Indiana Division of Aging
Area Plan
Templates and Attachments

2022-2023 Area Plan
Effective October 1, 2021 to
September 30, 2023

The purpose of this section is to outline the format and the templates that the Area Agencies are to submit for Area Plan 2022-2023.

Please reference the Area Plan Required Components Checklist below for a look at how this document is organized. On each of the pages in this document, you will find directions and information for you to input about your agency.

You must use this format and template as your final submission to the Division of Aging in the order of the documents provided.
CICOA Aging & In-Home Solutions

2022-2023 AREA PLAN REQUIRED COMPONENTS CHECKLIST
Please be sure to include this page and each of the required components below.

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Section 1- Narrative

The narrative portion of the Area Plan should be comprised of no more than 15 pages. The narrative should set the stage for your Area Plan and your AAA’s planned efforts on behalf of older individuals and caregivers in your Planning and Service Area (PSA). The narrative should, at a minimum, include the following:

- Your organization’s Mission Statement
- Description of your PSA, including, but not limited to, its physical and demographic characteristics, as well as any unique resources or constraints
- Description of your AAA and its role in providing leadership and developing long term services and supports (LTSS) in your PSA
- Summary of needs assessment activities and findings, including information on unmet needs and service gaps
- Overview of how your AAA conducts the planning process, establishes priorities, and provides opportunities for public involvement and input
- Overview of quality management activities related to both service management (including in-home service care plans per CHOICE guidelines) and provider management. Please do not attach any specific policies, procedures, or tools. These items should be available for review at the DA’s request.

Your narrative should serve as a rationale for your planned efforts and align with your proposed goals, objectives, and activities.

Section 1- Narrative

Mission Statement

CICOA empowers older adults, those of any age with a disability, and their caregivers by providing the innovative answers, services, and support they need to achieve the greatest possible independence, dignity, and quality of life.

Description of the PSA

CICOA Aging & In-Home Solutions serves the Central Indiana counties of Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby. These same eight counties were recently analyzed as part of the State of Aging in Central Indiana Report, of which CICOA was a key contributor. The report, led by The Polis Center at IUPUI, ‘was developed to act as the premiere source of data related to growing older in Central Indiana. The report, along with the accompanying interactive online portal and issue briefs, is intended to function as a tool to inform policy on state and local levels, influence the distribution of funds addressing older adult needs, and guide organizations as they work with older adults in their communities’. The report uses qualitative and quantitative data and analysis to understand the characteristics of and issues facing
older adults in Central Indiana.

Key findings of the report (centralindiana.stateofaging.org) released April 2021 include:

• 481,000 older adults in Central Indiana, representing 25% of the population.
  Boone County: 25.8%
  Hamilton County: 23.4%
  Hancock County: 29.3%
  Hendricks County: 25.7%
  Johnson County: 26.5%
  Marion County: 24.2%
  Morgan County: 31.2%
  Shelby County: 31.4%

• Older adults (age 55 and up) are the fastest growing demographic in Central Indiana. Approximately 20,000 individuals in Central Indiana reach the age of 60 every year. By 2030, one in every five residents will be over the age of 65.

• The number of older adults aged 55 and older increased by 105,000 since 2012, a 28% increase compared to a 5% increase of those 55 and under in the same period.

• The older adult population in Central Indiana is increasing at six times the rate of the younger population.

• Of the Central Indiana older adult population, 82,000 people are of color with 58,800 being African American.

• Four in ten older adults live alone.

• While health care is generally accessible in Central Indiana, the rural areas struggle from a lack of providers with a geriatric specialty. Four in five older adults provide care for another person; two in five do so for another adult age 60 and older. One quarter of those who care for others report being burdened by those responsibilities.

• Older adults in Central Indiana reported that their communities are good places to grow older. However, some older adults reported facing challenges related to remaining in their own homes, and providers reported facing difficulties accessing some older adults who need assistance.

• Healthcare and housing are the costliest expenses of older adults in Central Indiana. One in three older adults reported recently experiencing at least some difficulty affording daily expenses or finding affordable health insurance.

• One in five older adult homeowners spends at least 30% of their income on housing costs.
• Three in five older adults report difficulty maintaining their homes, both inside and out.

• Only one in four older adults in Central Indiana positively rates the ease with which they can use public transportation in their communities.

• In Indianapolis, one in three older adults lives in neighborhoods with minimal or no public transportation service.

• Two-thirds of older adults report not knowing about necessary services to assist them with remaining in their homes and communities as they age.

• About one in three older adults in Central Indiana reports feelings of loneliness or social isolation, and this is likely more prevalent among older adults experiencing poverty.

• In Indiana, disability is one of the biggest contributors to isolation in older adults.

• Alzheimer’s disease has become the third leading cause of death of those 85 years and older.

• Compared to older women, older men are disproportionately affected by deaths from falls and suicide. Black older adults are disproportionately affected by deaths from drug overdose including those due to opioids, compared to White older adults.

• Older adults in Central Indiana feel health care is broadly available, but one in four has trouble affording or obtaining the health care they need.

• Providers identify falls and the fear of falling, mental health and emotional issues, dementia and fragmented care as issues that need more resources and attention.

• Rural areas lack specialized geriatric healthcare services.

• Recipients of home- and community-based services report positive outcomes for hospital discharges and chronic conditions, but some who could benefit are unaware of or ineligible for those services.

• Low-income and other vulnerable Medicare recipients in Central Indiana visit hospitals and emergency rooms more frequently than other Medicare recipients.

• One in four older adults in Central Indiana is physically, emotionally or financially burdened by caregiving responsibilities, and most adults do not believe support services are available for caregivers.

• Median income of older adults is $54,067, with a poverty rate of 4.2%

• The poverty rate is three times higher among older adults of color.
Although Central Indiana residents are generally younger and wealthier than the state average, resources are not distributed evenly across communities. Despite overall growth in population, portions of the region are rural and experiencing population decline. There are gaps in services, notably for resources such as transportation and affordable housing. In both urban and rural settings, a number of communities are identified as food deserts and many low-income people lack access to healthcare services.

Description of CICOA

CICOA Aging & In-Home Solutions is the Area Agency on Aging and Aging & Disability Resource Center for the eight counties in Central Indiana. CICOA is a not-for-profit agency that has been helping seniors and people of any age with a disability remain comfortably and safely at home and in community settings since 1974. This is achieved by providing information, advocacy and support services to older adults, persons of any age with a disability and their caregivers in CICOA’s service area. CICOA also addresses the needs of individuals who qualify for services under the Medicaid Aged & Disabled (A&D) and Traumatic Brain Injury (TBI) Waivers, Indiana's CHOICE program, and accredited case management services for children and adults with intellectual/developmental disabilities through the Community Integration and Habilitation (CIH) Waiver and Family Supports Waiver (FSW).

We are the unbiased experts who provide the innovative answers, services and supports needed to help older adults and disabled individuals at risk of institutional placement remain at home, in better health, with better care, at a lower cost. Our core values include:

INDEPENDENCE: CICOA supports the exercise of individual initiative to make choices and to enjoy life without unnecessary restrictions.

DIGNITY: CICOA respects the rights of others, is sensitive to differences and affirms the dignity of all people.

QUALITY OF LIFE: CICOA strives to enhance people’s lives through the promotion of good physical, social, emotional and mental health and participation in the whole community.

IMPARTIALITY: CICOA provides equality of opportunity and treats all individuals in a fair manner, without prejudice and free from all special interests.

COLLABORATION: CICOA believes that partnering with other organizations creates greater opportunity for accomplishment of its mission than by working alone.

EXCEPTIONAL SERVICE: CICOA seeks to exceed its clients’ and stakeholders’ expectations with the highest quality programs, outreach, activities and communications.
CICOA’s vision is for a central Indiana community where older adults and those of any age with a disability can flourish. CICOA and its network of service providers are focused on the importance of social determinants of health and the impact of social supports on the Triple Aim in healthcare. The Triple Aim consists of better population health, improved quality of care, and lower costs of care.

CICOA’S Role In Providing Leadership In Our PSA

CICOA provides leadership in addressing the needs of older adults, persons of any age with a disability and caregiver supports. This includes promoting excellence in program qualities and designs, raising awareness, advocacy and policy, development and promotion of community collaborations and partnerships, and innovation in service delivery. CICOA’s role in options counseling, care transitions and care management provides opportunities to bring together consumers, service providers and healthcare professionals in identifying current and emerging needs. We are also proud to be recognized as innovative leaders throughout the country on various programs and services including healthcare collaborations, dementia friendly state initiatives, and our award-winning caregiver video series.

Examples of CICOA’s leadership role include:

• Establishing the CICOA Envision Lecture Series in 2019 as a platform to bring the foremost issues that impact seniors, people with disabilities, and our communities, beginning.

• NCQA accreditation renewal is in process for LTSS care management services as of June 2021.

• CICOA staff members serve on a variety of community collaborative organizations, including but not limited to, the Indy Hunger Network, the Indiana Dementia Care Advisory Group (DCAG), the Coalition of Human Services Planners, the Indiana Falls Prevention Coalition, the Mental Health and Aging Coalition, Reaching Resources, and Elders at the Table.

• Partnering with healthcare and higher education to promote geriatric career opportunities for healthcare professionals, including serving as a residency location for occupational therapy doctoral students through Indiana University School of Rehabilitation Sciences, participation in the Geriatric Workforce Enhancement Program (GWEP) with IU School of Medicine, and numerous partnership collaborations with University of Indianapolis, among others.

• Research collaboration and project participation with medical, research, and academic institutions (Regenstrief Institute, IU Center for Aging Research, Indiana University School of Medicine, St. Vincent Health primary care residency program, Stanford University School of Medicine, among
others).

- Leveraging CICOA’s Medical Advisory Council comprised of leading central Indiana advanced medical professionals to raise awareness of home and community-based long-term services and supports, improve coordination and communication between healthcare and HCBS LTSS providers, and implement and optimize new and innovative service delivery care models.

- Participation in multiple formal and informal partnerships with area hospitals and health systems that embed CICOA care management and options counseling staff in multi-disciplinary teams to facilitate effective care transitions and access to community supports. Examples include:

  IU Health (1 contract, multiple partnership collaborations)
  Oak Street Health (1 contract, multiple partnership collaborations)
  Eskenazi Health (2 contracts)
  Rehabilitation Hospital of Indiana
  Meridian Medical Services
  INHouse Primary Care
  Witham Health Services
  Hancock Regional Health
  Indianapolis VA Health and Hospital System

- Integration of internal and external data sources, including Indiana Health Information Exchange (IHIE), into a data lake to enhance CICOA’s data capabilities. This enhancement increases direct access to health information to provide better care to clients and address social determinants of health.

- Core contributor to the recently developed ‘Living Longer, Living Better’ program.

- State administrator for Dementia Friends Indiana to promote dementia awareness, stigma reduction, and accommodation of persons with dementia in the community.

  8,000 Dementia Friends as of May 2021
  Numerous large-scale partnerships across the state, including Indiana Dept. of Homeland Security and FSSA/Division of Aging
  Recognized as one of best Dementia Friends programs in the United States
  Steering Committee for Dementia Care Advisory Group

- Formal partnership with Purdue University to establish accredited community health worker program to meet the needs of current and future workforce demand and service delivery designs.

- Launched the CICOA Venture Studio, a model for intrapreneurship and corporate innovation. The Studio walks alongside staff to ideate, prototype, and launch new solutions.

- Launched Duett, a technology start-up for care management organizations and providers. Duett is
designed to match people who need in-home care with providers who offer the services.

CICOA's Role in Developing LTSS in our PSA

CICOA is always looking to improve current long-term services and supports (LTSS) while exploring opportunities for delivering and/or coordinating new LTSS. These examples include:

• Developing care transitions partnerships and educational opportunities with the Central Indiana clinical community to provide earlier intervention and access to CICOA services and supports.

• Recruiting additional service providers for HCBS in Central Indiana, with an emphasis on increasing the number of providers in the “donut” counties around Indianapolis.

• Participating in multiple community efforts to promote awareness of HCBS needs and resources for individuals.

• Developing additional resources for senior transit and paratransit services and increasing the number of vendors participating in paratransit services for persons with disabilities (My Freedom).

• Continuing development of caregiver-related education and support services, including developing a caregiver video series in Spanish, new and improving dementia education and support services through Dementia Friends Indiana, and implementation of the TCARE program for caregivers in 2020.

• Recruiting additional providers for home modifications.

According to the latest 2020 CHOICE annual report, the average cost per month of an A&D Waiver care plan is $1,581 or $18,972 annually. The average cost per month of a nursing home stay is $4,761 a month, or $57,132 annually. The average CICOA care managed client, who has a level of care eligible for nursing home placement, remains at home and in their community for an average of a little more than 3 years. Based on these figures, the cost savings through CICOA’s interventions over a 3-year period equates to roughly $111,480 per client.

Given Indiana’s continued ranking in the bottom quartile for home and based community services, combined with the rapidly growing demographic population of older adults in Central Indiana, this data supports the continued and enhanced need for investment in HCBS/LTSS. These investments support efforts to keep vulnerable older adults and people with disabilities in the least restrictive community settings and provide social supports that help promote better health, better quality care and reduce the overall costs of service delivery. This strategy, to promote HCBS options and address the quality of long-term care in all settings is consistent with the Triple Aim in healthcare.

There is a time and place for care in a skilled nursing facility but providing individuals the option
of remaining in their community for as long as possible is beneficial for the individual and helps reduce the overall costs of care.

Summary of Needs Assessments and Findings

CICOA and the other Area Agencies on Aging participated in the Community Assessment Survey of Older Adults (CASOA) in 2017. CASOA provides a statistically valid survey of the strengths and needs of older adults (age 60 and over) as reported by older adults themselves in CICOA’s 8-county service area. The report is based around 6 community dimensions:

1. Overall Community Quality
2. Community and Belonging
3. Community Information
4. Productive Activities
5. Health and Wellness
6. Community Design and Land Use

Overall Community Quality
Overall Community Quality explores how older residents view the community overall, how connected they feel to the community and how well they can access information and services offered by CICOA, as well as how likely residents are to recommend and remain in the community.

Most of CICOA’s older residents gave high ratings to the community as a place to live.

• About three-quarters of older adults would recommend CICOA to others.

• Just over half of respondents had lived in their community for more than 20 years and 85% planned to stay in the CICOA service area throughout their retirement.

• When compared to other communities across the nation, CICOA older residents had similar ratings for the Overall Community.

Community and Belonging
A “community” is often greater than the sum of its parts and having a sense of community entails not only a sense of membership and belonging, but also feelings of emotional and physical safety, trust in the other members of the community and a shared history. Older residents rated several aspects of Community and Belonging, including their sense of community and overall feelings of safety, as well as the extent to which they felt accepted and valued by others.

• Almost two-thirds of respondents reported “excellent” or “good” overall feelings of safety and between 6% and 23% had experienced safety problems related to being a victim of crime, abuse or discrimination.

• About 5 in 10 older residents rated the sense of community as “excellent” or “good”; similar
ratings were provided for CICOA’s neighborliness and valuing of older residents.

• When compared to other communities in the U.S., older residents in CICOA’s service area generally provided similar ratings for aspects of Community and Belonging.

Community Information
The education of a large community of older adults is not simple, but when more residents are made aware of attractive, useful and well-designed programs, more residents will benefit from becoming participants.

• About 5 in 10 survey respondents reported being “somewhat” or “very” informed about services and activities available to older adults, which was lower than reports from other communities in the U.S.

• About one-third of older adults felt they had “excellent” or “good” information about resources for older adults and 43% had “excellent” or “good” information about financial or legal planning services.

• About two-thirds of respondents had problems with not knowing what services were available and 56% had concerns with feeling like their voice was heard in the community.

• About one-third reported having problems with finding meaningful volunteer work, a rate that was similar to other communities.

Productive Activities
Productive activities such as traditional and non-traditional forms of work and maintenance of social ties combine with health and personal characteristics to promote quality of life in later life and contribute to active aging. Productive Activities examined the extent of older adults’ engagement participation in social and leisure programs and their time spent attending or viewing civic meetings, volunteering or providing help to others.

• About 8 in 10 elders felt they had “excellent” or “good” volunteer opportunities, but only about one-third participated in some kind of volunteer work, a volunteer rate lower than other communities in the U.S.

• About 14% of respondents had used a senior center in the community, which was similar to senior center use in other communities.

• About 5 in 10 seniors said that they had at least “minor” problems having interesting social events or activities to attend.

• The majority of older residents (65%) rated the recreation opportunities in the region as “excellent” or “good”; use of parks, libraries and recreation centers tended to be lower in Central Indiana than in other communities.
• Over half of older residents in CICOA said they were caregivers; respondents averaged between 9 and 11 hours per week providing care for children, adults and older adults.

• About one in four older adults in CICOA felt physically, emotionally or financially burdened by their caregiving.

• Only 63% of respondents were fully retired, and 36% of respondents experienced at least minor problems with having enough money to meet daily expenses.

• The value of paid (part- and full-time work) and unpaid (volunteering, providing care) contributions by older adults in Central Indiana totaled about $4.9 billion in a 12-month period.

Health and Wellness
Of all the attributes of aging, health poses the greatest risk and the biggest opportunity for communities to ensure the independence and contributions of their aging populations. Health and wellness, for the purposes of this study, included not only physical and mental health, but issues of independent living and health care.

Overall, the older adults in CICOA had similar ratings for aspects of physical health compared with other communities in the U.S. including ratings of fitness opportunities, physical health care and their own overall physical health.

• The portions of older residents reporting problems with doing heavy or intense housework (61%) and maintaining their yards (50%) was similar to elsewhere in the country while participating in moderate or vigorous physical activity (31%) was lower.

• About 4 in 10 older residents felt there was “excellent” or “good” availability of mental health care in Central Indiana while 8 in 10 rated their overall mental health/emotional wellbeing as “excellent” or “good.”

• The most cited mental health issues included feeling bored (48%), feeling depressed (42%) or dealing with a loss (41%). Fewer cited issues included figuring out which medications to take and when (10%) and having friends or family to rely on (29%); these mental health problems experienced by older adults tended to be like problems experienced by older adults in other communities.

• The availability of preventive health services was rated like the national average.

• About half of older adults reported at least minor problems with having adequate information or dealing with public programs such as Social Security, Medicare, and Medicaid.

• Close to one-quarter of respondents reported spending time in a hospital, and one-third had fallen and injured themselves in the 12 months prior to the survey. Falls and hospitalizations occurred at
similar rates in Central Indiana as in other communities.

• Many older adults reported at least minor problems with aspects of independent living, including 38% who reported having problems with performing regular activities, including walking, eating and preparing meals and 18% being no longer able to drive.

Community Design and Land Use
The movement in America towards designing more “livable” communities – those with mixed-use neighborhoods, higher-density development, increased connections, shared community spaces and more human-scale design – will become a necessity for communities to age successfully. Communities that have planned for older adults tend to emphasize access – a community design that facilitates movement and participation.

• Respondents rated the ease of getting to the places they usually must visit and ease of car travel positively with about 7 in 10 rating each as “excellent” or “good.”

• About 5 in 10 respondents felt they had “excellent” or “good” availability of affordable quality housing and variety of housing options.

• Some older adults experienced problems with having safe and affordable transportation available (26%) while others experienced problems with having housing to suit their needs (20%) or having enough food to eat (15%). Daily living problems tended to be like other communities across the nation.

• Over three-quarters of older residents rated their overall quality of life as “excellent” or “good”, which was similar to other communities in the U.S.

Additionally, feedback from CICOA grant partners during site visits in every county collectively identified these areas as being the biggest area of need and/or greatest demand:

• Affordable/accessible housing
• Transportation
• Caregiver respite and support services
• Senior hunger
• Access to healthcare

Overview of CICOA Planning Process, Priority Establishment, and Opportunities for Public Involvement and Input

CICOA continuously engages with the community in various ways to determine the needs, challenges and availability of resources for older adults, persons with disabilities and their caregivers.
Examples of participation and leadership in community coalitions, councils, and advisory boards include:

- City of Fishers age friendly and disability committees
- Shepherd’s Center of Hamilton County Reaching Resources
- Coalition for Human Services Planners
- Hamilton County Advisory Committee on Older Adult Mental Health
- University of Indianapolis Public Health Advisory Board
- Central Indiana State of Aging Research Report Advisory Committee
- Indy Hunger Network *(Tahric Brown, CICOA CEO, is Vice Chair)*

Examples of input from community partners and constituents include:

- Feedback from sub-grantee partner agencies at quarterly meetings
- Reports and findings from sub-grantee site visits
- Quarterly updates representing every CICOA county at Advisory Council meetings

Additional Narrative on Social Determinants of Health and Dementia

CICOA recognizes social determinants of health (SDOH) and dementia as Area Agency on Aging priorities. Both elements will affect all of healthcare for the foreseeable future. This includes how the landscape of healthcare evolves, how delivery of care practices is influenced, and how future reimbursement models are structured. CICOA will have a proactive and influential role in both these areas.

SDOH are not new concepts, but the concepts are receiving greater attention from advanced clinical providers and health systems. Eighty percent of health outcomes are driven by SDOH. The SDOH concepts will influence how healthcare is delivered and outcomes are achieved with the most complex, expensive, and vulnerable patient populations. CICOA’s clinical engagement program, established in early 2017, along with leadership from CICOA’s Medical Advisory Council (MAC), will continue to work in this realm and establish priorities with health systems to strengthen partnership opportunities, improve care delivery, and promote best practices.

Dementia is a priority area that CICOA has committed to address through the Dementia Friends Indiana (DFI) movement. DFI is a grassroots, community-driven movement that aims to better educate people about dementia, reduce the associated stigma, and take action to create more welcoming and conducive dementia friendly environments in our communities. DFI is administered in the state of Indiana by CICOA, and we have already seen the impact of this movement in a short amount of time. CICOA is committed to this movement and ensuring that Indiana is seen as dementia friendly, changing how the condition is perceived and understood in all
Hoosier communities. CICOA will continue to allocate our resources to this valuable initiative for the greater good of our communities and state. An investment in additional resources, particularly Title III dollars from the Older Americans Act, will be essential in this space for many years to come.

Additional Narrative on CICOA Service Activity and Community Impact

Following is a snapshot of programs, services and supports provided in our PSA. All figures are from the fiscal year ending June 30, 2020.

ADRC
# of website referrals: 7,117
# of MAW referrals: 4,369
# of CHOICE referrals: 247

OPTIONS COUNSELING
# of initial assessments: 4,097
# of client Medicaid Applications completed: 710
# of PAS clients assessed: 43

NUTRITION
Home delivered meals: 403,902
Neighborhood meals: 95,803
Meal vouchers redeemed: 31,703
Unduplicated meal clients: 1,784

IN-HOME SERVICES
Unduplicated clients served: 10,257
MAW clients: 7,665
CHOICE clients: 572
SSBG/Title III clients: 2,050

AWARENESS
County level awareness messages: 30
Media stories/press releases: 36
Health fairs attended: 205
Workplace presentations: 69

HOME MODIFICATIONS 47
Section 2 - Governing Board

Provide a listing of the AAA Board of Directors members, as well as annual board meeting schedule information.

Total Number of Board Members: 10

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<th>Title</th>
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<td>Peter Bisbecos</td>
<td>Board Chair</td>
<td>Hamilton</td>
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<tr>
<td>Mike Brower</td>
<td>2nd Vice Chair, Treasurer</td>
<td>Marion</td>
<td>08/2020-06/2022</td>
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<td>Sonja Buckner-Marion</td>
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<td>08/2020-06/2023</td>
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<tr>
<td>Anne De Prez</td>
<td>Immediate Past Chair</td>
<td>Hamilton</td>
<td>08/2020-06/2022</td>
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<td>Rev. Dr. Reginald Fletcher</td>
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<td>Marion</td>
<td>08/2018-06/2021</td>
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<td>Kathy Frank</td>
<td>1st Vice Chair</td>
<td>Johnson</td>
<td>08/2020-06/2022</td>
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<td>June Holt</td>
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<td>Tony Lloyd</td>
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<td>Brianna Saunders</td>
<td>Secretary</td>
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<tr>
<td>Michael Simmons</td>
<td>Click here to enter text.</td>
<td>Hendricks</td>
<td>08/2020-06/2023</td>
</tr>
</tbody>
</table>

Annual Board Meeting Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Location/Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 24, October 26, December 7, 2021</td>
<td>Bi-monthly meeting via Zoom and/or at 8440 Woodfield Crossing Blvd., Indianapolis IN 46240</td>
</tr>
<tr>
<td>February 22, April 26, 2022</td>
<td>Bi-monthly meeting via Zoom and/or at 8440 Woodfield Crossing Blvd., Indianapolis IN 46240</td>
</tr>
<tr>
<td>June 23, 2022 (TBD)</td>
<td>Annual meeting, TBD</td>
</tr>
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</tbody>
</table>

Explain any expiring terms – have they been replaced, renewed, or other?

The two expiring terms are filled; one member will renew and one will be replaced.
Section 3 - Advisory Council

Provide the following details regarding AAA Advisory Council members.

Total number of Advisory Board members (including vacancies) = 11 (5 vacancies)

<table>
<thead>
<tr>
<th>N/A</th>
<th>Information</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of members over 60 years of age</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Total number of family caregivers</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Total number of Title III recipients</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total number of elected public officials (or their designee)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total number of health care provider representatives</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Total number of Veteran health care providers (separate from above)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total number of nutrition project representatives</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total number of supportive service representatives</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total number of persons with leadership experience in private or volunteer sector</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Total number of older adults that reside in rural areas</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Total number of persons who are members of a minority race; include percentage of minority older adults in the PSA</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Percentage of minority older adults on advisory council (vs. total advisory council members)</td>
<td>36%</td>
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<tr>
<td></td>
<td>Total percentage of all older adults in the PSA</td>
<td>25%</td>
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<tr>
<td></td>
<td>Frequency of Advisory Council meetings</td>
<td>Quarterly</td>
</tr>
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</table>

Briefly describe the local governing board’s process to appoint Advisory Council members:

Application process and review by nominating committee to fill desired experiential gaps.

Recruitment efforts targeted to area service organizations, providers, consumers, and healthcare organizations, with a view toward diverse and inclusive representation, including representation of at least one member from each county in the service area.
## Section 4 - Target Population Specifications

Provide detail that a deliberate effort is directed toward the following AAA target populations, with supporting population information.

<table>
<thead>
<tr>
<th>Target Populations</th>
<th>Effort Description</th>
</tr>
</thead>
</table>
| Adults 60 years old or older with the greatest economic and social need | (1) CICOA is able to identify low-income older adults through collaborative efforts in the community.  
(2) Over one half of Neighborhood Meal Sites are located in Marion County Neighborhoods where seniors with the greatest social and economic needs reside.  
(3) CICOA contracts and partners with multiple health and hospital systems in Central Indiana. These healthcare partnership models allow for clinical professionals to better identify and connect the most vulnerable, older adult patient populations in the greatest need of CICOA intervention and support. These partnership models also aid in streamlining the referred patients to CICOA, resulting in faster connections to the home and community based services they need.  
(4) CICOA uses radio, television, media, and speaking engagements to promote its services.  
(5) CICOA’s Older Americans Act contracting with 17 senior and human service organizations requires them to demonstrate outreach to those with greatest economic and social need, age 60 or older.  
(6) CICOA has committed to outreach to faith based communities in which the 60 years and older population with greatest economic and social need is often identified. |
| Older minority and low-income minority individuals      | (1) All outreach efforts listed above to adults age 60 or older with the greatest economic and social need apply to the outreach to older minority and low-income minority individuals.  
(2) CICOA locates nutrition sites in the neighborhoods where low-income and older minority seniors reside.  
(3) CICOA partners with area community clinics in low-income and older-minority areas to provide outreach.                                                                                                                                                                                                 |
| Older individuals living in rural areas                 | (1) CICOA partners with senior services agencies in rural and less populated areas of every county to provide outreach, awareness, and education.  
(2) CICOA partners with hospital systems in rural and less populated areas of every county to provide outreach, awareness, and education.                                                                                                                                                                                                 |
| Older individuals who are Native American | 2010 Census Data indicates that only 0.26% of older adults living in the CICOA area of all ages identify themselves as Native American. This number totals only 690 individuals age 60 or older. CICOA will continue to strive to reach this population through collaborative efforts with partnering organizations and through outreach events held in the community. |
| Older individuals with limited English proficiency | (1) CICOA uses translations service for callers of almost any language to the ADRC.  
(3) CICOA seeks to hire individuals in its ADRC who have proficiency in other languages besides English.  
(4) CICOA has translated its brochures into Spanish, which is the most common language other than English in CICOA’s service area. |
| Older individuals with severe disabilities | All CICOA outreach and engagement efforts inherently target those with severe disabilities. |
| Older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction | 1) CICOA is increasing its emphasis on dementia education and support for those suffering with the disease and their caregivers by growing CICOA’s Care Aware program services.  
(2) CICOA supports the local chapter of the Alzheimer’s Association with Title III-E funds for their caregiver education and support programs.  
(3) CICOA has significantly invested in the Dementia Friends Indiana (DFI) movement as the state administrator. DFI's impact on the Central Indiana community has been substantial with its successes of advancing better understanding of the disease, reducing its stigma, and creating more welcoming and conducive community environments for those living with the condition and their caregivers. DFI puts an emphasis on the caregiver and draws awareness of the numerous challenges and health consequences of the caregiver role.  
(4) CICOA collaborates with health systems focusing on treating Alzheimer’s and other dementias, such as IU Health’s Alzheimer’s disease Research Center.  
(5) Beginning 2021, CICOA began implementing a dementia Care Coach as part of a grant pilot led by IU School of Medicine. The purpose of the Care Coach is providing additional education, support, and resource intervention targeting caregivers of those living with dementia. This enhanced level of intervention is an effort
| **Older individuals at risk for institutional placement, specifically including survivors of the Holocaust** | to minimize the inherit challenges associated with the condition, such as caregiver stress and burden, and maximize independence and health outcomes. |
| **Caregivers of adults 60 years old or older with the greatest economic and social need** | Meal choice is being expanded starting 7/1/21 to include Kosher meals. |
| (1) CICOA is able to identify low-income and social need older adult caregivers through collaborative outreach efforts in the community.  
(2) CICOA's CareAware program specifically focuses on caregiver outreach.  
(3) CICOA's partners, particularly CICOA's subgrantees, identify and refer caregivers to CICOA for support, planning, and intervention. |
| **Caregivers of older minority and low-income minority individuals** | (1) All outreach efforts to adults age 60 or older with the greatest economic and social need that have already been described apply to the outreach to older minority and low-income minority individuals.  
(2) CICOA locates nutrition sites in the neighborhoods where low-income and older minority seniors reside.  
(3) CICOA partners with area community clinics in low-income and older-minority areas to provide outreach. |
| **Caregivers of older individuals living in rural areas** | (1) CICOA partners with senior services agencies in rural and less populated areas of every county to provide outreach, awareness, and education to caregivers of older individuals.  
(2) CICOA partners with hospital systems in rural and less populated areas of every county to provide outreach, awareness, and education. |
| **Caregivers of older individuals who are Native American** | 2010 Census Data indicates that only 0.26% of older adults living in the CICOA area of all ages identify themselves as Native American. This number totals only 690 individuals age 60 or older. CICOA will continue to strive to reach this population through collaborative efforts with partnering organizations and through outreach events held in the community. |
| **Caregivers of older individuals with limited English proficiency** | (1) CICOA uses translations service for callers of almost any language to the ADRC.  
(3) CICOA seeks to hire individuals in its ADRC who have proficiency in other languages besides English.  
(4) CICOA has translated its brochures into Spanish, which is the most common language other than English in |
<table>
<thead>
<tr>
<th>Caregivers of older individuals with severe disabilities</th>
<th>CICOA’s service area.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers of older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction</td>
<td>All CICOA outreach and engagement efforts inherently target caregivers of those with severe disabilities.</td>
</tr>
</tbody>
</table>
| Caregivers of older individuals at risk for institutional placement, specifically including survivors of the Holocaust | (1) CICOA is increasing its emphasis on dementia education and support for those suffering with the disease and their caregivers by growing CICOA’s Care Aware program services.  
(2) CICOA supports the local chapter of the Alzheimer’s Association with Title III-E funds for their caregiver education and support programs.  
(3) CICOA has significantly invested in the Dementia Friends Indiana (DFI) movement as the state administrator. DFI's impact on the Central Indiana community has been substantial with its successes of advancing better understanding of the disease, reducing its stigma, and creating more welcoming and conducive community environments for those living with the condition and their caregivers. DFI puts an emphasis on the caregiver and draws awareness of the numerous challenges and health consequences of the caregiver role.  
(4) CICOA collaborates with health systems focusing on treating Alzheimer’s and other dementias, such as IU Health’s Alzheimer’s disease Research Center.  
(5) Beginning 2021, CICOA began implementing a dementia Care Coach as part of a grant pilot led by IU School of Medicine. The purpose of the Care Coach is providing additional education, support, and resource intervention targeting caregivers of those living with dementia. This enhanced level of intervention is an effort to minimize the inherit challenges associated with the condition, such as caregiver stress and burden, and maximize independence and health outcomes. |
| Older relative caregivers (age 55+) of children under 18 or adults age 18-59 with a disability | CICOA and our subgrantee partners provide caregiver education and support to older relatives age 55 or older through our Care Aware Program. |
|                                                        | (1) CICOA provides caregiver education and support to older relatives age 55 or older through our Care Aware Program.  
(2) CICOA partners with and provides grant support to The Villages of Indiana for their kinship care program to |
|provide support, counseling, and other resources for grandparents age 55 or older caring for grandchildren.|
Section 5 – AAA Service Overview

Please provide a description of the programs and services provided by your Area Agency on Aging, either directly or through grants/contracts to local service providers. Some services are already listed, but please add any additional services and programs that you provide. Please also attach a list of your congregate nutrition site listings. Please label as “22-23 AP AAA# – Attachment B – Congregate Nutrition Site Listings” when submitting.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description/Overview</th>
<th>Estimated Number of Requests/Inquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging and Disability Resource Center (including, but not limited to</td>
<td>The Aging and Disability Resource Center (ADRC) provides options counseling and information and referrals about services for long-term care needs. Based on the needs of our elderly and disabled clients we provide comprehensive information on options, services providers, and provide both informal and formal resources within the community of Marion county and the seven surrounding counties. Staff conduct phone assessments for referrals (i.e. home delivered meals, Traumatic Brain Injury, Medicaid Waiver, Choice) and determine the appropriate funding source. The ADRC also assist with State Health Insurance Assistance Programs (SHIP) counseling. This program speaks to Medicare, Medicaid, Medicare Supplement Insurance, Managed Care plans, prescription coverage and long-term financing options. The ADRC also provides community outreach, conducting options counseling out in the community at our local senior centers, faith-based centers, businesses, health fairs, and local community centers.</td>
<td>Estimated number or requests/inquires July 2019-June 2020: 83,011 calls 14,755 individual contacts for options counseling 17,400 community resource referrals 5,468 MAW/CH/HDM referrals</td>
</tr>
<tr>
<td>related to Information &amp; Assistance, Options Counseling, and Outreach)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management</td>
<td>FLOURISH - Care management is a comprehensive service comprised of specific task and activities designed to coordinate and integrate all other</td>
<td>Total Client count for below funding = 12.256 # of confirmed MAW</td>
</tr>
<tr>
<td>Services required in the participant's service/care plan. The care manager is responsible for making efficient and effective use of services to extend independent or semi-independent living and to authorize and provide accountability for dollars spent from public and local monies. The client population served by care management is a high-risk group, functionally impaired and often unable to advocate, coordinate or pay for in-home services for themselves. Components of care management include:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| - Person Centered Assessment of individuals to determine eligibility for services, functional impairment levels, and corresponding in-home and community services need by the individual. Initial level of care (LOC) assessment, biannual LOC assessment and ongoing reassessment of LOC, if needs change during the course of the service/care plan year. Monthly monitoring and 90 day visits to reassess of individuals needs utilizing the person centered monitoring tool.  
- Development of person-centered service/care plans, including coordination of formal and informal supports.  
- Periodic updates or enhancements of service plans/care plans in response to changes in functional needs or a decline in health. The care manager explores with the clients identified goals to work on through the service plan year and works to eliminate or decrease barriers if possible and if not, the individual and care manager may adjust the goals if mutually agreed upon to do so.  
- Assessment and care planning for discharge from institutionalization, from July 1, 2020 - April 30 = 9180 Pending MAW (yet to be confirmed = 811 CHOICE =444 SSBG = 7 Title III = 1814 (primarily managed by Meals & More Dept rather than Flourish) Terminated clients all funding due to death = 925 Terminated client for reasons other than death = 274 100% of participants with person centered goals A monthly average this past year of new clients is estimated at 250 a month. (data cited from referrals sent to Flourish from Options Counseling Dept) A monthly average of terminated clients (due to death or other reasons this past year is around 200 a month. (Data cited from outputs dashboard) |
including hospital rehabilitation facilities or long-term care settings
- Monitor the quality of home care community services and assist with identifying new service providers if current provider is not meeting the clients’ health and safety needs in the home
- Determine and examine the cost effectiveness of providing home and community based services (HCBS) to ensure the most appropriate use of funding
- Provide information on and referrals to needed community services as a supplemental part of the client's service/care plan
- Process the termination of services in the event of death, out of state move, or change in needs which require a different setting
- Funding is from the Medicaid Waiver program for Aged/Disabled (AD MAW) and Traumatic Brain Injury (TBI MAW) CHOICE SSBG
- Title III Client Assistance (supported by CICOA Foundation funds)

<table>
<thead>
<tr>
<th>In-Home Services</th>
<th>FLOURISH - refer to above care management description</th>
<th>Click here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Delivered Nutrition</td>
<td>CICOA delivers freshly prepared, frozen, wholesome meals every two weeks to residents of Marion and the surrounding counties, Monday-Friday.</td>
<td>Home delivered meals: 403,902</td>
</tr>
<tr>
<td></td>
<td>CICOA also provides a nutritional analysis of all menus to empower health-conscious consumers watching calories, fat, carbohydrates, sodium, fiber or calcium.</td>
<td></td>
</tr>
<tr>
<td>Congregate Nutrition</td>
<td>Please see Attachment B</td>
<td>Neighborhood meals: 95,803</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Metrics</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Nutrition Education              | (1) Diabetes Prevention Program  
(2) CICOA’s Nutrition programs are offered in all eight counties, except CSFP which is available in Marion, Morgan, and Boone Counties. The Commodity Supplemental Food Program (CSFP) works to improve the health of low-income elderly persons of at least 60 years of age by supplementing their diets with nutritious USDA Foods. | (1) We sponsor 53 participants in the Diabetes Prevention Program through the YMCA each year. 
(2) In FY2019 we served an average of 814 seniors per month-CSFP. In FY20 served an average of 875 seniors per month-CSFP |
| Legal Assistance                 | CICOA allocates funds to Indiana Legal Services to carry out provisions of legal services to vulnerable, low income, and at-risk older adults in CICOA's 8 county service area. | FY20 served 1,723 unduplicated clients.                                                       |
| Health Promotion: Evidence-Based | (1) Bingocize – NW Evidenced based program. The Bingocize® program meets the highest-level criteria for evidence-based disease prevention and health promotion programs as established by the Administration on Aging Evidence-Based Programs Review Committee. The program combines nutrition education and exercise for the older adult. Socialization is an added bonus. | FY19 17 participants; FY20 38 participants.                                                   |
| Health Promotion: Non-Evidence-Based | CICOA's focus has been on evidence-based programming to date; we will explore non-evidence based programming in this next Area Plan cycle. | n/a                                                                                           |
| Transportation                   | Way2go Transportation provides transportation options for older adults and people with disabilities in Central Indiana. We currently have three separate programs. Our Senior Transportation program which serves our senior population and the My | In FY2020 Way2go provided: 
15,782 Essential needs trips to 2,211 Individuals.                                              |
Freedom program which serves anybody of any age with a disability. We are also a traditional Medicaid provider for traditional Medicaid clients who reside and travel within Marion County. 

Our Senior Transportation program serves Marion County seniors aged 60 years or older, discounted transports for medical appointments, pharmacy runs or grocery shopping services. This service includes door to door service with assistance from the Way2go driver. Our drivers assist the client from the threshold of their door and out to our vehicle. The driver then secures the client before leaving. At the destination address, driver will assist the client inside to the reception area. A second part of this program is our grocery shopping shuttle service. This shopping service connects with more than 40 different low cost and senior apartment communities. Transportation works with the site coordinator to arrange for weekly, bi-weekly or monthly transports to ensure that their nutritional needs are met. 

Thirdly, Way2go partners with local provider Ztrips (FKA: Indianapolis Yellow Cab) to sell affordable discounted taxi coupons and wheelchair vouchers. Clients can use these coupons as an additional resource to travel for any reason they want but the transports must remain in Marion County. 

The My Freedom program is for people with disabilities in Marion County and the seven surrounding counties. This is a voucher-based program which allows clients who qualify for the program the ability to purchase low-cost vouchers for their transportation needs. We have several providers who accept these

| 1182 Medicaid trips |
| 36,682 phone calls answered by staff |
| 224,100 Miles driven |
| 2 Additional shuttles added to fleet |
| Way2go’s current fleet had 20 vehicles. |
| 14 shuttles and 6 minivans. |
| All vehicles are ADA accessible and can transport wheelchair clients. |
vouchers for payment. Each client who utilizes this program is given a list of providers to choose from and have the freedom to set up their own transports with whomever they choose from the list. Providers send in their monthly invoices for reimbursement from CICOA for the services they provided. Clients receive a reloadable electronic fare card. Clients call in to purchase their vouchers and they are electronically uploaded onto their card within a couple of minutes. Providers who provide trips under this program have an app on their phone or tablet and they swipe the clients’ fare card for payment and to account for their billing purposes. This is the only program in Central Indiana that allows for cross-county transports.

Way2go is also a traditional Medicaid provider under the Indiana state broker, Southeastrans. Under this program we provide no cost transportation in which Medicaid deems as a covered cost under the client’s insurance. These include trips for medical appointments and pharmacy runs. We have been a Medicaid transportation provider since 2017.

The demand for transportation far outweighs the availability in many areas of transportation. Dialysis transportation and cross county transports are in huge demand. Dialysis clients often experience hardship with transportation due to their treatment time. There are not many providers who provide transportation at 4am to ensure the client is there by 5pm. The also is said for the late clients who complete dialysis late in the evening and night. In FY2020, Way2go denied 8,136 transports and were unable to complete
many cross-county transports. Unfortunately, many cross-county transports are left undone as most transportation providers are grant funded specifically for the county in which they are located. This hinders clients from accessing the local VA if residing outside of Marion County and keeps others from seeing specialty doctors located in adjacent counties. Funding is much needed for cross-county transports and for dialysis trips.

| Long-Term Care Ombudsman | CICOA allocates funds to Indiana Legal Services to carry out provisions of long-term care ombudsman services to vulnerable, low income, and at-risk older adults residing in institutional care settings in CICOA's 8 county service area. | FY20 1,723 unduplicated clients served |
| Pre-Admission Screening | Any person seeking placement in an Indiana nursing facility who needs Medicaid assistance is required, by law, to complete a Pre-Admission Screening (PAS) evaluation. The purpose of this evaluation is to determine the appropriateness of nursing facility placement, or whether the individual can remain at home with support from in-home and community based services. | 220 Ascend PAS clients  
37 At-Home PAS clients  
Total = 257 PAS clients |
<p>| Care Transitions | In partnership with the Division of Aging, CICOA and Aging &amp; In-home Solutions received an award for the Administration for Community Living No Wrong Door Grant focused on Care Transitions. This project began in 2018-2020. The project provided funding for a total of 8 care managers 4 from CICOA and 4 from AIHS to receive evidenced based training on the care transition intervention. These trained care managers would take this knowledge and use it to better serve their client population. CICOA also had the benefit of being partnered with Eskenazi and IU/Methodist GRACE Team Care. | The project showed a 43% reduction in 30 day readmission rates over a 6 month pilot. |
| <strong>Dementia Friends Indiana</strong> | Dementia Friends Indiana (DFI) is a grassroots, community-driven movement that aims to better educate people about dementia, reduce the associated stigma, and take action to create more welcoming and conducive dementia friendly environments in our communities. DFI is administered in the state of Indiana by CICOA, and CICOA is committed to ensuring Indiana is a top dementia friendly state, changing how the condition is perceived and understood in all Hoosier communities. CICOA will continue to allocate resources to this valuable initiative for the greater good of our communities and state for many years to come. | Over 8,000 recognized Dementia Friends made in Indiana since August 2017. Numerous community driven, grass roots DFI partnerships representing all community sectors, including healthcare, government, private businesses, first responders, faith communities, and community based organizations. |
| <strong>Senior Center Support</strong> | CICOA supports senior centers in all 8 of its counties through a combination of sub-grantee funding and strategic collaborations. This support expands the outreach and quality of services to older adults, such as transportation, nutrition, caregiver support, and information &amp; assistance services. | CICOA allocates Title III-B, D, and E funds to 8 senior centers in its PSA. SHIP Counseling and Options Counseling support is offered and delivered in every CICOA county in collaboration with senior centers. |
| <strong>Family Caregiver Support for Caregivers of Older Adults</strong> | Family Caregiver Support Programs – provides both community outreach and education along with individual one-on-one options counseling geared toward caregivers. TCARE is the clinical based assessment tool that staff began using in 2020 for caregivers. The program helps | Estimated number or requests/inquires from July 2019–June 202: 551 one-on-ones 8,654 outreach |</p>
<table>
<thead>
<tr>
<th>Family Caregiver Support for Older Relative Caregivers</th>
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Caregivers with support groups, self-care, accessing resources, services in the community, planning for long-term and in-home care and housing options. This program helps educate caregivers on how to provide for their love ones, but also keep the caregiver healthy and supported.

Contacts in the community

205 workshops provided
Section 6 - Focal Point Specifications

Please provide assurance that your services and information are available within each of the counties in your PSA. Older Americans Act, Section 102 DEFINITIONS (21), defines the term “focal point” as a “facility established to encourage the maximum collocation and coordination of services for older individuals.”

<table>
<thead>
<tr>
<th>Name of Focal Point</th>
<th>Address</th>
<th>Counties of Service</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boone County Senior Services</td>
<td>515 Crown Pointe Dr. Lebanon, IN 46052</td>
<td>Boone</td>
<td>Transportation, I&amp;A, caregiver support and respite.</td>
</tr>
<tr>
<td>PrimeLife Enrichment</td>
<td>1078 3rd Ave SW, Carmel, IN 46032</td>
<td>Hamilton</td>
<td>Transportation, I&amp;A, caregiver support, nutrition, health and wellness</td>
</tr>
<tr>
<td>Shepherd's Center of Hamilton County</td>
<td>1250 Conner St, Noblesville, IN 46060</td>
<td>Hamilton</td>
<td>Education, outreach, advocacy, caregiver support</td>
</tr>
<tr>
<td>Hancock Senior Services</td>
<td>1870 Fields Blvd, Greenfield, IN 46140</td>
<td>Hancock</td>
<td>Transportation, I&amp;A, caregiver support and respite</td>
</tr>
<tr>
<td>Shelby County Senior Services</td>
<td>1504 South Harrison St. Shelbyville, IN 46176</td>
<td>Shelby</td>
<td>Transportation, I&amp;A, caregiver support and respite, health and wellness</td>
</tr>
<tr>
<td>Johnson County Senior Services</td>
<td>731 South State St. Franklin, IN 46131</td>
<td>Johnson</td>
<td>Transportation</td>
</tr>
<tr>
<td>Morgan County Connect</td>
<td>1369 Blue Bluff Rd, Martinsville, IN 46151</td>
<td>Morgan</td>
<td>Transportation</td>
</tr>
<tr>
<td>Hendricks County Senior Services</td>
<td>1201 Sycamore Lane P.O. Box 448 Danville, IN 46122</td>
<td>Hendricks</td>
<td>I&amp;A, Transportation, caregiver respite and support, nutrition, health and wellness</td>
</tr>
<tr>
<td>OASIS</td>
<td>10800 E Washington St, Indianapolis, IN 46229</td>
<td>Marion</td>
<td>Education, socialization, awareness</td>
</tr>
<tr>
<td>Heritage Place</td>
<td>4550 N Illinois St, Indianapolis, IN 46208</td>
<td>Marion</td>
<td>Socialization, caregiver support services, education</td>
</tr>
<tr>
<td>P.A.C.E.</td>
<td>2855 N Keystone Ave #170, Indianapolis, IN 46218</td>
<td>Marion</td>
<td>Medical care, caregiver respite, socialization, nutrition</td>
</tr>
<tr>
<td>Name of Focal Point</td>
<td>Address</td>
<td>Counties of Service</td>
<td>Services Provided</td>
</tr>
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</tbody>
</table>
Section 7 - Resources Inventory

Specify the total number of resources for in-home and community-based services into the following table.

<table>
<thead>
<tr>
<th>N/A</th>
<th>Resources; include total number of:</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Nursing facilities</td>
<td>169</td>
</tr>
<tr>
<td>☐</td>
<td>Assisted Living facilities</td>
<td>49 (Waiver providers)</td>
</tr>
<tr>
<td>☐</td>
<td>Adult Family Care facilities</td>
<td>20 ADS; 9 AFC (waiver providers)</td>
</tr>
<tr>
<td>☐</td>
<td>RBA/ARCH facilities</td>
<td>9</td>
</tr>
<tr>
<td>☐</td>
<td>Meal sites</td>
<td>30</td>
</tr>
<tr>
<td>☐</td>
<td>Senior centers</td>
<td>35</td>
</tr>
<tr>
<td>☐</td>
<td>Care Managers (Area Agency and independent)</td>
<td>13 agencies, 558 care managers</td>
</tr>
<tr>
<td>☐</td>
<td>Transportation Providers</td>
<td>28</td>
</tr>
<tr>
<td>☐</td>
<td>Mental Health Clinics</td>
<td>64</td>
</tr>
<tr>
<td>☐</td>
<td>Hospitals</td>
<td>39</td>
</tr>
<tr>
<td>☐</td>
<td>Veteran Administration (VA) hospitals</td>
<td>1</td>
</tr>
<tr>
<td>☐</td>
<td>Veteran Administration (VA) health clinics</td>
<td>4</td>
</tr>
</tbody>
</table>

Please explain how you coordinate care for participants with the other organizations listed above.

CICOA fully understands collaboration between other organizations is essential in optimizing the goal of creating the greatest level of independence, health, and quality of life for the older adult and disabled population, and their caregivers. CICOA has a very extensive and comprehensive database of resources for all inquires through the Aging and Disability Resource Center that allow for the connection of those seeking help to the resources they need. Similarly, clients receiving care management through CICOA receive an individualized, person centered plan of care that focuses on connecting clients to the resources, services, and support they need from other area community based organizations.

Additionally, CICOA is often a first line referral source from the majority of the above listed community resources. CICOA also supports a diversified group of 17 community organizations
through the granting of Title III funds through the Older Americans Act that serve to carry out unique and local services to older adults and those with disabilities throughout the 8 county Central Indiana PSA. CICOA is committed to the continuous partnership and collaboration development with area partners of all sectors and services in our PSA and will continue to align with community partner organizations in a way that makes all of us stronger together than we would be on our own.
Section 8 - Financials

1. AAA Cost Allocation
Provide financial details for the following bulleted items. **Attach as separate document(s) or spreadsheet(s) with your Area Plan submission. Please label the attachment as “22-23 AP AAA# – Attachment C – Cost Allocation Plan”**.
   - Staff salaries and wages
   - Employee Benefits
   - Facility (rent, electricity, gas, water and sewerage, and cleaning services)
   - Telephone and postage service
   - Insurance
   - Travel and transportation
   - Capital expenditures ($5000.00 or more)

2. Funding Allocation – by Percentage
Provide the percentage of total AAA program funding by (1) Personnel, (2) Operational, and (3) Direct Service categories. Programs include, but are not limited to, the following:
   - Older Americans Act, Title III and VII
   - CHOICE
   - Social Services Block Grant (SSBG)
   - Preadmission Screening and Resident Review (PASRR)
   - Medicaid Waiver
   - Grants

This funding allocation may be developed as a spreadsheet or document. Please include this with your Cost Allocation Plan in Attachment C.

3. Financial Stability
Provide the following information:
   - Number of months’ normal operating expenses currently on hand in reserve: **3.38 months**
   - Number of months’ normal operating expense currently available through a line of credit: **.81 months**
   - Average days to payment on invoices received: **45 days**
Section 9 - Disaster Preparedness

Please provide a narrative regarding your Disaster and Emergency Preparedness Procedures. When completing the narrative, please include how you “will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery (OAA Section 306(a)(17)). Please address:

1. Specific plans for disaster preparedness and emergency planning within the agency to maintain internal operations (including, but not limited to, information and assistance, case management, options counseling).
2. Details on how your agency is supporting participants by providing resources and guidance for disaster and emergency preparedness in the home and community-based setting.
3. Specific examples of changes your AAA has made or plans to make because of the COVID-19 pandemic.

Reference:  https://acl.gov/emergencypreparedness

Please provide any additional documents as needed for support. Please be sure to label your additional documents as “22-23 AP AAA# -Attachment D – Disaster Preparedness” and check the “Included” box in the Area Plan Components Checklist on page 2.

EMERGENCY PREPAREDNESS

Emergency Operations Plan

CICOA’s emergency operations and business continuity plans are focused in two areas: service continuity for clients and operational continuity for agency and staff.

1. Business Operations

In the event of a catastrophic loss of use of the CICOA offices at 8440 Woodfield Crossing Blvd, Indianapolis, IN, the following actions can be taken to minimize disruptions to operations:

Facilities: JLL is CICOA's landlord. JLL has available office space in other office buildings in the area that could be made available on a temporary basis on short notice through contact with the property manager.

Most of CICOA's staff works offsite, including in-home services care managers and nutrition staff. If necessary, staff can be directed to work from home or from an alternate site as appropriate. Success and feasibility of this offsite model was evidenced via the COVID-19 pandemic in 2020 and 2021.
Information Technology: CICOA has contracts with IT and telecom vendors for rapid replacement of computer hardware and software if necessary. This includes service with Dell Systems, Microsoft, (……………). Data backups are stored offsite and data is backed up weekly.

Leadership: A business continuity plan developed by CICOA outlines reporting locations for leadership staff. Leadership staff has Outlook Exchange to access emails remotely. Using VPN, supervisors are able to connect to CaMMS and other necessary platforms which allow them the opportunity to enter and review client information in the network.

Telephone services can be forwarded to a remote location within 24 hours if necessary.

2. Service Continuity

Severe weather is most likely to affect Meals and More Neighborhood meal sites and home delivery. If severe weather or other events occur that prevent the opening of the kitchen, a meal site or home meal delivery, CICOA notifies all staff and clients at the site. When funding is available, shelf-stable meals are delivered to the clients prior to inclement weather in the event of an emergency.

In-home service visits can be rescheduled.

In the event of an emergency or natural disaster ADRC staff have been trained and equipped to take incoming calls from their homes or cell phones. This is another operational area of CICOA where the success and feasibility of ADRC working remotely was evidenced during the COVID-19 pandemic. A memorandum of understanding exists with the local 2-1-1 Center to take after hour calls in the event of a disaster.

CICOA has an agreement with the American Red Cross of Greater Indianapolis to provide support for CICOA clients and other elderly persons or persons with a disability who require assistance with accessing services following multi-family events. In the event of a state or federally-declared emergency, CICOA’s care management staff can be activated to support the community’s long-term recovery efforts to assist older adults or persons with a disability who may need help to apply.
Section 10 - Estimated Services/Units/Expenditures

Please complete the table below estimating the type, quantity, and cost of services expected to be purchased or provided in the next federal fiscal year. Base these numbers on total expenditures regardless of age of recipient for all non-waiver funds reported in CaMSS. Estimates should be based on current expected funds excluding any additional COVID supplemental funds that may be awarded. Units of service are per ACL reporting requirements and may differ from care plan units. Convert as appropriate.

<table>
<thead>
<tr>
<th>Service</th>
<th>FFY 2022 Estimated Units</th>
<th>FFY 2022 Estimated Persons Served</th>
<th>FFY 2022 Estimated Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care (hour)</td>
<td>442,249</td>
<td>416</td>
<td>$2,480,119</td>
</tr>
<tr>
<td>Home &amp; Community Assistance (hour)</td>
<td>18,802</td>
<td>49</td>
<td>$86,532</td>
</tr>
<tr>
<td>Chore (hour)</td>
<td>0</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Home Delivered Nutrition (meal)</td>
<td>367,502</td>
<td>17,265</td>
<td>$2,526,234</td>
</tr>
<tr>
<td>Adult Day Care (hour)</td>
<td>24,056</td>
<td>20</td>
<td>$76,402</td>
</tr>
<tr>
<td>Care Management (hour)</td>
<td>127,540</td>
<td>46,005</td>
<td>$2,819,379</td>
</tr>
<tr>
<td>Assisted Transportation (one-way trip)</td>
<td>7,226</td>
<td>117</td>
<td>180,650</td>
</tr>
<tr>
<td>Congregate Nutrition (meal)</td>
<td>92,769</td>
<td>16,062</td>
<td>$2,089,776</td>
</tr>
<tr>
<td>Nutrition Counseling (hours)</td>
<td>0</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Legal Assistance (hour)</td>
<td>9,229</td>
<td>544</td>
<td>$77,180</td>
</tr>
<tr>
<td>Nutrition Education (sessions)</td>
<td>22,253</td>
<td>735</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Health Promotion: Evidence-Based (unduplicated persons)</td>
<td>N/A</td>
<td>941</td>
<td>$94,591</td>
</tr>
<tr>
<td>Health Promotion: Non Evidence-Based (unduplicated persons)</td>
<td>N/A</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Information &amp; Assistance (contact)</td>
<td>121,462</td>
<td>20,687</td>
<td>$697,701</td>
</tr>
<tr>
<td>Transportation (one-way trip)</td>
<td>54,447</td>
<td>2,845</td>
<td>$1,529,582</td>
</tr>
<tr>
<td>Other Services</td>
<td>N/A</td>
<td>N/A</td>
<td>$136,508</td>
</tr>
<tr>
<td>Service</td>
<td>FFY 2022 Estimated Units</td>
<td>FFY 2022 Estimated Persons Served</td>
<td>FFY 2022 Estimated Expenditures</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Title III-E Caregiver of Older Adults</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver Respite, In-Home (hour)</td>
<td>24,010</td>
<td>150</td>
<td>$98,711</td>
</tr>
<tr>
<td>Caregiver Respite, Out- of-Home (day) (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Respite, Out- of-Home (overnight) (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Care Management (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Counseling (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Training (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Supplemental Services</td>
<td>N/A</td>
<td>N/A</td>
<td>$34,090</td>
</tr>
<tr>
<td>Caregiver Support Groups (session)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Information and Assistance (contact)</td>
<td>6,788</td>
<td>4,758</td>
<td>$180,495</td>
</tr>
<tr>
<td>Caregiver Public Information Services (activity)</td>
<td>673</td>
<td>1,092</td>
<td>$158,385</td>
</tr>
<tr>
<td><strong>Title III-E Older Relative Caregiver</strong></td>
<td></td>
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<tr>
<td>Caregiver Respite, In-Home (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Respite, Out- of-Home (day) (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Respite, Out- of-Home (overnight) (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Care Management (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Caregiver Counseling (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Caregiver Training (hour)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Support Groups (session)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Supplemental Services</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Information and Assistance (contact)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver Public Information Services (activity)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Section 11 - CHOICE Plan Requirements

Per 455 IAC 1-5-3(a)(6), a CHOICE Plan must be submitted per the request of the Division of Aging and must contain the contents outlined below. At this time, we are requesting that you ensure that you have all required contents and that they are available upon request. Please note that you are NOT required to submit this information at this time.

CHOICE Plan Contents and Format:

Section 1 – Intake and Referral Process: Description of the referral and intake process, including eligibility determination protocols and method of eligibility notification.

Section 2 – Assessment Process: Description of the assessment process, format, and procedures used by AAA case managers including methodology for ensuring completion of ninety-day face-to-face assessments of CHOICE participants.

Section 3 – Nursing Facility Outreach: Describe the outreach and follow up methods for offering assessments to current nursing facility residents who apply for CHOICE.

Section 4 – Hiring Practices: Describe the methods of recruitment, screening, and hiring of staff.

Section 5 – Care Plan Development Process: Description of the procedures used to develop the plan of care including a timeline for the development process from start to implementation of services. Also, a description of the role the individual and/or their family play in the development of their care plan.

Section 6 – Area and Community Support Services: A list of all available long-term support services, both public and private, within the area.

Section 7 – Care Management and Service Coordination: Policies and procedures for the case management and service coordination, including case file documentation and record-keeping.

Section 8 – Coordinating CHOICE with Other Funding Sources: Policies and procedures for coordinating CHOICE with Medicaid state plan services, HCBS waiver services and other funding sources for in-home and community-based services. Describe the methodology for determining priority funding, last resort funding, and preventing duplication of services among funding sources.

Section 9 – Plans of Care Evaluation and Monitoring: Description of internal methods of evaluating plans of care to ensure participants are receiving quality services and direction. Describe how plans of care are selected for review, who conducts the monitoring, what criteria is used to evaluate the appropriateness of service and stewardship of funding, and the frequency of monitoring. Include policies and procedures for conducting QIPs internally and in collaboration with FSSA DA or its contractor.

Section 10 – Cost Sharing: Description of CHOICE cost sharing plan procedures, including cost share collection methods.
Section 11 – Complaint and Appeal Procedures: Description of complaint and appeal procedures, which include the process for notifying applicants or participants of the right to an administrative hearing, which incorporates the FSSA DA Complaint Policy for HCBS.

Section 12 – Waiting List: Description of policies and procedures for operating, maintaining, and clearing the AAA waiting list for CHOICE services in accordance with the requirements contained in these CHOICE Guidelines.

Section 13 – Budget: Budget Narrative and breakdown of spending in accordance with the contract between AAA and FSSA DA on the following categories: A Breakdown of Proposed Spending on Consumer Services; Assessments; Care Plan Development; Reassessments; AAA Administration; Any Other Appropriate Costs.

Section 14 – Provider Selection: Description of processes and procedures for selecting service providers. Including methods for ensuring a variety of CHOICE providers for participants to choose from.
Attachments

Attachments I – VI
   Please see explanations provided in the 2022-2023 Area Plan Guidelines.

Attachment A - Organizational Chart
   Please provide an organizational chart showing schematically all staff members, including titles and positions. Please include document and label, “22-23 AP AAA# - Attachment A - Organizational Chart”.

Attachment B - Congregate Nutrition Site Listing
   See Section 5 – AAA Service Overview above and label as “22-23 AP AAA# – Attachment B – Congregate Nutrition Site Listings” when submitting.

Attachment C - Cost Allocation Plan
   See Section 8 – Financials above and label document(s) “22-23 AP AAA# – Attachment C – Cost Allocation Plan”.

Attachment D – Disaster Preparedness
   See Section 9 – Disaster Preparedness above and additional documents as “22-23 AP AAA# -Attachment D – Disaster Preparedness” and check the “Included” box in the Area Plan Components Checklist.
Verification of Intent

This Area Plan is hereby submitted to the Indiana Division of Aging for approval.

If awarded funding, the applicant Area Agency on Aging will carry out all activities under the Area Plan on Aging in accordance with Federal and State statute/policy. The Governing Board and Area Agency Director have each had the opportunity to participate in the planning process and to review and comment on the Area Plan. Both the Governing Board and Area Agency Director actively support the planning and development of community-based systems of care and will ensure compliance with the assurances set forth in this Area Plan. The undersigned recognize the responsibility within each community to establish systems in order to address the care needs of older individuals and their family caregivers in this planning and service area.

1. **Taufrie Brown**
   (Type Name)
   
   ![Signature]
   (Signature) Area Agency Director
   
   6/4/2021
   Date

2. **Peter Bisbecos**
   (Type Name)
   
   ![Signature]
   (Signature) Governing Board Chair
   
   6/4/2021
   Date
Assurances

By signing this document, the authorized official commits the Area Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020:

Sec. 306(a), AREA PLANS
(a) Each area agency on aging...Each plan shall—
(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;
(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and
(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

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

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

(6) provide that the area agency on aging will –
(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;
(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;
(C) (i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;
(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—
(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or
(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and
(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;
(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans’ health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;
(E) establish effective and efficient procedures for coordination of—
(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and
(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—
(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;
(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—
(i) respond to the needs and preferences of older individuals and family caregivers;
(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and
(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;
(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and
(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—
(i) the need to plan in advance for long-term care; and
(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—
(A) not duplicate case management services provided through other Federal and State programs;
(B) be coordinated with services described in subparagraph (A); and
(C) be provided by a public agency or a nonprofit private agency that—
(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;
(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;
(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or
(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) provide assurances that—
(A) the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title; and
(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

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

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—
(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;
(B) disclose to the Assistant Secretary and State agency—
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship;
(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships;
(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships;
(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

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

(15) provide assurances that funds under this title will be used—
(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

(18) provide assurances that the area agency on aging will collect data to determine—
(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and
(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under Title IV in fiscal year 2019.

BY SIGNING THIS PAGE, YOU ARE STATING THAT YOU HAVE READ AND AGREE TO ABIDE BY THESE ASSURANCES.

Taufric Brown

(Type Name)

[Signature]

(Date)
2020-2021 Area Plan Progress Report: Logic Models  
(July 1, 2019-March 31, 2020)

**Instructions:** Complete the Logic Models based on the 4-6 Logic Models in your approved  
2020-2021 Area Plan on Aging for July 1, 2019 - March 31, 2020. Fill in the white space on the  
templates below. The Goals and Objectives must match the wording exactly of those included in 
your approved plan.

<table>
<thead>
<tr>
<th>AAA Name:</th>
<th>CICOA Aging &amp; In-Home Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area:</td>
<td>Aging and Disability Resource Center functions</td>
</tr>
<tr>
<td><strong>Goal:</strong> (include exact language from approved Area Plan)</td>
<td>The goal of the ADRC is to accurately, consistently and efficiently provide access to quality home and community-based services to residents or persons within CICOA’s area.</td>
</tr>
<tr>
<td><strong>Objectives</strong> (include exact language from approved Area Plan)</td>
<td>Provide the functions required for phone options counseling; face to face counseling; assistance with Medicaid applications and service planning, with an emphasis on person-centeredness.</td>
</tr>
<tr>
<td><strong>Inputs</strong> (resources used (e.g. staff, funding, vehicles))</td>
<td>Utilize all grant funds as outlined in the yearly contact/grant to support ADRC phone options counselors and supportive staff. Funds to be utilized according to pay point guidelines.</td>
</tr>
<tr>
<td><strong>Activities</strong> (what has been done, the “how” (use action verbs))</td>
<td>Answer all calls live; enter all information from calls into Vision Link. Assessment inquiries are being logged &amp; triaged for a return call from phone options counselors within 2 business days. Face to face assessments were conducted within 10 days until COVID-19 precautions went in effect and face to face assessments have been replaced with phone assessments until DA notifies us of re-engaging in a face to face fashion with our clients. Documentation is being sent to DA w/in 20 business days. Plans of care are needs based and follow person centeredness. ADRC guides consumers with unbiased referrals and resources to meet their needs. Finally; clients are reviewed and assessed in the event they need assistance &amp; support filling out Medicaid applications.</td>
</tr>
</tbody>
</table>
| **Outputs** (products of activities (e.g. number of trips)) | 83,001 calls 
14,755 individual contacts for options counseling
17,400 community resource referrals
5,468 MAW/CH/HDM referrals |
| **Outcomes** (specific changes or benefits that resulted (e.g. 5% increase in program participants)) |  

97% of all calls answered live. 100% of all referrals have been entered into Vision Link & CaMMS CM system. 100% of clients with face to face assessments have received the InterRAI. 90% of clients referred for in-home services have been seen within 10 days.

**Measurement Indicators** *(data used to measure achievement of goals/objectives)*

All data is provided on a monthly basis and from it we can see how close the ADRC is to hitting their goals. These data points are leveraged to help further develop our talent in the ADRC in an effort to bring their outcomes and outputs closer to their forecast/projections.

**External Factors** *(factors within the broader system/environment that have affected program operations and outcomes (e.g. staffing, weather))*

Global pandemic COVID-19 has impacted our business operations in that most staff started working remotely around the 13th of March and what we have learned is that our work can continue to take place and our clients are still able to be served in a timely manner.
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<tr>
<td>Priority Area:</td>
<td><strong>Dementia Care and/or Caregiver Support (455 IAC 1-10-5)</strong></td>
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</table>

### Goal: (include exact language from approved Area Plan)

Provide intensive one-on-one counseling for caregivers of Dementia/Alzheimer’s patients through the Rosalynn Carter Institute (RCI) through their Resources Enhancing Alzheimer’s Caregiver Health (REACH)

### Objectives (include exact language from approved Area Plan)

Provide education, a focus on safety for the patient, caregiver support and build upon skills to help the caregiver manage the challenging behaviors of the patient and help with their stress.

### Inputs (resources used (e.g. staff, funding, vehicles))

Caregiver options counselors that completed the RCI & REACH training has afforded them the opportunity to provide intensive one-on-one counseling to caregivers in need.

### Activities (what has been done, the “how” (use action verbs))

Caregiver options counselors are facilitating 12 individual trainings over a 6-month period either in the home of caregivers or over the phone.

### Outputs (products of activities (e.g. number of trips))

We have held X/9 face to face & X/3 telephone sessions.

### Outcomes (specific changes or benefits that resulted (e.g. 5% increase in program participants))

Number of CareAware clients in FY20 was 551, a 24% increase from FY19.

### Measurement Indicators (data used to measure achievement of goals/objectives)

Data is reported monthly and tracked in monthly outputs reporting.

### External Factors (factors within the broader system/environment that have affected program operations and outcomes (e.g. staffing, weather))

Global pandemic COVID-19 has impacted our business operations in that most staff started working remotely around the 13th of March and what we have learned is that our work can continue to take place and our clients are still able to be served in a timely manner.
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<tbody>
<tr>
<td>Priority Area:</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td><strong>Goal:</strong> (include exact language from approved Area Plan)</td>
<td>Increase the knowledge level of Central Indiana health systems and clinical providers on how SDoH influence patient health outcomes, leading to improvements of care delivery models among systems.</td>
</tr>
<tr>
<td><strong>Objectives</strong> (include exact language from approved Area Plan)</td>
<td>1) Partner with multiple Central Indiana university clinical programs to provide students SDoH education &amp; experiences. 2) Develop public education forums on topics related to SDOH. 3) Explore partnership pilots involving SDoH applications with area health systems, research entities, universities, etc. 4) Identify champion in clinical/medical community to engage peers about the importance of SDoH when coordinating care.</td>
</tr>
<tr>
<td><strong>Inputs</strong> (resources used (e.g. staff, funding, vehicles))</td>
<td>1) Funds for developing materials specific to SDoH. 2) Dedicated CICOA staff time. 3) Funds and space for hosting public forums on SDoH. 4) Funds to equip interns/students with the tangible equipment and resources needed. 5) Funds for related conference attendance. 6) Funds for related medical/clinical/other conference exhibiting. 7) Funds for various membership dues for medical/clinical groups.</td>
</tr>
<tr>
<td><strong>Activities</strong> (what has been done, the “how” (use action verbs))</td>
<td>(1) Partnership with St. Vincent primary care residency program involving physician residents shadowing CICOA care managers in client homes so these future physicians have a first-hand perspective of the role social determinants play in the health outcomes of their patients. (2) Establishment of CICOA Lecture Series in 2019, starting with Dr. Jennifer Sullivan, FSSA Secretary, lecturing on role and impact of social determinants. (3) Partnerships with academic and research institutions to study various social determinants factors. (4) Piloting new programs and/or service delivery models with local health systems.</td>
</tr>
<tr>
<td><strong>Outputs</strong> (products of activities (e.g. number of trips))</td>
<td>(1) CICOA is involved in 4 current, active research studies with respective academic and research partners. (2) 4 CICOA Lecture Series have been delivered. (3) Formal partnerships with University of Indianapolis (schools of public health, social work, aging and community, and nursing) and IUPUI School of Rehabilitation Sciences where CICOA hosts an occupational therapy doctoral student to conduct their final residency each year.</td>
</tr>
<tr>
<td><strong>Outcomes</strong> (specific changes or benefits that resulted (e.g. 5% increase in program participants))</td>
<td>(1) Over 25 St. Vincent physician have experienced first hand, real world understandings of how social determinants outside the clinical setting influence...</td>
</tr>
</tbody>
</table>
overall patient health outcomes. (2) 4 active research studies underway that will result in the increased understanding and application of social determinants factors. (3) 1 occupational doctoral student completed her doctoral residency in 2019 and the next doctoral resident is scheduled to begin her residency in January 2020. (4) New caregiver focus and program improvements occurring as a result of University of Indianapolis public health student conducting a research and program implementation project at CICOA. (5) New pilot project centered on nutrition established with local health system utilizing CICOA registered dietician on a paid contract.

| Measurement Indicators (data used to measure achievement of goals/objectives) |
| CICOA is investing in a data lake platform to gather, assess, and utilize data related to social determinants of health initiatives. |

<p>| External Factors (factors within the broader system/environment that have affected program operations and outcomes (e.g. staffing, weather)) |</p>
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<tbody>
<tr>
<td><strong>Priority Area:</strong></td>
<td>Clinical Engagement</td>
</tr>
<tr>
<td><strong>Goal:</strong> <em>(include exact language from approved Area Plan)</em></td>
<td>Increase number of new health/hospital contracts in Central Indiana by 6/30/2021</td>
</tr>
<tr>
<td><strong>Objectives</strong> <em>(include exact language from approved Area Plan)</em></td>
<td>1) Leverage expertise and influence of CICOA’s Medical Advisory Council (MAC) to open opportunities and consult on strategies for engaging clinical community. 2) Establish, with guidance of MAC, a formal, organized and strategic contracted partnership proposal. 3) Develop talking points and key messaging that resonates with clinical professionals and C-Suite leaders that influences their perception of CICOA as genuine healthcare partner. 4) Develop new and improve existing relationships with key health/hospital leaders. 5) Identify key metrics/outcomes that demonstrate success of partnerships.</td>
</tr>
<tr>
<td><strong>Inputs</strong> <em>(resources used (e.g. staff, funding, vehicles))</em></td>
<td>1) Dedicated allocation of key staff time to oversee clinical engagement activities. 2) Engagement, retention and coordination of MAC 3) Dedicated study &amp; understanding of healthcare climate and research of similar models that have been tried in the past. 4) Money for proposals and other materials specific to clinical community. 5) Investment in a platform to capture data outcomes. 6) Investment in CICOA personnel to serve role as embedded staff member in clinical settings.</td>
</tr>
<tr>
<td><strong>Activities</strong> <em>(what has been done, the “how” (use action verbs))</em></td>
<td>1) Two formal, in-person MAC meetings as a group annually, with ongoing engagement throughout the year via email. (2) Development of organized strategic proposal and talking points related to health system partnership proposals (3) Meetings with leaders/decision makers of health/hospital networks to propose and discuss partnership details. (4) Providing consistent quality assurance guidelines with partners to improve program processes &amp; delivery.</td>
</tr>
<tr>
<td><strong>Outputs</strong> <em>(products of activities (e.g. number of trips))</em></td>
<td>1) 5 current contracts. (2) 2 new contracted partnerships. (3) 100% MAC members retained and engaged. (4) 4 new health systems engaged in partnership dialogue.</td>
</tr>
<tr>
<td><strong>Outcomes</strong> <em>(specific changes or benefits that resulted (e.g. 5% increase in program participants))</em></td>
<td>1) Strategic focus on clinical engagement, including development of strategic proposal plan and leverage of Medical Advisory Council member expertise, resulted in 2 new paid contracts for the first time in over 5 years. (2) In addition to actual hospital contracts, opportunities for new and innovative partnerships involving nutrition, Dementia Friends Indiana, and caregiver programming established with area health/hospital systems. (3) All three existing contracts renewed. (4) Recognition and site visit from Stanford University School of</td>
</tr>
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</table>
Medicine Center for Clinical Excellence in 2019 to learn best practices of CICOA’s work with the clinical community.

<table>
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<th>Measurement Indicators (data used to measure achievement of goals/objectives)</th>
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<tbody>
<tr>
<td>CICOA is investing in a data lake platform to gather, assess, and utilize data related to social determinants of health initiatives.</td>
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<tr>
<td>The ever-changing landscape of healthcare and the ways hospital and health systems adapt to these changes, including health outcome metrics, policies and billing incentives, to name a few, will influence both the approach to clinical engagement strategies and the outcomes achieved as part of those strategies.</td>
</tr>
<tr>
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<tr>
<td>Priority Area:</td>
</tr>
<tr>
<td>Goal: (include exact language from approved Area Plan)</td>
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<td>Objectives (include exact language from approved Area Plan)</td>
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<td>Outcomes (specific changes or benefits that resulted (e.g. 5% increase in program participants))</td>
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</table>
**Measurement Indicators** *(data used to measure achievement of goals/objectives)*

Monthly tracking of Dementia Friends made, number of info sessions, number of Champions. IRB approved research being conducted at IU Health Saxony Hospital to measure impact of DFI on clinical staff treating patients with dementia.

**External Factors** *(factors within the broader system/environment that have affected program operations and outcomes (e.g. staffing, weather))*

The COVID-19 global pandemic resulted in the significant momentum of DFI and various initiatives being slowed and postponed. It’s fully anticipated for the momentum and focus of DFI to return to the same high levels occurring before the pandemic.
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<tbody>
<tr>
<td>Priority Area:</td>
<td>Cross County Transportation</td>
</tr>
</tbody>
</table>

**Goal:** *(include exact language from approved Area Plan)*

Increase cross county ridership for Marion County & the 7 surrounding counties

**Objectives** *(include exact language from approved Area Plan)*

1) Grow awareness of cross county connect points for clients and providers within Marion county and the seven surrounding counties. 2) establish additional community providers for clients to choose from for cross county trips. 3) increase ridership and trips for clients to meet the demand for meeting their essential needs including transports for medical appointments.

**Inputs** *(resources used (e.g. staff, funding, vehicles))*

(1) Dedicated Way2go staff time lead by Director (25% of time)  
2 Full time dispatchers, 1 community connect coordinator from CIRTA, 1 administrative assistant to answer phones.  
(2) Software scheduling system for multiple providers to utilize  
(3) additional money for advertising information, marketing, brochures, training materials and new website.

**Activities** *(what has been done, the “how” (use action verbs))*

Way2go Transportation provides transportation options for older adults and people with disabilities in Central Indiana. We currently have three separate programs. Our Senior Transportation program which serves our senior population and the My Freedom program which serves anybody of any age with a disability. We are also a traditional Medicaid provider for traditional Medicaid clients who reside and travel within Marion County.

**Outputs** *(products of activities (e.g. number of trips))*

In Fy2020  
Way2go provided:  
15,782 Essential needs trips 2,211 Individuals  
1182 Medicaid trips  
36,682 Phone calls answered by staff  
224,100 Miles driven  

Way2go’s current fleet had 20 vehicles. 14 shuttles and 6 minivans. All vehicles are ADA

**Outcomes** *(specific changes or benefits that resulted (e.g. 5% increase in program participants))*

2 additional shuttles added to fleet. A potential grant opportunity for a pilot program to increase number of dialysis trips in partnership with a dialysis clinic is being finalized. The grant funding is secure but a clinic partner has not yet been confirmed.

**Measurement Indicators** *(data used to measure achievement of goals/objectives)*

(1) Track number of trips taken with software system  
(2) Track number of clients utilizing the transportation with software system  
(3) Track number of trips taken from each different county with the software system
(4) Track number of community providers who are providing the transports using the software system

<table>
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<th>External Factors (factors within the broader system/environment that have affected program operations and outcomes (e.g. staffing, weather))</th>
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<tbody>
<tr>
<td>The demand for transportation far outweighs the availability in many areas of transportation. Dialysis transportation and cross county transports are in huge demand. Dialysis clients often experience hardship with transportation due to their treatment time. There are not many providers who provide transportation at 4am to ensure the client is there by 5pm. The also is said for the late clients who complete dialysis late in the evening and night. In FY2020, Way2go denied 8,136 transports and were unable to complete many cross-county transports. Unfortunately, many cross-county transports are left undone as most transportation providers are grant funded specifically for the county in which they are located. This hinders clients from accessing the local VA if residing outside of Marion County and keeps others from seeing specialty doctors located in adjacent counties. Funding is much needed for cross-county transports and for dialysis trips.</td>
</tr>
</tbody>
</table>
2022-2023 Area Plan: Logic Models

**Instructions:** Fill in the unshaded fields on the templates below. Please see Area Plan Guidelines for more information, including the required components to include.

<table>
<thead>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Aging and Disability Resource Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>Ensure consistent, quality, and timely information and access to long-term services and supports.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Measurement Indicators</th>
<th>Staff Responsible</th>
<th>Progress &amp; Completion</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AAA will work to improve internal processes to ensure timely and accurate documentation and claiming.</td>
<td>Four triage staff and sixteen options counselors to handle 360 plus appointment slots weekly to ensure a two-business day response time.</td>
<td>Each call is handled via a phone queue, as the call comes in it is picked up by a triage staff member, they determine the callers need, check a phone options counselors’ calendar, pick either an options or intake appointment slot, and schedule that slot for the individual letting them know the</td>
<td>Each options counselor has their calendar filled with six appointment slots that are filled by a triage staff member every day, this allows up to 360 available appointment slots per week. Other staff members are assigned to</td>
<td>This change has drastically increased the number of referrals for MAW, CH and HDM almost doubling the amount customarily received and the amount of community resource referrals we are providing clients.</td>
<td>Since implementation of the appointment slots and triage we have been generating key performance indicators (KPI) on a monthly basis to ensure the proper amount of staff needed and time allotted to help our clientele. This is currently being done by tally sheets used by each individual staff</td>
<td>ADRC staff and phone options counselors.</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>External Factors</td>
<td>We have incorporated 2-4 floating staff to assist when we have an increase in requested appointments for that day, handle unexpected emergency cases, covering for staff that call in sick or have taken the day off, and adjust when we have been closed due to bad weather or loss of power.</td>
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<th>Priority Area</th>
<th>Dementia Care and/or Caregiver Support (455 IAC 1-10-5)</th>
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<tbody>
<tr>
<td>GOAL.</td>
<td>Support caregivers’ ability to provide ongoing informal supports.</td>
</tr>
<tr>
<td>Objectives</td>
<td>Inputs</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. AAA will increase the number of Caregivers of Older Adults receiving Title III-E Respite, Counseling, Training, and/or Support Group services in the PSA.

| The agencies two caregiver options counselors completed the TCARE training which helps them provide intensive one-on-one counseling as TCARE specialists for ongoing support based on the caregivers needs. | Caregiver has the option to do a preassessment on their own to learn more about their own concerns as a caregiver and if this is assistance they may need. A full assessment will be done by a caregiver options counselor to assess their potential caregiver needs that focus on six areas of burden: relationship, objective, stress, uplifts, depression, and identity discrepancies. Once the assessment is completed the caregiver options counselor would receive scores in each of these six areas with the caregiver. Based on those scores | Based on the care plan and resources they are being provided after 3-6 months the assessment is given again to measure impact by care plan and identify if progression has been made. If that current care plan is not working, a new one is developed to fit the needs of the caregiver. If the plan has worked and progression has been made, they then move on to another | TCARE reports an 84% reduction in caregiver stress and depression. 54% of caregivers are still engaged with the TCARE program after 1 year. TCARE assists in three areas to help restore balance for the caregiver in regards to their identity discrepancies. It helps change actions (behavior)- the tasks and responsibilities that he/she assumes. Change his or her judgment about the appropriateness of her action (self-appraisal). | Data is collected throughout the utilization of working with TCARE at different times throughout the care plan and addressing each area of burden for the caregiver. | CICOA CareAware staff. |
| the TCARE platform priorities the areas of focus to assist the caregiver. Together with the caregiver options counselor and caregiver they create a treatment/care plan together to discuss priorities, expectations, and resources/intervention techniques based on what the assessment shows as their greatest needs. An assessment will be readministered every 3-6 months to see effectiveness of the care plan and if they can move on to another area of burden for the burden to work through. | Change his or her personal rules and expectations for care (identify standards or personal rules). In the case of a big change, this may require a change in identity to become consistent with the type and level of care responsibilities that are necessary to provide safe and adequate care. In the case of a small change, this may be a matter of “tweaking” the rules. |
The goal of the TCARE program is to help avoid caregiver burnout. Provide emotional support and access to resources for the caregiver. The goal of this program is to help with crisis prevention instead of management. Assist them before burnout can even occur.

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Protecting Elder Rights and Preventing Abuse, Neglect, and Exploitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>Protect and enhance the rights and prevent the abuse, neglect, and exploitation of older Hoosiers.</td>
</tr>
<tr>
<td>Objectives</td>
<td></td>
</tr>
<tr>
<td>1. AAA will facilitate awareness of and involvement in addressing the needs of residents in long-term care settings.</td>
<td>CICOA utilizes Indiana Legal Services (ILS) as a sub-grantee to carry out all provisions of Ombudsman services. OMB specific funding is required to carry out these provisions. ILS responds to the needs of older adults in the form of advocacy and inquiry in long-term settings of CICOA PSA.. Number of long-term care facility Ombudsman requests. Number of long-term care facility residents served. Number of cases resolved.</td>
</tr>
<tr>
<td>2. AAA will facilitate coordination of legal assistance services and Adult Protective Services.</td>
<td>1) CICOA utilizes Indiana Legal Services as a sub-grantee to carry out all provisions of 1) ILS responds to the needs of older adults, targeting the most vulnerable, in need of elder 1) Number of requests for elder legal services. 1) Number of clients receiving legal services. 2) Number of clients 1) Number of legal services cases resolved. 2) Number of APS referrals resolved. 1) Indiana Legal Services 2) Adult Protective Services</td>
</tr>
</tbody>
</table>
### 2022-2023 AREA PLAN

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL</strong></td>
<td>Respond creatively to the challenges facing older adults, those of any age with a disability, their caregivers and the organizations that serve them. We seek the leading edge in designing and building the future of home and community-based care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Measurement Indicators</th>
<th>Staff Responsible</th>
<th>Progress &amp; Completion</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AAA will introduce new HCBS ventures to the Indiana and</td>
<td>1 ) CICOA to establish a privately funded innovation fund. 2) CICOA to establish a venture studio</td>
<td>As a fully resourced entity within CICOA, the Studio will launch solutions via our own ideation process.</td>
<td>1) Value of innovation fund. 2) Number of ventures launched.</td>
<td>1) Number of investments made. 2) Number of ventures launched.</td>
<td>Our success will be measured by the growth velocity of our Portfolio companies’ growth velocity,</td>
<td>Jonathan Haag, Director of Strategy and Innovation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>national market. for intrapreneurship and corporate innovation.</td>
<td>Our pipeline is filled by three ideation activities: Bellowship, Speed Week, and the Institute. A Bellowship matches a promising intrapreneur to a “bellow” for one year. The intrapreneur will receive assistance, resource, training, and encouragement from their “bellow” to ideate, prototype, and launch their solution. Speed Week is an internal business design competition to advance the brand, business plan, and go-to-market strategy in the pipeline.</td>
<td>enterprise value and financial return on investments will serve as the measures of our success.</td>
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</tbody>
</table>
of 3-4 concepts, ultimately resulting in the next CICOA company or offering.

The Institute translates data into innovation. The better we understand the needs of communities and populations, the closer to market our solutions will be.

### External Factors
The unpredictable and changing landscape of healthcare and LTSS can be a variable that can affect product priorities, consumer needs, and project timelines.

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Social Determinants of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>Increase the knowledge level of Central Indiana health systems and clinical providers have on how SDoH influence patient health outcomes, leading to improvements of care delivery models among systems.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Measurement Indicators</th>
<th>Staff Responsible</th>
<th>Progress &amp; Completion</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Expand partnerships with Central Indiana university clinical programs to</td>
<td>1) Dedicated CICOA staff time. 2) Key CICOA constituents</td>
<td>Expand current primary care residency partnership</td>
<td>Number of university school clinical</td>
<td>A minimum of 1 health/hospital system increases</td>
<td>Tracking number of health/hospitals who have changed model</td>
<td>Dustin Ziegler, VP Community Programs</td>
<td></td>
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</tr>
</tbody>
</table>
provide students SDoH education & experiences.  
2) Expand partnerships and pilots involving SDoH applications with area health systems, research entities, universities, etc.  
3) Identify champions in clinical/medical community to engage peers about the importance of SDoH when coordinating care.  

| that can influence CICOA’s introductions and connections to key partners (i.e., health systems, universities, research institutions). | program with St. Vincent to other health system residency programs to expose SDoH experiences with CICOA.  
2) Establish CICOA as a preferred doctoral residency site for future clinicians of all fields.  
3) Identify a respected member of the medical community to champion the role of SDoH in conjunction with CICOA efforts.  
4) Engage in SDoH related research projects with | program partnership s and other related partnership s.  
2) Number of education opportuniti es (presentatio ns, exhibiting, in-services, etc).  
3) Number of care delivery model improveme nts resulting from efforts. | consideration of SDoH in health outcomes in a way that changes their model of care delivery.  
2) A minimum participation in 1 SDoH related research study to advance education/understanding of role of SDoH in health outcomes. | of care delivery. (2) Tracking number of defined partnerships. |
2022-2023 AREA PLAN

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Clinical Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>Increase number of new health/hospital contracts in Central Indiana by 6/30/2023.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Measurement Indicators</th>
<th>Staff Responsible</th>
<th>Progress &amp; Completion</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Leverage expertise and influence of CICOA's Medical Advisory Council (MAC) to open up opportunities and consult on strategies for engaging clinical community. (2)</td>
<td>(1) Dedicated allocation of key staff time to oversee clinical engagement activities. (2) Engagement, retention, and coordination of MAC (3)</td>
<td>(1) 2 formal, in-person MAC meetings as a group annually. (2) Researching trends, indicators, best practices of any similar models</td>
<td>(1) Number of health/hospital contacts. (2) Number of formal partnership meetings. (3) Number</td>
<td>Secure 2 new formal, contracted partnerships by 6/30/2023. (2) Establish at least 2 additional new non-contracted partnership</td>
<td>Tracking number of new formal, contracted partnerships. (2) Tracking number of new, non-contracted partnerships.</td>
<td>Dustin Ziegler, VP Community Programs</td>
<td></td>
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<tr>
<td>Establish, with guidance of MAC, a formal, organized, and strategic contracted partnership proposal. (3) Develop talking points and key messaging that resonates with clinical professionals and C-suite leaders that influences their perception of CICOA as genuine healthcare partner. (4) Develop new and improve existing relationships with key health/hospital leaders (5) Identify key metrics/outcomes to measure that demonstrate</td>
<td>Dedicated study and understanding of healthcare climate and research of similar models that have been tried in the past. (4) Money for proposals and other materials specific to clinical community. (5) Investment in a platform to capture data outcomes. (6) Investment in CICOA personnel to serve role as embedded staff member in clinical settings.</td>
<td>that have been attempted. (3) Updating strategic proposal and talking points (4) Meeting with leaders/decision makers of health/hospital networks to propose and discuss partnership details. (5) Drafting formal contracts. (6) Establishing outcome measurements. (7) Providing consistent quality assurance with partners and improving program processes and delivery.</td>
<td>of new non-contracted partnership collaborations. (4) Number of new contracted partnership. (5) Engagement and retention of MAC.</td>
<td>initiatives as result of clinical engagement efforts by 6/30/23.</td>
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<tr>
<td>External Factors</td>
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<th>success of partnerships.</th>
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2022-2023 AREA PLAN

ATTACHMENT III
### EXEMPT SERVICES WAIVER FORM

*(Title III-B; Title III-E; Ombudsman; SSBG; CHOICE)*

The Older Americans Act permits AAAs to perform some services directly without receiving a waiver from the State Unit on Aging. Those are Ombudsman, Care Management, Information and Assistance, and Outreach services. For monitoring and information purposes, this form must be completed for each of those services the AAA wishes to provide directly. Waiver to provide all other services directly must be requested using the *Application for Waiver for Direct Provision of Service*.

**AAA Name:** CICOA Aging & In-Home Solutions

**Authorized Signature**

June 7, 2021

**Date**

1. **Cost per Funding Source (if applicable):**
   - Title III-B= \( \text{Click here to enter text.} \)
   - Title III-E= \( \$321,000 \)
   - SSBG = \( \$1,223,331 \)
   - CHOICE= \( \$2,443,076 \)
   - Title VII= \( \text{Click here to enter text.} \)
   - OMB Assisted Living= \( \text{Click here to enter text.} \)
   - OMB EA= \( \text{Click here to enter text.} \)

2. **Service to be provided:**
   - □ Ombudsman
   - ☒ Care Management
   - □ Information and Assistance
   - □ Outreach

2. **Position/Title of AAA staff to be involved:**

<table>
<thead>
<tr>
<th>Position/Title of AAA staff to be involved</th>
<th>Full-Time</th>
<th>Part-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Director</td>
<td>☒</td>
<td>□</td>
</tr>
<tr>
<td>2 Assistant Directors</td>
<td>☒</td>
<td>□</td>
</tr>
<tr>
<td>11 Care Manager Supervisors, 11 Care Manager Team Leaders, 6 Care Manager Trainers, 134 Care Managers, 5 Care Coordinator Assistants, 1 Claims Management Specialist, 1 Home Modification Provider Coordinator, 1 Home Modification Specialist, 1 Administrative Assistant, 1 File Clerk</td>
<td>☒</td>
<td>□</td>
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</table>

Click here to enter text.
EXEMPT SERVICES WAIVER FORM  
(Title III-B; Title III-E; Ombudsman; SSBG; CHOICE)

The Older Americans Act permits AAAs to perform some services directly without receiving a waiver from the State Unit on Aging. These are Ombudsman, Care Management, Information and Assistance, and Outreach services. For monitoring and information purposes, this form must be completed for each of those services the AAA wishes to provide directly. Waiver to provide all other services directly must be requested using the Application for Waiver for Direct Provision of Service.

AAA Name: CICOA Aging & In-Home Solutions

[Signature]
Authorized Signature  
June 7, 2021  
Date

1. Cost per Funding Source (if applicable):
   - Title III-B= $Click here to enter text.
   - Title III-E= $158,040
   - SSBG =$440,000
   - CHOICE=$Click here to enter text.
   - Title VII=$Click here to enter text.
   - OMB Assisted Living=$Click here to enter text.
   - OMB EA=$Click here to enter text.

2. Service to be provided:
   - Ombudsman
   - Care Management
   - Information and Assistance
   - Outreach

2. Position/Title of AAA staff to be involved:

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<tr>
<th>Position/Title</th>
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<tbody>
<tr>
<td>1 Director</td>
<td>☒</td>
<td>□</td>
</tr>
<tr>
<td>2 Supervisors</td>
<td>☒</td>
<td>□</td>
</tr>
<tr>
<td>2 Team Leads, 16 Phone Options Counselors, 2 CareAware Options Counselors, 1 Community Outreach Options</td>
<td>☒</td>
<td>□</td>
</tr>
<tr>
<td>Counselor, 4 Call Routing Specialists, 1 Receptionist, 1 Options Counselor Assistant</td>
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</table>
APPLICATION FOR WAIVER
FOR DIRECT PROVISION OF SERVICE
(Title III-B, C, D, and E; SSBG; CHOICE)

AAA Name: CICOA Aging & In-Home Solutions

The Area Agency on Aging requests approval of the Division of Aging for direct provision of:

**Caregiver Support**

for funding source (check all that apply):

- [ ] Title III-B
- [ ] Title III-C1
- [ ] Title III-C2
- [ ] Title III-D
- [x] Title III-E
- [ ] SSBG
- [ ] CHOICE

by setting forth its justification for use of the funds and staff below and by describing the activities through which it has tried to recruit and develop other providers of this service. A separate application for waiver is included for each service that the AAA or other agency with the same board of directors as the AAA wishes to provide. This form must be completed in full.

June 7, 2021

Authorized Signature

<table>
<thead>
<tr>
<th>1. Cost per Funding Source (if applicable):</th>
<th>2. Provide justification for the use of funds and staff to provide the service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title III-B = $Click here to enter text.</td>
<td>The CareAware Options Counselor provides direct telephone assistance to caregivers to help them problem-</td>
</tr>
<tr>
<td>Title III-C1 = $Click here to enter text.</td>
<td>solve their unique situation. The options counselor refers caregivers to community resources, provides linkage with</td>
</tr>
<tr>
<td>Title III-C2 = $Click here to enter text.</td>
<td>other agencies or programs, and offers education, emotional support, advocacy and follow-up. The</td>
</tr>
<tr>
<td>Title III-D = $Click here to enter text.</td>
<td>CareAware Options Counselor is responsible for reaching out to the larger social service/aging community with a</td>
</tr>
<tr>
<td>Title III-E = $140,039</td>
<td>focus on health and related organizations that serve people with disabilities and their caregivers. The</td>
</tr>
<tr>
<td>SSBG = $Click here to enter text.</td>
<td>CareAware Options Counselor facilitates training and expert information related to assisting family caregivers.</td>
</tr>
<tr>
<td>CHOICE = $Click here to enter text.</td>
<td>This includes detailed knowledge about issues impacting caregivers, national and local resources, programs,</td>
</tr>
<tr>
<td></td>
<td>funding, and eligibility requirements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Position/Title of AAA staff to be involved:</th>
<th>Full Time</th>
<th>Part Time</th>
<th>% of time on administration of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Aware Options Counselor</td>
<td>[x]</td>
<td>[ ]</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Community Outreach Options Counselor</td>
<td>[x]</td>
<td>[ ]</td>
<td>Click here to enter text.</td>
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<tr>
<td>Click here to enter text.</td>
<td>[ ]</td>
<td>[x]</td>
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<td>Click here to enter text.</td>
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<tr>
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<td>[ ]</td>
<td>[x]</td>
<td>Click here to enter text.</td>
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</tbody>
</table>
4. List the names and addresses of providers who could provide this service to persons in the PSA. Do not limit your list to present providers or to those providers physically located in the PSA. Attach additional pages if you need more space.

5. Describe past activities aimed at recruiting or encouraging the development of other provider(s) of this service. Attach additional pages if you need more space.
   
   In addition to its own efforts to support family caregivers, CICOA and its CareAware department have supported other organizations’ development, ongoing outreach, and service to family caregivers in a variety of ways:
   1) CICOA has awarded Title III-E grant funds to numerous not-for-profit service providers in Area 8 including, but not limited to, selected adult day services who, in turn, use these funds for such things as caregiver education, caregiver counseling, and respite. As one example of CareAware’s direct involvement with these organizations, CareAware staff has met with caregiver support groups offered by Catholic Charities, in order to offer encouragement and support to leadership as these leaders seek to educate their caregiver attendees.
   2) CICOA’s CareAware staff has aggressively solicited and provided in-service trainings to allied health and human services organizations to increase staff understanding of how they can reduce serious risks to both caregiver and care recipient by including caregivers within the scope of “person-centered” care.
   3) CICOA has consistently partnered with organizations dedicated to reaching caregivers:
      a. as financial sponsors to promote and support selected caregiver events such as The Voice of Aging Conference (Applegate Elder Law), Alzheimer’s Association State Education Conference, St. Vincent Center for Healthy Aging, IU Foundation Alzheimer Disease Caregiver Symposium
      b. being available on-call when providers have questions about caregiver-related issues
      c. as speakers/educators at selected caregiver conferences held by partner agencies
      d. continually functioning in one-on-one mutual referral of individual caregivers with staff at agencies such as Alzheimer’s Association to ensure that all caregivers receive the most appropriate support according to the need.

6. Describe proposed activities for the period covered by this plan aimed at recruiting or encouraging the development of other provider(s) of this service. Attach additional pages if you need more space.
   
   In CICOA’s ongoing effort to recruit and foster the development of other provider(s) of this service to caregivers, CICOA proposes to:
   1) continue its engagement in all of the above activities
   2) place an increased emphasis on relationship-building in the following areas:
      a. Title III-E sub-grantees—e.g. soliciting more frequent opportunities to work with these agencies, being more available to speak to these groups to ensure timely delivery of information they may need for their caregivers
      b. utilization of opportunities to cultivate closer relationships with agencies such as Alzheimer’s Association, i.e. those in a position to assess caregivers, or make/receive, caregiver referrals for individualized care while remaining open to new opportunities and needs as they may become apparent.

7. Attach proof of advertising aimed at recruiting alternative provider(s) of this service.
PUBLIC NOTICE – FY-2022/23 Funds Available for Bid

CICOA Aging & In-Home Solutions expects to receive federal and state grants through the Indiana Family and Social Services Administration. The expected amounts for services are as follows: Older Americans Act Title III-B Social Services $1,345,847; Title III-D Preventative Health/Health Promotion $81,235; and Title III-E Caregiver Support Services $531,748; Title III-C-1 Congregate Meals and Title III-C-2 Home Delivered Meals $2,286,482 for residents 60 years and older in Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan and Shelby Counties. Applicants for provision of area-wide services must have the capability to provide services in all eight (8) counties. Applicants for provision of single-county services must have the capability to provide service county-wide.

Title III-B Access & Other Services

Area-wide services: Legal Assistance $ 41,549

Counties Allocations:
Boone County: Access Services* $ 26,942
Hamilton County: Access Services* $ 62,191
Hancock County: Access Services* $ 31,449
Hendricks County: Access Services* $ 52,947
Johnson County: Access Services* $ 54,902
Morgan County: Access Services* $ 31,682
Shelby County: Access Services* $ 30,823

* Access Services are defined as Information & Assistance, Outreach, and Transportation Services.

Contracts awarded to the above Title III-B Access, Title III-D Preventative Health/Health Promotion, Title III-E Caregiver Support Services, and Legal services will operate with a two-year commitment, subject to the availability of funds. The expected funds advertised herein are for the first year of the agreement. Providers who wish to apply for the above Title III-B Access, Title III-D Preventative Health/Health Promotion, Title III-E Caregiver Support Services, and Legal funding must:

1. Download grant application(s) at CICOA.org beginning Thursday, April 15, 2021.
2. Email completed application(s) as an attachment to Ms. Keithley at mkeithley@cicoa.org by Thursday, May 13, 2021 at 3 p.m.

(S-4/19/21 - 000-4692479) hspa10p
## APPLICATION FOR WAIVER

FOR DIRECT PROVISION OF SERVICE

(Title III-B, C, D, and E; SSBG; CHOICE)

**AAA Name:** CICOA Aging & In-Home Solutions

The Area Agency on Aging requests approval of the Division of Aging for direct provision of:

**Evidence-Based Health Promotion**

for funding source (check all that apply):

- [ ] Title III-B
- [ ] Title III-C1
- [ ] Title III-C2
- [x] Title III-D
- [ ] Title III-E
- [ ] SSBG
- [ ] CHOICE

by setting forth its justification for use of the funds and staff below and by describing the activities through which it has tried to recruit and develop other providers of this service. A separate application for waiver is included for each service that the AAA or other agency with the same board of directors as the AAA wishes to provide. This form must be completed in full.

**Authorized Signature:**

![Signature]

June 7, 2021

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### 1. Cost per Funding Source (if applicable):

<table>
<thead>
<tr>
<th>Source</th>
<th>Cost per Source</th>
</tr>
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<tbody>
<tr>
<td>Title III-B</td>
<td>$Click here to enter text.</td>
</tr>
<tr>
<td>Title III-C1</td>
<td>$Click here to enter text.</td>
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<tr>
<td>Title III-C2</td>
<td>$Click here to enter text.</td>
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<tr>
<td>Title III-D</td>
<td>$16,447</td>
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<tr>
<td>Title III-E</td>
<td>$Click here to enter text.</td>
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<tr>
<td>SSBG</td>
<td>$Click here to enter text.</td>
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<tr>
<td>CHOICE</td>
<td>$Click here to enter text.</td>
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</tbody>
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### 2. Provide justification for the use of funds and staff to provide the service:

CICOA uses a portion of its TIIID funding for coordination of evidence-based health promotion programs through its Meals & More department. This allows for targeted delivery of programming related to nutrition, healthy eating and self-management of chronic health conditions impacted by diet. Lay leaders and peer facilitators conduct programs. CICOA personnel provide coordination of workshops offered in Central Indiana.

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### 3. Position/Title of AAA staff to be involved:

<table>
<thead>
<tr>
<th>Name</th>
<th>Full Time</th>
<th>Part Time</th>
<th>% of time on administration service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiffany Cox, RD / Dietitian, Meals &amp; More</td>
<td>☒</td>
<td>☐</td>
<td>5%</td>
</tr>
<tr>
<td>Click here to enter text.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### 4. List the names and addresses of providers who could provide this service to persons in the PSA. Do not limit your list to present providers or to those providers physically located in the PSA. Attach additional pages if you need more space.

WKU Research Foundation, 1906 College Heights Blvd. #11026, Bowling Green, Kentucky 42101-1026
YMCA of Greater Indianapolis, 615 N. Alabama Street, Suite 200, Indianapolis, IN 46204
5. Describe *past* activities aimed at recruiting or encouraging the development of other provider(s) of this service. Attach additional pages if you need more space.

CICOA allocates about 80% of its Title IIIID funding to other organizations for Evidence-Based Health Promotion programs in the PSA. Additionally, IIIID funds available for competitive bid are published as part of the public awareness efforts each 2yr cycle.

CICOA’s IIIID funding to cover a portion of salary and expenses for Tiffany Cox, the Registered Dietitian who works with the local Diabetes Prevention and Education coalition. The RD helps coordinate community awareness of the program and makes referrals to the EBHP programs provided through the Indianapolis YMCA and other partners, she also supports the efforts of trainers and master trainers to schedule courses and recruit participants in the programs.

6. Describe *proposed* activities for the period covered by this plan aimed at recruiting or encouraging the development of other provider(s) of this service. Attach additional pages if you need more space.

The waiver request is to continue using a portion of CICOA’s IIIID funding to cover a portion of the salary and expenses for the Registered Dietitian and travel expenses for the VISTA worker.

CICOA is a member of the Indy Hunger Network and participates as a VISTA site through this coalition. One of the VISTA’s has a work plan that includes expanding nutrition and wellness education opportunities for participants in the Title III and other food assistance programs in serving older adults. One of the new course offerings is Bingocize, a EBHP program that provides nutrition education at neighborhood meal sites and other venues.

7. Attach proof of advertising aimed at recruiting alternative provider(s) of this service.
PUBLIC NOTICE – FY-2022/23 Funds Available for Bid

CICOA Aging & In-Home Solutions expects to receive federal and state grants through the Indiana Family and Social Services Administration. The expected amounts for services are as follows: Older Americans Act Title III-B Social Services $1,345,847; Title III-D Preventative Health/Health Promotion $31,735; and Title III-E Caregiver Support Services $531,748; Title III-C-1 Congregate Meals and Title III-C-2 Home Delivered Meals $2,286,482 for residents 60 years and older in Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan and Shelby Counties. Applicants for provision of area-wide services must have the capability to provide services in all eight (8) counties. Applicants for provision of single-county services must have the capability to provide service county-wide.

Title III-B Access & Other Services

Area-wide services: Legal Assistance $ 41,549

County Allocations:
Boone County: Access Services* $ 26,942
Hamilton County: Access Services* $ 62,191
Hancock County: Access Services* $ 31,469
Hendricks County: Access Services* $ 52,947
Johnson County: Access Services* $ 54,902
Morgan County: Access Services* $ 31,682
Shelby County: Access Services* $ 30,823

* Access Services are defined as Information & Assistance, Outreach, and Transportation Services.

Contracts awarded to the above Title III-B Access, Title III-D Preventative Health/Health Promotion, Title III-E Caregiver Support Services, and Legal services will operate with a two-year commitment, subject to the availability of funds. The expected funds advertised herein are for the first year of the agreement. Providers who wish to apply for the above Title III-B Access, Title III-D Preventative Health/Health Promotion, Title III-E Caregiver Support Services, and Legal funding must:

1. Download grant application(s) at CICOA.org beginning Thursday, April 15, 2021.
2. Email completed application(s) as an attachment to Mo Keilhley at mkeilhley@cicoa.org by Thursday, May 13, 2021 at 3 p.m.

(5 - 4/19/21 - 000-4692479) hspaxlp
APPLICATION FOR WAIVER
FOR DIRECT PROVISION OF SERVICE
(Title III-B, C, D, and E; SSBG; CHOICE)

AAA Name: CICOA Aging & In-Home Solutions

The Area Agency on Aging requests approval of the Division of Aging for direct provision of:

Community Access Transportation

for funding source (check all that apply):

☑ Title III-B  ☐ Title III-C1  ☐ Title III-C2  ☐ Title III-D  ☐ Title III-E  ☒ SSBG  ☐ CHOICE

by setting forth its justification for use of the funds and staff below and by describing the activities through which it has tried to recruit and develop other providers of this service. A separate application for waiver is included for each service that the AAA or other agency with the same board of directors as the AAA wishes to provide. This form must be completed in full.

June 7, 2021

Authorized Signature  Date

<table>
<thead>
<tr>
<th>1. Cost per Funding Source (if applicable):</th>
<th>2. Provide justification for the use of funds and staff to provide the service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title III-B= $133,740</td>
<td>CICOA proposes to use a portion of its Title III B, SSBG and CHOICE funds to provide non-emergency medical transportation and other paratransit services (Way2Go) in Marion County. Funding will support personnel and operating expenses for the program.</td>
</tr>
<tr>
<td>Title III-C1= $Click here to enter text.</td>
<td>CICOA began operating the senior transit service in Marion County in 2011, when the Indianapolis Senior Center closed its doors. CICOA expanded the program to include all of Marion County, increased the number of vehicles in the fleet and leveraged additional financial and in-kind resources to support the service. In addition to its own fleet, CICOA contracts with other local providers for weekend and after-hours services.</td>
</tr>
<tr>
<td>Title III-D= $Click here to enter text.</td>
<td>Transportation is a high-demand service for older adults. It required significant investment for capital (fleet and equipment) and logistical support. Under CICOA's direction, the program has expanded its coverage area, added new vehicles to the fleet, and dramatically increased ridership.</td>
</tr>
<tr>
<td>Title III-E= $Click here to enter text.</td>
<td></td>
</tr>
<tr>
<td>SSBG = $415,158</td>
<td></td>
</tr>
<tr>
<td>CHOICE= $Click here to enter text.</td>
<td></td>
</tr>
</tbody>
</table>
### 2022-2023 AREA PLAN

#### ATTACHMENT V

3. **Position/Title of AAA staff to be involved:**

<table>
<thead>
<tr>
<th>Position/Title</th>
<th>Full Time</th>
<th>Part Time</th>
<th>% of time on administration of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Director</td>
<td>☒</td>
<td>☐</td>
<td>10%</td>
</tr>
<tr>
<td>1 Driver Supervisor</td>
<td>☒</td>
<td>☐</td>
<td>10%</td>
</tr>
<tr>
<td>1 Billing Specialist and Administrative Assistant</td>
<td>☒</td>
<td>☐</td>
<td>15%</td>
</tr>
<tr>
<td>2 Dispatchers</td>
<td>☒</td>
<td>☐</td>
<td>30%</td>
</tr>
<tr>
<td>14 Full Time Drivers</td>
<td>☒</td>
<td>☐</td>
<td>35%</td>
</tr>
<tr>
<td>1 Occasional Driver</td>
<td>☐</td>
<td>☒</td>
<td>35%</td>
</tr>
</tbody>
</table>

4. List the names and addresses of providers who could provide this service to persons in the PSA. Do not limit your list to present providers or to those providers physically located in the PSA. Attach additional pages if you need more space.

Way2go Transportation 8440 Woodfield Crossing Blvd., Ste 175 Indianapolis, IN 46240
Access Johnson County Public 3500 N Motion St Franklin, IN 46131
Boone County Senior Services 515 Crown Point Lebanon, IN 46052
Foster Financial Inc 9644 Morel Ct Indianapolis, IN 46256
Hendricks County Senior Services 1201 Sycamore Ln Danville, IN 46122
Ztrips 3801 W Morris St Indianapolis, IN 46241
Indy Airport Taxi 4849 W Washington St Indianapolis, IN 46241
Morgan County CONNECT 1369 N Blue Bluff Rd Martinsville, IN 46151
Indy Friendly Travel 3702 N Emerson Ave Indianapolis, IN 46218
A-Tin Transportation 55 S State Ave Indianapolis, IN 46201
AI Transportation 2737 E 56th St Ste G Indianapolis, IN 46220
Avail Medical Transport PO Box 807 Noblesville, IN 46061
Blue River Medicar 4427 N Billman E Shelbyville, IN 46176
Compassionate Medical 636 E 34th St Indianapolis, IN 46203
Disabled American Veterans 575 N Pennsylvania St Indianapolis, IN 46204
EZ Rider 8181 Jordan Ln Indianapolis, IN 46240
Home Link Transportation 10948 Innisbrook L Fishters, IN 46037
Indy-Go Open Door 1501 W Washington St, Indianapolis, IN 46222
Little Red Door 1801 N Meridian St, Indianapolis, IN 46202
Road to Recovery (American Cancer Society) 5635 W 96th St Ste 100, Indianapolis, IN 46278
Seniors Helping Seniors 9616 Hamilton Hills Dr, Fishers, IN 46038
Hamilton County Express 1555 Westfield Road Noblesville, Indiana 46062
Hancock Area Rural Transit 1870 Fields Blvd, Greenfield, IN 46140
Johnson County Senior Services 731 S State St, Franklin, IN 46131
Primelife Enrichment 1078 3rd Ave SW, Carmel, IN 46032
Mooreville Senior Citizens Center 4305 E State Rd 144, Mooresville, IN 46158
Cancer Association of Shelby County 31 Public Sq, Shelbyville, IN 46176
Sblay Go 1504 S Harrison St, Shelbyville, IN 46176
Wheel to Wellness Reuben Senior & Community 6905 Hoover Rd Indianapolis, IN 46260

5. Describe past activities aimed at recruiting or encouraging the development of other provider(s) of this service. Attach additional pages if you need more space.

CICOA actively supports the development of additional transportation and paratransit resources in Central Indiana. CICOA awards Title III funds to one focal point provider in each county (referred to as a county service corporation.) In addition to grant funding, CICOA participates in several coalitions to promote the programs and encourage additional community support for senior transportation.
In addition to its own services, CICOA coordinates transportation through a network of providers. Way2go provides a service called My Freedom. This allows clients of any age with a disability that makes it hard for them to utilize public transportation, the option of having a transportation service pick them up at their home and provide door to door service. Additionally, this service also allows clients to cross county lines for their transportation needs. Multiple providers signed an agreement to provide these services to clients and be reimbursed by CICOA for the transports. Providers have enjoyed being able to electronically submit their invoices for payment and they also can scan a client's fare card to verify that the client has paid fare available. This is the only program in central Indiana that allows cross county transports.

Way2go transportation became a Medicaid provider back in 2017 and continues to be a provider for traditional Medicaid services under the Indiana state broker, Southeastrans. These services include transportation for medical appointments and for pharmacy runs.

6. Describe proposed activities for the period covered by this plan aimed at recruiting or encouraging the development of other provider(s) of this service. Attach additional pages if you need more space. As noted above, CICOA continues to promote the development of additional transportation resources and providers. This includes working with CIRTA (Central Indiana Regional Transit Authority) and others to identify additional funding for medical and non-medical transit services.

Transportation services in Central Indiana are hampered by the fragmentation of services. Many transit systems operate only within a single county. Many of the organizations that receive federal transportation funding for capital equipment only use their fleet to provide trips for their clients/members. Rather than additional providers, CICOA is focused on increasing the coordination of existing resources. CICOA has invested in routing/scheduling software to help coordinate service among multiple providers. We continue to work with other providers to establish services that provide trips across county lines.

7. Attach proof of advertising aimed at recruiting alternative provider(s) of this service.
PUBLIC NOTICE – FY-2022/23 Funds Available for Bid

CICOA Aging & In-Home Solutions expects to receive federal and state grants through the Indiana Family and Social Services Administration. The expected amounts for services are as follows: Older Americans Act Title III-B Social Services $1,345,847; Title III-D Preventative Health/Health Promotion $81,235; and Title III-E Caregiver Support Services $531,748; Title III-C-1 Congregate Meals and Title III-C-2 Home Delivered Meals $2,286,482 for residents 60 years and older in Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan and Shelby Counties. Applicants for provision of area-wide services must have the capability to provide services in all eight (8) counties. Applicants for provision of single-county services must have the capability to provide service county-wide.

Title III-B Access & Other Services

| Area-wide services: Legal Assistance | $41,549 |

| County Allocations:               |
| Boone County: Access Services*    | $26,942 |
| Hamilton County: Access Services* | $62,191 |
| Hancock County: Access Services*  | $33,149 |
| Hendricks County: Access Services*| $62,947 |
| Johnson County: Access Services*  | $54,962 |
| Morgan County: Access Services*   | $31,682 |
| Shelby County: Access Services*   | $30,823 |

* Access Services are defined as Information & Assistance, Outreach, and Transportation Services.

Contracts awarded to the above Title III-B Access, Title III-D Preventative Health/Health Promotion, Title III-E Caregiver Support Services, and Legal services will operate with a two-year commitment, subject to the availability of funds. The expected funds advertised herein are for the first year of the agreement. Providers who wish to apply for the above Title III-B Access, Title III-D Preventative Health/Health Promotion, Title III-E Caregiver Support Services, and Legal funding must:

1. Download grant application(s) at CICOA.org beginning Thursday, April 15, 2021.
2. Email completed application(s) as an attachment to MKelthley@cicoa.org by Thursday, May 13, 2021 at 3 p.m.
*NOTE: CICOA is undergoing organizational change with development and implementation of the FY22-FY24 strategic plan; changes will be completed by 12/31/21.*
# Neighborhood Meal Sites Listed by County

Revised 05/19/2021

CICOA Aging & In-Home Solutions  
8440 Woodfield Crossing Blvd., Ste. 175  
(800) 489-9550  
TDD: (317) 254-5497

Web Site: www.cicoa.org

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**Boone County**

**Thorntown**  
Thorntown Public Library  
124 N Market Street  
Thorntown, IN 46071  
Lunch Served: 11:30 am

**Crawford Manor**  
9940 Hoosier Village Drive  
Indianapolis, IN 46268  
Lunch Served: 11:15 am

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**Hamilton County**

**Carmel**  
PrimeLife Enrichment  
1078 3rd Avenue SW  
Carmel, IN 46032  
Lunch Served: 11:30 am  
Mon, Tue, Thurs Only

**Sheridan**  
Spicewood Garden Apts.  
901 Basil Lane  
Sheridan, IN. 46069  
Lunch Served: 12:00 pm

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**Hendricks County**

**Danville**  
Hendricks County Senior Center  
1201 Sycamore Lane  
Danville, IN 46122  
Lunch Served: 12:00 pm

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**Johnson County**

**Greenwood**  
Social of Greenwood  
550 Polk Street  
Greenwood, IN. 46143  
Lunch Served: 11:30 am

**Marion County**

**Beech Grove – 46107**  
Cambridge Square of Beech Grove  
331 E. Churchman Place  
Beech Grove, IN 46107  
Lunch Served: 11:00 am

**Indianapolis – 46201**  
John Boner Community Center at New Life Manor  
1030 N. Beville Ave  
Indianapolis, IN 46201  
Lunch Served: 11:00 am

**Indianapolis – 46202**  
Indiana Ave. Apartments  
825 Indiana Ave.  
Indianapolis, IN 46202  
Lunch Served: 11:00 am

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**Indianapolis – 46204**  
Barton Annex  
501 N. East St.  
Indianapolis, IN 46204  
Meal Served: 10:30 am

**Indianapolis – 46205**  
Stetson Senior Apartments  
703 E. 30th Street  
Indianapolis, IN 46205  
Lunch Served: 11:00 am

**Indianapolis – 46220**  
Carriage House of Glendale  
2520 Tacoma Circle, Bldg 3  
Indianapolis, IN 46220  
Lunch Served: 12:00 pm

**Indianapolis – 46226**  
Community Alliance of Far Eastside (C.A.F.E.)  
8902 E. 38th St.  
Indianapolis, IN 46226  
Lunch Served: 11:00 am  
Mon, Tue, Wed, &Thurs. Only

**Indianapolis – 46227**  
Bethany Village  
3554 S. Shelby St.  
Indianapolis, IN 46227  
Lunch Served: 11:00 am

**Indianapolis – 46202**  
Green Park Terrace  
110 E. Meridian School Rd.  
Indianapolis, IN 46227  
Lunch Served: 11:30 am
Neighborhood Meal Sites Listed by County
Revised 05/19/2021

CICOA Aging & In-Home Solutions
8440 Woodfield Crossing Blvd., Ste. 175
(800) 489-9550
TDD: (317) 254-5497

FOR INFORMATION AND MEAL RESERVATIONS
PLEASE CALL (317) 803-6042

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**Indianapolis – 46228**
Mt. Zion Suburban
5260 N. Michigan Rd.
Indianapolis, IN 46228
Lunch Served: 11:00 am

**Indianapolis – 46254**
AHEPA WEST
5685 Eden Village Drive
Indianapolis, IN 46254
Lunch Served: 12:00 pm

**Indianapolis – 46256**
AHEPA
7355 Shadeland Station Way
Indianapolis, IN 46256
Lunch Served: 11:00 am

**Indianapolis – 46260**
Elder Source of Greater Indianapolis
6701 Hoover Rd.
Indianapolis, IN 46260
Lunch Served: 12:00 pm
Tuesdays Only

**Indianapolis - 46240**
Nora Commons on the Monon
8905 Evergreen Ave.
Indianapolis, IN 46240
Lunch Served: 11:00 am

**Indianapolis - 46268**
The Towers of Crooked Creek
7988 N. Michigan Rd.
Indianapolis, IN 46268
Lunch Served: 11:00 am

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**Morgan County**

**Martinsville**
Ken-Mar Apartments
210 W. Pike Street
Martinsville, IN 46151
Lunch Served: 11:30 a.m.

**Shelby County**

**Shelbyville**
Shelbyville Senior Center
1504 S. Harrison Street
Shelbyville, IN 46176
Lunch Served: 11:00 am

Monday – Friday unless noted otherwise
CICOA offers a voucher program that enables individuals age 60 and over to have more options and increased flexibility in their dining choices. For a suggested contribution of $3.00 per meal, seniors can receive a re-usable meal card that may be redeemed at any participating cafeterias and restaurants for breakfast, lunch or dinner. Participating locations have varying hours as listed below.

**PARTICIPATING LOCATIONS**

Community Hospital East
7am-7pm

Community Hospital North
Breakfast 6:30-10am / Lunch 11am-2pm / Dinner 2-8pm

Community Hospital South
Breakfast 6:30-10am / Lunch 10:30am-1:30pm / Dinner 4pm-7pm

Crestwood Village South Restaurant
7am-7pm

Grandma’s Pancake House & Restaurant (Shelby County)
6am-8pm

Hancock Regional Hospital
Breakfast 6:30-10:30am M-F / Lunch 11-2pm M-Su / Dinner 4-7pm M-Su

Hendricks Regional Health
Breakfast 7-9am / Lunch 11:30am-1:30pm / Dinner 5-7:30pm

Major Hospital (Shelby County)
Breakfast 7-10:30am / Lunch 11am-1:30pm / Dinner 5-7pm

Riverview Health (Hamilton County)
Breakfast 7-10am / Lunch 11am-2pm / Dinner 2-7:30pm

St. Vincent Health – 86th Street
Breakfast 6:30-10am / Lunch & Dinner 10:30am-7pm

Witham Hospital (Boone County)
Breakfast 6:30-9:30am / Lunch 11am-1:30pm

**VOUCHER ENROLLMENT SITES**

Boone County Senior Services
Enrollment applications are available Monday through Friday from 8 am to 4:30 pm while supplies last. Contact Jenny Lemen 765-482-5220
CICOA Meals & More Department
Enrollment applications are available Monday through Friday from 8:30 am – 4:30 pm by appointment only. Contact Meals & More 317-803-6042

Community Hospital East
Enrollment applications will be available on the first Wednesday of each month, 10 am to noon at the Touchpoint program office at Community Hospital East. Contact Victoria Dowell 317-621-4870

Community North Hospital
Enrollment applications are available on the first Wednesday of each month from 10 am to noon. Contact Victoria Dowell 317-621-4870

Community Hospital South
Enrollment applications are available on the first Wednesday of each month from 8am to 11am. Contact Victoria Dowell 317-621-4870

Crestwood Village South
Please see building managers for enrollment applications or Contact Barbara Jarjoura 317-885-3461

Greenfield Senior Center
Enrollment applications are available on the first Monday and Wednesday of each month at the Patricia Elmore Senior Center, 280 Apple Street in Greenfield. Contact Kim Voorhis 317-477-4343

Hancock County Senior Services
Enrollment applications are available 9-12 noon on Wednesdays, Contact Joyce 317-462-3758 at Hancock County Senior Services, 1870 Fields Blvd., Greenfield.

Hendricks County Senior Services
1201 Sycamore Lane, in Danville, Contact Becky Maher 317-745-4303

Horizon Center-Shelby Senior Center
Enrollment applications are available each month from 8 am to 4:30 pm at the Horizon Center while supplies last. Contact Kamessa "Kami" LaRue 317-398-0127

Prime Life Enrichment
Call for an appointment. Contact Mackenzie Coughlin, Outreach Coordinator 317-815-7000

Riverview Hospital Gift Shop, 395 Westfield Rd, Noblesville IN 46060
Monday- Friday 8:30 am -4:30 pm

St. Vincent Hospital Community Outreach Department
2001 W 86th St., Indianapolis. Contact Damita Moore 317-338-2205
FINANCIALS

AAA #8 Cost Allocation Plan

<table>
<thead>
<tr>
<th>FY2021 Budget (Budgets for FY22 &amp; FY23 TBD)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff salaries and wages</td>
<td>$17,650,542</td>
</tr>
<tr>
<td>Employee Benefits $</td>
<td>$7,198,900</td>
</tr>
<tr>
<td>Facility (rent, electricity, etc.)</td>
<td>$665,000</td>
</tr>
<tr>
<td>Telephone and postage $</td>
<td>$619,080</td>
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<tr>
<td>Insurance</td>
<td>$129,070</td>
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<tr>
<td>Travel and Transportation</td>
<td>$417,180</td>
</tr>
<tr>
<td>Capital Expenditures ($5,000 or more)</td>
<td>0</td>
</tr>
</tbody>
</table>

Funding Allocation – by Percentage
Provide the percentage of total AAA program funding by (1) Personnel, (2) Operational, and (3) Direct Service categories.

<table>
<thead>
<tr>
<th>Program</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>$24,849,442</td>
<td>64.6%</td>
</tr>
<tr>
<td>Operational</td>
<td>$4,123,640</td>
<td>10.7%</td>
</tr>
<tr>
<td>Direct Service</td>
<td>$9,498,059</td>
<td>24.7%</td>
</tr>
<tr>
<td>Total FY21 budget:</td>
<td>$38,471,141</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program</th>
<th>Percent of budget (FY2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Americans Act (OAA), Titles III and VII</td>
<td>13.8%</td>
</tr>
<tr>
<td>CHOICE</td>
<td>10.6%</td>
</tr>
<tr>
<td>Social Services Block Grant (SSBG)</td>
<td>5.6%</td>
</tr>
<tr>
<td>Waiver Intake &amp; Preadmission Screening and Resident Review (PASRR)</td>
<td>6.8%</td>
</tr>
<tr>
<td>Medicaid Waiver</td>
<td>35.7%</td>
</tr>
<tr>
<td>Grants</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other Federal</td>
<td>6.9%</td>
</tr>
<tr>
<td>Other State &amp; Local</td>
<td>1.4%</td>
</tr>
<tr>
<td>Other Income</td>
<td>12.0%</td>
</tr>
<tr>
<td>In-Kind</td>
<td>7.1%</td>
</tr>
</tbody>
</table>
**POLICY:** CICOA will have a contingency and disaster recovery plan to assure continued successful agency operation and patient care in the event of natural or manmade emergencies. CICOA will also have plans in effect to access ePHI while in emergency operation mode.

**PURPOSE.** To have ready the tools and information needed to immediately respond to any emergency. To assure the agency staff knows what specific steps are necessary to protect and restore business operations, assure employee and patient safety and protect data resources in the event of business interruptions, natural disasters or man-made emergencies.

I. PROCEDURES FOR IMPLEMENTATION:

A. Applications and Data Critical Analysis

1. CICOA must assess the relative criticality of specific applications and data for purposes of developing its Data Backup Plan, its Disaster Recovery Plan and its Emergency Mode Operation Plan.

2. The assessment of data and application criticality shall be conducted every two years in conjunction with the risk analysis to ensure that appropriate procedures are in place for data and applications at each level of risk.

B. Data Backup Plan

1. CICOA must establish and implement a Data Backup Plan pursuant that would enable the creation and maintenance of retrievable exact copies of all ePHI determined to be of significant risk.

2. The Data Backup Plan must apply to all designated files, records, images, voice or video files that may contain ePHI.

3. The Data Backup Plan must require that all media used for backing up ePHI be stored in a physically secure environment, such as a secure offsite storage facility or, if backup media remains on site, in a physically secure location, different from the location of the computer systems it backed up.

4. If an offsite storage facility or backup service is used, a written contract or Business Associate Agreement must be used to ensure that the Business Associate will safeguard the ePHI in an appropriate manner.
5. Data backup procedures outlined in the Data Backup Plan must be tested on an annual basis to ensure that exact copies of ePHI can be retrieved and made available.

C. Disaster Recovery Plan

1. To ensure that CICOA can recover from the loss of data due to an emergency or disaster effecting systems containing ePHI, CICOA must establish and implement a Disaster Recovery Plan that will enable the restoration and/or recovery of any loss of ePHI and the systems needed to make that ePHI available in a timely manner.

2. The Disaster Recovery Plan should include procedures to log system outages, failures and data loss to critical systems and procedures to train the second level support personnel to implement the disaster recovery plan. Second level on call personnel will respond to the disaster.

3. The Disaster Recovery Plan must be documented and easily available to the necessary personnel at all times, who should be trained to implement the Disaster Recovery Plan.

4. The Disaster Recovery Procedures outlined in the Disaster Recovery Plan must be tested on a periodic basis to ensure that ePHI and the systems needed to make ePHI available can be restored or recovered.

5. In the event of a global public health emergency such as COVID-19, CICOA will follow guidance provided by Indiana Family & Social Services Administration, Division of Aging on ensuring all LTSS case management standards are completed either virtually or telephonically until Division of Aging communicates the end of these alternative workflow processes.

D. INITIAL PROCEDURE. The Disaster and Emergency Team will document the following information in binders:

- Contact information for key vendors, serial numbers, etc.
- Specific emergency notification procedures, names, numbers of staff (phone tree)
- Work around procedures as in equipment, telephone, electricity, etc.
• IT procedures to bring up lost IT functions in the proper sequence and testing
• Accountability during contingency operations
• All emergency policies
• Specific triggers to activate emergency procedures
• Location of data backup

E. Copies of Disaster Recovery Plans will be located in secure locations, which can be easily accessed by the disaster recovery team members.

F. All employees will be notified of the designated disaster recovery team employees.

G. Training will be given and drills performed and documented. Vendors will be contacted for their testing strategies and procedures for system failures.

H. An application and data criticality analysis shall be performed to determine which systems, applications and data are most vital for restoration, to determine which systems require the most focus.

I. Periodically review the data resources of the agency including operational data and ePHI.

J. An emergency operation mode plan shall be created to ensure critical ePHI data can be accessed in the event of a disaster, while the DRP is in effect.

K. Any physical media will be reused on a rotating basis. All backups will be encrypted upon storage.

L. Data backups will be stored in a secure off site facility.
Addendum

COVID RESPONSE - RECOVERY PLAN
Effective Date: March 18, 2020

PURPOSE. To assure the agency staff knows what specific steps are necessary to protect and restore business operations, assure employee and client safety, and protect data resources during the occurrence of the COVID-19 pandemic.

I. Procedures for Implementation

A. Communication

1. Daily communication from Chief Executive Officer or an alternate member of CICOA’s Strategy Team will be distributed to all agency staff via email. This communication will include updates from federal, state, and local government concerning health precautions, client safety and data security.

B. Employee Safety

1. Agency staff will be instructed to follow safety guidelines announced and regularly updated from the Center for Diseases Control.
2. If deemed necessary, CICOA offices will close with monitored, limited or no access. Necessity will be based on Marion County positivity rate.
3. If CICOA access is permitted, PPE will be provided for employees and be available in all common areas.
4. Expectations concerning masks and social distancing will be communicated and changes updated regularly.
5. Agency staff experiencing direct exposure or symptoms will self-quarantine for the recommended period.
6. Agency staff testing positive are asked to report results to CICOA’s Human Resources along with the following information:
   • When did you receive a positive test result?
   • When were you last in CICOA offices?
   • What areas did you visit (breakroom, restroom, specific departments, reception area, etc.)?
   • Did you have contact with other individuals in the building, is so please provide names.
7. CICOA will develop a “Return to Work” plan taking into consideration the
current CDC guidelines as well as information from the State/Division of Aging and/or FSSA.

C. Client Safety

1. CICOA will not perform Home Visits or other client facing services such as community events until deemed safe by the State/Division of Aging and/or FSSA.
2. CICOA will suspend services at the congregate meal sites. However, meals will be delivered to clients requesting meal assistance.
3. CICOA’s Way to Go Transportation will remain operational for essential services.
4. CICOA will reinstate services based on direction from the State/Division of Aging and/or FSSA.

D. Protection of Data Resources and PHI

1. Server security will be confirmed with CICOA’s Information Systems managed service vendor, Innovative Integration.
2. PHI is and will be protected through CICOA’s VPN log-on for offsite access. This remote access will be further secured with a dual log on process and security enhancement through Forticlient.
3. System updates will be consistently ran as security patches are released from application manufacturers to further protect company data and systems.