

COMMISSION ON AGING

VIRTUAL MEETING MAY 20, 2021

10 a.m. to noon

Call to Order: Chairperson called the meeting to order and did a roll call. There are 12 members on the Commission on Aging, with 9 needed for a quorum. Margaret Smith absent, James Goen, present. JoAnn asked him introduce himself to the Commission members. Jim Goen said he previously served as the Indiana State Director of the Green Thumb, Inc. older worker employment and training program which was authorized by Title V of the Older Americans Act for about 22 years. The Indiana program was allocated 700 positions serving 87 counties. He was the founding board chair of the National Older Worker Career Center, (nowcc.org) a not for profit of Arlington, Virginia. The program now employs over 1,300 older adults across the United States serving federal agencies including the U.S. Dept. of Agriculture, U.S. Environmental Protection Agency and the U.S. Forrest Service and they are in 48 states and Porta Rico. He was engaged with them for 10 years and still stays in touch with them and they've had interesting movement and expansion. He is currently employed by the Indiana National Guard as a Community Relations Specialist and his special interest is in older workgroup training. He was with on the Commission on Aging 15 years previously and is delighted to be part of the Commission again. JoAnn said thank you. Lauren Mullet was present, Jennifer Lantz was present, Debra Lambert was present, Dan Mustard was present, Robert Bischoff was absent, Michael Sullivan was present, Judith Schoon was present, Sue Grossbauer was absent, Kelli Tungate was present, Megan Springer was present, and Dr. Ehlman was present.

JoAnn announced that a quorum was present. She said the minutes have been quite lengthy because of their packed meetings, and she thanked Willie Poindexter and secretary Dan Mustard. She saw one correction and said this should impact Dr. Ehlman; it is HRSA not URSA, as funding use in the minutes. She asked if anyone else had any amendments to the minutes. JoAnn asked for a motion for approval of the March 18, 2021 the minutes. Judith Schoon made the motion, which was seconded and approved unanimously by the Commission.

New Business: JoAnn introduced Dr. Ehlman, Vice Chair of programs who talked about their presentation topics for the year. Dr. Ehlman said she wanted to thank Dr. Burke and the group who put together the plan for their presentations to finish out their calendar year. She and JoAnn had a chance to meet and talk about processes, as they talked about topics and as they move into the next calendar year. They want to select topics that would be important for this Commission to consider. They talked about using some time in the November meeting to brainstorm ideas that are important to the state and important to the work of the Commission. The plan is to put together a topical calendar for the following year and then have a draft that they pull together that a small group can review and approve those topics, and then work to get those individuals selected. Looking at this as a 12-month process as they think about the needs of the state, they are very open to suggestions. She asked JoAnn if she wanted to add to that.

JoAnn said they have a lot happening in the state of Indiana, they're in some ways going through a process. The nursing home industry was built around the 1965 legislative actions for Medicare and Medicaid and they are making some adjustments to that. In some ways she thinks about this as similar to the deinstitutionalization of the sister services for older adults; they're doing more home and community based services, which appears to be happening state by state. It is somewhat analogous to taking children out of orphanages and moving our behavior health population out of state mental hospitals. We still need nursing homes; they are not talking about closing nursing homes down, but they are increasing capacity for home and community based services, and it will be a big move. The Commission on Aging, by statute, is to look at the wellbeing of older adults in Indiana and there is a lot going on now. These topics are important, and Katie would like to get feedback from people so that we can take a portion of the November meeting to talk about topics for next year. Michael Sullivan agreed, and he suggested that this is where workforce development would come in. Katie said "thank you" and stated that the November agenda included a discussion about workforce development.

JoAnn said that some of the changes coming at the state level have shaped today's agenda, and we have presentations coming up today that will be related to older adults who need some assistance due to dementia. Melissa Keyes will be first. She is the Executive Director for Indiana Disability Rights, and then Dr. Counsell will talk about the Alzheimer's disease Program's initiative grant in Indiana.

Presentation: Melissa shared her screen to present slides. She thanked them for giving her the opportunity to talk with them about an issue she is extremely passionate about, which is the individual's right to make decisions. Melissa is the Executive Director for Indiana Disability Rights, which is the state's protection and advocacy organization, so they provide legal services to people with disabilities across the state in a number of different areas. She has a Master's Degree in Clinical Psychology with a focus on developmental disabilities, serious mental illness, and a law degree with a focus on arguing and table banging. So, between the two, she has a lot of experience in this area as well as some student loan debt. She is hoping she can task two of the meeting attendees to volunteer to do a little exercise with her. Jennifer Lantz and Deb Lambert volunteered. Melissa asked each of them to quickly share three things that are important to them and part of their identity. To give an example, for her central value it is her family, her work and having free time to spend on hobbies that she enjoys. Deb said family is extremely important to her, a second thing would be helping others grow and develop professionally, and personally, that fills her bucket. She loves to camp and she is getting ready to camp this weekend and that refills her bucket. Jennifer said for her it is her family, traveling and exploring new places and in her professional life, encouraging leadership, building people up in her company and the work that they do.

Melissa said "Deb, you have 30 seconds to choose one of those on Jennifer's list that she can no longer have." Deb said "That would make me sad; but [she would take away] travel." Melissa said "So Jennifer, no more travel" and "thank you for your participation." She asked Deb "How did it feel, having to make that decision?" Deb said, "I didn't like doing that. It's hard taking things away from people." She likes to find the yes. Melissa asked how she came up with her decision to get rid of travel. Deb stated that you can't get rid of family, it would be cruel, and developing other people not only helps her but it helps the greater good and sadly travel is for her benefit. She felt like that would be the least painful for her to have to give up if she had to give up one of the three. Melissa said "You rationalized it a little bit?" and Deb said "Yes." Melissa said, "Did you think to ask Jennifer?" Deb said, "No, because you did not explicitly say that I could do so." Melissa asked Jennifer "How did it feel to have someone else decide

which one of your three things had to go away?" Jennifer said "Not good, because I didn't want anyone making decisions for me." Melissa asked if she would have picked travel. Jennifer said she would have picked travel. Melissa said "Thank you for your help."

Melissa said she did this exercise for a few reasons, mostly to annoy the introverts (just kidding.) Actually, the purpose was to remind people that everyone has things in their life that are important to them and that those values are really individualized. When we impose our own values on it we don't necessarily consider what might be important to the person without getting their input and information and direction. The purpose was to remind us that we all have things that fill our bucket and we all have things that are core to our identity. The cool thing about all of these things; your family, your job, everything, it comes down to decisions that you have made in your life and how you got there. Everything comes down to that, that's how core and important making decisions and having input is. Its everything from the little things like what you eat for breakfast to the monumental things like do you want to buy this house. There are all kinds of decisions that can have a huge impact on our life. The second reason she does this exercise is to highlight the fact that surrogate decisionmakers have a big responsibility; they may need to make decisions quickly with little input. And whenever possible they really want people to make decisions themselves to the greatest extent possible and for as long as possible because that is what they want, that is what we all want. And the way to do that is through supported decision making and that is what she is going to talk about today.

She will spend a little bit of time on how we can support decision making in Indiana. Fortunately, a couple of years ago they passed a law in Indiana that formally recognizes supported decision making as a less restrictive alternative to guardianship. The legal definition is "Supported decision making refers to the process of supporting and accommodating an adult in the decision making process to make, communicate and effectuate life decisions, without impeding the self-determination of the adult." What does that mean? In plain language, supported decision-making is a tool and accommodation to help people make decisions. The person uses supporters to help them through the decision making process. They make the final decision, and that is the key and the central component to it. They choose and use supporters to help them through the decision-making process, but they make the decision that is the key and central component to it.

Melissa asked, "Who can use decision making supports? The answer is anybody who needs help making decisions." We already do this in our everyday lives, with some degree of formality, over others. When you are deciding whether to buy a house, you probably don't flip a coin and say this one or this one. You sit down and maybe write down a budget, you may talk to your realtor, etc. you do this kind of stuff so at the end of the day you feel informed and confident in your ability to make that decision. That is a form of decision making where you are using whatever tools and supports you need to help you make that decision. Nobody comes at you and says, "Quick, tell me what house you want to buy, where do you want to live." You are given the opportunity to sit down and think that through and you are empowered to do so. People don't question your ability or your desire to use supports and services to make that decision. That's the cool thing about supported decision making; it is a lot of things that we all do naturally. When we talk about formalized supported decision making, the law that was passed is making sure that the person that is using those supports, as well as their supporters, are all on the same page as to how they want that support to be given. One of the cool things about the concept of supported decision making, as well as the legal concept of supported decision making, is that it can really be used with other decision making arrangements to customize and individualize the supports the

person needs. You can use supported decision making within a current guardianship as a way to develop those decision-making skills, and you can use it as a supplement to informal services and supports.

Melissa said she wanted to talk briefly about the issue of capacity, because that really becomes the sticking point from the legal perspective when you start talking about guardianship versus decision-making supports. Historically, capacity has been treated as a yes or no, either you have it or you do not, and that is decided by a court based on evidence that is presented to it. But when you think of capacity as an actual functioning idea it really exists on a spectrum. There are things that a person may have great capacity for, but when it comes to how to read and understand loan documents or financial shares that may be way over their head. So the person calls their dad who walks them through it, but just because the individual can't do the things with finances and shares it doesn't mean they don't have capacity, it just means that in that area they need a little support. Unfortunately when we look at guardianship we tend to look at it as a yes or no; do you meet that capacity definition instead of looking at it as a spectrum and tailoring the supports to make sure the person has what they need to be able to make decisions themselves. When we think about capacity, we need to think about how it is determined by situation, the complexity and the subject matter of the issue as well as internal and external factors especially for older adults and persons with disabilities. A few examples include time of day, physiological state, active systems of their disorder, lack of sleep, etc. All of these can go into someone's capacity to make decisions. Capacity can also change over time based on someone's skill acquisition. Our goal should always be to start with the least restrictive option that is necessary for the person to get the support that they need. The current options can be used in combination, they can change over time to suit a person's need but it has to be more than a blanket one-time solution.

Melissa said as part of the supported decision making statute, they also passed a definition of less restrictive alternatives that is a bit of a catchall. It is a way to meet a person's need that restricts fewer rights of the person than would the appointment of a guardian. This would include, but not be limited to, supported decision-making agreement, appropriate technological assistance, and appointment of a representative payee, appointment of a health care representative and the creation of a power of attorney. She said if anyone is interested in doing a deep dive into how these work she would be happy to do that in a separate presentation.

Melissa said that she thinks it is easier to use an example to show the differences of power of attorney, supported decision-making and guardianship because those are the three that get interchanged the most frequently. Example; Diana has schizophrenia, lives alone and is retired. Her adult son helps her out around the house, and helps her when anything major comes up. Diana slipped on some wet tile and is injured, so her son goes with her to an orthopedic doctor's office visit. The doctor says she has a tear in her ligament and she needs to get either regular steroid shots and physical therapy or surgery. Neither option sounds desirable to Diana and causes her some anxiety and because of her condition and the presence of her son the doctor begins to question her ability to consent for treatment. Under supported decision-making, if Diana had her son as a supporter she had be able to use his support, however she wanted to be able to make this decision herself. In the presence of the supported decision making agreement, at least in Indiana, the agreement would allow the doctor to recognize that Diana is using some accommodations to make her decision. The doctor would recognize that as evidence of her informed consent and would know that she able to make this decision without a higher level of intervention. Under a power of attorney, if Diana has previously named her son as POA for medical

decisions, the doctor could look to her son, in conversation with Diana, to make that decision on his mother's behalf in accordance with the language in the POA. He would presumably talk to his mom and go with the option that best supports her wishes. If Diana didn't like the way he was performing as her POA, she could remove her permission to represent and appoint someone else, so she has the power to name who will be helping to make decisions. Under guardianship, if her son were guardian, the doctor would exclusively listen to her son to make that decision. Her son would hopefully look to Diana's wishes for best practices to make that decision, but he would not necessarily be required to do that. Supported decision-making enables the individual to make the decision yourself using the support you need. Power of Attorney relinquishes some authority and allows the individual to choose someone to assist in the decision making process, under these specific circumstances you appoint someone to make the decision for you. Under guardianship, the court has appointed someone to make the decision for you.

Why do we need decision making supports? This is a human rights issue and everybody wants control over his or her own life. While it has been signed but not ratified in the U.S., the UN Convention on the Rights of Persons with Disabilities along with 40 other states, countless organizations and individuals all agree that the right to make decisions about your life, the right to self-determination, is essential and it's something that should be protected and promoted. There is also health and wellness benefit associated with being able to retain that control. Research has shown when someone has the ability to maintain control or exert control over their life there is better health outcomes and more engagement in the community.

Melissa asked, "How can we support decision making in Indiana? They all agree everyone wants as much control in decision making as possible for as long as possible, so why aren't we doing it more?" There are 2 major reasons: 1) people don't know about it or how to use it or know what to do with it when presented with a decision making support and 2) our current system is not setup to meaningfully consider it. It is very easy to get guardianship and it's very hard to get out of that guardianship and move to a less restrictive option. While education is undoubtedly important, and it's an effort they are currently working on, she really wants to focus on the second issue in particular. Last week she participated in the 4th annual guardianship summit with researchers, advocates, thought leaders from around the world gathering every 10 years to nerd out and talk about the future direction of guardianship and decision making supports. One thing became abundantly clear; while progressive in its recognition of supported decision-making as a less restrictive alternative, Indiana's guardianship code is woefully inadequate.

When we talk about how we can support people with disabilities and those who are aging to preserve autonomy for as long as possible, here is some key things that we can focus on in Indiana concerning the guardianship code. Our code, both as written and in practice, does not provide a great deal of protection for people at risk for guardianship. Indiana lacks standardization. It is determined on a county-by-county court rule and it lacks requirements for representation. Almost anybody can serve as another person's guardian. There is no ongoing review of the guardianship to make sure that it continues to be necessary nor is there an easy path to transition over to something less restrictive. There are few safeguards and little oversight and accountability. Looking at other states, Indiana falls way behind. Here are some concrete recommendations that she is hoping the Commission might be interested in supporting:

- Convene a workgroup with the goal of recommending changes to current guardianship code, making sure that the workgroup has equal representation from both disability and aging communities and advocates including people at risk of guardianship. The workgroup could be composed of professionals, family guardians, attorneys, judges (all the interested stakeholders) but it cannot be just the same voices at the table that it has been. Real change is necessary.
- Next is to fund some pilot projects. For example, try to start a guardianship ombudsman program to provide the courts with some relief in a consistent way for guardians or people under guardianship to get education and assistance if there are issues within the guardianship.

It is long past time for Indiana to acknowledge the problems and work toward a solution, because everyone is at risk of guardianship at some point and we owe it to ourselves and to others to make the system better. She included some resources and shared her slides. Her contact information is Melissa Keyes, Executive Director Indiana Disability Rights mkeyes@IndianaDisabilityRights.org (317) 722-3463.

Erin Wright shared a question from the online chat feature: “Are there neighboring states that are doing this as well?” Melissa said, “Yes, currently there are 40 states that have at least recognized supported decision-making somewhere in the legislature, as far as neighboring states Wisconsin, Indiana there are about 40 states so far who have made this a priority.” Another chat question: “Can you talk a little bit about the supported decision-making planning grant?” Melissa said, “Indiana was fortunate to be one of 3 states to receive a small grant from the Administration on Community Living to develop a state plan to increase the use of supported decision-making and less restrictive alternatives. That grant is currently wrapping up and it will be finished in September. They are finalizing the final draft plan and opening it up for public comments in a couple of weeks.” She would be happy to share that information once it is final. The goal is to identify what we need to do to make that education, awareness, and access piece better. A lot of the recommendations that she talked about have been included in that plan and they also mirror some of the recommendations from the 4th annual guardianship summit.

Kristen LaEace wanted to throw something out just to give a little more context to the Commission on Aging. Melissa ran through a series of concerns about our current guardianship code. A couple of years ago a new national uniform code was put out by the Uniform Code Commission on Guardianship and for Indiana to really take this seriously and improve its guardianship code, it is going to take the backing of the Probate Study Commission. They have tried to get their attention in small ways, even just providing education about the Uniform Commission, but there are quite honestly some “old fogey” attorneys on there who wrote the update in the 80’s. That was the last time it was updated and they do not want to move. They think it is just fine because it was their piece of work, and they are trying to get them to embrace this responsibility to move forward with best practice. It occurred to her that one of the ways that they could do that is to have the Commission on Aging put out a white paper/position paper on this and perhaps the position paper could be signed by the Indiana Commission on Aging, it could be signed by Indiana Disability Rights, it could be signed by the Indiana Statewide Independent Living Council, etc. That is one step the Commission could formally take that they could use to get more interest of more of a ground swell of push, sense of dissatisfaction and push the Probate Study Commission to take some steps with that.

The other thing that occurred to her during the first part of Melissa’s presentation is that what she is talking about is extremely person-centered, and with the current emphasis on person centeredness in

their Options counseling and case management practices and training. She wondered if there could be more formalized training on supported decision-making, and perhaps it should be added to some of the case management training that is currently taking place, either as an initial requirement or one of the ongoing educational requirements. She stated that perhaps the question is directed more to the Division of Aging, but those were two thoughts that came to her as she was listening to Melissa. She just throwing it out there to see if anybody on the Commission has a response.

JoAnn opened the discussion to Melissa's presentation or Kristen's suggestions. Judith Schoon said she had guardianship over her father and her presentation broke it down to a very simple level and it was appreciated, she took notes and will be using them in a seminar that she does. Judith asked JoAnn if they had someone who was writing white pages for them. JoAnn said she was thinking about how this process could go forward. They might put it into the category of advisory committee, and inquired if someone is interested in chairing that committee and perhaps some other people would like to get onboard, they could take on the responsibility to write a position paper and bring it back to the Commission, and with their approval, release it. JoAnn said that seems to be the way to move it along and it's a good time to be doing this. Judith Schoon said she would be willing to help; Megan Springer, Jennifer Lantz, and Deb Lambert said they would volunteer. Deb said another suggestion would be to contact Leading Age Indiana, with the purpose of doing a presentation to their board. Perhaps they would write a position paper on it as well. Additionally, the Indiana Health Care Association, because we have many residents with guardianships and some guardians are better than others are. Deb said she is on the board of LeadingAge Indiana and she would happy to do an introduction to Eric if she thought that would be helpful. JoAnn asked who would like to chair that committee and report their progress to the Commission. Judith said she would chair the committee. JoAnn asked what they would like to call the committee. JoAnn asked Melissa and she said supported decision making and that she has tons of data if anybody is interested she would be happy to share as much information as possible. JoAnn said the committee would be called the Supported Decision Making Advisory Committee. Melissa said she had to leave for another meeting and she looks forward to working with them. JoAnn told Dr. Counsell they were ready for his representation.

Presentation: Dr. Counsell said he wanted to provide them with components of his presentation. One is to tell them about the IU grant from the Administration for Community Living to advance geriatric dementia care and home and community based services in Indiana, and the second component is an update on the dementia care initiative of the Division of Aging and Family and Social Services Administration. The IU grant focuses on strengthening and expanding the IU/AAA dementia capable home and community based services system. This is funded by the ACL out of their Alzheimer's disease program initiative and they applied for the grant through Indiana University, although it was a broad initiative across many organizations including the Division of Aging. They were 1 of 10 states awarded in the 2020 round. The main focus was to design, implement, and evaluate new and expanded home and community based services to help people with Alzheimer's disease and related dementia ADRD and their caregivers. The award was a million dollars over 3 years and it required a 25% match. They did get five area agencies on aging involved in this project and they are donating as an in-kind \$333,333 in match funding a tremendous commitment from these 5 area agencies to advance in this area.

Dr. Counsell said he would tell them more about how they are making the in-kind match through the dementia care coaches that they've each have hired and are working to provide counseling to persons living with dementia and their caregivers. Their particular grant goal is to enhance, strengthen and

expand the existing IU/AAA dementia capable home and community based services system. The whole focus is to help people remain independent in the community as long as possible. Their first objective is to provide dementia capable home and community based services to individuals living alone or aging with intellectual and developmental disabilities (IDD). The IDD component is new for them, and is an example of strengthening the existing system and looking particular at people with Down Syndrome who are at high risk of early onset Alzheimer's disease. The second objective is to provide dementia training to family caregivers and home and community based services direct care workers. The third objective is to have quality assurance quality improvement mechanisms and to expand and have sustainability beyond the grant funding.

For their grant to be successful, they had to show that they had an existing dementia capable system. Their new partners in this initiative are Aging & In-Home Services of NE Indiana, LifeStream Services, REAL Services, Thrive Alliance, Indiana Association of Area Agencies on Aging, Dementia Friends Indiana, IU Center for Youth and Adults with Conditions of Childhood, Indiana Professional Management Group, University of Indianapolis Center for Aging & Community, Division of Aging, Disability & Rehabilitative Services and Indiana FSSA.

The main program is supporting caregivers of people with dementia who are living alone or have IDD living with a family caregiver. This will be delivered through care coaches who are community health workers type job description qualification with at least a high school degree. The training was intended to be a intensive 5-day training, but it was reduced to 10 intensive half day virtual trainings at the end of January and February. It was based on the medical home dementia care training program that was developed at the IU Center for Aging Research. The primary intervention that they have proven through research and multiple trials to better relieve people with dementia from behavioral systems but also to decrease caregiver stress is what's been coined the caregiver stress prevention bundle. It has four components, 1) caregiver counseling, education and referral, 2) development of a crisis plan, 3) weekly respite care and 4) monthly support group participation.

Dr. Counsell said the second component he referred to is around training direct care workers. Focusing in particular around staff providing attendant care or the home and community assistance services, which are typically for activities of daily living and instrumental activities of daily living. The direct care workers originally envisioned would have training out of the Eskenazi Center for Brain Care Innovation in person and they were going to hold them at each of the 5 area agencies on aging. The area agencies on aging would eventually be able to provide these trainings themselves to direct care workers in their planning and service areas. The focus on this training for direct care workers would focus on caregiver stress, communication, agitation and mobility. The direct care workers would get a certificate of completion and try to fold this into their ongoing training.

Those are the two main interventions. They hope that at the end of the three years they would have served 300 people living alone with dementia and another 100 with the IDD community and their caregivers, and then another 600 waiver participants with dementia who are living with their family caregivers. Each care coach would be helping out about 180 individuals over about 2-1/2 years, the IDD folks will be served by the care coach out of the Eskenazi Center for Brain Care Innovation working with IPMG care managers. The goal is to demonstrate that they reduced dementia behavior symptoms and caregiver stress and increased the quality of life for people with dementia and their caregivers. They will also increase the competence of 500 direct care workers, which would be 100 trained by each area

agency on aging over the next 2-1/2 years. The Administration for Community has a tool that assesses the system's dementia capability in their home, community based services, and they look to improve upon those measures. Each partner area agency on aging has hired a site coordinator, care coaches that were new staff positions funded by a third of the grant and two-thirds by the area agencies as part of the in-kind match, and hired the project site care managers. The Steering Committee has substantive involvement in the planning, implementation, and coordination of the project. This includes the activities of their own organization, identify resources and opportunities for enhancements, assist in developing strategies to address barriers and challenges and help with sustainability planning including identification of resources and avenues for program continuation and expansion. They successfully completed their planning phase at the end of January; they had a review and received the green light after some modest revisions to their workplan. Their implementation phase started in February, at which time they conducted the intensive training for care coaches, and they started to see and serve people with dementia.

Dr. Counsell said the timeline outline includes the planning phase August 2020 through January 2021, the implementation phase will be February 2021 through July 2023 in which they will hire care coaches, have the orientation and dementia training, implement the HABC Monitor to be used by the care coaches, identify participants living with dementia and their caregivers. The care coaches will implement CSPB in collaboration with waiver care managers and begin dementia care case conferences with dementia care expert trainers and IU and CICOA expert trainers will conduct DCW dementia training with Triple A project site coordinators and care coaches. At the end of April they developed a care coach dashboard to show their progress and correct their course if needed.

They had a virtual site visit a couple of weeks ago, and it went very well. They had Dr. Boustani provide the history of the research and implementation of the caregiver stress prevention bundle. They shared some of the unique aspects that they had in terms of developing a job description for the care coach, the hiring and training process, the development of REDCap and they had Dr. Ciccarelli and IPMG there to explain the plan around supporting persons with IDD and ADRD. The highlight was a live dementia care case conference where each of the 5 care coaches from the Triple A presented a case. They had great engagement with the area agency executive directors particular around expressing to ACL their commitment to this project including the matching funds and sustainability.

Dr. Counsell said he would take questions. Erin Wright presented a question from chat: Will the care coaches be from the Triple A or the providers?" The care coaches are from the Triple A's; they have been hired by each of the 5 participating area agencies on aging. There was a comment about the slides and Melissa Keyes sent hers out to everyone and Erin volunteered to send his out to everyone.

Dr. Counsell said the update presented is from last September and was commissioned by the Division of Aging about 2 years ago. They presented recommendations to the Division of Aging out of the Advisory Group last fall. The Indiana Dementia Care Initiative goal is to develop and expand dementia capable home and community based services that maximize the ability of people with dementia to remain independent in the community and including supporting their caregivers. The dementia capable home and community system has several components all the way from identifying people to programming, staff skills, workers being trained, public awareness and education, quality assurance and dementia friendly communities. They have a couple dozens of organizations that have been involved in the Dementia Care Advisory Group over the last of years and they've recently added caregiver homes. Kelli

Tungate has joined in the organization, being very involved with waiver participants under the Structured Family Caregiver program.

They kicked off almost 2 years ago and have had many meetings looking at what people are doing currently, and had planned to do, and then reviewed the elements of dementia care capable systems and came up with recommendations that the Advisory Group made to the Division of Aging for going forward. It ended up being very timely, and Alzheimer's Association and others included many of these recommendations around legislative session. They wanted to have the whole aging network, especially the area agencies on aging, to have increasing awareness of dementia and associated caregiver issues so that they could better provide access to information and resources to clients and serve them. They wanted to facilitate person centered planning that took into account people with dementia and their caregiver issues, provide training to direct care workers in assisting folks. In addition, the goal is to collaborate with the Dept. of Health around awareness activities for the public and education around early signs of dementia, and access to additional information. Probably the strongest recommendation was to add a dementia coordinator to the Division of Aging staff to man this full time and to support cross agency efforts and including work together and opportunities with the Dept. of Health to better address this growing challenge.

They did put the session on hold, at least the Advisory Group, while the Division of Aging is considering those recommendations. They were successful in getting the grant through the Administration for Community Living so they are starting to address some of those recommendations and goals under the IU grant. They have also started with the Division of Aging and care managers, and adult protection care workers across the state are engaged with the IU Workforce Enhancement Program. A series of ECHO virtual sessions scheduled that are case-based, with discussions around various topics, including dementia and age friendly health systems, and how to incorporate that into their work. Under the LTSS reform initiatives, they are contracting with Medicare Advantage health plans, especially the dual special needs plan that serve dual eligible seniors. In those contracts they are specifically identifying people on the waiver program and those with dementia who will be referred to and coordinate care with the area agencies on aging. They hosted one lunch and learn with a presenter from the Alzheimer's Association, and he presented around dementia care activities within the Division of Aging and Adult Day Services. Tomorrow they have a lunch and learn to provide more health care perspective around those with dual diagnosis. This presentation from IU Geriatrics will include dementia as a component.

Erin Wright and company have put out guidelines and the area plans are due in early June from the Triple A's, which will outline their work for the next couple of years. Included in the area plans is a priority area of dementia care and/or caregiver support. Finally, the Governor signed into law recently Indiana House 1117, which establishes a state dementia strategic plan, which is an ongoing initiative. He has more details on that the dementia strategic plan which will identify and reduce the prevalence of dementia in Indiana. It has to include proposed state actions, implementation steps and recommendations to carry out the plan and it must follow the processes under HB 1177. The first report is due in about 6 months, and an annual report is due in December to summarize the strategic plan and to report outcomes from the implementation of the plan. That concluded his update on the dementia care initiatives for the state, and on the next steps for this house bill. He is tasked with leading this effort from the Division of Aging, and plans to deploy the Dementia Care Advisory Group that they have had ongoing for the last couple of years, which includes its core planning team. They also plan to align this with their LTSS reform activities. JoAnn said she was going to open it up for questions or comments

for Dr. Counsell. JoAnn thanked Dr. Counsell for reporting on all of the work happening and since we unfortunately do not have a cure for some of these dementias, it's so refreshing to see evidenced based approaches integrated into our policies.

Discussion: JoAnn said she had one more little piece to do before the Division of Aging update. She's giving them an update from the Living Longer Living Better Guide Advisory Committee. They've just created a 2nd advisory committee, they have about 15 partnering agencies working with them on the development of the guide and now the dissemination of it. One of their partners, Qsource, has offered to help them disseminate the guide that is targeted towards helping local communities to take action to appreciate aged and dementia friendly initiatives within the community and encourage the health care systems that are serving those communities to become more aged and dementia friendly. This is a grass roots initiative in conjunction with the state of Indiana. Qsource has made podcasts available to them, and they will put them on their website and anybody can access them. They can use them throughout the state for education, they are proposing eight podcasts, and she is going to ask for approval from the Commission for this. This is all being done right now and she is still contacting people to help with this, the 1st podcast will be an overview of what the guide is all about, what the Commission is hoping to do with it with helping communities to become more age and dementia friendly. On podcast 2, they will offer an opportunity to explain what the area agencies on aging are. She thinks there is some confusion between area agencies on aging and senior centers, and Dan Mustard suggested that senior centers can take the lead in some of the communities and host and coordinate a local care coordination group to initiate aging and dementia friendly initiatives in the communities. As a result, they will have a podcast on senior centers and that work, defining senior centers and the work that they can do to be the lead entity, which will be podcast 4. Podcast 5 will reach out to faith communities and parish nurses. They will work through the parish nurse association to see if some of them can initiate local care coalitions in their communities. They are also reaching out to Indiana Minority Health Coalition, to see if they can work with them and create a podcast for strengthening aged and dementia friendly initiatives in minority communities. She is reaching out to see what they can do just to support what is already going on with other work. Podcast 7 would take a look at aged and dementia friendly initiatives for hospitals and podcast 8 more age and dementia friendly initiatives in nursing homes to work more particular with hospitals and area agencies on aging with care transitions and so forth.

JoAnn said this is in process, and she asked Mitzi from Qsource if she wanted to weigh in on this. Mitzi said JoAnn has been the force behind getting this running, and the purpose of the podcast is to take a little bit of that load off. We really believe in this guide and tool kit and the ability for communities to move them forward in becoming more age friendly dementia friendly communities as a whole. JoAnn has been gracious enough in a couple of the communities that they work in to come up and meet with those communities and review the tool kit and introduce the concepts. Frankly, JoAnn cannot do that in 92 counties, so this offers an opportunity to have this information out there. It is going to be somewhat instructional, how to use the tool kit etc. They really believe in that, and they are looking forward to getting starting on the podcast and having that resource available. JoAnn asked if there were any questions or comments from the Commission. She is going to be reaching out to some of them while she is trying to pull portions of this together, and if anybody has any suggestions to reach out to her she is trying to get the communities energized. She is going to ask for a motion to do the 8 podcasts and disseminate their guide. Judith Schoon made the motion and Jennifer Lantz seconded and approved unanimously by the Commission. JoAnn said she is hoping the second advisory group can work

collaboratively and if they need action on things they can bring it back to the Commission for approval. JoAnn asked for an update from the Division of Aging

Division of Aging Update: Erin Wright said she was going to do the update. She has a couple of Older Americans updates and a couple of funding updates. Dr. Counsell mentioned the area plans in the second part of his presentation, and the area agencies 2022-2023 area plans on aging are due to the Division of Aging early next month. These plans are a requirement for their designation as a Triple A under the Older Americans Act. As they've talked about previously, the Commission has a role in the review of these plans. She is meeting with Dr. Burke next week to talk through the logistics of the Commission's review and feedback and they will plan to dive into the plan at the July meeting. Through the Americans Rescue Plan Indiana received close to twenty-seven million dollars in Older Americans Act Title III, Title 7 Ombudsman funding, this is about the same amount of funding if not slightly more that they typically receive each year for Older Americans Act services. The funding period is over 3-1/2 years so its available through September of 2024 and the award falls under the same guidelines and services as regular Older Americans Act funds. The ACL did highlight vaccine access and social isolation as uses for these new dollars. ACL is really encouraging states to think long term and strategic in regards to these funds as it is an opportunity to better set up for success in meeting the future needs of the older population as the older population continues to grow. They are really sorting through what this will look like in Indiana and they will want to hear from the Triple A's. One particular challenge is this money comes with a required match, which was unexpected. Unlike the other COVID funding that they received, (CARES and Families First) they did not require any state or local match. They are trying to figure out what is feasible at the state level how much they can find for match each year, what the timing has to be, so they're really trying to figure that out before they can distribute the funds to the Triple A's through the funding formula.

Prior to receiving the ARP funding, they received a little under a million dollars in Older American's Act funds for the Triple A's and close to \$600,000 in ADRC funds from the CDC and ACL for vaccine access. The intent of these funds is to support access vaccines in a number of ways outreach, transportation, targeted education, and help with appointment scheduling or reminders. The Triple A's have really been integral to the state's effort to vaccinate the populations they serve; since January the network has made over 55,000 outreach contacts and registered around 4,700 homebound individuals in a Hoosier homebound portal as a connection point to local health departments and EMS to provide in-home vaccinations. They will be distributing the Triple A's vaccine money in the near future as well. Erin said she wanted to also mention it is Older Americans Month, Governor Holcomb issued a proclamation which is available on their website and the theme this year is "Communities of Strength". Erin asked if anyone had any questions. Judith Schoon said one of the things that she does is go out to talk to different partners and see if they can help with our Living Longer/Living Better initiative. One of the organizations that she is working with wanted to know if, under the new law, if they going to be able to meet the deadline for the request for changing from total asset protection to the national partnership plan. And do they feel they will be able to keep all the protections for people who have already brought total asset protections. JoAnn said they have that as the topic for July, to look at some long term insurance, the Indiana Partnership Plan. Could she put that on hold for July; are you all right with that? Judith asked if they know when that has to be totally approved. Erin said she couldn't answer that. JoAnn said in the July meeting they need to review the area plans and they had some things on there for long term care insurance.

Senior Center Coalition Update: Dan Mustard said in the interest of time he will hit a couple of things. They recently sponsored a presentation webinar done by Kathy Brown from the IUPUI School of Philanthropy on funding raising during the pandemic. They got some great information out to some of their members and they did the first of their series of brown bag sessions. This one was concerning a topic that is important to senior centers right now, which is reopening, and vaccines. With so many people vaccinated, are senior centers going to bring back activities and bring people back together in greater numbers? That topic is very important to people right now. As Dr. Burke mentioned, they are participating in the Living Longer Living Better dissemination in the communities where there are community centers who do have the capacity to lead that charge. They are trying to get senior centers involved in that. For them locally in Bartholomew County, one area that they think is easy to bring people together is two areas of mortality that cause concern. They have been tracking reports from their health department for many years now and originally they did that as a way to compare the longevity of people who are members of their center with the life expectancy in Bartholomew County. Two of the numbers that they saw showed some alarming trends. One is that the people over the age of 50 who failed to make it to average life expectancy, and that number keeps increasing. They have seen that number go up from 341 in 2018 to 439 in 2019 and then in 2020 that number was 511. It is an alarming trend, so they want to work with their Healthy Communities Council to figure out if there's a way, as a group, that they can move that number. The other one is the statistical number of people who pass away in clusters during specific times of the year. These "dying seasons" are easily identified and one can clearly see that there are certain months of the year that are much more dangerous for people. This provides an opportunity to partner with local mental health providers and some other community members to come together to see if we can impact that number and reduce the number of people who pass away in November, December, and January.

I-4A Update: Kristen LaEace shared the packet that she sent. There is a lot that has happened both at the state and federal level that is critical in order to understand the context of what is happening in Indiana and nationally. She will run through some Indiana legislative highlights quickly, she won't go through the entire report, but feel free to reach out to her with any questions. Their big victory, thanks to advocacy, is that they made sure CHOICE services and funding were a priority and because of the revenue forecast that came in at the end of April they completely restored the line item to the amount that it had been the last 2 years. They are not sure how this is going to play out in terms of required reversions that the Governor's office places on things, but given the revenue forecast they are hopeful that it won't be at 18% or they'll release some of the money that they've been requiring because of the economy. The green highlighting in the report indicates pieces of legislation that they liked or supported, the yellow highlighting has to do with things with which they are not happy. For instance, they were not happy with the civil immunity related to COVID-19. HB 102 passed, but they think it's a little too broad, it doesn't offer the amount of consumer protection that it needs to offer. On insurance matters, she directed Judith to HB 1405 which is the bill that deals with the requirement that we switch to the federal plan versus the state plan. I4A supports the concept of Telehealth. In general, the state significantly expanded providers who could telehealth. However, it only allows licensed professionals, but it does not necessarily include all the Medicaid care managers for the Medicaid waivers certified by the state. They worked hard on that but they could not get the state and the legislature to budge on that requirement. Another thing she brought to the attention of the Triple A's, especially in their local communities, is the part of the legislation that went through on the budgeting. A \$500 million regional development initiative called READI, is broad and allows organizations and communities to come

together and really put out some creative ideas for the community. She is talking about this because it's a perfect opportunity to find partners in the community that are working on this and talk about the importance of age friend communities, whether it is something specific around aging services or aging housing or services, etc. She's included an article as well as the eligibility guidelines and an FAQ so they can have some background. Erin mentioned the Older American's Act funding that came through the American Rescue plan, and she has the presented the title by title, state by state list. There is \$26 million in Title III funding, and there is an additional Ombudsman grant that brings the state up to \$27 million that Erin talked about. She included information on the purpose of the funding as well as fiscal guideline that they put out and if you have any ideas or thoughts get in contact with Erin as some states have put out RFIs. There is also information on vaccine funding, another part of the American Rescue plan has to do with the amount of match the state gets for Medicaid services. So the state is going to get extra federal money for providing the Medicaid services it already provides but it sounds like it has to talk about they want to use that funding and it has to be used for home and community services. She put the letter to the Medicaid director in there to bring this to their attention and she would be interested to hear what our Medicaid department thinks about this.

Kristen said another big thing is the Biden Administration's infrastructure plan. He is talking about the home health infrastructure and long-term care and they do not know where this is going to go but they need to pay attention to it. If something does happen in congress, it could be big for home and community based services because there is a lot of discussion on whether or not infrastructure includes things like health care or is it just roads and bridges. There are a couple articles in there about that, N4A released its public policy priorities, which she has included for their perusal. She included the Older American's Act funding request that they are putting into appropriations so they can see how much they are asking for and basically they are asking to double a lot of the funding, a copy of presentation the Triple A's made to FSSA and stakeholders regarding what they see as their helpful role in managed long term services and supports they will find out in June what the state's take is on all this is going to be, some best practices included in the packet and an article on the increasing number of older adults getting divorced. She will stop there.

JoAnn asked Megan if there was any comment about her participation in the hill conference. Megan said it was very interesting sitting in on some of them. She did the N4A summit and there was quite a bit of information. One of the things that she noticed from the hill visits is the education. Many people are not aware of some of the things that are offered and available out there. The outreach and education to people who outside of the aging community on what is needed and necessary has been a big deal.

JoAnn said she wants to thank Kristen LaEace and I4A. Here at the local community care coalition level, she has been in contact with their county commissioner and she has a couple of them interested in some of the legislation that is happening at the state and federal level and how it will influence local government. She utilized the material that Kristen gives them to feed them some information and move things along. She is encouraging them also when they do advocacy efforts in their community this is helpful information. With no further business the meeting was adjourned.

Submitted by Willie Poindexter and Dan Mustard