COMMISSION ON AGING
March 17, 2022 minutes
10:00 a.m. to 12 noon

Call to Order: JoAnn Burke called the meeting to order. JoAnn said since there weren't enough members participating to have a quorum, the vote on the minutes and the election of new officers would be tabled until the May 19th meeting.

Presentation: Emergency elder abuse shelter as presented by Evan Lubline Chief Executive Officer and Han Jacobs Meadway Director of Shalom Sanctuary & Strategics Initiatives Hooverwood Living. The CDC defines elder abuse as an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation to trust that causes or creates a risk of harm to an older adult, including physical, sexual, psychological harm, neglect, and financial exploitation. Abusers most frequently are family members and caregivers. They know that a lot of the shelter options have not been safe or successful especially with APS or law enforcement involvement. They have been in touch with APS and have been working hard with them. Indianapolis had an elder abuse shelter that operated from 1985-93. The Marion County Home which Doug May oversaw had 100 admissions over the 8 years in operation, but there hasn't been anything similar in Indiana since that time on a formal level. There are informal structures in place to provide shelter but there has not been a formal program since that time leaving a major gap in the care system.

Currently there are 15 elder abuse shelters nationally which partner through a group called Spring Alliance out of New York where they share resources and best practices. They've been lucky to partner with them and start this program. They were able to look at Hooverwood Living, a skilled nursing and rehab facility, and Kraft Commons, an assisted living facility. They were interested to see if they have the capacity, resources, and trained staff to start providing this need to the community without opening a new building or adding additional staff are this time. The goal of the Hooverwood Living Family is to be a full-service continuum of care in the community, helping older adults age successfully in the least restrictive and safest environments as possible. They've gotten this started as a community program, they've been very lucky to design the program with the support of the Marion County APS, the Marion County Districts Attorney's Office, and Center for at Risk Elders. They've put together a community advisory committee that meets quarterly and includes representatives from APS, Marion County District Attorney's Office, Center for At Risk Elders, Indiana Legal Services, healthcare providers and social service providers. Some of their internal and external stakeholders include Dr. Healy Hooverwood Living Medical Director and their staff, Leading Age Indiana, AJAS and Hancock Hospital.

Their mission is to provide safe and appropriate housing, care, and resources for older adults who experience elder abuse. Their vision is a continuum of community resources that ensure older adults are safe, cared for, and respected. Their team of professionals are equipped to respond to older adults' unique strengths and vulnerabilities and the voices of older adults continue to inform their work. They've structured their program to be a shelter first model knowing that they can partner with other resources throughout the community that are experts in other fields that they can provide. Other models across the nation and in other communities look different, some are more based in the community and finding short term placements in hotels or other options, but the strength that they have is having a fixed safe place for people to stay and being able to partner and outreach with other community partners. The program isn't entirely self-funded. Some shelter participants can have their

stay funded by Medicaid, Medicare, or insurance, especially those who have been in the hospital. The organization is a subgrantee and part of the ACL grant for the Elder Justice Innovation Grant through Weinberg Center at Riverdale. This is a 2 year ACL Innovation grant that is focused on showing the efficacy of the shelter model and being able to show that individual who use a shelter program is less likely to be associated with APS afterwards and can report that they are feeling safer and in a safe environment after a discharge from a shelter program. The grant is just getting starred they are in the data gathering phase of that grant, they've also received generous funding from the Sephardic Foundation on Aging, the Jewish Federation of Greater Indianapolis, and individual donors. They also become a vendor for FSSA for APS emergency placements. Their model has an admission based eligibility, an assessment of medical needs, an assessment of social services needs where they develop an advocacy plan, they refer and monitor services and finalize the appropriate discharge plans tailored to the individuals capacity.

Their referrals into the shelter come from APS, local hospitals or medical centers, senior centers, District Attorney's Office, legal service agencies, home health agencies, law enforcement, EMS basically any professionals that are interacting with older adults. The criteria that they've setup for the elder abuse shelter at Hooverwood Living is that they have availability and capacity so they can accommodate referrals referred by an approved referral source, referrals age 60 and over, they have experienced or is at substantial risk of experiencing abuse either physical, sexual, psychological, financial or neglect by an intimate partner, family member, caregiver, or other trusted individual. They've really focused on this first year of their program working with folks who have been abused or at risk of abuse with another person involved. They are in need of temporary shelter and agrees to stay for a temporary period such as when the person committing the abuse is being removed from the home. Individuals experiencing incapacity and clients of APS are welcome. As they have gotten started they've set up some limitations as their program is up and running such as self-neglect, hoarding, active substance abuse and type of infestation that would put other occupants and staff at risk and someone who would be a safety risk to the facility and the occupants.

Since opening in June 2021 they've admitted 4 participants, 3 women and 1 man, ages 65 to 85. Three white/Caucasian, 1 African American all 4 have some limitations with respect to memory and ADLs and 1 has an ID/DD diagnosis and all referrals have been APS involved. The program has received about 25 referrals an average of 2-3 referrals per month. Their limiting factors have mostly been related to covid and an outbreak, so they have to be very careful in terms of admissions. The other piece that he wants to highlight is that there is a myth around social service programs that only the most vulnerable, the most economically insecure, the most medically frail are at risk and that's not been the case in terms of these 4 participants and about half of those have independent financial resources. He wanted to open it up for questions. Jennifer Lantz asked if they take individuals just in the Indianapolis area. He said they've focused so far on the Indianapolis area, they've had referrals in Hamilton County, Hancock County and Boone County, they've focused on that so far because most of their community partners are local working with CICOA their local area agency, but he is open to working with folks further abroad. And he really sees this as a model that could be replicated across the state.

Kelli Tungate said this is such a wonderful program she incredible impressed with the work that has been done. Her question he mentioned serving individuals since January 2021 is that a funding limitation or capacity, what more would he need to serve more families at the present time. He said the folks that he has not admitted has really been space around memory care has been one and then covid

has been the other biggest, the third limiting factor is folks that wouldn't have necessarily met the criteria where there's a potentially dangerous situation, but it's largely related to lack of affordable housing for seniors. Sometimes there's an issue where a person is facing eviction but its not necessarily a situation of personal abuse but the way the program is setup that's been a limiting factor. In terms of things that would really make the difference to be able to provide more the largest is knowing there would be other providers around the state that would be amenable to admitting these participants other than them.

Deb said she wanted to piggyback on what he was saying and say thank you and Evan both for being on the call today. There are over 500 nursing homes in the state of Indiana and what she would love to see happen as a result of this conversation is whether its built around the Triple A's in the community but really put together a system so some of their exclusionary criteria would not be exclusionary criteria for them. Because they tend to serve a different population, they tend to serve younger adults, they tend to have intellectual developmental disabilities, they tend to serve adults who have some mental illness issues although they cannot be in an acute like episode of delusional, schizophrenia that has to be stable before they take those folks. She sees hopefully being able to expand this program throughout the state for the betterment of adults who are comprised and identify the key communities if we had 4 or 5 nursing homes who said yes we want to come alongside Hooverwood and do this program throughout the state so that they could rollout this type of program before there is an emergency and have crisis intervention teams through the police department to be aware of this program that would be a huge win-win for the state of Indiana.

JoAnn said she was going to put in an ask there has not been a formal infrastructure at local levels to take care of these situations. The Commission by statute is to look at issues related to older adults in Indiana that need attention, they can develop advisory committees for the Commission. She thinks they need an advisory committee to the Commission and asked Deb is she might be willing to take some leadership and bring some people together on the advisory committee to come back to the Commission and they can go from there with work and bring awareness. Deb said she would love to do that and thank you for the opportunity. JoAnn said she hopes the presenters might be willing to be on the advisory committee and other people on the Commission and others on the meeting today. JoAnn asked if they could get with Deb by email if they are interested in serving on this advisory committee. Deb said anyone interested email her, her email address is on the invite for the zoom call. JoAnn said for Commission members we need representation across the state for this so if you know people or facilities in your area, please get in touch with them and get connected with Deb.

JoAnn said they have an update for the Division of Aging team.

Division of Aging Update: Darcy Tower said she works with the Division of Aging and oversees the Aged and Disabled Waiver and Traumatic Brain Injury Waiver and the providers and most recently the care managers who render those services. Today she wanted to share a little bit of information about the Division's process in developing 2 new waiver services for the Aged and Disabled Waiver. Each of the new services that they've developed were based on conversations that they had with providers and consumers and caregivers, and they also reviewed their incident reporting trends to determine gaps where new services could be most supportive to people. The first service that she would like to talk about is caregiver coaching and behavior management. During the first of Indiana's public health emergency the Division developed a high risk response plan to identify folks whether waiver or non-waiver who would be at an elevated risk if they lost services. They didn't have a backup plan and to the

Division's knowledge they didn't have an identified caregiver, so their care managers worked hard every week to check in with folks about any unmet needs. During the calls they learned that many of participants did have informal supports that had gone unidentified and in talking with these folks who really were doing caregiving work they learned that they needed support and didn't have it. Many of the participants that they talked to weren't part of any of the direct caregiver services on their waiver and that could have been for a number of reasons. So, at that point they decided that they needed to determine a way to figure out who is doing caregiving how do they identify that. What are the strengths and areas that need support for the folks identified and what resources are available to support caregivers who need something other than what is currently offered on the Aged and Disabled Wavier. Part of that work that the Division did, and she really wants to put a spotlight on Elizabeth Peyton of the Division who developed a caregiver assessment for caregivers to administer. And through that assessment work and talking with providers who work with caregivers, talking with care managers who work with caregivers and reviewing their incident report trends they learned that one of the areas where caregivers have stress is financial and the other area where they saw stress in caregiving is for consumers who have a dementia diagnosis, maybe they have some strong sundowning symptoms or consumers who had an identified serious mental illness or maybe a combination of the both. They learned from caregivers that they don't feel equipped to meet the needs of these individuals which leads to caregiver burnout and nursing home placement. They have been able to tackle some of these gaps they learned about related to caregivers, they now have their caregiver assessment, they also have the financial component addressed by allowing caregivers to be hired by a personal services agency or home health agency for reimbursement and they also have a program called Structured Family Caregiving and they provides a stipend to caregivers in addition to training and education. If a caregiver would like reimbursement and doesn't really want the oversight or training and education, they do have a self-directed program where the caregiver can be paid through a fiscal intermediary.

The piece that they really worked on this year through the new waiver service is the participant who are not part of one of the services that she just talked about but has an identified caregiver who does need support. They also really wanted to put more a spotlight on caregivers who need interventions to support participants who have dementia or have a serious mental illness. The Division's new service is called caregiver coaching and behavior management and it supports participants who don't receive Structured Family Care or self-directed care but who have a caregiver who needs support. The difference between one is offered through Structured Family Care versus this new service is that Structured Family Care really focuses in on the participants needs and how we help the caregiver wrap services around that participant. This new service is really more focused on the caregiver and their needs and what do they need to be able to support the participant at home.

Darcy said she wanted to take a deeper dive into the service and how it looks in real time. She wanted to tell them about Pam and Lucille, Pam is Lucille's daughter and full-time caregiver and now Lucille lives with Pam because of some increased dementia and Pam wanted to keep Lucille at home as long as possible. Pam is a teacher full-time, mother, and grandmother. She has a great group of friends, and they are always traveling together and doing lots of social activities. Pam was able to have a nurse staff hours for her mother during her workday, when she comes home she is assuming that full-time care for her mother. Pam's mother's sundowning is starting to create night situations where she is not sleeping during sleep hours, and neither is Pam, so she has stopped socializing with her friends because she is too tired. And she is worried that when she has other providers in the home, she may need to be there to help them with her mother. She's got some depression and she's really experiencing burnout. Pam

shared these concerns with her caregiver coach through the new service, the coach performed an assessment to learn about Pam's strengths and her areas of need. The caregiver coach also learned about Lucille's day to day activities and needs through a different assessment. What they realized when it came to the sleep issues is that Lucille is not active during the day, she is watching a lot of television, so when it's time to sleep she is not tired. The caregiver coach was able to work with her paid support her nurse to increase her activities during the day, she now goes to adult day a couple of times a week, so she's engaging both her mind and her body. And by increasing the cognitive and the physical activity she's tired at the end of the day and so that's improved her sleep habits which in turn has allowed Pam to get some sleep. The caregiver coach also worked with a local elder volunteer program so a friend visits Lucille on the days that she's not going to adult day. And Pam is being more intentional working with the coach to be more intentional about scheduling her activities ahead of time, she was able to hire a respite provider to care for her mother and schedule that ahead of time and then she's able to use tech equipment like facetime if she needs to check in on her mother if she's having a little anxiety about how she's doing. They had the caregiver coach create a service plan for both Pam and Lucille and the coach is consistently addressing their needs and modifying both based on the changing needs of the caregiver and the participant.

The most important take away from the new service is that it really does open up another option, another choice for waiver participants who have a caregiver that does not receive waiver services through Structured Family Care or self-direction. And she thinks there's also more of an emphasis around dementia and mental health piece in helping the caregiver have the tools to support behaviors from the diagnoses. Their second service is called goal engagement about a year ago the Division attended a lunch and learn with John Hopkins to learn about a program they implement called CAPABLE it is a acronym and it stands for Community Aging in Place Advancing Better Living. It's identified as an evidenced based program it's person directed, and it addresses both functional ability and healthcare costs related to functional impairments. It's a program that lasts between 4 to 5 months about and it integrates a team of occupational therapist a nurse and a handy worker. This team works together alongside with the participant to set goals and develop action plans, the purpose of those action plans is to change behaviors to improve health and independence. During the program the participant will be learning new skills and practicing those new skills to improve the quality of their life. They worked with John Hopkins, and they also worked with the Massachusetts Division of Aging who recently implemented CAPABLE into their new waiver. The Indiana Division of Aging did keep sort of the roots of the CAPABLE program, but we call it Goal Engagement.

Darcy said she wanted to talk a little bit about some of the benefits of implementing small environmental changes for waiver participants that can have a big impact. She would like to look at the current services they offer for home adaptations on the waiver and how this service will differ from those. A retired music teacher she loves to play the piano, but her arthritis caused her to much pain, and she was able to obtain supportive arthritis gloves and a back brace to improve her function to play the piano and that in turn increased her joy of being at home. What the Division has observed in learning more about these small environmental changes is the impact of the environmental change is less about managing the chronic conditions and more about promoting and improving functional capacity. The individuals on their wavier their independence and health is usually compromised by chronic illnesses so the inability of these folks to successfully manage everyday functions increases their likelihood of admission to a nursing facility and it threatens their independence. The premise of CAPABLE is rooted in resilience theory and it tells us that people at any age are resilient, and they are

surrounded by many overlapping resilient systems and when small environmental changes are implemented that work to engage a person's mind, body, and spirit they do see a decrease in disability and an improvement in physical function and self-care skills. And they also find that individuals reach their goals to remain at home.

The current waiver today addresses home adaptations in three different ways they have home modification which supports an independent assessor, the home modification(s) and specialized medical equipment. But often what they see with these services is that they exist in silos, when you think about home adaptations in terms of physical structure of the home and what needs to be done as opposed to how this person is navigating within their home. These services don't combine that integrated team. So, to start a shift in breaking down the functional barriers among providers and thinking more about how people navigate within their home and community and how we can use equipment to empower independence they implemented Goal Engagement. It's a 4 to 5 month program with a $3,000 budget per person per year and that pays for an OT, it pays for a nurse, a handyman and equipment that can also be purchase through Medicaid as well. But any equipment that wouldn't be purchased through Medicaid, they can purchase for this service.

The team will be trained through John Hopkins to do skills like motivational interviewing, active listening, and coaching. The goal is to understand how a successful life is defined by the participant, so the participant is the one deciding their functional goals. The goal of Goal Engage is that a change in a person's physical environment will stimulate a change in an individual's motivation. She wanted to walk them through the program components of Goal Engagement and the role each team member plays during the 4 to 5 month implementation. The participant is the driver of the team they will do a self-assessment and set their own goals and priorities and they will be a part of the brainstorming team thinking through options and solutions about how to achieve these goals. They will be consistently working and making progress doing exercises learning more about the new equipment in order to practice the new skill and become an expert at it. There is the occupational therapist who makes up to 6 visits during those months they'll conduct a functional and mobility assessment, they'll identify the home risks and needed modifications and equipment and do a fall prevention and equipment guidance. They will develop alongside with the rest of the team an action plan that will help the participant meet their goals. The registered nurse makes up to 4 visits taking a health history, reviewing current health providers, identifying any key health issues, reviewing pain and medication issues and is also a partner in that action planning process. The handy worker joins the team in the first month they receive a work order for the home modification and household items and they're consistently conferring with the participant and the occupational therapist about that equipment. The handy worker will obtain the supplies and install the improvements. The average cost of the home improvements and supplies is about $1,300 per participant.

Darcy said she wanted to walk them through what this looks like in real time. She wants to tell them the story of Mrs. R., she is a 76 year old retired music teacher who lives in her own home and has always been really active until recently. She has arthritis, a tremor in her hand and she has lung disease, and she is having a tough time doing her daily activities and she's not socializing much. When she tries to do activities she finds herself really exhausted, often losing her breath and she's in a lot of pain. She shared these challenges with her OT and her nurse, and they worked together with the handyman to help her develop goals and the group came up with solutions then to help her meet those goals. Her first goal was to prepare food without shortness of breath and so the handy worker lowered the cabinets so she

could reach the items she needed with less energy and installed an above stove mirror so that she could see the food that she was preparing while she was seated. She also has a reacher that helps her have better control to pick up items. Her second goal was to be in less pain when she plays the piano and so the handy worker added an extended chain to the light and then he switched the bulb to led so she could better see the music. She also has the arthritis compression gloves and a back brace to decrease her pain and then another step that they took was to build her a higher bench for her back pain. Her final goal was to bathe using less effort and so the handy worker smoothed out the bathroom threshold entry so she could easily push her rolling walker into the bathroom. Then the shower doors and frame were removed, and a secure shower curtain rod was installed so that she could better get into and out of the shower with ease and she also received a new tub bench a part of this program that allowed her more movement within the shower in a safer way. Those are the 2 waiver services that they are adding, they haven't been approved yet by CMS, but they are in the process and some of them have provided really thoughtful and helpful comments through the public comment sharing, and she is happy to take any questions.

Deb Lambert asked if there is a limit on the number of people that each of those two programs will serve. Darcy said there is no limit on the number of people. Tauric said he didn't have a question but thank you so much for sharing this information they are very excited with this work. Jennifer said they are excited too these are going to be excellent services, what is the approximate timeframe that you think these will be ready to actually launch. Darcy said it is hard to say because they never know how long CMS is going to take to review the service. But they are getting ready to send it though, she thinks if approved by CMS it will likely be October.

JoAnn said she wanted to give everyone a chance to comment this is a very exciting program she would guess this linked to the Division of Aging addressing issues related to in the plan to strengthen family caregiving support and this other very interprofessional program to address quality of life for older people very exciting. Thank you Darcy, we look forward to seeing these programs in enacted. JoAnn said she made a little change in the agenda because they've had a very busy legislative session, she asked Kristen LaEace to join her at the table and let them know what has come out of the legislative session. She also wants her to comment a bit on the area agencies on aging are part of the Older Americans Act connected in with the State Units on Aging and the Administration on Aging and as Indiana moves forward with plans for managed long term services and supports perhaps in your report you could address some of the issues on how Triple A's might see themselves participating in managed long term services and supports. Kristen said she would be happy to.

I-4A Update: Kristen LaEace said she understands that Rebecca is going to help her and share the screen with the information packet. She is going to try to work through some parts of the information packet. She understands that Willie is out of the office, and so she shared the packet with Kristie and she's gonna try to get it to everyone, but there is nothing different than what you'll see on the screen versus what you see in your packet. She wants to start out by recognizing that this is nutrition awareness month, and it is actually the 50th anniversary of the Older Americans Act nutrition programs. The area agencies on aging and Kristie Garner worked to get a proclamation from the Governor every year regarding nutrition awareness week. The Triple A's prepare special events, they all serve a special menu, they have special placemats and she wanted to highlight the work of all the nutrition directors.

In their packets they just finished up the General Assembly and they have included shortened version of the report that their lobbyist prepares for them related to outcomes of the General Assembly. There

was a lot that area agencies on aging weighed in on they try to take a broad view and weigh in on social determinants of health things that are very specifically aging related in aging services as well as health care in general. She wanted to highlight a few good outcomes, there was a small increase to the senior property tax credit they weighed in on that and they appreciate that that went through. They also supported the creation of a tax credit for contributions to the Able Account 529A savings accounts. When these were established they first support that and have weighed in on supportive legislation every time it's been proposed. Unlike the 529 accounts the regular accounts these Able Accounts did not have a state tax credit associated with them. The legislation mirrored the 529 tax credit, and it will start she's believes in 2024, it was a compromise they wanted it to be effective this year.

Another thing they weighed in on which was really introduced and supported by the Alzheimer's Association was a requirement that in-home care workers as part of their regular training regimen that the training had to include training on Alzheimer's and dementia annually. It does not increase the total number of training hours that in-home care workers must receive but it is training that should be included in that regimen annually. One of the big issues that they worked through in the General Assembly was related to legislation sponsored by the nursing facilities related to managed long term services and supports. The legislation originally would have required FSSA to promulgate some alternative models and it also included a lot of provider protections that the nursing facilities were particularly interested in on behalf of their membership. The Triple A position throughout the General Assembly was to ensure that the legislation did not negatively impact some of the roles that the Triple A's hoped to perform in MLTSS. There were organizations weighing in on both sides the nursing facilities supported the legislation FSSA opposed it along with other organizations. The bill ultimately died in the House Ways and Means Committee. There was a tiny bit of wording that was inserted in a conference committee report that prohibits FSSA from entering into managed care contracts until January 31, 2023, but from everything that she can tell this won't materially affect FSSA's ability to move forward with managed care. They will see in their packet a bunch of legislation that has to do with inter-jurisdictional compacts psychology just thinks related to medical licensing etc. there's also a bill that expands the ability of our state to educate more nurses. Things that were related to the healthcare workforce particular an expansion of that workforce or creating more ease for people to move into the state or provide services across state lines, they have supported in rural areas that have less access to services in general as well as the border counties. There is a lot of other stuff on the report that they may have an interest in.

Kristen said on page 10 of the packet one of the things that did pass the session was an affordable housing tax credit that rides alongside the federal low-income housing tax credit that bill has been the General Assembly for about 4 years it hasn't passed, it has something that they have weighed in support every year. On page 16 is the federal update in addition to the state legislative actions that just took place they have also just recently the federal government did pass omnibus spending legislation which basically put in place the fiscal year budget for the states for the federal government for federal fiscal year 22. The Older Americans Act was increase in various places she doesn't believe there were any decreases anywhere but at much significantly lower levels than were originally proposed. There areas in which Indiana will see increases coming in, based on the formula distribution once it comes out, she doesn't know that it will have a substantial impact in Indiana but the document one from USAging will show you the comparisons between what our current budget is what the proposals were and what came out in the end. That's what happening at the federal level, the other thing that they were working on nationally was the build back better plan, which not only would have provided support for the

homecare workforce, but it also had a provision in it that would eliminate the match requirement on the ARPA funding. Indiana is one of those that will not release the Older American Act ARPA funding they haven't seen it because of the match requirement, so that bill is dead. Working they are working on now is a smaller packet primarily focused on addressing the higher costs that consumers are experiencing inflation etc. and national advocates are going to continue to move forward and try to get all the good proposals that were in build back better related to the issues we care about. They're going to be working on getting those into the stimulus package it could even include that match waiver. If you are talking with your federal legislators in the next couple of weeks, it's really important that you talk about the need for the economic stimulus package we are not allowed to call it build back better anymore. It is expected to go through the reconciliation process which gets it through the Senate that's where we're at federally.

Further down the packet starting on page 20 there are actions that the White House and the Executive Administration are taking related to both the covid-19 and nursing facilities they're putting out a big effort related to nursing facility quality. Their packet includes information about that on the next several articles, on page 34 the federal government has also put out a toolkit related to fighting against health misinformation. There are a couple infographics in their packet related to that and there's a larger toolkit related to it and she knows that there's all kins of money out there related to vaccine messaging and covid-19 messaging that is just now being implemented from the CDC grants from the ADRC money that came in related to covid-19 and so these toolkits may be useful. New poverty guidelines were published and there's some stuff in there about grand families and kinship care. On the last pages of the packet pages 79-81 and point out that AARP is accepting feedback on their scorecard and ways to improve the scorecard. They want to improve the underlying measurements to better align those with what constitutes a quality long term services and support system as well as to kind of dig into some of the data collection. That's everything in the packet and she is going to stop for any questions.

Kristen said that JoAnn had asked her to share a little bit about the Triple A's perfect world for MLTSS. It really is the same as the perfect world she shared she shared with them back in January the last 2 times that she has talked to them she shared a description of some of their concerns related to MLTSS as well as some of the ways they thought inclusion of the area agencies on aging as being embedded in MLTSS could help alleviate several of those concerns. Most of them were related to the consumer experience they have actually had the opportunity to present to the FSSA team on what they have dubbed the front end and the back end. The front end being all that initial inquiry and assessment and initial movement of a consumer towards MLTSS eligibility and the back end once they've selected a plan been enrolled what happens with their care management on the back end. With the care management on the back end, they have proposed required participation of community-based organizations and area agencies on aging as mandated service coordinators basically the role they're now for waiver clients. The area agencies on aging have been fortunate to engage in lots of conversations with multiple managed care entities about that role kind of as a different line of focus. There is a lot of promising language coming out of the managed care entities about their desire to work with the area agencies on aging network in that care management role. In addition, they've talked about the front end, and they had the opportunity to share and provide education to FSSA about the important impact of options counseling and how they work with consumers in getting them the assistance they need whether that be through Medicaid or other funding sources or no funding sources at all and just problem solving with the resources the consumer has available. They want to ensure that folks continue to receive the service regardless of their funding eligibility and they're also hoping to connect more individuals particularly

those who are only Medicare Advantage involved right now and maybe Medicaid eligible but not on waiver, connect more of those individuals with their options counseling and the ADRCs and they were able to present that information last week in a presentation format and then several weeks prior in a written format. They've been advocating for those roles and in the next several weeks they're probably going to start seeing what decisions FSSA has made regarding their program design. They have scheduled a series of meetings with their broad stakeholder group in which they are going to be rolling out program design components in terms of what they're proposing. There will also be some sort of updated timeline shared so they're not quite sure if they are still on the timeline of RFP release in May and still making contract awards by January 31st of next year, it had originally been proposed by the end of December. They have been very consistent in terms of their discussion about what they think is an important role the Triple A's can plan and they've also had a lot of support from the Division of Aging.

JoAnn said thank you for giving us an update on legislative policies as well as her involvement with administrative policies that are being developed through FSSA related to managed long term services and supports. There are lots of questions out there about what's going on and what the status of everything is so let's open it up and ask questions if you have them or comments. Kristen said the biggest summary is that it's moving forward it's kind of on time and they're going to be finding out literally at the end of March through April where FSSA has landed. JoAnn said people are saying in the chat box to the update you're referring to sausage making someone made that term when it's in the legislative process and we're kind of there now in the administrative policy process over the next couple of months in Indiana. She really appreciates her update.

JoAnn said they have the advisory committee reports on the living longer living better collaborative initiative. She gave a couple of presentations on their living longer living better guide in the last few weeks one was to the senior center coalition of Indiana and also last week the quality conference will be in the next month she gave a presentation that's been recorded, and she will be part of a panel for the CMS quality conference and the Commission's living longer living better guide is being used as a model across the country now.

JoAnn asked Judith if she had a report from the shared decision-making committee. Judith Schoon said congratulations on getting that out that's huge Indiana is doing quite a few things better. They've talked to some people, and she has talked to people individually, but they've not had any group meetings lately. Everybody who's made ideas or working on their ideas and working forward so they will have a meeting soon and those individual ideas will bring to the group. JoAnn said thank you anyone comments-questions to Judith.

JoAnn asked Dan Mustard to give them an update on the senior center coalition of Indiana. Dan said as Dr. Burke mentioned on March 4th they had a senior center coalition conference that had about 40 different leaders from around the state who came together to talk about senior centers. They called it changing the game preparing for a new era in long term services and support a lot of it was just getting information out to senior center leaders about MLTSS and some of the things that were happening at the state level. They met the Hendricks County senior services in Danville, and it was a very productive day. Kristen LaEace with Indiana Association of Area Agencies on Aging who they just heard from was their first speaker and she gave a legislative review, and it included a lot of key information about ways that non-profit organizations can have an impact on state legislation. It is not always something that is part of their day to day so that was really helpful information. They had a lot of comments about that so thank you for presenting, her presentation is available on their website, and he has posted the link to

their website. Right now, it is housed at the Millrace Center website under the Pittman Institute tab, but all the information is there as well as Dr. Burke's presentation. They were both recorded and available. With long term services and supports being such a big topic living longer living better really gives people kind of a handle on how to create coalitions at the local level and also leverage some of the work that's already being done without having to necessarily create something from scratch. A lot of times it's just presenting information about what's happening in the world of senior services to some of the local coalitions that exist and piggyback on that. Dr. Burke gave a great presentation about that and then they followed it up with a panel discussion. He facilitated a panel that included Janice Holiday from Marshall County and Kara Kellerman from Tipton County both of whom are involved in some local coalition building and so they shared that information with the leaders who were there. Overall, it was exciting for them to finally get this off the ground they had originally planned on the conference being in March of 2020 and so it was put on hold for 2 years because of covid. A big thank you to Kristen and Dr. Burke for being part of that and sharing information.

They have an upcoming brown bag session that is for senior center leaders and key staff at senior centers those are done via zoom. They are usually the last Friday of the month and there is a link that he posted that will have some information and how folks can join their next brown bag session and the topic is going to be what they call board games. It's basically how to develop relations with board of directors to share some information. Its an opportunity for senior center leaders to network and present information about how to best work with their board of directors. They've had some other brown bag sessions in the past that covered similar topics that were well received, so if there's a topic that they are interested in please share the information if you know senior center leaders, if you're involved with the local Triple A and you work with the senior center please direct them and share the link with them so that folks can get signed up for the brown bag session.

Dan said also in the planning stages right now, they are looking to do a boot camp for new senior center leaders and that will cover a lot of different information and more information will be coming up and they'll post that on the website as well. If anybody has any questions about those things he would direct them to the website and he would be happy to answer any questions, there's a lot of exciting things happening and as they're coming out of the pandemic its been a stressful time obviously for everyone but especially so for senior center leaders who were trying to do any kind of social programming and activities at a time when folks were at risk and so its exciting for them getting to see our numbers come back. We were providing services for most of the pandemic, and they were open from June on in 2020 so they've been open for a good long time. Many seniors centers have been open, and others are closed or have just recently reopened so their approach has been a little bit different depending on where you live in the state, but they're starting to see folks coming back now and they're excited about that.

JoAnn said comments or questions for Dan. She thanked Dan very much he's certainly been very involved in the work of getting the senior center coalition in Indiana active and thanked him for giving her the opportunity to share the Commission's guide with the senior center. She is going to echo what Kristen said and for our May meeting she hopes she's not the only one sitting at the table. She gave a shout out please try to come back in person, is there anything else anyone has before we come to a close, with there being none she adjourned the meeting.