ACRONYMS

AAA	Area Agency on Aging
AARP	American Association of Retired Persons
AAS	Aging and Adult Services
ACL	Administration for Community Living
ADA	Americans with Disabilities Act; Aged and Disabled Adults Medicaid Waiver
ADC	Adult Day Care
ADI	Alzheimer's Disease Initiative
ADL	Activities of Daily Living
ADRC	Aging and Disabled Resource Center
ADRDA	Alzheimer's Disease and other Related Diseases Association
AFC	Adult Foster Care
AHCA	Agency for Health Care Administration
AIMS	Agency Information Management System
ALF	Assisted Living Facilities
AOA	Administration on Aging
APS	Adult Protective Services
ARC	Aging Resource Center
ASA	American Society on Aging
BPL	Below Poverty Level
BEC	Benefits Enrollment Center
CAP	Corrective Action Plan
CARES	Comprehensive Assessment and Review of Long-Term Care Services
CCDA	Community Care for Disabled Adults
CCE	Community Care for the Elderly
CCSA	Community Care Service Area
CDBG	Community Development Block Grant
CEU	Continuing Education Unit
CIRTS	Client Information and Registration Tracking System
CIS	Client Information System
CMS	Centers for Medicare and Medicaid
COA	Council on Aging
COEA	Council on Elder Affairs
CSS	Community Service System
DAC	Disaster Application Center
DAP	Disaster Application Program
DAR	Daily Activity Report
DCA	Department of Community Affairs
DCF	Department of Children & Families
DDPO	Director of Disaster Planning Operations
DEM	Division of Emergency Management
DFO	Disaster Field Office
DFS	Department of Financial Services
DHHS	Department of Health and Human Services
DOEA	Department of Elder Affairs
DPOAA	District Aging and Adult Services
DRC	Disaster Recovery Center

DRM	Disaster Recovery Manager
EARS	Emergency Alert Response Service
ECMIS	Elder Care Management Information System
EHEAP	Emergency Home Energy Assistance for the Elderly Program
EPC	Emergency Preparedness Coordinator
ES	Economic Services
ESD	Emergency Services Director
ESF	Emergency Support Function
FAHA	Florida Association of Homes for the Aged
FALA	Florida Assisted Living Association
FASP	Florida Association of Service Providers
FCOA	Florida Council on Aging
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FEOC	Forward Emergency Operations Center
FFY	Federal Fiscal Year
FMMIS	Florida Medicaid Management Information System
F4A	Florida Association of Area Agencies on Aging
GR	General Revenue
GRTS	Geriatric Residential Treatment Systems
HB	House Bill
HCBS	Home and Community Based Services
HCDA	Home Care for Disabled Adults
HCE	Home Care for the Elderly
HHA	Home Health Agency
HFA	Housing Finance Agency
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily Living
ICF	Intermediate Care Facility
ICP	Institutional Care Program
I&R	Information and Referral
ITN	Interest to Negotiate
JCE	Jacksonville Coalition for Equality
JTPA	Job Training Partnership Assistance Program
LGBT	Lesbian, Gay, Bisexual, Transgender
LIHEAP	Low Income Home Energy Assistance Program
LNS	Limited Nursing Services
LOC	Level of Care
LSP	Local Service Program
LTCOC	Long Term Care Ombudsman Council

MaRCy	Mobile Resource Center
MDC	Memory Disorder Clinic
MIPPA	Medicare Improvements for Patients and Providers Act
MOW	Meals on Wheels
N4A	National Association of Area Agencies on Aging
NCOA	National Council on Aging
NFCAA	Northeast Florida Community Action Agency, Inc.
NOI	Notice of Instruction
NSIP	Nutrition Services Incentive Program
OAA	Older Americans Act
OMB	Office of Management and Budget
OSS	Optional State Supplementation
PDAA	(State Office of) Aging and Adult Services
PI	Primary Individual
POA	Power of Attorney
PSA	Planning and Service Area
RELIEF	Respite for Elders Living in Everyday Families
RFI	Request for Information
RFP	Request for Proposal
RSVP	Retired Senior Volunteer Program
SAGE	Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders
SCO	State Coordinating Officer
SCORE	Senior Corporation of Retired Executives
SECC	Senior Emergency Coordination Center
SEOC	State Emergency Operations Center
SE4A	Southeastern Association of Area Agencies on Aging
SHINE	Serving Health Insurance Needs of Elders
SHIP	State Health Insurance Assistance Program (SHINE in Florida)
SHIP	State Housing Initiatives Partnership
SMMCLTC	Statewide Medicaid Managed Care Long Term Care Program
SNF	Skilled Nursing Facility
SPA	Service Provider Application
SSA	Social Security Administration
SSI	Supplemental Security Income
SUA	State Unit on Aging
USDA	United States Department of Agriculture
VDC	Veterans Directed Care
VDHCBS	Veterans Directed Home and Community Based Care (aka Veterans Choice)

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ElderSource
Planning and Programs Committee Agenda
June 15, 2023
11:00 AM

I. **Old Business**

A. **Minutes**

- April 20, 2023

B. **ElderSource Programs**

- **Programs Report**
  - Program/Planning updates - (Fred)
  - Report Highlights and Contract Updates (Terika)
  - Surplus/Deficit Report (Terika)
  - Numbers Served/Monthly Expenditures (CCE; ADI; HCE; OA3B/E; OC32/1)-(Terika)

- **Community Services Report** (Renee)
  - Helpline
  - Intake and Screening Team
  - Medicaid Eligibility Team
  - SHINE/SMP/MIPPA/BEC

- **Operations Service Report** (Fred**)**
  - Brief programmatic updates
  - Senior to Senior
  - Caregiver Program(s)/Supports (*TCare program, etc*.)
  - Telephone Reassurance Programs (The *Caring Connections* Telephone Reassurance Program, etc.)
  - Tablet Program
- **Updates**
  - Area Plan update-(Janet)
  - Emergency Preparation & Planning (Janet)

Programs Committee Minutes
10688 Old St Augustine Rd
Thursday April 20, 2023
11:00 AM
Via Zoom

Present
Barbara Greene
Cynthia Griffin
Walette Stanford

Staff
Linda Levin, CEO
Trina Nullet, CFO
Fred Richards, VP of Plan/Prgs/Compl/Inclu
Janet Dickinson, Planner
Sherry Holmes, Administrative Assistant

Absent
Grady Williams - Excused

Meeting Called to Order
Walette Stanford called the meeting to order at 11:05 AM.

Approval of Minutes
A motion to accept the December 15, 2022 minutes and the February 16, 2023 minutes was made by Barbara Greene and seconded by Cynthia Griffin. Motion was unanimously approved.

Programs Report
Fred Richards reviewed highlights from the Programs Report:

- APS - All high-risk referrals were accepted.
- We are currently exploring the Vaccination Grant.
- ADI and CCE – We are projecting significant surpluses in these Programs. We met with our Providers to ensure that if we are not exhausting all of our funds that we are providing or transferring funds to our other PSAs' Programs that would benefit from these funds for services.

Older American Act (OAA) Programs

- Title IIIB *(Support Services)*
- Title IIIC1 *(Congregate Meals)*
- Title IIID *(Health and Wellness)*
- Title IIIC2 *(Home Delivered Meals Programs)*
- Title IIIE *(Care Giver Support Program)*

Fred noted that there is no concern with these Programs spending out.

Surplus Deficit

General Revenue

Alzheimer Disease Initiative (ADI) and Community Care for the Elderly (CCE)

A meeting was held with the Providers on April 5 to address the surpluses in ADI and CCE.

Barriers Identified:

- Low client referral volume
- Staff recruitment
- Securing Home Health Aides
- Clients moved or deceased before services could start
- Challenges with vendor availability

Solutions Discussed:

- Add clients as contract increases are going to occur for period of July 2023 to June 2024 (need is growing)
- Providers continue to work to hire staff and approve additional vendors
- Providers submit revised budgets
- Purchase consumables-authorize monthly
- Provide home improvement

Other Suggestions:

- Shelf stable meals
- Purchasing Hurricane Kits
- Commodity supply deliveries $100-$200 monthly

The legislation to allow 10% carry forward- if it passes it will be for the 2023-24 contract period.

Transfer of funds: On April 5th we offered DOEA, $800,000 of our CCE funds to be reallocated to other PSAs rather than leaving the funds on the table.

Veterans Directed Care Program

Veterans are referred to this program through the Veterans Administration Medical Centers (VAMC) located in Gainesville and Orlando. We have a total of 83 Veterans enrolled in this Program. Orlando has 25 Active, Gainesville has 56 and South Georgia has 2 clients enrolled. Referrals are projected to increase in April. This Program is being restructured and adding one full-time Person-Centered Counselor to ensure quality service and an opportunity to expand our service reach. There are 25 pending cases.

Florida Disaster Fund Award (Volunteer Florida)

The MOU for the Ian Response ($600k) grant was signed on February 14, 2023. There are no restrictions on the use of the funds. Possible geographic areas of focus/delivery of service are St. Johns, Volusia and Flagler Counties. The MOU was revised to have partnered agencies make referrals in the counties affected by Hurricane Ian. ElderSource will accept the referrals externally and address them internally through our existing Senior 2 Senior program. If the referral volume exceeds our capacity to address, we may hire a Coordinator position.

United Way Flagler/Volusia – We have confirmed a partnership with their Community Impact Sr. Manager, Ms. Francine Martin, on February 7.

St. Johns Housing Partnership, Inc. – We are exploring a partnership with this agency, and they would oversee the St. Johns area. A meeting is scheduled for next week.

VIND – Volusia Interfaith/Agencies Networking in Disaster – We are exploring a partnership with them, and they would oversee the Volusia and Flagler areas. A meeting is scheduled for May 3.

USAging-Aging and Disability Vaccination Collaboration

This grant has been on hold as the staff's focus was on launching the Volunteer Florida grant, but we were still active communicating with various partners and seeking clarification from the grantor USAging on who we can partner with. The focus is on vaccinations, support services, transportation, personal support referrals and outreach and education. There are quite a few Centers for Independent Living (CIL) that are interested and unfortunately Florida Health is not interested at this time. Fred noted we will continue to form and develop partnerships and not give up as there is an opportunity for us to pull down those funds and make an impact on vaccinations.

ADRC Summary Report

Renee Knight, VP of Community Services reviewed the ADRC Summary with the committee. The report detailed the following information:

- Helpline
- Intake & Screening Team
- Medicaid Eligibility Team
- SHINE/SMP/MIPPA/BEC

Caregiver Support Programs

Linda Levin, CEO noted that we are going through a transition and the reporting by Tameka Holly and Kyle Sanchez has changed. Fred Richards will be overseeing this report. Kyle is now the Director of Operations for our sister company Medicaid Management Service, Inc. (MMS). A new Programs Manager will be hired for the services that we provide directly and will continue to develop those services and new services as we go forward.

Area Plan Update

Janet Dickinson, Planner presented a detailed and informative Power Point presentation to the committee. Janet noted that she is working on the next Area Plan for 2024-2027. This process will involve the Programs Committee, Board of Directors, and Advisory Council on the different sections of the Plan. The Program Module is due to the DOEA on September 15, 2023 and the Contract Module is due on October 3, 2023. Janet did an overview of the Area Plan and discussed the following:

- Program Module: Outline
- 2024 Program Module: Goals Section
- 2024 Area Plan: Next Steps
- USAging Building Accountability for Health Equity Learning Collaborative (BAHELC)

See Power Point Slides 28-34 for detailed information.

There was no further business for discussion and the meeting was adjourned.

Meeting adjourned at 11:50 AM
Minutes prepared by Sherry Holmes, Administrative Assistant

Veterans Directed Care Program
Service Trends (number enrolled): ***88 May; 87 April; and 83 in March***

Veterans are referred to this program through the Veterans Administration Medical Centers (VAMC) located in Gainesville and Orlando.

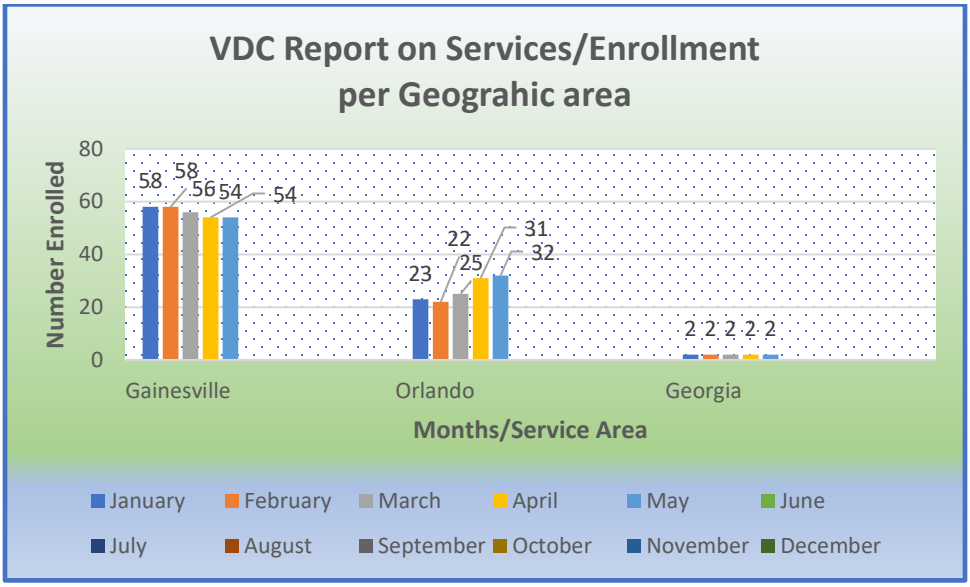
Orlando has **32 Active/enrolled**, one (1) pending/new enrollment paperwork completed and sent to fiscal.

Gainesville has 54 enrolled Veterans and 26 pending veterans to be referred by VA.

South Georgia: 2 clients enrolled (One veteran has a monthly Admin fee of $640, and the other is $591 -total of $1,231).

These numbers served, may change when we start to receive the new referrals from Gainesville.

Referrals are projected to be sent two (2) per week it is still unsure when they will begin. It was confirmed during the May Monthly Check in with the VA and ElderSource that we are capable of handling two per week.



Creating efficiency and focusing on Person Centered Care: We are restructuring the DVC program, adding 1 F/T Person Centered Counselor (in process of hiring) to ensure quality service delivery and an opportunity to expand our service reach (increase service or client volume).

Florida Disaster Fund Award (Volunteer Florida)

The MOU for Ian Response grant signed on February 14, 2023 ($600k). There is no timeline for expending these funds. There are no restrictions on the use of the funds, if it is used for **Hurricane Ian**. The grantor will not require any financial documents. The reporting requirements include the following:

- Summary of activities
- Counties activities took place in
- Successes/accomplishments
- Number of volunteers
- Number of volunteer hours
- Share two - three unique outcomes achieved with funding
- Number of survivors assisted

Possible geographic areas of focus/delivery of service: St. Johns; Volusia and Flagler

Activity related to grant: We are actively seeking providers to assist in expending the funds, as stipulated.

Update on securing interested agencies/partnerships in the month of April:

On March 17th, we were informed by the grantor (Volunteer Florida) that we will not be able to subcontract our work with partnering agencies, as originally planned. Therefore, the following actions were taken in the month of March to reorganize our approach and ensure we meet the grant expectations:

During the week of 3/20- We revised the MOU to have partnering agencies make referrals in the counties affected by Hurricane Ian (St. Johns, Volusia, and Flagler Counites). The MOU clearly designates role and responsibilities. Our agency, ElderSource (Northeast AAA) will accept the referrals externally and address them internally through our existing Senior 2 Senior program and/or we may need hire for a coordinator position (Job Description created) if the referral volume exceeds our capacity to address. Referral forms and a process was developed and fully described in the MOU for our partnering, referral agencies or organizations.

Partnerships secured or being explored in the month of March through May:

- **St. Johns Housing Partnership**, **Inc**.(**In process/exploring**): The St. Johns Housing Partnership is committed to promoting safe, decent, and affordable housing in north Florida. We do this by creating links between the public and private sectors on projects that create low- and moderate-income housing, rebuild neglected homes and neighborhoods, thus benefiting disadvantaged areas and enhancing community economic and social development.
- **VIND - Volusia Interfaiths/Agencies Networking in Disaster (MOU signed on 5.3.23):** This agency brings together existing inter-faith organizations, religious leaders, non-profits, emergency management and government agencies, and volunteers to share in the responsibilities

of assisting those who have lost shelter, food, clothing, and accessibility as a result of several types of disasters.

- **Meeting conducted in person on 5.3 (Wednesday) with VIND (engaged provider) and providing meeting summary/highlights below:**
    - VIND is a long-term recovery center
    - Vetting clients for income (1 person < $40,950 and family of 4<$58,500)
    - Confirm value of home prior to service engagement, will not serve homes that are valued at >$323,000
    - Home ownership is verified by VIND prior to service engagement-Ensure that the Deed is clear (no liens)
    - Will not cover reverse mortgages (concern person loses home after repairs)
    - They use the ISAA FEMA list to verify damage was from Hurricane Ian
    - FEMA Registration List: Currently identified 37,317 Total Homeowners
    - We plan to start the project with less expensive repairs and will escalate to larger costs or services later in the grant process (more complex cases will be discussed in a "unmet needs table" where cases will be mutually discussed and addressed.

Update on June/Partnership Status: The MOU was officially signed by the organization VIND on 5.3.23. Currently, they are assessing the needs and anticipate sending referrals/clients to us the week of May 21st.

USAging- Aging and Disability Vaccination Collaboration

Description of Funding Opportunity: Led by USAging, the Aging and Disability Vaccination Collaborative will distribute funding to enable organizations across the aging and disability networks to perform an array of vaccination promotion activities. Organizations selected for funding will host community vaccine clinics, provide in-home vaccinations, provide transportation to vaccination sites, and will conduct outreach and education to older adults and people with disabilities among other activities.

Collaborative Funding Opportunity- Summary

- **Focus:** Reach older adults and people with disabilities most at-risk to negative health consequences of not being adequately vaccinated.
- **Grant/Partnering Agency Amounts:** $50,000/Agency and $33/shot
- **Required Activities:** Meet all required grant activities either through internal agency operations OR in partnership with entities in your geographic area.

Eligible Service Deliveries: The required grant activities will be grouped into three overall categories of service delivery to include: Vaccinations, Supportive Services, and Outreach.

1. **Anticipated Number of Vaccinations--*Clinic/Event-based or In-Home ****

Refers to the **number of vaccinations** rather than the number of people vaccinated. For instance, one individual ***might receive both the COVID-19 and Influenza vaccinations***. In this example, you would ***count two vaccinations***.

- **Flu &Covid and /Shingles and Pneumonia (Shingrix and pneumococcal) vaccinations**: On 1.26, in addition to Influenza and Covid the grant also allows for Shingles and Pneumonia shots (*can count multiple shots for individual served*)
- **$33 per vaccination** in arms (estimated amount to cover administration and giving vaccination in the clinic)

2. **Receive Supportive Services ***
   Supportive Services **include transportation to/from vaccination sites, assistance with scheduling vaccinations, personal support, and accompaniment** for those who need assistance acquiring the vaccination, and referral services to obtain vaccinations. *For example, assisting in signing up or coordinating activities for an individual to access a* vaccine. *Transportation and personal support, for example you can accompany an induvial to the appointment or cover costs of transportation.*
3. **Receive Outreach and Education***
   Refers to ensure that individuals in your service area have **complete and accurate information regarding vaccine**s in general and grant-specific activities. The ADVC partnership will provide the opportunity for grantees to co-brand vetted information available through the ADVC Resource Hub.

***Examples of Services Delivered*:**

- **Vaccinations** Community and/or In-Home
- **Supportive Services** Assistance to acquire appointments
- **Transportation**—arrange and/or provide
- **Personal support** to receive the vaccination
- **Referrals** to other needed services
- **Outreach and Education**

Update on securing interested agencies/partnerships in the month of May:

- **Flagler Pharmacy and Partner with Flagler County Fire Rescue (expressed interest):** Meeting conducted on 5.16 to finalize outputs/ outcomes and next steps in the application process.
- **AHEC/ Name: Tonia Harris tharris@northfloridaahec.org (expressed interest)-Currently exploring implementation and design of program with CEO- T. Harris.**
- **Wildflower Healthcare (M**ichelle P. Colee, Executive Director) 268 Herbert Street St. Augustine, FL 32084- Connected on 5.19 and exploring interest and partnership week of May 29th.
- **Tyler Morris-CIL Jacksonville tmorris@ciljacksonville.org**: Met on 5.15.23 and will follow up with CIL after meeting with USAging on 5.331 (Wednesday). Follow up areas/action:
  - *Needs clarification on grant is it different-Disability Rights Florida (joint effort for covid and influenza)*
  - *Their role perhaps could be providing Sign Language Interpreters at each event.*
  - *After we get confirmation about the Disability Rights grant, we can proceed with estimating numbers served through outreach/transportation and partnership with pharmacy for vaccinations.*

- **Baptist Health and Insurance Company-Nelson and Associates Insurance (**Kimberly Branham-Nelson) expressed interest in a partnership.

- **ARC-The Villages-met with Jean C. Wetstein,** Vice President, Independent Living Support Services and Abigale (Abbey) Such, OTR/L-*They have dining for Adults with Disabilities and may be interested in congregate dining contracts.* They are also interested in the Vaccination Grant and may be able to partner with a local pharmacy. They would hold and outreach and education event with vaccinations provided on site (possibility in June)

Planning and Programs Department Update June 2023

Report Highlights:

* Adult Protective Services - All high risk referrals were accepted. During the month of June ElderSource will begin reviewing client files monthly to ensure compliance is being met.
* No Aging Out clients were received during the months of March and April.
* After our most recent review of PSA4 surplus/deficits it was communicated to the Department that funds were available to transfer and monies were moved to another PSA.
* During the month of May we completed our 2023 annual DOEA monitoring. At this time no findings were found and a few ares for improvement were noted. Once our completed monitoring report is received we'll be sure to share this information with you all.
* Department currently fully staffed with 2 full time contracts managers.

Contract Update:

1. All Enhanced HCE contracts have been signed. Internally we have hired a short-term case manager who is currently assessing clients on our waitlist and arranging services as needed. Expenditures have begun and we are closely monitoring. At this time it has still not been determined whether an extension under this contract will be granted.
2. Internally transferring funds from St. Johns to Baker County in CCE.
3. Internally transferring funds from The City of Jacksonville to Aging True in RELIEF.
4. EHEAP Contract end date has been changed to June 30, 2023 (originally September 30, 2023). New contract anticipated to start July 1, 2023.
5. 2022 carryforward dollars have been sent down from the Department. Currently working on allocations to update/amend provider contracts.
6. 2023 provider General Revenue allocations have been distributed to providers. Currently working on contract negotiations in preparations for the upcoming contract year.

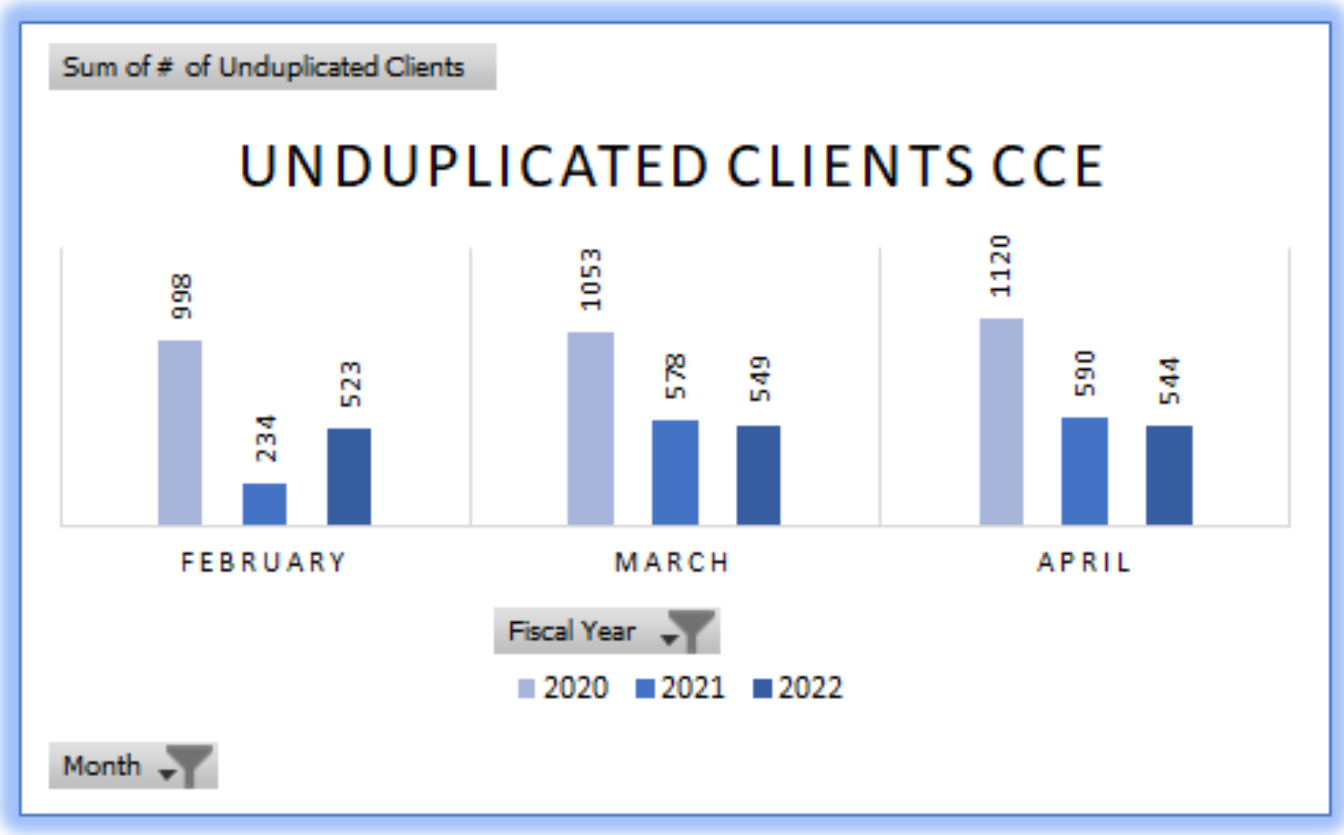
Surplus Deficit

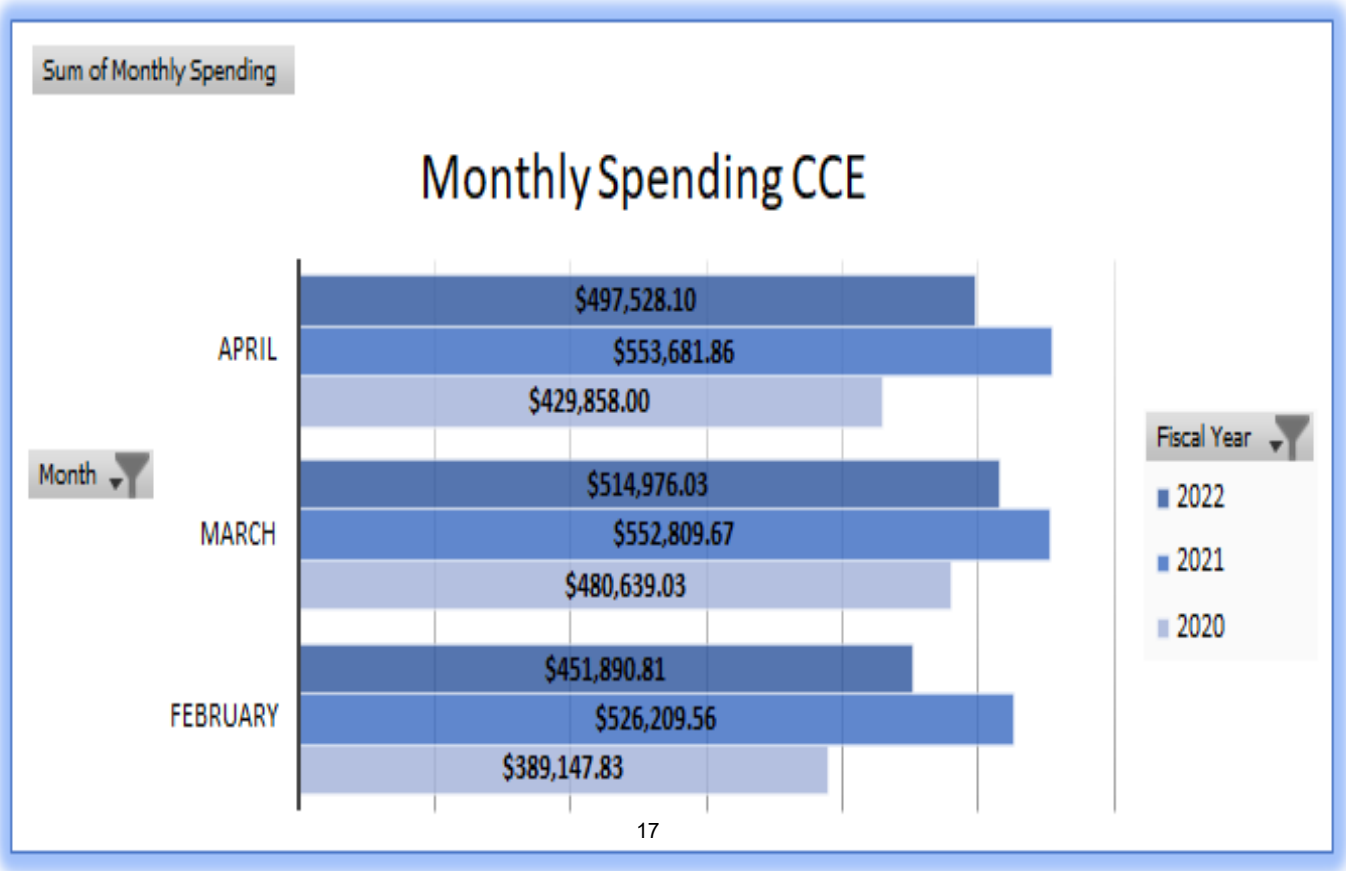
Program	Contract Amount	Projected S/D (Based on current monthly spending)	Projected S/D (Based on Average Monthly Spending)	Comments
ADI	$3,715,407.29	$1,547,605.73	$1,833,520.87	Making internal transfers where applicable. Surplus expected with funds available to transfer to another PSA.
CCE	$7,450,928.00	$1,353601.67	$1,740,481.26	Making internal transfers where applicable. Surplus expected with funds available to transfer to another PSA.
HCE	$731,377.50	$105,159.61	$117,102.34	Expenses expected to fall more in line in the coming months. No concerns with spending out at this time.
LSP	$450,000.00	($177.41)	$37,514.78	Expenses expected to fall more in line in the coming months. No concerns with spending out at this time.
RELIEF	$334,313.00	$25,158.96	$21,164.11	Expenses expected to fall more in line in the coming months. No concerns with spending out at this time.
OA3B	3,527,641.00	($802,970.34)	($866,867.72)	In month 4 of this grant. Monitoring and providing technical assistance to providers as needed. No issues with spending at this time. Currently over by 8.35%.
O3C1	$1,983,582.00	$217,924.64	$180,928.08	In month 4 of this grant. Monitoring and providing technical assistance to providers as needed. No issues with spending at this time. Currently under by 3%.

Program	Contract Amount	Projected S/D (Based on current monthly spending)	Projected S/D (Based on Average Monthly Spending)	Comments
O3C2	$2,013,855.00	$568,252.86	$173,053.38	In month 4 of this grant. Monitoring and providing technical assistance to providers as needed. No issues with spending at this time. Currently under by 3%.
OA3D	$146,606.00	$23,318.40	$7,848.35	Billing has just began under this grant. Will continue to monitor and provide technical assistance.
OA3E	$1,001,166.37	$605,885.80	$204,913.96	In month 4 of this grant. Monitoring and providing technical assistance to providers as needed. No issues with spending at this time. Currently under by 6.53%.
NSIP	$537,608.00	($90,823.12)	($29,325.04)	No concerns with spending out at this time.

Community Care for the Elderly

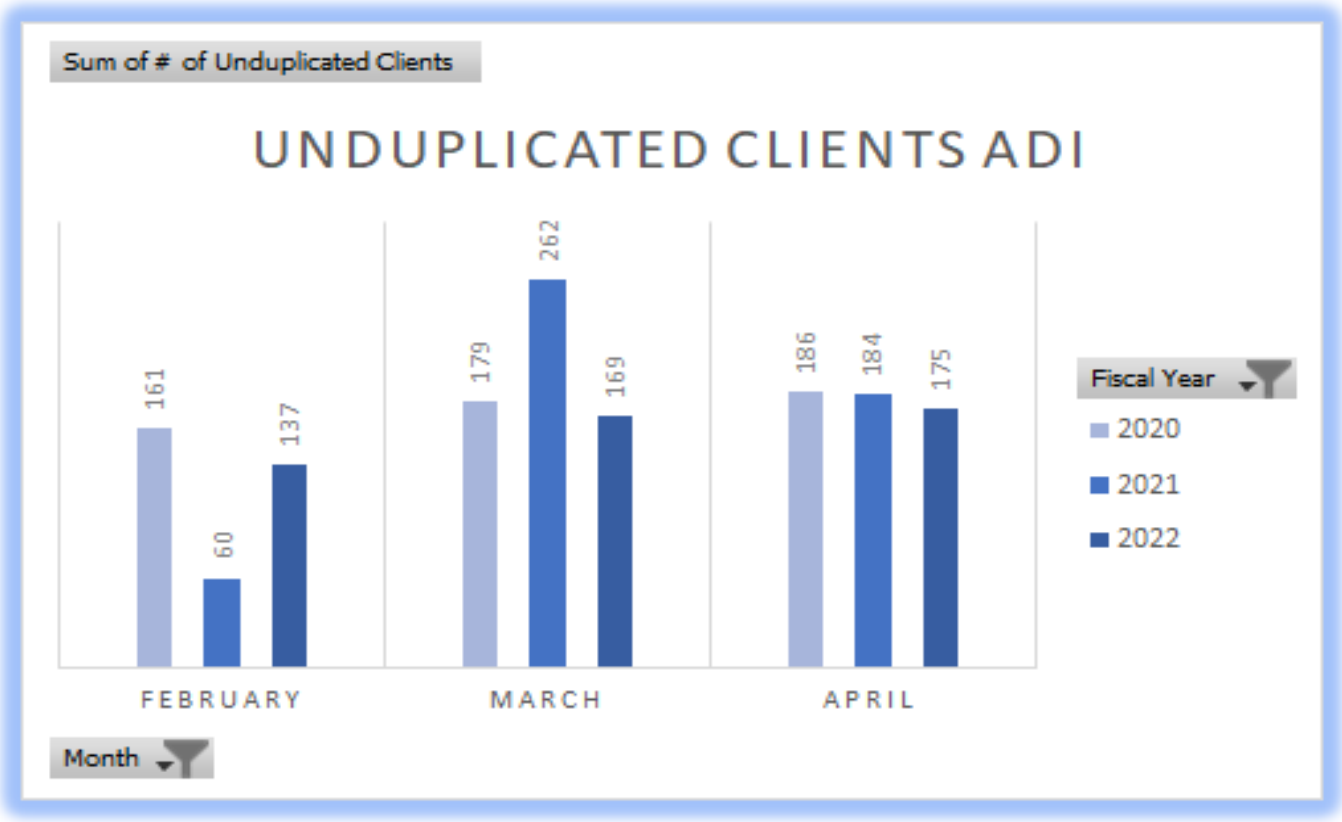
The primary purpose of the CCE program is to prevent, reduce or delay premature or inappropriate placement of older persons in nursing homes and other institutions. Additional purposes of the CCE program are to provide the following: 1) a continuum of services alternatives to meet the diverse needs of older people; access to services for elder most in need; and a local resource that will coordinate delivery of services for the frail elder/caregiver.

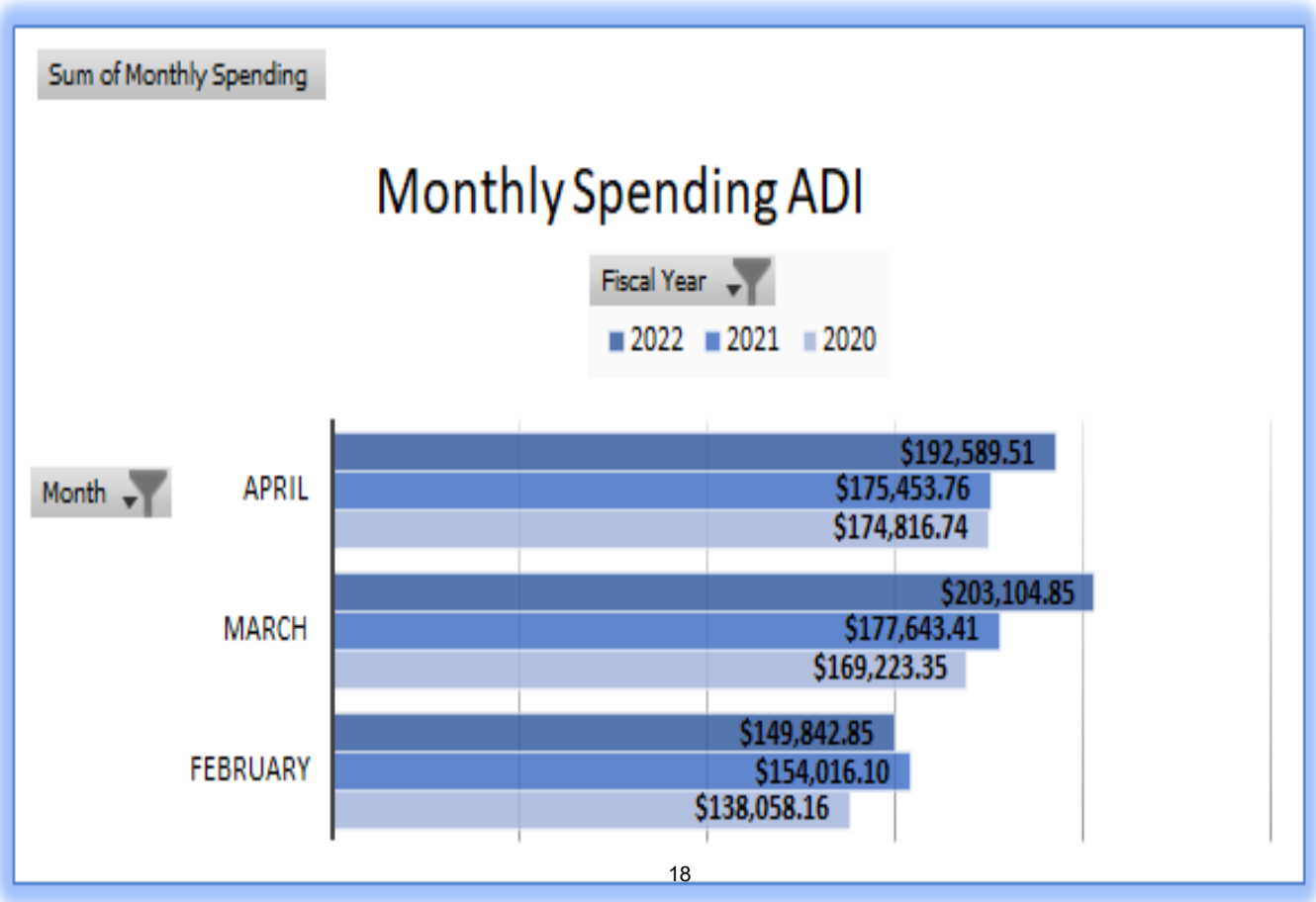




Alzheimer's Disease Initiative (ADI)

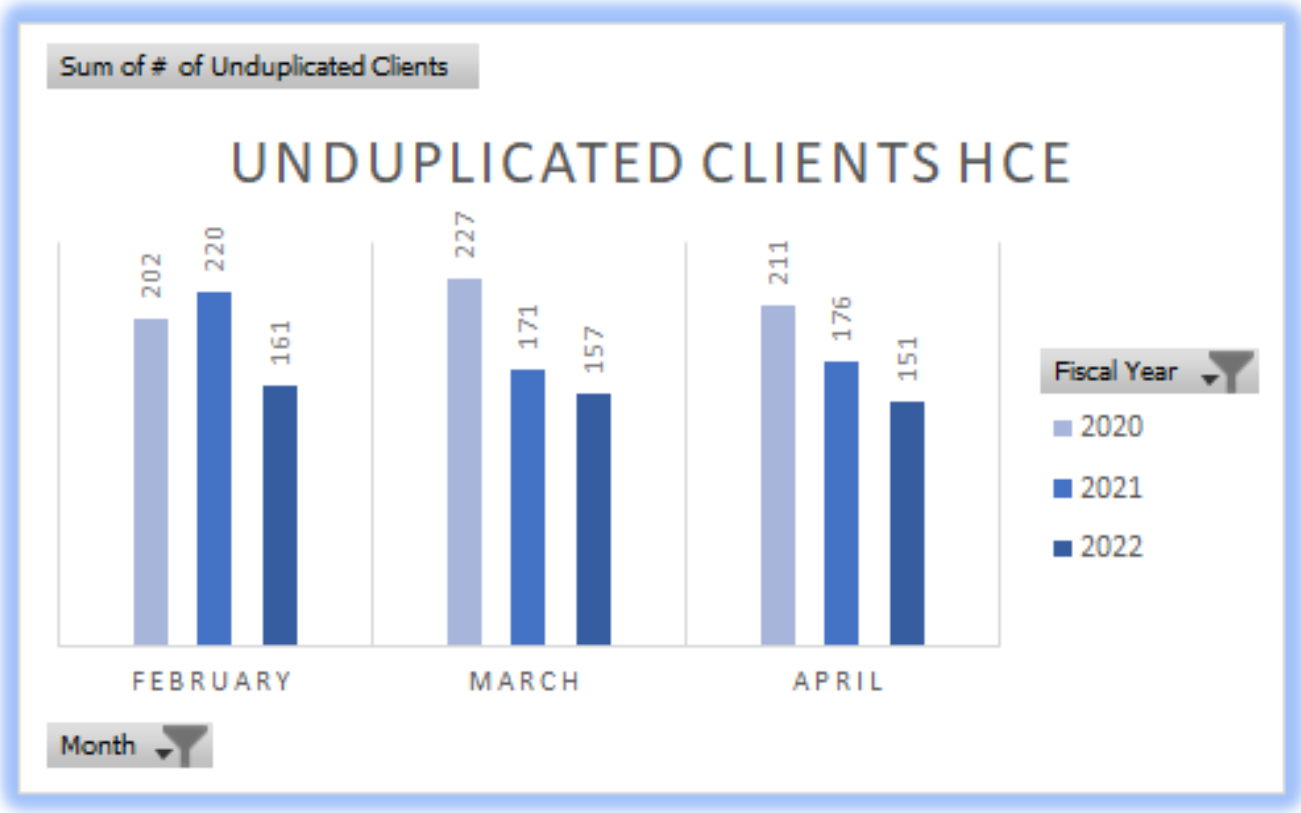
The purpose of the ADI is the following: to address the special needs of clients with Alzheimer's Disease (AD) or related memory disorders, as well as their caregivers; and to find through research the cause, treatment and ultimately a cure for AD or related memory disorders.

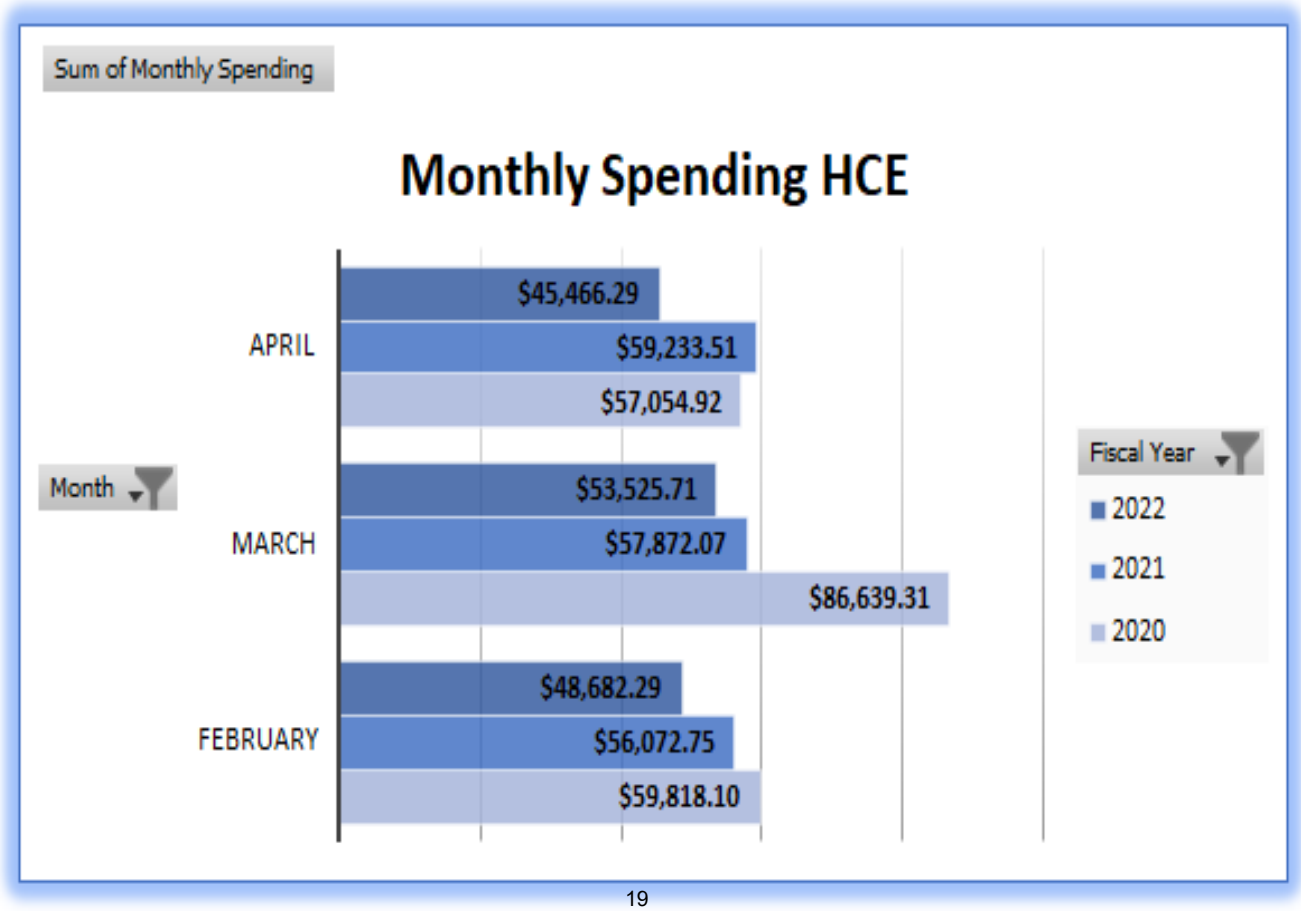




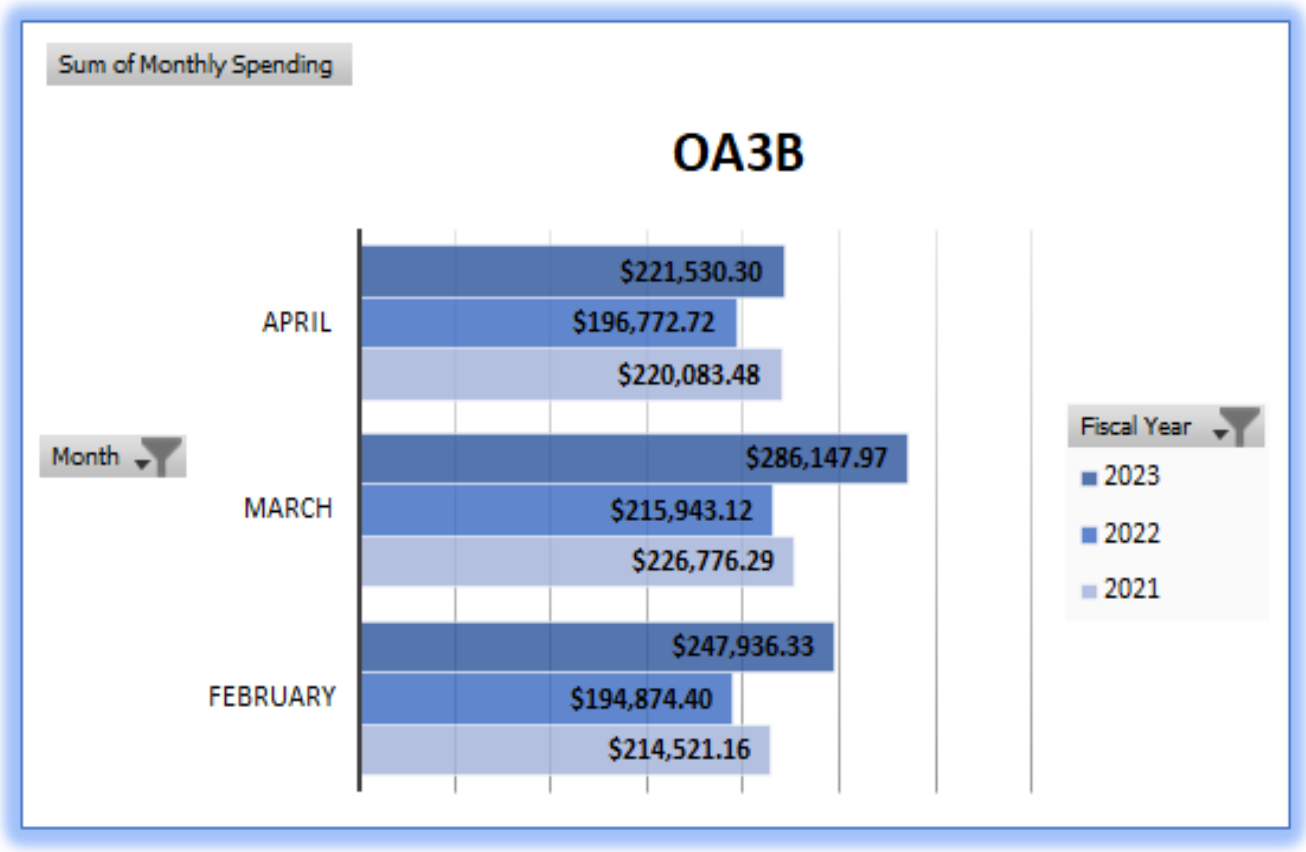
Home Care for the Elderly

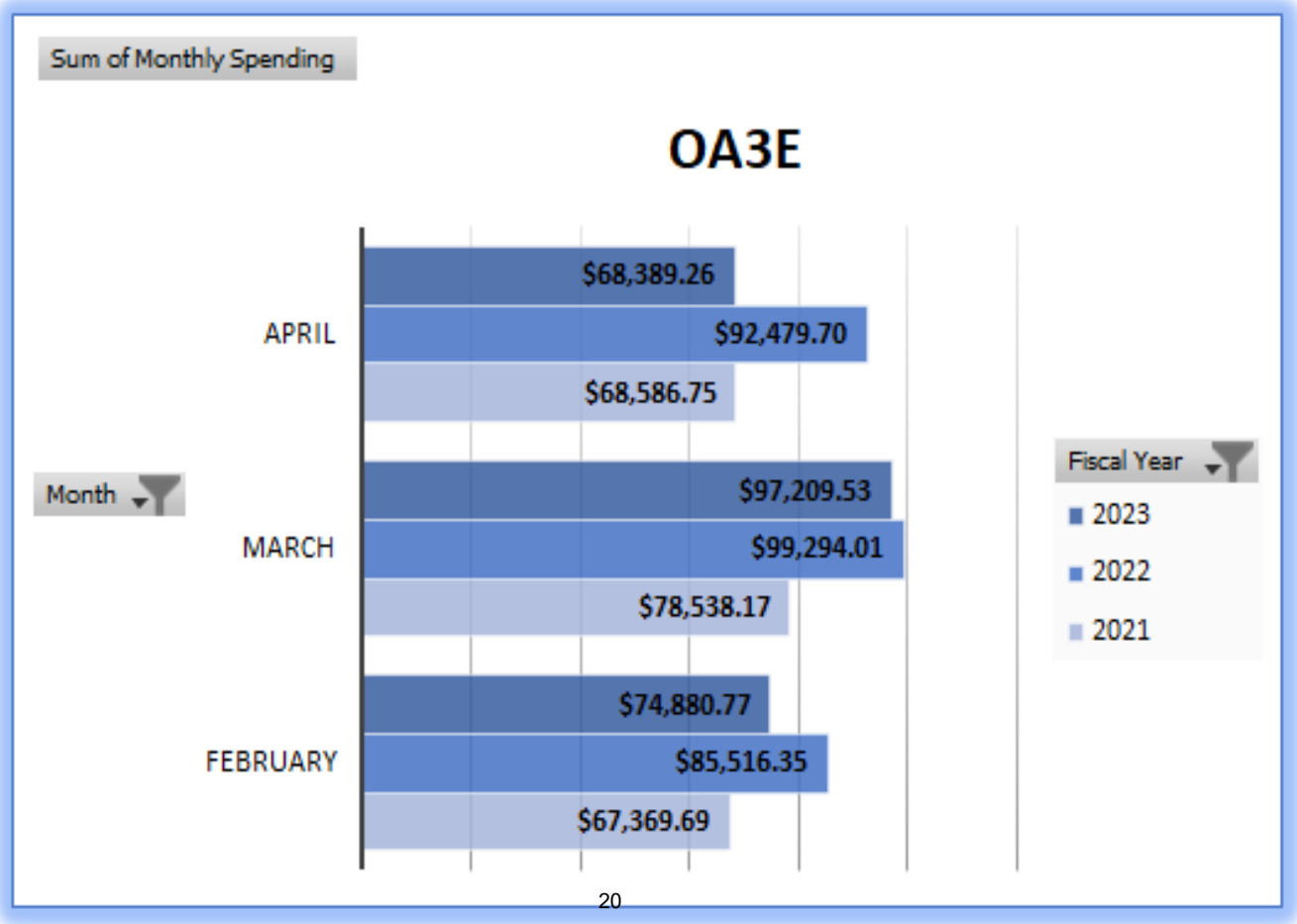
The purpose of the HCE Program is to encourage the provision of care for elders in family-type living arrangements in private homes as an alternative to nursing homes or other institutional care settings.



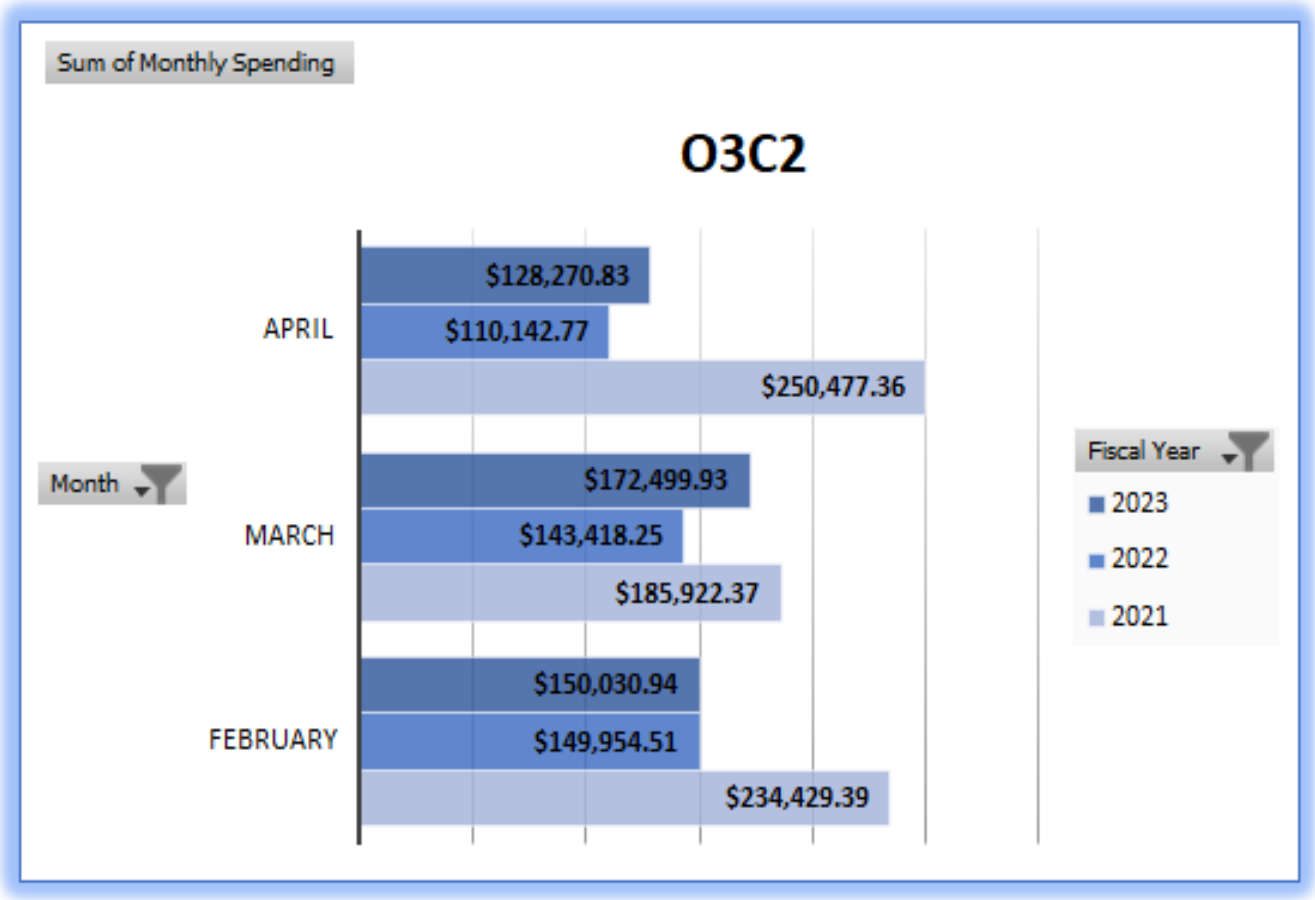


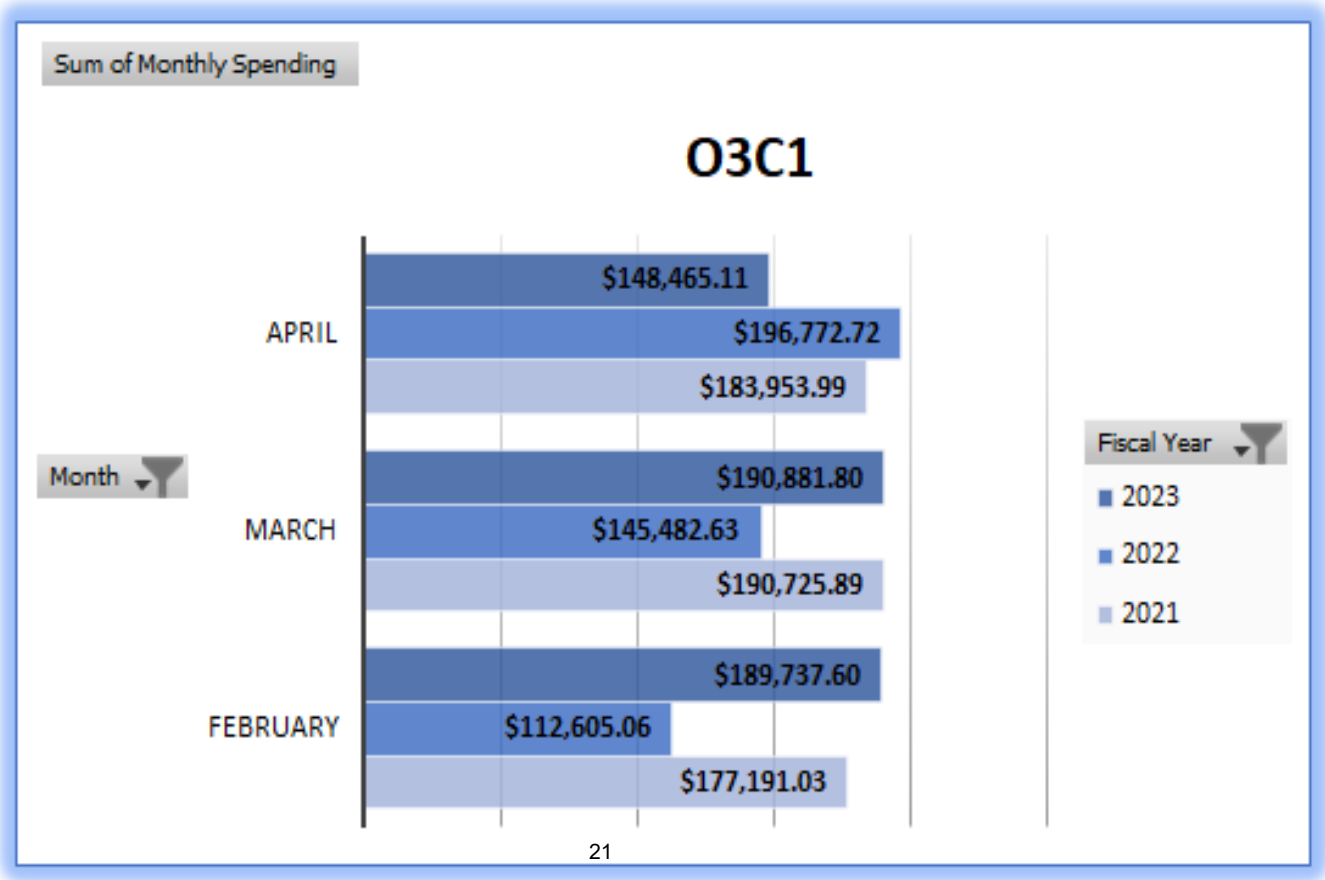
Older American Act Monthly Spending





Older American Act Monthly Spending

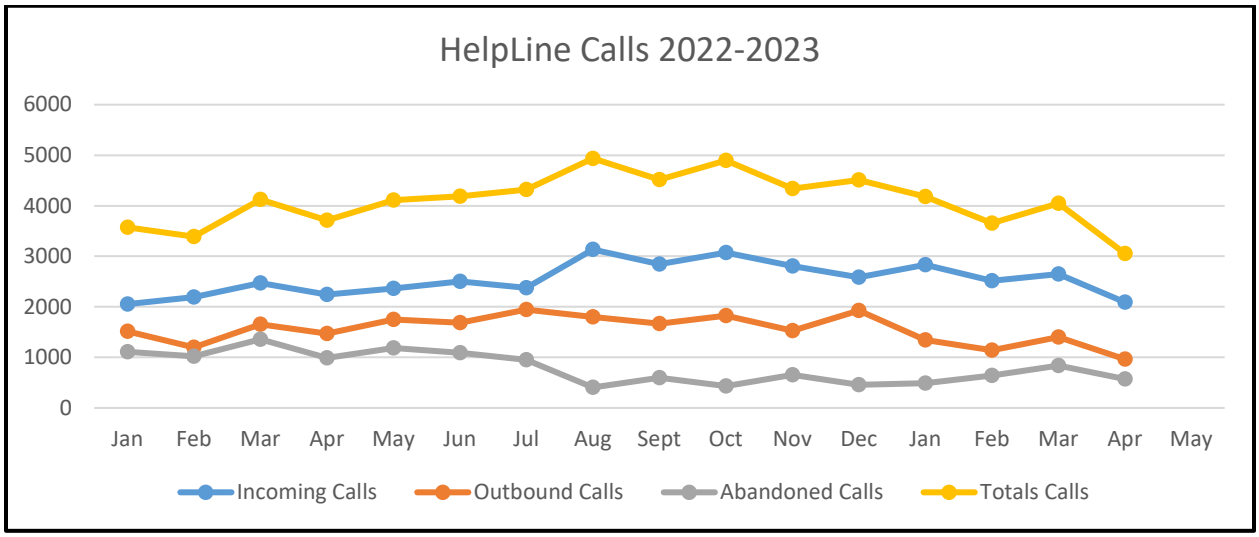




ADRC Dashboard Summary
June 2023 (Reports thru April)

HelpLine

The HelpLine had two open positions after one staff member was promoted to the Medicaid Eligibility Team and another to the Intake & Screening Team. One of the positions was filled in April but the staff member is still in training. As a result of the loss of staff and staff in training, call volume for April was lower than the past months. Once new staff are hired and trained, we expect to be back on track. The HelpLine Supervisor continues to serve on the eCIRTS committee for the development and design of the HelpLine functionality (deployment planned for late 2023/24).

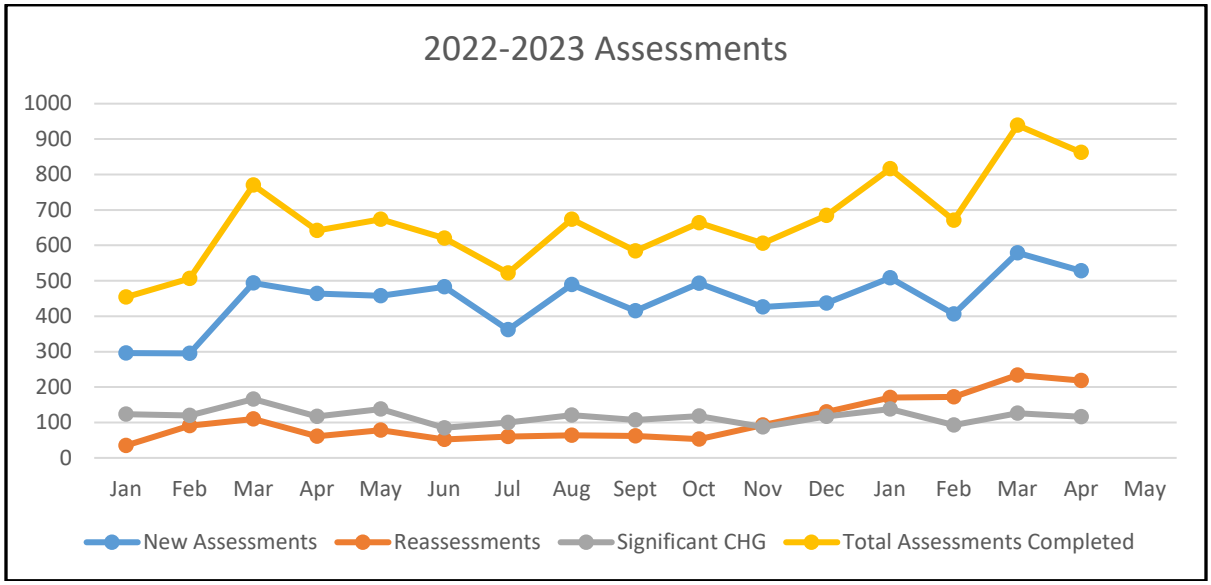


April

Walk-ins: 21
Voicemail: 713
Fax: 208

SHINE Referrals: 136
Screening Referrals: 849
APS Referrals: 7

Intake & Screening Team
The Intake and Screening Team is fully staffed, trained and screening. Screening appointments are being scheduled out 30-35. Several staff members are working overtime to focus on the reassessment list resulting in the highest number of reassessment screenings completed since June 2021.



Percent Screened for Significant Change:
March: 18%
April: 18%

Medicaid Eligibility Team
The team is fully staffed. The new staff is in training and is expected to receive a caseload in July. Staff are carrying a high caseload.

Number of Clients Released for LTC Processing:
January: 210
February: 140

SHINE/SMP/MIPAA

The SHINE, SMP and MIPPA grants were on target for March– April. Staff and volunteers are continuing to offer and provide Medicare presentations to the community. Most counseling sessions occur via telephone. The number of active volunteers is 38.

SHINE Contract (Must meet 60% of Benchmark)												
2023-24	Apr	May	Jun	Jul	Aug	Sept	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Clientl Contacts	209											
% of Goal	107%											128%
Outreach Events	7											
% of Goal	88%											82%
SMP Benchmarks 3 **(must be 50% to meet contract)**												
2022-23	Jun	Jul	Aug	Sept	Oct	Nov	Dec	**Jan**	**Feb**	**Mar**	**Apr**	**May**
Group Outreach	8	7	8	10	16	13	6	9	7	9	7	
% of Goal	73%	64%	73%	91%	84%	100%	75%	90%	88%	90%	88%	0%
People Reached	208	159	146	194	238	234	172	164	71	146	116	
% of Goal	52%	62%	54%	57%								
Individual One-on-One	128	98	149	162	182	230	138	192	235	266	149	
% of Goal	78%	59%	75%	84%	67%	65%	98%	74%	92%	160%	119%	0%
MIPPA Benchmarks 8 **(must be 50% to meet contract)**												
2022-23	Sept	Oct	Nov	Dec	Jan	Feb	Mar	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Completion of LIS Apps.	48	45	34	32	28	33	35	19				
% of Goal	130%	85%	62%	84%	127%	92%	167%	86%	0%	0%	0%	0%
# LIS Eligibility	118	213	209	124	105	117	106	77				
% of Goal	104%	102%	107%	109%	69%	59%	87%	74%	0%	0%	0%	0%
# LIS Benefit Explanation	101	141	139	83	74	99	80	67				
% of Goal	104%	87%	97%	101%	59%	57%	92%	82%	0%	0%	0%	0%
Completion of MSP Apps	92	70	87	69	109	118	100	69				
% of Goal	99%	57%	66%	57%	99%	105%	77%	110%	0%	0%	0%	0
# MSP Eligibility Activities	121	181	201	141	120	142	145	99				
% of Goal	100%	88%	102%	126%	82%	73%	142%	92%	0%	0%	0%	0
# MSP Explanation	109	113	128	102	98	122	120	83				
% of Goal	107%	72%	90%	128%	84%	73%	148%	108%	0%	0%	0%	0
Extra Help/LIS/	11	16	13	5	9	7	8	7				
% of Goal	85%	94%	100%	63%	90%	88%	89%	88%	0%	0%	0%	0
Preventative Services	9	15	12	5	9	7	8	7				
% of Goal	150%	167%	133%	125%	129%	100%	114%	88%	0%	0%	0%	0

Senior to Senior Program

Program Description: Program provides financial assistance for seniors, age 60 and above, who are in crisis in Baker, Clay, Duval, Nassau, and St Johns Counties. Senior to senior is funded through grants from The Community Foundation for Northeast Florida with funding from the J. Wayne and Delores Barr Weaver Senior to Senior Fund Endowment, and the Jim Moran Foundation. An in-house EASE (Emergency Assistance Serving Seniors) program also provides limited funds for Flagler and Volusia counties. The financial crisis is defined as something unexpected that has occurred over the past couple of months, such as a medical problem, a plumbing issue, a pest infestation, etc., which has caused a financial hardship. The most common areas of assistance are rent/mortgage, utilities, home repairs, and assistive devices. Senior to Senior serves approximately **230 to 250+** seniors per year. The intended outcome of the assistance is to resolve the financial crisis so the senior will remain financially stable and independent in the future. Assistance is limited to once a year and to one specific crisis per lifetime.

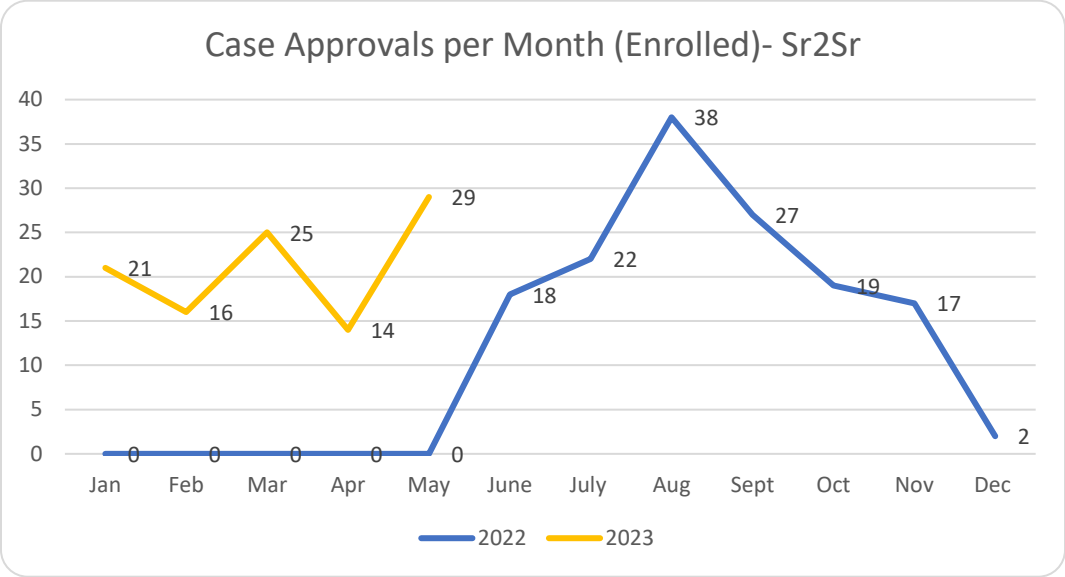
Funding Composition: Our organization receives $130,000 from Weaver Fund to serve 100 clients; we also received $100,000 from Moran to serve 130 clients served and $25,521 from EASE – the largest amount we've ever received from this Night with the Stars Fundraising account and funds are unrestricted with no established outcomes.

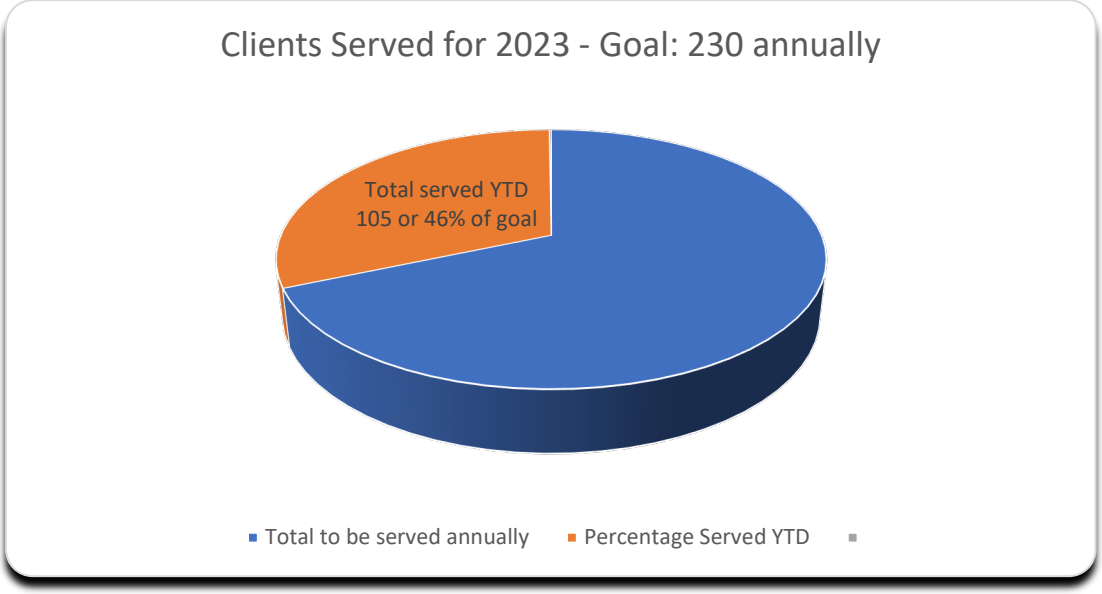
Service Output/Outcomes: The Senior-to-Senior program is currently fully staffed. Staff identified seniors to adopt during this holiday season. The goal for the Senior-to-Senior program is to serve approximately 230 seniors throughout a grant year, through the three funding sources mentioned above totaling $250,000. An update was made to the grant tracking workbook that enables the team to see how much funds are available per client to remain on track to serve 230 by the end of the grant year.

Note/Numbers to Serve per Grant/Funding Source (*goal 230 individuals served*): 100 through Weaver, 130 through Moran for a total of 230, in addition, then however many served through EASE.

	Jan	Feb	Mar	Apr	May	TOTALS
Moran	16	11	17	7	9	60
Weaver	4	2	3	5	12	26
Moran & Weaver Combined	-	-	1	1	3	5
EASE	1	3	4	1	5	14
TOTALS	21	16	25	14	29	**105**

- **Current output (individuals served):** *One Hundred and Five (105) clients* served to date or 46% of the grant goals (goal to serve 230 clients annually).
- **Cases for approval for the month in 2023:** January 21; February 16; March 25; April 14; and May 29.





Caregiver Program(s)/Supports

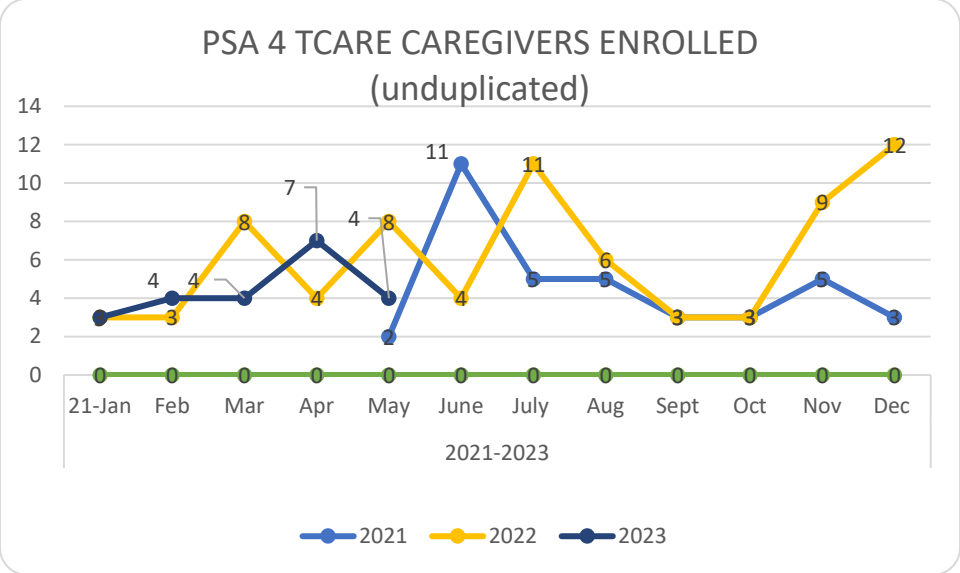
Tailored Caregiver Assessment & Referral (TCARE) Program

Program Description: TCARE is a caregiver support program designed to help prevent caregiver burnout by providing meaningful information and referrals that may help specific caregiving experiences. It is available for northeast Florida caregivers of any age who are caring for a loved one age 60 or older who is still living at home, whether that be in the caregiver's home or their own home.

Service Output/Outcomes: As off the end of 2022, ElderSource served 113 family caregivers through the TCARE program. TCARE funding has paid for a total of 146 counseling sessions. The TCARE Specialist also made 324 referrals to community partners and provided other services in 2022. The TCARE assessment asks

if a caregiver intends to place their loved one in an out of home care setting, such as a nursing home or other long-term facility. As of the end of 2022, 92% of reassessed caregivers reported lowered or maintained "intention to place now" at time of reassessment. Also, at the end of the 2022 fiscal year, 94% of reassessed caregivers reflect feeling more up lifted, or the same level of uplifted, in their caregiving duties at time of reassessment; 92% reported lowered or maintained relationship burden levels at time of reassessment; 91% reported lowered or maintained stress burden; as well as reported lowered or maintained identity discrepancy, which is how a caregiver feels about the caregiving duties that conflict with their identity as relative.

As of 5.31.2-23, or within the first 5 months of 2023 (*3 Jan; 4 Feb; 4 March; 7 April; 4 May***); In 2023, to date, our organization has enrolled 22 new family caregivers. In total, with active/current and enrolled there are 81 active family caregivers engaged i**n the TCARE program. TCARE funding has paid for a total of **41 counseling sessions**. The TCARE Specialist also made 136 **referrals to community partners** and provided other services in 2023. The TCARE assessment asks if a caregiver intends to place their loved one in an out of home care setting, such as a nursing home or other long-term facility. As of the end of May 2023, 89% of **reassessed caregivers reported lowered or maintained "intention to place now" at time of reassessment**. Also, at the end of the May 2023, **90% of reassessed caregivers reflect feeling more up lifted, or the same level of uplifted**, in their caregiving duties at time of reassessment; **92% reported lowered or maintained relationship burden levels** at time of reassessment; **88% reported lowered or maintained stress burden; as well as reported lowered or maintained identity discrepancy,** which is how a caregiver feels about the caregiving duties that conflict with their identity as relative.



<u>YouMeCare Program</u> – *This is not a separate program; this is just a resource/referral used in TCARE.*

Program Description: If a TCARE caregiver shows an increase of stress and/or depression through a reassessment and expresses that there is no home care in place, the TCARE specialist can send a referral to YouMeCare. Through a grant we can offer 50 caregivers with 27 hours of respite care until October 31, 2023. Our intended impact is that we will see an improvement of scores with the reassessments, and to provide support to the fact that respite is beneficial to caregivers' well-being.

Service Output/Outcomes: As of May 31, 2023, we provided **22 caregivers with a combined 381 hours of respite care.**

Powerful Tools for Caregivers

Program Description: Powerful Tools for Caregivers is a six-week course that meets weekly over Zoom. This class gives caregivers the skills to take care of themselves while caring for someone else. Class participants are given The Caregiver Help book to accompany the class and provide additional caregiver resources. The intended clients are caregivers that live in the seven counties of Northeast Florida. The intended impact of this program is to teach family caregivers ways to reduce stress, have tough conversations, communication skills with their loved one, and to take care of themselves.

Service Output/Outcomes: In 2023, there were **3 classes held or 60% of the annual goal of conducting 5 classes.**

**** Two classes are scheduled to start during first week of Sept. ****

Trualta

Trualta is an online resource that helps families manage care at home with a library of lessons on assorted topics, solving day-to-day needs. Their lessons give simple, practical advice. Even better, lessons are short (about 5 minutes), making it easy for caregivers to fit them into their busy schedule. To be referred to set up a Trualta account, the caregiver must be a family caregiver that resides within the seven counties of Northeast Florida. The intended impact of this program is to provide caregivers with a hub for information and resources that align with their specific caregiving needs.

Service Output/Outcomes (updates): As of 5.31.23, **eighteen (18) persons have been engaged** in the online resource.

Virtual Caregiver Support Groups

The virtual caregiver support group is open to all caregivers to be able to connect with other caregivers, seek advice, and to share information. This group takes place on Zoom twice a week. As of now the group takes place on Wednesdays at 1:00pm and Thursdays at 6:00pm, but the day and time for the Thursday session will be changing at the end of the month. If is anyone is interested in the group, they can email caregiversupport@myeldersource.org to be added to the contact list.

Service Output/Outcomes: in 2023, approximately forty-five (45) virtual caregiver support groups were conducted.

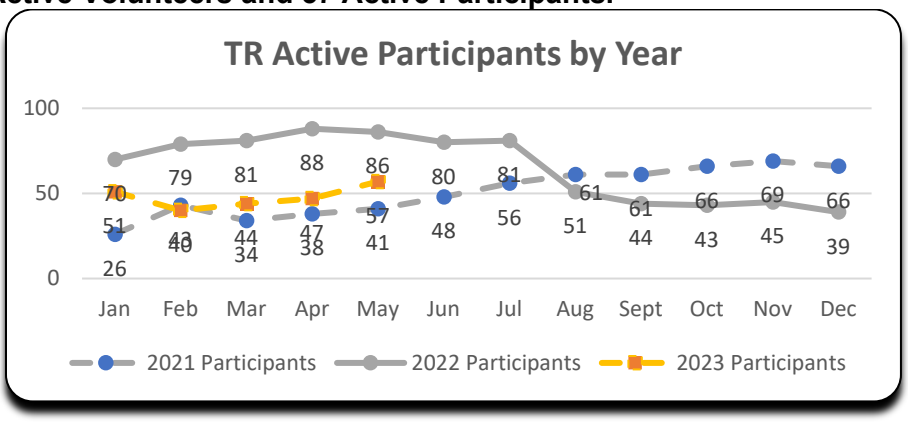
The Telephone Reassurance Program(s)

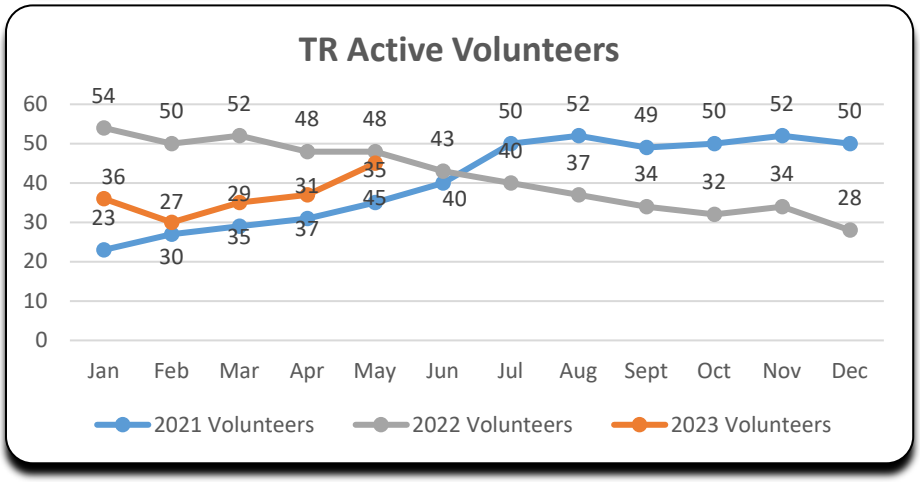
The *Caring Connections* Telephone Reassurance Program

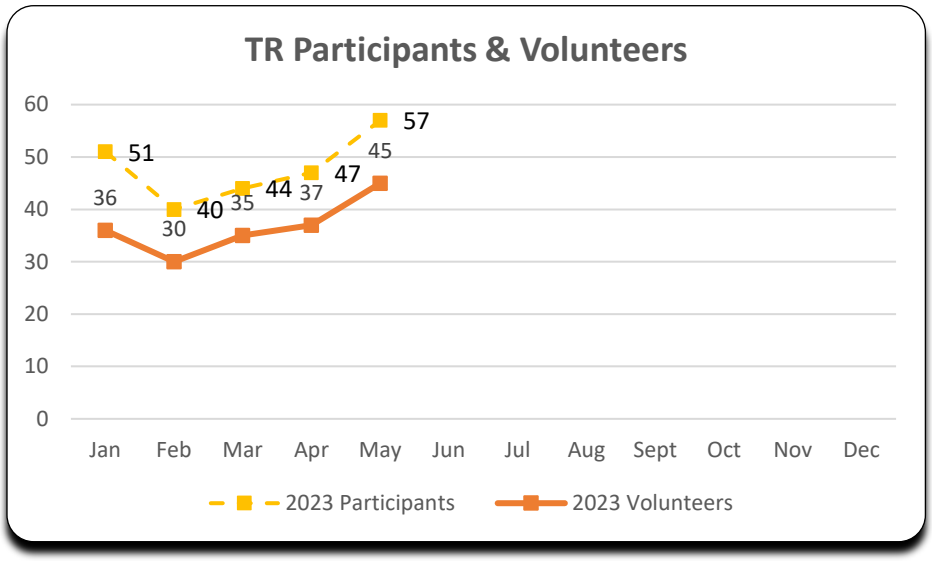
Program Description: The *Caring Connections* Telephone Reassurance Program provides friendly telephone calls from trained volunteers to older adults who are living alone and/or are homebound. The goals of the program are to reduce isolation, loneliness, depression, anxiety, and cognitive decline often faced by homebound seniors. Regular phone calls from volunteers help seniors stay connected to their community and engaged in meaningful relationships. Keeping seniors socially engaged also improves their overall quality of life physically, emotionally, and mentally. Seniors who are interested in receiving a telephone call from volunteers can sign themselves up or be referred by a caregiver, family member, friend, Customer Service Specialist from the HelpLine, or service provider. Seniors are eligible if they**:** Are 60 years old or older, live alone or are homebound, and reside in Baker, Clay, Duval, Flagler, Nassau, St. Johns, or Volusia County.

Numbers served and volunteered per month in 2023:

- **Jan. 36 Active Volunteers and 51 Active Participants.**
- **Feb. 30 Active Volunteers and 40 Active Participants.**
- **March 35 Active Volunteers and 45 Active Participants.**
- **April 37 Active Volunteers and 47 Active Participants.**
- **May 45 Active Volunteers and 57 Active Participants.**







The iN2L (*It's Never Too Late*) Tablet Program

Program Description: The iN2L Tablet Program offers content-driven engagement to support social interaction, cognitive and physical exercise and therapy, education, reminiscing, areas of interest, memory support, and more with touch screen systems ideal for both group engagement and individual experiences. Each tablet comes preloaded with designed and curated content, including games, puzzles, movies, audiobooks, and more. Seniors can customize their experience based on their content preferences, photos, and contacts. One-touch video calls, photo sharing, and texting is available. This program is for older adults 60 or older who reside in Baker, Clay, Duval, Flagler, Nassau, St. Johns, or Volusia County.

Service Output/Outcomes:

In August, ElderSource started a tablet program funded through the American Recovery Plan Act (ARPA). This program is ***monitored by the Care Connector who delivers the Caring Connections Telephone Reassurance program***. The tablets are supplied by a company called iN2L (It's Never Too Late) and were ordered, assigned, and delivered. iN2L provides monthly usage reports showing total number of hours each client has used each feature. We expect to see lower usage around the holiday months. ***Fifty tablets*** were ordered, assigned, and delivered. iN2L provides monthly usage reports showing total number of hours each client has used each feature. We expect to see lower usage around the holiday months.

Numbers served to date: In 2023, to date we have 50 Participants actively using tablets in their homes and we have another 18 more that will be distributed this month. As of April 2023: 50 of the tablets were shipped out to Clients, the number of active users change each month. The number of "active" users for the month of April is 17. Anita Thaxton is in the process of contacting those that are not showing active usage to find out why they are not using them and answer any questions they may have to effectively engage them in the program. ***Update on 6.6.23: 14 of 50 tablets actively used and attempts at re-engagement are being taken by program staff.***

New Programs/Others (*Community Health Navigator program*)

Community Health Navigator program

To address social determinants of health barriers and to effectively navigate a complex health care and social services delivery system our organization will be hiring two Community Health Navigators to enhance the quality and impact of our services delivered to older adults and caregivers most in need. Health Navigators are trusted health and social service professionals who share life experiences with the individuals and communities they serve. These Health Navigators (HCN) bridge access to health care and social services and perform a range of roles, such as health education, care coordination, care transitions support, connection to social services, advocacy, and assistance with accessing health and long-term services and support.

An increasing number of initiatives for people with complex needs are integrating HCN's into their teams to address health-related social needs more effectively across a range of settings, including medical and behavioral health providers, public health, and managed care organizations.

Program Goals (the intended benefit to participants and/or the community):

- Reduce unnecessary hospital re-admissions. Evidence by diversion of nursing home or hospital placement in case notes and client records.
- Ensure access to quality care and assisting with navigation as evidenced by client records and/or change in status.
- Ensuring the person is being served in the least restrictive environment thereby reducing inappropriate costly and inappropriate healthcare interventions. Evidenced by placing individuals in the least restrictive and cost environment setting.
- Addressing the Social Determinants or Drivers of Health and removing barriers to accessing care. Evidenced by client records, service interventions and addressing one of the three core areas such as transportation, language and cultural barriers, and lack of insurance.

NOTE: Our success in attaining the outcomes in this grant will be measured by our ability to enroll and engage between 50 to 100 program participants ages 60+ or adults with disabilities.

The goals will be achieved through one of more of the following service interventions and deliverables:

- Health Care Navigator helps to improve coordination of client care, reduce healthcare barriers and advocate for clients.
- Health Care Navigators build working relationships, solve problems, direct clients to resources, and manage information
- The Health Care Navigator may provide a social determinants or drivers of health (SDOH) screening to assess additional needs.
- The Health Care Navigator, with permission from the client or client's legal representative, may be present with the client in the hospital or rehab facility or accompany the client on medical appointments.
- The Health Care Navigator, with permission from the client or client's legal representative, may be present when medical staff explain tests, results, procedures, and care plans.
- The Health Care Navigator will not make any health care decisions for the client but will assist with communication and understanding and provide administrative and emotional support.
- The Health Care Navigator will be able to keep the family informed and involved, after receiving written permission from the client or client's legal representative.
- The Navigator will connect the person to other supportive services.

The activities we will undertake as part of your program:

- Recruit, hire and train two (2) Healthcare Navigator positions to address healthcare inequities and access
- Our Healthcare Navigators will be trained to deliver quality care and will be experts in understanding and navigating our complex healthcare and social service delivery system
- Our organization will be ready to launch this program on October 1, 2023.

Grant Submitted on 5.15.23: Community Foundation Grant submitted to support the Health Navigator role ($25k request).

- Form Name: 2023 Program Grant Application
- Submission Time: May 15, 2023, 9:49 am

Area Plan - Public Hearings

- Volusia County:

Thursday, June 22, 2023

1:30 PM – 2:30 PM

President's Banquet Hall at
Bethune-Cookman University
740 West International Speedway Blvd,
Daytona Beach, FL 32114

- Duval County: still in development; to likely be held in late July or beginning of August.

Area Plan Sections - Completed or Nearing Completion

- Introduction to the Area Plan
- Program and Contract Module Certification
- AAA Board of Directors; AAA Advisory Council
- Funds Administered and Bid Cycles; Resources
- Executive Summary; Mission and Vision Statements
- Profiles *(identifies counties, communities, data on socio-demographics, resources, partnerships, etc.)*
- *Emergency Preparedness*

Plan Sections - Still Delving Into

- Performance and Targeted Outreach
- Unmet Service Needs and Opportunities
- Strategies part of Goals and Objectives
- Direct Service Waiver Request Forms
- Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis *(share your thoughts with me by phone call or email)*

Area Plan: Next Steps

- Public Hearings- complete the Volusia County hearing, and finish arranging one in Duval County
- Continue to complete sections of the Plan, while gathering feedback, and fine-tuning information
- Present draft of the Full Plan prior to the next Planning & Programs Committee meeting, so the document can be reviewed, and feedback/suggestions can be discussed as needed
- Obtain Advisory Council and Board of Directors approvals

ElderSource's Emergency – Disaster Preparations

Emergencies and Disasters can come in many forms:

Important Note:

When there is a Disaster, ElderSource becomes responsible for providing supports to our clients, our providers' clients, and for all older adults within PSA 4.

ElderSource
start here for help

ElderSource's Emergency-Disaster Contacts

- Key Players:
  - Emergency Coordinating Officer (ECO) = Janet Dickinson, Planner
  - Manager on Duty = Leadership rotates this role
  - 1st Alt ECO= Tameka Gaines-Holly, Chief Operations Officer (COO)

  - 2nd Alt ECO = Renee Knight, VP of Community Services
  - 3RD Alt ECO = Fred Richards, VP Planning & Programs
  - Communications Vice-President = Andrea Spencer
  - CEO = Linda Levin

ElderSource's Emergency Preparation Activities

- We get our staff prepared: we encourage personal preparation and provide links to helpful sites; we give guidance as to how staff are to protect work equipment at both their remote work site (we provide surge protectors and plastic); and at ES office
- We update our Plans:
  - CEMP- Comprehensive Emergency Management Plan
  - COOP- Continuity of Operations Plan
  - Crisis Communication Plan
- We review, and update as needed, our related Policies and Procedures: various scenarios
- Staff and Manager on Duty receive training: 2023 Annual training is completed
- We complete drills throughout the year: 1st drill for this season was done 6/7/2023
- We have communication tools: Texting app, phone tree, staff directory and emergency contacts