sustainability.

Strategies:

- Review, identify, and implement opportunities to enhance program income
- Adopt uniform service standards and terminology
- Assist AAAs in identifying cost models for their services

Objective 1.2 Work with AAA network to identify and promote new service delivery models that are person-centered as well as cost-effective for long-term sustainability

Strategies:

- Analyze cost and other program data to identify opportunities for program efficiencies, modifications, and improvements
- Restructure nursing facility admission screening process and AAA reimbursement
- Assess effectiveness of nutrition program
- Assess effectiveness of targeting formula at the local level
- Participate in the National Core Indicators-Aging & Disabilities (NCI-AD) survey

Objective 1.3 Promote availability of person-centered service options through the AAA network, regardless of consumer's financial need.

Strategies:

- Promote private pay options
- Increase awareness in the medical community, of the aging network's ability to provide:
  - Care transitions
  - Patient education

- Patient advocacy
- Caregiver support

Objective 1.4 Support provider network in workforce development and culture change initiatives.

Strategies:

- Collaborate with ISDH and provider associations to promote leadership development in the provider network
- Develop and implement an ongoing provider education program
- Continue monitoring and evaluation of providers for program compliance

Performance Measures:

- Percentage of older adults using services
- Consumer satisfaction/quality reports
- Average expenditure per unit of service for care planning, meals, and case management
- Project income percentages across Title III services
- Percentage increase of persons ages 60 and over participating in nutrition program
- Percentage increase in reported information assistance contacts
- Percentage served in targeted populations

Goal #2: Strengthen Self-Determination for Hoosiers' LTSS

Strengthen the rights of Hoosiers to self-determination in their long-term services and supports (LTSS), regardless of their position on the financial spectrum.

CASOA's study found that:

- One in four (25%) respondents reported spending time in a hospital in twelve months prior to the survey. Nearly one-third (32%) spent time in an emergency room; and 4% spent at least one day in a nursing facility/rehabilitation facility.
- One-third (33%) of older adults had fallen and injured themselves in the twelve months prior to the survey. At least 28% of respondents reported falling or injuring themselves in their home.
- At least 16% of older adults reported at least minor problems with aspects of independent living, including 3 in 10 (36%) who reported having problems with performing regular activities, including walking, eating and preparing meals.

Supporting self-determination—or independence—focuses on the fulfillment of basic psychological needs for autonomy, competence, and relatedness, each of which is important throughout the lifespan. Dacey and Newcomer stress that assisting adults in meeting these needs becomes even more significant during one's later years. Older adults whose psychological needs are not sustained can quickly lose energy and vitality, along with the ability to find joy in discovering new interests. Putting a foundation in place for this support requires 1) a combination of person-centered care for those at home and in nursing facilities, 2) face-to-face assessments promoting the availability of long-term care options before any in-home services begin, 3) educating younger Hoosiers (ages 30-50) on the value of long-term care planning for not only their parents but themselves, and 4) ensuring the coordination and continuity of health care through care transition training for case managers as older adults transfer between different locations or different levels of care.

Person-centered care

Research by The Council on Quality and Leadership has shown that person-centered models recognize the value of community membership, and the ability for individuals to include their families, friends, neighbors, co-workers, and others as potential supportive and collaborative resources. Interestingly, CASOA's survey found that slightly less than half (49%) older residents rated the sense of community as "excellent" or "good;" similar ratings were provided for the community's neighborliness and valuing of older residents.

When a nursing facility (NF) resident receives person-centered care, it means he has choice, purpose, and meaning to his daily life. NFs with a culture of person-centered care support their residents in achieving levels of physical, mental and psychosocial well-being that are individually realistic. Consistent with the Advancing Excellence in America's Nursing Homes campaign, this keeps the person at the center of the care planning and decision-making process. Care plans are living documents revised to reflect the person's changing needs. In person-centered care, active listening and observation by staff are key elements so NF personnel can adapt to each resident's changing needs *regardless of their cognitive abilities.*

Indiana Culture Change Coalition

The Indiana Culture Change Coalition (Coalition) is a volunteer-based organization dedicated to transforming long-term care in the state of Indiana. The Coalition uses research and proven methods of caregiving as well as leadership styles to influence positive change in healthcare, particularly in the areas of aging and disability services. Much of it focuses on nursing home care, but the mission of the Coalition—allowing individuals to live a dignified and meaningful existence—can be applied in a variety of settings, including home and community-based care.

At the heart of person-centered care is a relationship-based approach that puts the person at the center of the health system. "Put the person before the task" is a recurring theme throughout person-centered planning, and it reminds us that we must make a conscious effort to give control back to the individual and look to them to set the pace for schedules and activities. In today's world of task-oriented caregiving, we often put our tasks, checklists, and schedules before the person, losing all sense of relationship and robbing the individual of independence and autonomy.

Community Living Program Project (CLP)

Features of this project include a person-centered approach that requires strong ADRCs with enhanced options counseling and case management services, as well as the following characteristics, based upon the following components from the CLP:

- Personal accountability: Reliance on the individual's willingness to use their own resources to pay for their care.
- Enhanced resource management: With support from their case manager/Options counselor, clients will be encouraged to identify their support network and maximize all other resources before relying on state and federal support.
- Identification of critical needs: Targeting resources to meet the critical needs only for as long as they are needed.
- Leveraging resources: Leveraging of community funding, volunteers and fund development to meet identified non-critical needs through enhanced information management systems.

- Empowering: Clients work with their case manager/Options counselor to improve their health or personal situation by establishing attainable goals.
- Authorizing necessary services only, thereby reducing care plan costs and enhancing the ability to serve more clients.
- Immediate access: Providing services to those most in need when the help is needed.
- Face to face access: Providing benefits and options counseling face to face rather than relying solely on a phone assessment.
- Action plan: Providing the client with a road map to meet their needs by outlining their options, if they have the ability to direct and pay for their own care.
- Follow up: comprehensive follow up to insure the action plan was appropriate and needs have not changed.
- Ombudsmen: Increasing the visibility of the Ombudsmen services in nursing facilities decreases abuse.

Educating younger people on long-term care planning

Younger people seem to be more knowledgeable about long-term care financing and are more likely to be saving for their future needs than are older Americans, as indicated by a 2013 national survey conducted by insurance company Northwestern Mutual. However, out of more than 2,000 people surveyed, only about 30% said they were saving for future long-term care needs. The number was highest (36%) for those between 18 and 34 years old. Only 21% of people between the ages of 45 and 54 said they were saving. The 18- to 34-year-old respondents were less likely than other groups to put their faith in insurance programs. Only 37% of this demographic said they believed Medicare, Medicaid or other insurance generally covers long-term care, compared with 52% of those 55 or older.

Polls have generally shown widespread misunderstanding about how one pays for long-term care, and how commonly it is needed. If younger people are beginning to have a firmer grasp on long-term care needs and the most common payment methods, it could be because they are increasingly becoming caregivers for family and friends. About 70% of caregivers polled said they've made plans to address their own future needs. But, despite the trend toward planning among younger respondents, the survey showed that, overall, *people are still largely unsure about how the nation's long-term care system works.*

Care transitions

According to Dr. Eric Coleman, the term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. For example, in the course of an acute exacerbation of an illness, a patient might receive care from a primary care physician (PCP) or specialist in an

outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she would receive care from a visiting nurse. Each of these shifts from care providers and settings is defined as a care transition.

Many of these transitions are urgent and spur-of-the-moment, often leaving patients completely unprepared for what happens next, and uncertain about their role. Coleman and Berenson state that, while in an institutional setting, patients often adapt to their surroundings and become complacent and dependent on others. Once discharged to another care setting such as the home, patients and their caregivers are suddenly expected to take over managing recovery, with very little support or preparation. Care Transitions® trainings were designed in response to the need for a patient-centered, interdisciplinary intervention that addresses continuity of care across multiple settings and practitioners.

Care transitions between hospitals and nursing facilities can also be problematic as patients/residents transfer between the two. A 2014 study conducted by the Department of Health and Human Services Office of Inspector General, found that these transitions often happen hurriedly with little or no preparation. They may occur during nights and weekends when nursing facilities may have fewer or less experienced staff, involve clinicians with no prior relationship to the resident, and often happen so quickly that the nursing facility staff hasn't time to respond skillfully in a timely manner.

High-Performing LTSS System

The 2011 study conducted by AARP, The Commonwealth Fund, and The SCAN Foundation—*Raising Expectations*—revealed that the ultimate goal of a LTSS system should be to "enhance the well-being and quality of life of individuals who are at risk…[and] help to maintain their families in their role as caregivers." The study continues, stating that a "high-performing LTSS system has five characteristics: 1) affordability and access, 2) choice of setting and provider, 3) quality of life and quality of care; personal preferences are honored whenever possible, 4) support for family caregivers, and 5) effective transitions and organization of care."

Objectives, Strategies, and Performance Measures

Objective 2.1 Develop systems, tools, and expectations that focus on the delivery of person-centered care.

Strategies:

- Develop and implement a new needs-based assessment instrument that can be used in evaluating needs for LTSS as part of the agency's Balancing Incentives Program (BIP)
- Evaluate 90-day review and other assessment tools in compliance with CMS person-centered care requirements
- Promote the provision of face-to-face assessments and options counseling before the delivery of in-home services
- Collaborate within AAAs to expand care transitions partnerships throughout the state

- Continue integration/operationalization of ADRC model throughout AAA network

Objective 2.2 Educate Hoosiers on the importance of advance planning.

Strategies:

- Train AAA staff on advance planning discussions
- Integrate advance planning decisions and documentation within case management system
- Champion establishment of statewide advance planning repository

Objective 2.3 Collaborate with the Indiana State Department of Health (ISDH) and the nursing facility professional community to promote a culture of person-centered care for those residing in institutions.

Strategies:

- Provide input on issues relating to Alzheimer's Disease or Related Dementia (ADRD) in healthcare facilities, as the State updates regulations or develops quality improvement projects
- Collaborate to reinvigorate the *Indiana Culture Change Coalition*
- Collaborate with academic, community, and other agency stakeholders to create a statewide implementation plan for Physician Orders for Scope of Treatment (POST)

Performance Measures:

- Waitlist
- Participant/client satisfaction
- Hospital readmissions
- Number of signed advance directives
- NF report card scores (improved)
- Percentage increase of outreach contacts
- Number of regulations/quality improvement projects with substantive DA involvement
- Decrease in low-need individuals receiving services in nursing facilities

Goal #3: Statewide focus on family caregivers

Create a statewide focus on the needs of family caregivers.

CASOA's study found that:

- Over half (about 6 in 10 or 60%) of older residents said they were caregivers.
- Respondents averaged between eight and eleven hours per week providing care for children, adults, and older adults.
- About one in five older adults in Indiana felt physically (23%), emotionally (26%), or financially (20%) burdened by their caregiving.

Family support is key in an older adult's ability to remain in his or her home and in the community, but according to the AARP Public Policy Institute 2011 study, it comes at great cost to not only the persons providing the care, but their families, and to society. If family caregivers were not available to their loved one, the economic cost to the country's health care and LTSS would drastically escalate. In 2009, nearly one million family caregivers in Indiana provided care to an adult with limitations in daily activities at any given point in time, and over 1.3 million provided care at some time during the year. The estimated economic value of their unpaid contributions was approximately $9.4 billion in 2009, up from an estimated $7.8 billion in 2007.

Family Caregiving Coalitions

As indicated by the National Alliance for Caregiving, the country's long-term care system is less a "system" than a disjointed collection of services managed by a variety of public and private agencies with inconsistent coordination and often gaps in services. Similarly, the system currently in place for supporting family caregivers in providing long-term care is rudimentary and often inadequate. The National Family Caregiver Support Program (NFCSP), a federal program administered by the Administration for Community Living, provides critical help to caregivers with a comprehensive array of services, but it is limited mostly to caregivers of the elderly and is woefully underfunded. Additional support from both public and private organizations, as well as citizens in the community, is needed.

Family caregiving coalitions can help develop new partnerships at local and state levels and present a coordinated approach to addressing the needs of family caregivers. Coalitions can ultimately provide family caregivers a variety of benefits, including new and improved services delivered to more caregivers; enhanced access to information and referral services, advocacy for state and federal legislation; and support networks or groups.

Lifespan Respite Care Program

The Administration for Community Living (ACL) operates the "Lifespan Respite Care Program," authorized by Congress in 2006 under Title XXIX of the Public Health Service Act (42 U.S.C 201). Lifespan Respite Care programs are coordinated systems of accessible, community-based respite care services for family caregivers of children and adults of all ages with special needs. Such programs reduce duplication of effort and assist in the development of respite care infrastructures at the state and local levels. Once implemented, Lifespan Respite Care programs work to improve the delivery and quality of respite services available to families across the age and disability spectrum.

Lifespan Respite Care Programs advance the following objectives: 1) Expand and enhance respite services in the states, 2) improve coordination and dissemination of respite services, 3) streamline access to programs, 4) fill gaps in service where necessary, and 5) improve the overall quality of the respite services currently available. Since 2009, Congress has appropriated approximately $2.5 million per year to implement Lifespan Respite Programs. As of 2012, competitive grants of up to $200,000 each were awarded to eligible agencies in thirty states and the District of Columbia.

National Caregivers Month

According to the Administration on Aging (AoA), November is National Caregivers Month, and a time to acknowledge the important role family, friends and neighbors play in caring for sick, elderly, and disabled friends and relations, not only in the home but in nursing facilities. Caregivers offer a range of services, from emotional and spiritual support and assistance with financial matters, to transportation and home- and health-related services. And they provide an estimated $450 billion worth of uncompensated care to loved ones annually. Additionally, the Family Caregiver Alliance states that unpaid family caregivers will likely continue to be the largest source of long-term care services in the U.S. Given the statistics on the increase in the older population and rates of illness among older adults, more people in the U.S. will be taking on caregiver responsibilities and experiencing a range of issues related to the time, activities, and money they must allot to caregiving.

Maximizing dementia caregiver capability training

For dementia caregivers, growing consensus suggests that more comprehensive and multi-component interventions are necessary. Such interventions must be individually tailored to meet specific goals, values, and preferences of both family caregivers and the person being cared for—after an individual in-home assessment of the caregiver and care recipient. Programs that provide a combination of education, skills training, coping techniques, and counseling show positive results, but more research is necessary, especially on interventions targeted to families caring for loved ones with multiple chronic conditions.

Evidence-based caregiver trainings

Recommendations have been made for evidence-based trainings for those persons who care for patients with Alzheimer's or a related dementia. For example, the *Savvy Caregiver* program is intended to train families and others for the unfamiliar role they face as caregiver for a relative or friend with dementia. The *Savvy Caregiver* is a twelve-hour training program delivered in two-hour sessions over a six-week period. The program focuses on helping caregivers think about their situation objectively and providing them with the knowledge, skills, and attitudes they need to manage stress and carry out the caregiving role effectively. An evaluation of *Savvy Caregiver* found statistically significant positive outcomes for caregivers who participated in the program with respect to the caregivers' beliefs about caregiving, their reactions to the behavioral symptoms of their care recipient, and their feelings of stress and burden.

Another example of caregiver training is *Powerful Tools for Caregivers* (PTC). PTC is based on the highly successful Chronic Disease Self-Management Program, and is a national program sustained by extensive collaborations with community-based organizations. In six weekly classes, caregivers develop a wealth of self-care tools to: reduce personal stress; change negative self-talk; communicate their needs to family members and healthcare or service providers; communicate more effectively in challenging situations; recognize the messages in their emotions, deal with difficult feelings; and make tough caregiving decisions. The six-week PTC class has been shown to have a positive impact on caregiver health for a diverse group of caregivers including rural, ethnic minorities, adult children of aging parents, well-spouses/partners, caregivers at different stages in the caregiving role, and living situations, financial, and educational backgrounds.

Moving Indiana Forward

In 2012, principals of the state's top organizations in aging expertise formed a group tasked with transforming service delivery to meet the needs of Indiana's soon-to-explode older adult population. The idea was to create a grass roots effort with a broad base at the local level, which would provide an opportunity for shared ideas and identifying solutions. Comprised of members of the state's Division of Aging, Area Agencies on Aging, nationally-known associations, and leading trade associations, the group began by identifying quality indicators, assessing the current status of aging services, establishing goals and charting a course for moving Indiana forward to becoming a premier state in the provision of aging services.

The group produced a number of key indicators known to be effective in Long-Term Supports and Services (LTSS): 1) caregivers are supported; 2) LTSS consumers have options for home and community-based care that are just as accessible as institutional care; and 3) consumers are able to access the information they need to make good choices, and insure quality in their chosen care setting. Implementation strategies are yet to be developed.

Objectives, Strategies, and Performance Measures

Objective 3.1 Develop a state plan on supporting caregivers.
Strategies:

- Assess current state of Hoosier caregivers; research caregiver's true needs
- Incorporate caregivers' needs into consumer needs-based assessment
- Facilitate creation of caregiving coalitions
- Explore Lifespan Respite Care Program funding through the Administration for Community Living (ACL)
- Resume *Moving Indiana Forward* project by focusing on caregiver support

Objective 3.2 Increase awareness of services already available to support caregivers.
Strategies:

- Promote National Caregivers' Month events
- Identify funding for public awareness campaign
- Encourage area-wide caregivers' workshops to educate caregivers on network of services and identifying case management concept
- Develop resource and guidance tools for individuals ages 30-50 to inform and assist them with long-term care planning

Objective 3.3 Promote caregiver training that maximizes the abilities of caregivers to care for persons with Alzheimer's Dementia and Related Dementias (ADRD).
Strategies:

- Support *Savvy Caregiver* training in conjunction with local Alzheimer's Associations
- Promote *Powerful Tools* training resources through ADRCs
- Identify other training resource materials
- Identify potential partnerships with community entities and academic institutions to identify and promote other support models

Performance Measures:

- Number/percentage of caregivers served by AAAs
- Measure caregiver responses
- Number/percentage of aging network staff and caregivers receiving training to improve knowledge of and response to people with dementia
- Satisfaction survey results from Press Ganey survey conducted among NF residents, friends and family members, and employees, as part of the state's quality improvement initiative

Goal #4: Statewide Community Readiness for Older Population

Assess and facilitate community readiness for an expanding and diverse older population with a multiplicity of needs.

CASOA's study revealed the following:

- Slightly less than half (49%) of older residents rated the sense of community as "excellent" or "good;" similar ratings were provided for the community's neighborliness and valuing of older residents.
- Just over half (55%) of survey respondents reported being somewhat or very informed about services and activities available to older adults.
- Only just over 3 in 10 older adults felt the agency had "excellent" or "good" information about resources for older adults (36%) and financial or legal planning services (40%).
- Over half (about 60%) of respondents had problems with not knowing what services were available and feeling as though their voices were heard in the community.
- Nearly one-third (31%) reported having problems with finding meaningful volunteer work.
- Less than 2 in 10 (18%) respondents had used a senior center in their community.
- Nearly half (47%) of older adults said they had at least "minor" problems having interesting social events or activities to attend.
- The most commonly cited mental health issues included feeling bored (46%), feeling depressed (40%), and experiencing confusion or forgetfulness (40%).

Between the years 2010 and 2050, Indiana's population will increase 15 percent—from 6.48 million to 7.48 million residents—consistent with population projections released by the Indiana Business Research Center. More than one-third of this growth has already begun as the state's population will climb to 6.85 million by 2020. Indiana will continue to grow over the following decades, but at increasingly lower rates.

On our way to adding another million Hoosiers, the state's population itself will continue to undergo major shifts. Indiana's population of 2050 will have a far different age structure and geographic distribution than it does today. The dominant force behind Indiana's changing population dynamics is the aging baby boom generation. The first boomers hit age 65 in 2011 and the entire cohort will be of traditional retirement age by 2030. By that point, the *senior population's share of the state total will jump from 13 percent in 2010 to 20 percent* before beginning to level off. All other age groups will see their share of total population decline over the same period.

Community readiness: a system of service needs

We already know the majority of older adults wish to remain in their homes and communities as they age—research has shown that providing home and community-based services is a cost-effective model in allowing them to do so. As the older adult population continues to increase, communities must work to ensure they are prepared to accommodate this shift in demographics. Partners for Livable Communities' Ellie Dalrymple states there is no single answer because everyone faces unique challenges as they approach old age; however, communities need a system of services that integrate health care, daily living needs, transportation, housing, recreation, social services, and educational, social, and cultural opportunities. To adopt these principles, the cooperation of local, state, and federal officials is crucial.

Engaging older adults

According to *Coming of Age* Director Dick Goldberg, "Communities must respond or miss the opportunity of fully engaging the largest, most educated generation of social innovators in the nation's history." Older adults are looking for a variety of opportunities to keep active and remain engaged in civic life. They often have the skills, connections, and time to put toward helping their communities. Utilizing these assets, however, will require new models of volunteering, and changing the lens through which we traditionally view our older residents.

Despite the desire of baby boomers and older residents, most community organizations are not prepared to manage the large numbers of volunteers and mobilize their full range of skills. Age stereotypes are often a major barrier to meaningful engagement of older people; several national and local initiatives have focused on how to engage older adults to solve community problems as well as how to help older people link to opportunities in their community.

Lifelong Indiana Coalition

Still in its initial stages, the Lifelong Indiana Coalition (Coalition) is a group of organizations from the civil and social services sector, the private sector, and the general public that have joined together to work toward a common goal: making Indiana communities more age- and ability-friendly. The Coalition is comprised of members in civic leadership and policymaking positions, community development and preservation organizations, service support providers, the business community, including property owners and private developers, persons in the disability community, and persons who wish to age in place. This collaborative process is based on the practice of providing all stakeholders with the information necessary to make good decisions for all Hoosiers.

Identifying existing replicative programs

The Aging Network's *Volunteer Collaborative* is a national resource center that helps aging and disability networks engage talented older adult volunteers to meet growing needs for services. The *Volunteer Collaborative* offers online resources, comprehensive training, and opportunities for leaders to learn best practices from each other. This collaborative support is provided by the U.S. Administration on Aging/Administration for Community Living (AoA/ACL), the National

Association on Area Agencies on Aging (n4a), the National Association of States United for Aging and Disabilities (NASUAD), AARP Foundation, The Corporation for National and Community Service, and The Council for Certification in Volunteer Administration (CCVA).

The *Volunteer Collaborative* enables organizations to 1) build capacity through skilled volunteers, who provide solutions that keep older adults and people with disabilities healthy and independent, and 2) expand opportunities to serve to a broad, diverse range of potential volunteers, including people who receive aging or disability services.

The Community Experience Partnership is a group of community foundations located across the United States. Called *Partners*, nearly forty community foundations have worked to find new ways to engage the rapidly growing population of people over 60 in activities that serve others, improve quality of life and tackle pressing issues. The *Partners* initiative is demonstrating timely new ways to respond to the needs of communities—and of one of America's most vital population groups. *Partners* is helping redefine traditional perceptions of aging, and creating new pathways for older adults to engage in lifelong learning and personal development, and solving social needs through volunteering or employment in the nonprofit or government sectors.

Disseminating community information to older adults

The 2003 National Assessment of Adult Literacy revealed that only 3% of adults age 65 and older were proficient in health literacy skills. Low health literacy among the elderly is associated with higher hospitalization rates, an inability to manage chronic diseases, and increased mortality. The National Academy for an Aging Society estimates that *$73 billion in unnecessary healthcare costs can be attributed to inadequate health literacy through misunderstood health information and subsequent patient noncompliance.*

Carolyn Speros, in her 2009 article reflecting the need for promoting health literacy in older adults, indicates that being health literate involves a number of simultaneous cognitive processes that can be demanding for persons of any age. "Retrieving prescriptions and referrals, selecting providers from a list of names and addresses, calculating when to take multiple medications, interpreting medical terminology, comparing different insurance plans, and sifting through a myriad of health-related information available in magazines, online, and from television are just a few of the complex thought processes involved in selecting, understanding, and using health-related information."

According to *Raising Expectations*, the 2011 research study undertaken by AARP, The Commonwealth Fund, and The SCAN Foundation, demonstrated that states that successfully inform people with LTSS needs about their available options for home and community-based services and offer an array of those service choices, can then cost-effectively focus on consumers' preferences.

Mental health and aging

In 2012, a research study by the Institute of Medicine found that mental health and/or substance abuse conditions in older people are associated with a wide range of negative effects, including emotional distress, functional disability, reduced physical health, increased mortality, suicide, high rates of hospitalization and nursing home placement, and high costs. The research identified 27 conditions that can have substantial negative effects on an older person's emotional well-being, functional and self-care abilities, and quality of life. Although available data do not support definitive prevalence estimates, the study concluded that at least 5.6 million to 8 million older adults have one or more of these conditions—about 14 to 20 percent of the overall elderly population. Depressive disorders and dementia-related behavioral and psychiatric symptoms are the most prevalent. Serious mental illness—including schizophrenia and bipolar disorder—is less common, but has significant implications for the workforce and care delivery.

Many older adults who have mental health or substance abuse conditions also have acute and chronic physical health conditions, and some have cognitive and functional impairments. The interaction of physical health conditions, cognitive and functional impairments, and mental health or substance abuse conditions can result in difficult caregiving situations for families, physicians, and other health care professionals, and residential care and home and community-based service providers. For example:

- Age-related changes in the metabolism of alcohol and drugs, including prescription drugs, can cause or exacerbate alcohol and drug use conditions and increase an older person's risk of dangerous overdoses, even for people who have used alcohol and drugs at the same dose and frequency for many years without serious negative effects.

- Loss and grief are common in old age. The death of a spouse, partner, close relative, or friend can trigger or exacerbate depression and lead to severe, debilitating symptoms. Providers may find it difficult to distinguish major depression and grief when a patient is in the midst of a significant loss.

- Medications to treat common acute and chronic physical health conditions in older people can cause and exacerbate mental health or substance abuse conditions and, conversely, medications to treat those conditions can cause or worsen physical health conditions.

- Cognitive and functional impairments can complicate the detection and diagnosis of mental health or substance abuse conditions. Cognitive impairment can also reduce an older person's ability to comply with treatment recommendations, including any prescribed medications.

Objectives, Strategies, and Performance Measures

Objective 4.1 Foster the engagement of older Hoosiers in their communities.
Strategies:

- Engage existing aging network volunteer opportunities to serve other older adults

- Encourage expansion and develop clearinghouse of best practices of coordinated multigenerational activities
- Continue coordination with SCSEP program to hire low-income older adults
- Create data collection system for AAAs to report volunteer engagement

Objective 4.2 Advocate for needs of older adults in the community planning process.
Strategies:
- Work with AAAs in cataloging existing local advocacy initiatives
- Promote local advocacy training efforts
- Participate in *Lifelong Indiana Coalition*

Objective 4.3 Elevate awareness of older adults who are at risk for mental health and substance abuse issues including suicide.
Strategies:
- Continue collaboration with Mental Health and Aging Task Force
- Develop education sessions for AAA staff on mental health and aging in conjunction with DHMA
- Monitor level of suicide ideation and attempts within HCBS participants

Performance Measures
- Number and type of program innovations identified and replicated
- Number and increase of older adults involved in community planning process
- Number of older adults engaged and amount of volunteer time contributed and/or value of volunteer time in AAAs
- Measure incident resolution time frames

Goal #5: Advocacy and Protection for Older Adults

Strengthen statewide systems for advocacy and protection for older adults.
Strengthen Indiana's Adult Protective Systems (APS) through leadership and advocacy efforts with all stakeholders.

CASOA's study found that:

- Between 8% and 14% of respondents had experienced safety problems related to being a victim of crime or abuse.
- Between 3% and 8% of older adults experienced being a victim of fraud or a scam.
- Between 4% and 2% of older adults reported being physically or emotionally abused.

Indiana's Quality Assurance Unit within the DA reports a 180%-plus increase in its financial exploitation reports over the past seven years. Annually, the state's Adult Protective Services investigates over 10,000 cases. These investigations are comprised of 25% abuse, 30% neglect, 30% self-neglect, and 15% financial abuse; however, it is estimated *that less than 10% of abuse, neglect, or exploitation episodes are actually reported.*

According to a 2012 article on elder abuse in *Generations*, a journal published by the American Society on Aging, recent estimates suggest that one in ten older adults in the United States experiences physical, psychological, and sexual abuse, neglect and financial exploitation. Direct costs associated with elder financial exploitation were estimated to be nearly $3 billion in 2011, a 12 percent increase from 2008. In more than two-thirds of substantiated cases of elder abuse, the perpetrator is a family member in a caregiving role—usually an adult child. Studies suggest that the explanation for elder abuse is much more complex than caregiver stress alone. Elder abuse is associated with increased risk of premature morbidity and mortality. For every case of elder abuse that is reported, an estimated 23.5 are not.

In 2012, almost 87% of Adult Protective Services programs across the country saw an increase in the number of reports and caseloads over the previous five years, with the increases ranging up to 100%. There may be more than 5 million elder abuse victims in the United States compared with 1.25 million victims of child abuse. Physical abuse ranks among the most frequent nursing home complaints received. Financial exploitation of elders is the most reported type of elder abuse.

Public safety workforce trainings on Alzheimer's Disease (AD) and other dementias
In 2013, Indiana's General Assembly passed HEA 1044, which specifies that minimum basic training requirements for each person accepted for training at a law enforcement training school or academy must include six (6) hours of training in interacting with persons with AD or related senile dementia. The law also states the law enforcement academy must provide in-service

training concerning interacting with AD or related senile dementia, and high-risk missing persons. This bill became effective July 1, 2013.

World Elder Abuse Awareness Day

The U.S. Department of Health and Human Services' National Center on Elder Abuse is behind World Elder Abuse Awareness Day (WEAAD), which launched June 15, 2006 by the International Network for the Prevention of Elder Abuse and the World Health Organization at the United Nations. The purpose of WEAAD is to provide an opportunity for communities around the world to promote a better understanding of abuse and neglect of older persons by raising awareness of the cultural, social, economic and demographic processes affecting elder abuse and neglect. In addition, WEAAD is in support of the United Nations International Plan of Action acknowledging the significance of elder abuse as a public health and human rights issue. WEAAD serves as a call-to-action for individuals, organizations, and communities to raise awareness about elder abuse, neglect, and exploitation.

How many people are impacted?

An estimated 7.3 million older adults—20 percent of older Americans—have been victimized by financial abuse, according to a 2010 survey by the Investor Protection Trust, a nonprofit investor education organization. Adults ages 60 and older lost an estimated $2.9 billion to fraud in 2010, a 12 percent increase from the $2.6 billion loss estimated in 2008, as indicated by a 2011 study by the MetLife Mature Market Institute.

Consumer education on fraud/scams

Research is beginning to reveal that certain changes in the aging process may make older adults more susceptible to fraud than their younger counterparts. A recent study by University of California - Los Angeles found that changes in the aging brain may make older adults less likely to perceive suspicious or deceitful facial expressions. Other research by the Center for Retirement Research at Boston College, indicates that the ability to make effective financial decisions declines with age. In addition to brain changes, social factors can make a person more vulnerable to fraud. A 2011 MetLife Mature Market Institute report concluded that "In almost all of the cases [of elder financial abuse studied], there existed a combination of tenuous, valued independence and observable vulnerability that merged in the lives of victims to optimize opportunities for abuse by every type of perpetrator — from the closest family members to professional criminals."

Expert panel members participating in the Elder Investment Fraud and Financial Exploitation survey released in 2012, revealed that, in their experience, nearly 8 in 10 (77.6%) of older adults are very vulnerable to investment fraud and financial exploitation. Over 70% of the same experts felt the best financial education for this population to avoid fraud, scams, and exploitation are programs delivered by local professionals, such as caregivers, Ombudsmen, APS workers, law enforcement agencies, and health care professionals.

Objectives, Strategies, and Performance Measures

Objective 5.1 Improve APS data collection and operational systems
Strategies:

- Clarify coding of cases opened, investigated, referred, and closed
- Develop model for consistent case identification and resolution in partnership with Indiana Prosecuting Attorneys Council (IPAC)
- Expand monitoring of critical incidents affecting health and safety to all service recipients
- Participate in APS national database study
- Investigate alternate placement/housing for at-risk individuals when other options are not available or appropriate, i.e., not meeting NFLOC or BDDS guidelines for placement

Objective 5.2 Improve APS integration into the aging network
Strategies:

- Arrange collaborative meetings between Ombudsmen, AAAs and APS units, legal service providers, and other stakeholders
- Encourage local ANE (Abuse, Neglect, and Exploitation) community trainings by AAA outreach programs in conjunction with local APS units and Ombudsmen
- Collaborate with National Ombudsman network for enhanced trainings for the Indiana Aging Network
- Secure technical assistance from National Adult Protection Services Resource Center (NAPSRC)
- Promote programming for World Elder Abuse Day

Objective 5.3 Increase focus on recognition and prevention of financial exploitation
Strategies:

- Continue working with Indiana Guardianship Task Force to increase funding
- Increase availability of guardianship services
- Increase the capacity of financial institutions to recognize and report suspicious financial activities
- Coordinate to enhance community education opportunities, including a possible statewide conference
- Identify network of interested parties (Schools of Social Work, and other higher education departments, volunteer groups, and civic organizations), to promote awareness

Performance Measures

- Number/types of trainings conducted
- Number/types of consumers and professionals reached
- Number/types of partners involved
- Data changes attributable to efforts
- Consistent response to abuse in nursing facilities
- Measure incident resolution time frames

Quality Management

Management Responsibilities

All Area Agencies on Aging (AAAs) are monitored through surveys conducted by the Division of Aging (DA) at a minimum of every three years to assure compliance with Indiana Administrative Code 455 IAC Article 2. This recurring review evaluates each agency's personnel and operational policies, hiring practices, incident reporting, and complaint resolution procedures.

Data Collection

The DA uses INsite, an in-house software program for most data collection and reporting. In 2013, the consistency of data collection improved through a number of changes to the program. From 2010 to 2013, Indiana's AAAs used a Harmony-maintained program known as SAMS to collect and report on nutrition program data. Also in 2013, the DA made the decision not to renew the contract with Harmony, and the AAAs returned to using INsite for those functions. This move allows the DA to extract data out of a single system rather than combining data from multiple sources. Also as part of the move, a number of changes made to the INsite software to put more stringent business rules in place. These changes significantly helped in reducing missing data regarding issues such as rural versus urban status, poverty status, ethnicity, and race.

Whereas the DA feels these are very positive steps in improving data integrity, it also recognizes there are significant issues with the use of INsite that must be addressed. Attempts in the past to replace this software failed for one reason or another, partly because it is a critical program that not only performs a variety of vital functions for the DA and the AAAs, but also is used by two other Family and Social Services Administration (FSSA) divisions. INsite is based on a FoxPro program—a technology that is quite outdated. INsite is also limited in its ability to provide real time data across all levels and all organizations. FSSA again has plans underway to replace the DA's system as early as April, 2015. Meanwhile, the DA continues to work with its technology vendors to maximize the abilities of INsite.

Remediation

With any management deficiencies identified in the aforementioned compliance review, an area agency must file a corrective action plan within a ten (10) day period. After the plan is accepted, another survey may be conducted to assure implementation.

Other data collection issues, particularly with respect to the data necessary for the State Program Report (SPR), exist outside of software limitations. There is a continued need to provide training and education to AAA staff and monitor potential data gaps more closely throughout the year. In March of 2013, the DA held a training focusing on SPR reporting requirements for AAA staff, with a second, similar training in April of 2014. Additionally, DA staff members have been

working one-on-one with AAAs to correct data issues as they arise, specifically with preparation of the SPR.

The DA is also working to further link SPR reporting requirements to the claims process with AAAs. We anticipate this change will create a clearer connection between funding and service delivery, resulting in less missing service unit data.

Continuous Improvement

FSSA is currently conducting a self-assessment regarding the Medicaid Information Technology Architecture (MITA) framework. As part of that process, each FSSA division is performing a self-assessment on its position in terms of the framework regarding non-Medicaid programs. This assessment process has produced numerous discussions about gaps the DA has in the collection of some data related to the satisfaction of clients, grantees, and other partners in our processes. The results of this assessment will help guide our efforts going forward in measuring the effectiveness and efficiency of our programs.

The DA is also working to disclose more data to AAAs than in the past. Specifically, we are now sharing data that allows one AAA to see how it compares with other Indiana AAAs. The focus initially is on expenditures per unit of service, but our plan is to include program income data as well as administrative costs per client served. This data will aid the DA in identifying potential efficiencies or inefficiencies in the AAA network in terms of program operations. Best practices can then be identified and hopefully replicated in other areas. As data gaps are reduced and data quality improves, the DA will also be better positioned to identify populations that we must work harder to target with needed services.

FY 2014 State Plan Guidance
Attachment A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of

low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall—
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on—
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency-
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17) Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief services delivery.

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.
(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except-
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order

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REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.
(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency-
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

Yonda Lyden, Director, Division of Aging — 6/27/2014

Signature and Title of Authorized Official — Date

Attachment B
Information Requirements

States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.

Section 305(a)(2) (E)

Describe the mechanism(s) for assuring preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan.

The Division of Aging (DA) Operations Manual requires that the "DA shall assure that preference will be given to providing services to older adults with greatest economic need and older adults with social need with particular attention to low-income minority adults and older adults residing in rural areas and include proposed methods of carrying out the preference." One mechanism Indiana uses for assuring services are provided appropriately to older adults is its formula for distributing Title III funds. This formulaic method of allocation attempts to direct funds to older Hoosiers with the greatest economic and/or social needs. The formula is specifically weighted with regard to low-income minority older adults and those residing in rural areas. Additionally, Indiana's PSA designations were originally designed to take into account the geographical distribution of older adults with the greatest economic and social needs, giving particular attention to low-income, minority older adults.

The Area Plans submitted by Indiana's AAAs must contain a description of how the AAA assures preference to the target populations for each funding source. The Area Plan is required to include assurances regarding:

- adults age 60 years old or older with the greatest economic and social need;
- older minority and low-income minority individuals;
- older individuals living in rural areas; and
- older individuals who are Native Americans.

As part of their targeting efforts, AAAs are also required to develop and implement an intra-area funding formula that addresses target populations. Additionally, the AAA's Advisory Council shall meet at least quarterly. The AAA shall document any recommendations made by the

Advisory Council concerning matters regarding the AAA's target populations and assure those recommendations are considered by the appropriate decision-making persons. Furthermore, in the provision of outreach services, the AAA shall place special emphasis on reaching older adults with the greatest economic or social needs, giving particular attention to low-income minority older adults and older adults who reside in rural areas.

The DA is also required to conduct annual evaluations of, and public hearings on, activities and projects carried out under the State Plan, including an evaluation of the effectiveness of the DA in reaching older adults with the greatest economic and social needs, giving particular attention to low-income minority older adults. In conducting such evaluations and public hearings, the DA is required to solicit the views and experiences of entities that are knowledgeable about the needs and concerns of low-income minority older adults. The DA has approached this requirement in various ways throughout the past. Input from AAAs and public hearings have always been a large part of these activities. However, these activities are rarely formalized and are not structured to focus all input on targeting populations identified by the OAA as being most at-risk. Going forward, DA leadership is committed to a higher level of structure and organization of these activities, particularly in the monitoring of AAA effectiveness in reaching target populations. The State will strengthen its ability to monitor services delivered to persons with the greatest social need when its new case management system becomes available for use in 2015.

Moreover, Indiana requires that the State Plan contain specific strategies for service delivery and systems enhancement for targeted populations. In this most recent state plan, the DA has accomplished this specifically with Objective 1.2 calling for the DA to work with the AAA network to identify and promote new service delivery models that are person-centered as well as cost-effective for long-term sustainability, and the accompanying strategy to evaluate the effectiveness of current targeting practices. Goal No. 4 also touches on the needs of the rural population through the statewide focus on community readiness for the older population. The DA will work to assess and facilitate community readiness for an expanding and diverse older population with a multiplicity of needs.

Section 306(a)(17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Each of Indiana's sixteen Area Agencies on Aging is required to include emergency preparedness in its Area Plan, which is submitted to the DA every two years. Natural disasters most likely to occur in Indiana include severe winter weather, floods, or tornados. Each area plan must address outreach and advocacy efforts to older adults and persons with disabilities so access to needed services and life-sustaining information will continue during an emergency. During winter months, for example, nutrition staff members plan for emergencies or inclement weather, and deliver extra frozen or shelf-stable meals to home-delivered meal clients in anticipation of potential missed delivery days. The AAA must describe its emergency plan, policies and procedures, and submit a copy of its emergency plan and all associated material. The plan shall include not only an internal AAA plan but also a plan for client service continuation and inter-agency coordination. For example, local law enforcement and emergency planning relied on AAA staff to identify and assist with tornado victims in south central Indiana in 2013.

Section 307(a)(2)

The plan shall provide that the State agency will:

(C) *Specify a minimum proportion* of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance). Provide specific minimum proportion determined for each category of service.*

Contracts with each Area Agency on Aging stipulate that in order to align spending with the goals of Title III, VII, and the Division of Aging, the following minimum expenditures are required:

1) 40% of Title III B funds must be expended for access services, which includes case management, information and assistance, outreach, transportation, and assisted transportation,

2) 15% of Title III B funds must be expended for in-home services, which includes adaptive services, adult day care, attendant personal care, homemaker, and other services necessary to prevent institutionalization,

3) 3% of Title III B funds must be expended for Legal Assistance, and

4) 3% of Title III B funds must be expended for Long-Term Care Ombudsman services.

Section 307(a)(3)

The plan shall:

...

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.
(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).*

According to AoA's Aging Integrated Database (AGID) data, Indiana's total population for persons ages sixty and older in 2010 was 1,191,736. Nearly one-third (31.1%) of those persons live in rural areas. Estimated costs of providing such services for FY15 are based on AAA contracts for Title III for FFY 2014 totaling $21,247,909, and are as follows:

TIII B 15	TIII C1 15	TIII C2 15	TIII D 15	TIII E 15	Total
$1,784,999.48	$ 2,341,290.28	$ 930,689.37	$125,207.98	$765,102.63	$5,947,289.73

Based on the following Indiana rural population estimates, the same costs as above are projected for FYs 16-18:

	2015	2016	2017	2018
Indiana Rural Population	1,173,949	1,168,079	1,162,239	1,156,428

(iii) *describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*
Each Area Agency on Aging (AAA) is required to submit annual Area Plans to the DA, and must include discussions of its population who live in rural or isolated areas, how those populations are targeted in outreach efforts, and any additional information on programming aimed at older adults and those with disabilities living in rural counties.

Section 307(a)(10)
The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*

As previously mentioned, roughly one-third (31.3%) of Indiana's population ages 60 and older reside in rural areas, and this is a weighted factor in Indiana's instrastate funding formula. The DA allocates that amount at the local Area Agencies on Aging level which, through their own Advisory Councils and input from the local communities, determine how best to spend those

dollars. Many senior centers and congregate meal sites are located in rural areas to maintain ease of use and access for this particular population.

Section 307(a)(14)

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared---

(A) *identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency*; and

(B) *describe the methods used to satisfy the service needs* of the low-income minority older individuals described in subparagraph (a), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

According to the Aging Integrated Database (AGID), nearly 19,000 (18,801) older minority Hoosiers had income below poverty level in 2012, while just over four percent (4.1%) of older adults in Indiana had limited English-speaking abilities. Current software in use by the DA does not provide for quality reporting of limited English proficiency in the individuals served by AAAs. Indiana is planning a transition to a new case management software system that will offer a number of enhancements, and limited English proficiency will certainly be one of the new data elements available for tracking and reporting.

Information regarding Area Agency on Aging (AAA) programs and available services is distributed in neighborhoods and communities with high populations of older minorities and low-income older minority populations through local churches, community centers, neighborhood associations, and social services organizations that focus on serving the needs of these populations. Indiana recognizes that the meaning of original text or spoken word must be conveyed plainly, accurately, and culturally when interpreting conversations among consumers, case managers, and providers, so the AAAs make every effort to use translators when providing services to those populations with limited English proficiency.

Reporting is reviewed on a regular basis to determine gaps in service to targeted populations of older minority and older low-income minority populations. AAAs are encouraged to conduct trainings (including cultural competency, customer service principles, etc.), which focus on methods to improve service delivery among older minority and low-income minority populations. Additionally, the DA supports AAAs in establishing partnerships with local organizations that provide support to immigrant and refugee families; these alliances will

strengthen the AAAs' abilities to provide services to older adults, persons with disabilities, and populations with limited English proficiency, and their caregivers.

Section 307(a)(21)
The plan shall:
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III)*, if applicable, *and specify the ways in which the State agency intends to implement the activities.*

Indiana has no recognized tribal organizations; however, any Native American older adults and those with disabilities are targeted in any statewide or local/community outreach efforts.

Section 307(a)(29)
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Indiana's Family and Social Services Administration, an agency that comprises five divisions including the Division of Aging, recently adopted a new Continuity of Operations Plan (COOP). The COOP has the purpose of ensuring that essential functions will continue in the event of circumstances that prevent FSSA staff from operating in their normal facilities. The plan is quite elaborate in its design, and expectation is that essential operations would resume within twelve (12) hours of its activation. From that point, COOP's "roadmap" becomes increasingly more detailed and leaves very little room for unknowns.

The DA has provided the COOP decision-makers in FSSA with information on how the AAA network can be of use to FSSA in emergency situations. DA's existing network with the AAAs and their service providers as well, provides a highly functional framework that could be utilized by Indiana's office of Homeland Security and other agencies in emergency situations to distribute critical supplies and information.

Advance preparation for emergencies is taken very seriously in each of Indiana's sixteen Area Agencies on Aging (AAAs). AAAs have emergency preparedness plans in place when a disaster

significant enough to cause widespread damage occurs, or when an emergency significantly impact a AAA's services or client population. Each AAA has emergency operations and business contingency plans in place, which are submitted to the DA as part of the Area Plans.
AAAs focus primarily on their own disaster recovery processes in their planning. The new Area Plan format the State is currently developing will ask them to include specific information about any partnerships with local disaster response entities, their involvement in community disaster planning efforts, and planning for communications with clients in disaster situations.

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

The Indiana State Department of Health (ISDH) Emergency Operations Framework (EOF) establishes the foundation upon which ISDH supports State efforts in assisting local jurisdictions impacted by a disaster or other emergency that requires State resources in the form of information, supplies, equipment, personnel, and technical assistance.

The ISDH EOF covers the response phase of emergency management, and expands upon the Emergency Support Function to the State Comprehensive Emergency Management Plan (CEMP). The State CEMP is the guiding document that establishes a basis for how the State and its many agencies coordinate together in mitigating, preparing for, responding to, and recovering from disasters. The CEMP identifies the processes and procedures by which State government coordinates emergency preparedness and identifies the roles and responsibilities of the various State agencies as they pertain to emergency preparedness and response within the State. The Executive leadership of all State agencies, including ISDH, with a role in emergency preparedness and response have signed a letter of agreement to support the responsibilities identified within the State CEMP. The Indiana Family and Social Services Administration (FSSA), of which the Division of Aging is a part, is a close partner with ISDH; FSSA is also represented on the Senior Advisory Committee for Emergency Preparedness.

Section 705(a)(7)
In order to be eligible to receive an allotment under this subtitle, a State shall *include in the State plan submitted under section 307*:

(7) *a description of the manner in which the State agency will carry out this title* in accordance with the assurances described in paragraphs (1) through (6).
(Note: Paragraphs (1) through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

Much of how the Division of Aging performs the above-described activities is described in its Operations Manual, which is currently undergoing review and being revised to current standards. However, at a minimum, the DA meets monthly with the AAAs through their association, the Indiana Association of Area Agencies on Aging, or I4A, which provides leadership and advocacy for Indiana's evolving home and community-based services network. The DA also provides trainings—case manager orientation, for example—for AAA staff throughout the year. Twice a year, the DA holds regional meetings across the state with local AAA staff, updating them with new information and listening to their concerns. DA staff members are also available to AAAs via telephone or e-mail. It is worth mentioning that the DA functions as one of five divisions within Indiana's Family and Social Services Administration, whose mission is to develop, finance, and compassionately administer programs to provide healthcare and other social services to Hoosiers in need in order to enable them to achieve healthy, self-sufficient, and productive lives.

The DA also uses funds made available by State statute to provide Adult Protective Services (APS) for the elderly. Funding also is made available through the Social Services Block Grant to supplement state funding.

Indiana places very few restrictions on its Ombudsmen. Working as advocates for the individual, Ombudsmen are free to talk to anybody: the legislature, law enforcement, and the media. Public awareness of the APS program is through outreach, including brochures and blurbs in telephone books. Referrals are made to the local unit or through the statewide toll-free hotline.

The protection of client information is addressed in state statute IC 12-10 for APS, and does not permit information to be shared with anyone or any agency other than law enforcement.

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Several AAAs and local APS staff have held work groups and community forums to discuss concerns about abuse, neglect, and exploitation. As a part of this State Plan, the DA plans to formalize these community forums with all AAAs and APS units along with other stakeholders. On June 17, 2014 an Elder Justice Forum was hosted by the Indiana Association of Area Agencies on Aging and the Division of Aging. Participation included representatives from broad-based stakeholders including representatives from the State Division of Mental Health, Disabilities, the State Bar Association, Elder Law Attorneys, State Long-Term Care Ombudsman, public television, banking officials, State Prosecuting Attorney Council, and State Adult Protective Services as a first step in expanding the discussion to the broader community about abuse, neglect and exploitation.

Yonda Lyda — 7/31/2014

Signature and Title of Authorized Official

Attachment C – Intrastate Funding Formula (IFF) Requirements

Intrastate Distribution of Funds

Funds received under the Title III of the Older Americans Act, as amended, are distributed within the state in accordance with a formula that addresses the geographical distribution of older individuals with the greatest economic or social needs, with particular attention to low-income minority older individuals and those residing in rural areas. After allocating a base of $120,000 to each planning and service area, the formula incorporates factors that consider economic and social need and low-income minority status based on statistical and demographic data. The table below illustrates the formula factors for the distribution of the funding.

Funding Formula Factors for OAA Title III

Formula Factors for Distribution by Planning and Service Area			
Factor	Weight	Data Source	Purpose
Share of population 60 and older	30%	2010 U.S. Census	Reflect the geographical distribution of older individuals within the state. OAA Section 305(a)(2)(C)(i)
Share of population 60 and older below poverty level	45%	AOA Aging Integrated Database	Reflect the state's population of older individuals with greatest economic need. OAA Section 305(a)(2)(C)(ii)
Share of minority population 60 and older below poverty level	5%	AOA Aging Integrated Database	Reflect the state's minority population of older individuals with greatest economic need. OAA Section 305(a)(2)(C)(ii)
Share of population and older residing in rural areas	10%	2010 U.S. Census	Reflect the state's population of older individuals residing in rural areas. OAA Section 307(a)(10)
Share of minority population 60 and older	5%	AOA Aging Integrated Database	Reflect the state's minority population of older individuals with greatest social need. OAA Section 305(a)(2)(C)(i)
Share of population 60 and older with limitations of activities of daily living	5%	2010 U.S. Census	Reflect the proportion of older individuals with the greatest need for services. OAA Section 305(a)(2)(C)(i)

State of Indiana
Title III
State Fiscal Year Ended June 30, 2013

State of Indiana				
Title III				
State Fiscal Year Ended June 30, 2013				
		Total Amount	Less Base	Amount to be Allocated
Administration	III A - 3100	$ 2,213,747		
Support Services	III B - 3101	$ 6,711,965		
Congregate	III C-1 - 3102	$ 8,057,701		
Home Delivered	III C-2 - 3103	$ 4,073,446		
		$ 21,056,859	$ -	$ 21,056,859
Preventative Health	III D - 3104	$ 404,191		$ 404,191
Family Caregiver	III E - 3105	$ 2,890,164		$ 2,890,164
		$ 24,351,214		$ 24,351,214

APPLICATION OF FUNDING FORMULA		
ALLOCATION OF OLDER AMERICANS FUNDS	DISTRIBUTION BY WEIGHT	
CATEGORY	PERCENT ALLOCATION	DOLLAR ALLOCATION
60+(30%)	30.00%	$ 6,317,058
60+ <POVERTY (45%)	45.00%	$ 9,475,587
60+ MINORITY < POVERTY (5%)	5.00%	$ 1,052,843
60+ RURAL (10%)	10.00%	$ 2,105,686
60+ MINORITY (5%)	5.00%	$ 1,052,843
60+ ADL LIMITED (5%)	5.00%	$ 1,052,843
TOTALS	100.00%	$ 21,056,859

INTRASTATE FUNDING FORMULA

1. DETERMINATION OF FUNDING FACTOR OF EACH AREA AGENCY ON AGING
    - FF=.3X(a/A)+.45X(b/B)+.05X(c/C)+.1X(d/D)+.05X(e/E)+ 05X(f/F)

2. APPLICATION OF FUNDING FACTOR IN ALLOCATION OF FUNDS FROM IIIA, IIIB, IIIC1, IIIC2, AND IIID PER AREA AGENCY
    - N=(FF*(x-l))+l
    - IF N>1.05P OR N<.95P, THEN N=1.05P OR N=.95P

3. EXCESS DUE TO APPLICATION OF 5% IS DISTRIBUTED AMONG REMAINING AGENCIES ON PRO RATED BASES

LEGEND

	CENSUS CODES	
CATEGORY	STATE	AREA
60+(30%)	A	a
60+ <POVERTY (45%)	B	b
60+ MINORITY < POVERTY (5%)	C	c
60+ RURAL (10%)	D	d
60+ MINORITY (5%)	E	e
60+ ADL LIMITED (5%)	F	f
ALLOCATION (MINUS BASE)	X	x
FUNDING FACTOR	FF	
PRIOR YEAR FUNDING FACTOR	P	
NEW YEAR FUNDING FACTOR	N	
FUNDING BASE	L	l

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TITLE III FY 2012-2013 DISTRIBUTION FUNDING FORMULA CALCULATIONS				BREAKDOWN OF TITLE III-A, B, C1 AND C2				
				10.51%	31.88%	38.27%	19.34%	100%
Area	Allocated	Base	Total	IIIA	IIIB	III C1	III C2	Total
1	$ 2,780,611		$ 2,780,611	$ 292,331	$ 886,332	$ 1,064,040	$ 537,909	$ 2,780,611
2	$ 2,150,053		$ 2,150,053	$ 226,039	$ 685,339	$ 822,748	$ 415,927	$ 2,150,053
3	$ 1,821,199		$ 1,821,199	$ 191,466	$ 580,515	$ 696,907	$ 352,311	$ 1,821,199
4	$ 900,235		$ 900,235	$ 94,643	$ 286,954	$ 344,487	$ 174,150	$ 900,235
5	$ 904,451		$ 904,451	$ 95,087	$ 288,298	$ 346,101	$ 174,966	$ 904,451
6	$ 1,629,570		$ 1,629,570	$ 171,320	$ 519,432	$ 623,578	$ 315,240	$ 1,629,570
7	$ 944,990		$ 944,990	$ 99,349	$ 301,220	$ 361,614	$ 182,808	$ 944,990
8	$ 4,152,491		$ 4,152,491	$ 436,559	$ 1,323,624	$ 1,589,009	$ 803,299	$ 4,152,491
9	$ 681,834		$ 681,834	$ 71,682	$ 217,338	$ 260,913	$ 131,901	$ 681,834
10	$ 445,515		$ 445,515	$ 46,838	$ 142,010	$ 170,483	$ 86,185	$ 445,515
11	$ 735,723		$ 735,723	$ 77,348	$ 234,515	$ 281,535	$ 142,325	$ 735,723
12	$ 499,702		$ 499,702	$ 52,535	$ 159,282	$ 191,218	$ 96,667	$ 499,702
13	$ 898,404		$ 898,404	$ 94,451	$ 286,370	$ 343,787	$ 173,796	$ 898,404
14	$ 739,515		$ 739,515	$ 77,747	$ 235,724	$ 282,986	$ 143,059	$ 739,515
15	$ 583,331		$ 583,331	$ 61,327	$ 185,939	$ 223,220	$ 112,845	$ 583,331
16	$ 1,189,235		$ 1,189,235	$ 125,027	$ 379,074	$ 455,077	$ 230,057	$ 1,189,235
TOTALS	$21,056,859		$ 21,056,859	$ 2,213,747	$ 6,711,965	$ 8,057,701	$ 4,073,446	$ 21,056,859

Division of Aging State Plan Attachments 2015 – 2018

State of Indiana
Title VII and State Ombudsman Funding
State Fiscal Year Ended June 30, 2013

Title VII			Federal	State	Total
			Title VII	Title VII AL Program	
AAA	Bed Count	% of Total Beds	$ 173,376	$ 310,124	
1	5638	8.28%	$ 14,359.71	$ 25,685.73	$ 40,045.44
2	7113	10.45%	$ 18,116.46	$ 32,405.57	$ 50,522.03
3	8115	11.92%	$ 20,668.50	$ 36,970.51	$ 57,639.01
4	3531	5.19%	$ 8,993.28	$ 16,086.61	$ 25,079.89
5	3353	4.93%	$ 8,539.92	$ 15,275.68	$ 23,815.60
6	5118	7.52%	$ 13,035.29	$ 23,316.70	$ 36,351.99
7	2180	3.20%	$ 5,552.35	$ 9,931.69	$ 15,484.05
8	16259	23.89%	$ 41,410.86	$ 74,073.13	$ 115,483.99
9	2303	3.38%	$ 5,865.63	$ 10,492.06	$ 16,357.69
10	1079	1.59%	$ 2,748.16	$ 4,915.73	$ 7,663.89
11	1187	1.74%	$ 3,023.23	$ 5,407.76	$ 8,430.99
12	1555	2.28%	$ 3,960.51	$ 7,084.31	$ 11,044.81
13	2191	3.22%	$ 5,580.37	$ 9,981.81	$ 15,562.18
14	3234	4.75%	$ 8,236.84	$ 14,733.53	$ 22,970.37
15	1273	1.87%	$ 3,242.27	$ 5,799.56	$ 9,041.83
16	3943	5.79%	$ 10,042.62	$ 17,963.61	$ 28,006.24
Total	68072	100%	$ 173,376.00	$ 310,124.00	$ 483,500.00

Bed count obtained from Indiana Department of Health

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