ANNUAL REPORT 2018—2019 (FY 19 REPORT)

AGING & IN-HOME SERVICES
OF NORTHEAST INDIANA

Community Anchored Integrated Health Care

CONNIE BENTON WOLFE
President & CEO

A LETTER FROM OUR CEO

What a special year it has been! Aging & In-Home Services (AIHS) continues to achieve our Board-approved Strategic Organizational Priorities that improve our client outcomes, enhance our service offerings, diversify our revenue streams, and bring national recognition to the work we are doing in northeast Indiana with community-anchored integrated health care.

Our journey has milestones labeled "First community-based organization to achieve NCQA — Long-Term Services & Supports accreditation" — "First AAA in state to qualify for Medicare billing for Nutrition Counseling services" — "First AAA in country to develop and implement fee-for-service Care Transitions contract with regional commercial insurer" — "First AAA in Indianan to have all Case Management staff certified in Person-Centered Planning" — " First community-based organization in Indiana to support development of statewide Advance Care Planning coalition" — "First President of Indiana Area Agencies on Aging for-profit subsidiary implementing statewide contract with Managed Care Organizations."

As AIHS strives to stand at the forefront of innovative care for our populations, we have discovered best practices for traditional programs and innovative models of care. In February 2018, we received a letter from the State of Indiana Office of Medicaid Policy and Planning accepting our Letter of Intent to establish a PACE program here in Allen County. PACE, Programs for All-Inclusive Care for the Elderly, is the acronym for a unique model of integrated care that combines the best of community-based support with robust clinical services for complex patients. Our efforts to prepare for PACE can be followed on **https://agingihs.org/programs-resources/pace/pace-news/**.

As we end our 44th year and enter our 45th year of service to this community – our promise to you is to expand our mission to promote independence, dignity and advocacy for all older adults, persons with disabilities and their caregivers.

Connie Benton Wolfe

COMING 2020

PACE
OF NORTHEAST INDIANA

AGING & DISABILITY RESOURCE CENTER (ADRC)

The ADRC provides streamlined access to information, care options, short-term case management, and benefits enrollment across a spectrum of long-term care services and supports. Options Counselors can refer as well as connect you to an array of services.

Our ADRC receives over **1,500** calls per month!

FAMILY CAREGIVER CENTER

The Family Caregiver Center provides support and services to caregivers of individuals age 60 or over or an individual of any age who has dementia or a related disorder. The goal of the program is to reduce caregiver stress and to support the individual's ability to remain in the community with loved ones rather than be institutionalized.

"Without the support of AIHS I would not be the caregiver I am today!"

NUTRITION PROGRAM

Aging & In-Home Services' (AIHS) Nutrition Program is funded by the Older Americans Act (OAA). The Older Americans Act supports congregate and home-delivered meals for people aged 60 and older to address the problems of food insecurity, promote socialization, and promote the health and well-being of older adults through nutrition and nutrition-related services.

Our Nutrition Program served over **193,236** meals this past year

Person Centered Planning & Care

We use an innovated way of thinking and doing that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. AIHS is one of the first Area Agencies on Aging to be trained in the Person Centered Planning approach by the State of Indiana!

JUST CALL US

Options Counselors in our ADRC talk with you to determine services you are requesting and begin to gather information from you to prepare for your assessment.

IN-HOME ASSESSMENT

Review Activities of Daily Living

POPULATION HEALTH

Population Health focuses on the Social Determinants of Health by meeting people where they are. These individuals are typically people who have had a recent hospital discharge or a complex diagnosis. Our Care Transitions Coaches help empower individuals struggling with the gaps – gaps from lack of knowledge, services, time, preparedness or support.

"By addressing individual's Social Determinants of Health our Care Transitions program sees a significant reduction in hospital readmissions!"

GERIATRIC & DISABILITY CASE MANAGEMENT

Geriatric & Disability Case Management is a comprehensive approach to promote health and safety in a community-based setting through continuity and quality of services.

Our Case Management Program defers nursing home placement by **3+ years**!

CUSTOM CARE

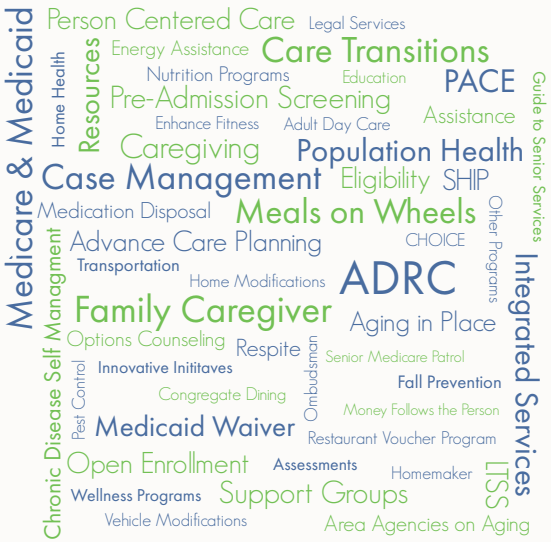
Custom Care, our private pay service model, was established to be responsive to the needs of older adults, persons with disabilities, and their caregivers regardless of their income. Custom Care provides services on a fee-for-service basis to those who exceed the income guidelines of program funding sources. Custom Care offers individualized and targeted solutions for immediate needs, ongoing support, and future care planning.

(ADLs) and acknowledge your

Social Determinants of Health (SDOH).

The conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment and social support networks, as well as access to health care.

ELIGIBILITY DETERMINATION & OPTIONS TO KEEP YOU

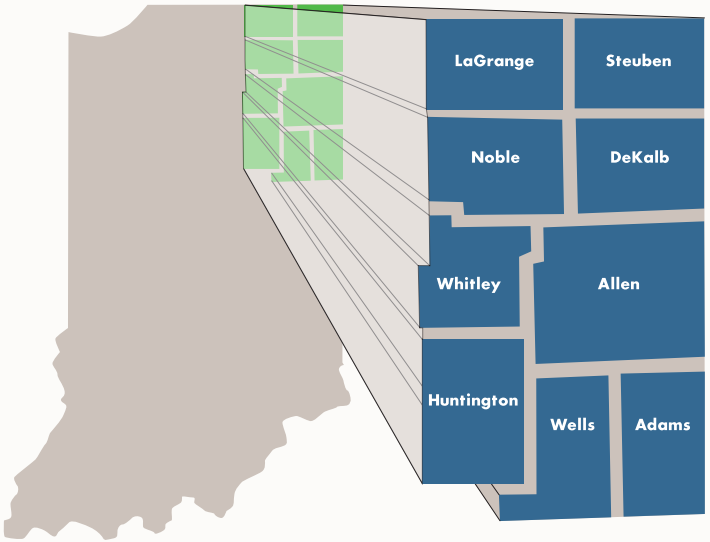


Evaluation complete: resources provided

OUR CLIENTS

102 Age of oldest client
<1 Age of youngest client
65% Female
35% Male
28% Minority
36% Living alone
55% Below poverty level (below poverty = $12,490 or less per year for one person)

AREA WE SERVE



Division of Aging

ACCREDITED NCQA CASE MANAGEMENT FOR LONG-TERM SERVICES & SUPPORTS 3 YEARS

INCONNECT ALLIANCE

DEAP DIABETES EDUCATION ACCREDITATION PROGRAM
AADE American Association of Diabetes Educators

TOP 3 REFERRALS

In-Home Services

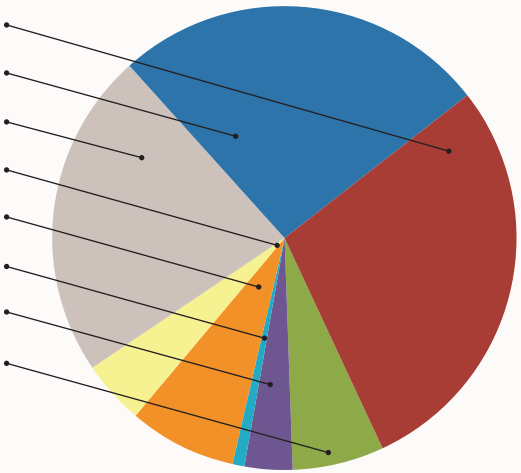
Family Caregiver Program

Home Delivered Meals

REVENUES FY 19 BY FUNDING

Total Revenue: $10,519,574

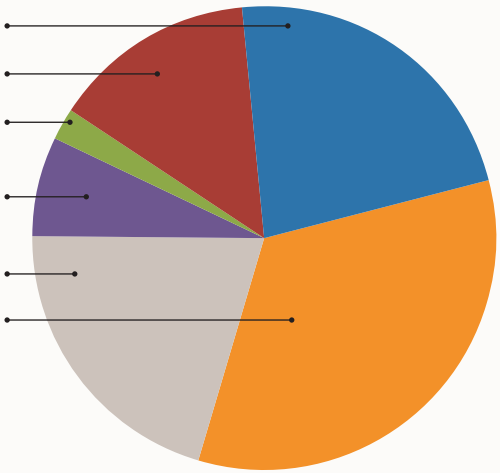
Federal Funds	$3,036,485
Medicaid Waiver	$2,736,894
State Funds	$2,397,068
Local Funds	$452,638
ADRC	$808,057
Client Contributions	$81,301
Other Revenue	$361,385
In-Kind	$645,742



EXPENSES FY 19 BY PROGRAM

Total Expenses: $10,328,707

Family Caregiver	$293,577
Nutrition	$1,849,451
Population Health	$311,003
Management & general	$859,931
Aging Direct Services	$2,668,178
Case Management	$4,346,564



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Visiting Nurse

SPECIAL DONOR RECOGNITION

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Parkview Health Systems

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