Aging & In-Home Services
OF NORTHEAST INDIANA

HEALTH HAPPENS HERE

2016–2017 ANNUAL REPORT

To promote independence, dignity, and advocacy for all older adults, persons with disabilities, and their caregivers.

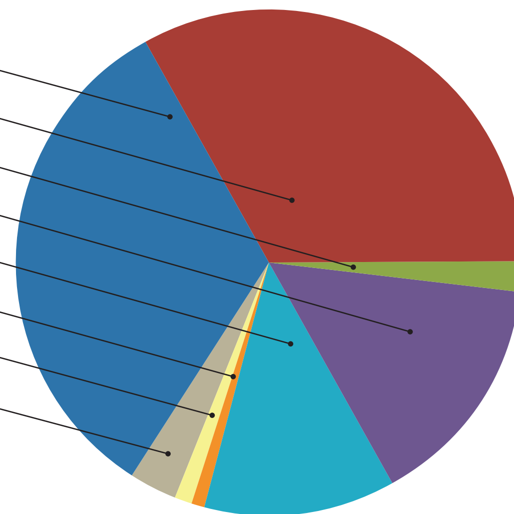
www.agingihs.org
2927 Lake Avenue, Fort Wayne, IN 46805
260-745-1200 800-552-3662

REVENUES FY 17 BY FUNDING SOURCE (FY17 AUDITED)

Total Revenue : $8,868,505.00

Increase/Decrease in Net Assets : $179,251.00

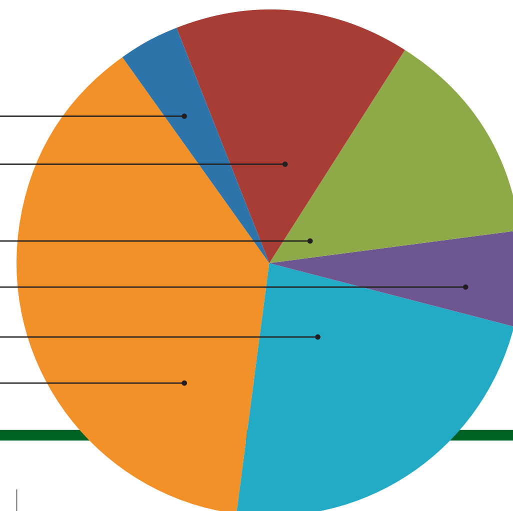
Source	Amount
Federal Funds	$2,951,659.94
State Funds	$2,903,685.40
Local Funds	$110,493.92
Medicaid Waiver	$1,335,067.49
CCTP Medicare	$1,102,032.25
Client Contributions	$111,084.99
Other Revenue	$87,172.01
In-Kind	$267,609.00



EXPENSES FY 17 BY PROGRAM (FY17 AUDITED)

Total Expenses : $8,689,554.00

Program	Amount
Family Caregiver	$273,207.81
Nutrition	$1,399,859.00
Community & Integrated Services	$1,134,574.55
Administration	$472,538.00
In-Home Services	$2,925,987.00
Case Management	$2,483,387.64

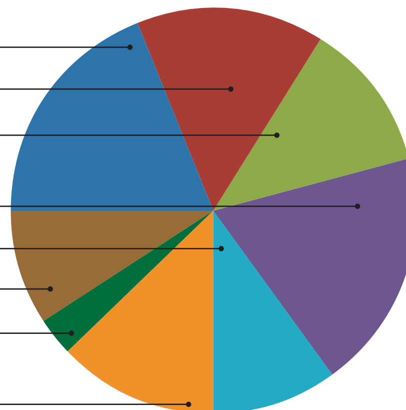


OUR CLIENTS

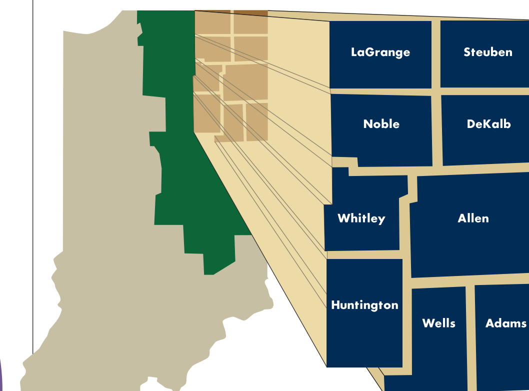
108	Age of oldest client	67%	Female
<1	Age of youngest client	33%	Male
79%	Caucasian	58%	Living with spouse/family
21%	Minority	42%	Living alone
49%	Above poverty level		
51%	Below poverty level (poverty level is defined as $12,060 or less per year for one person)		

CHRONIC CONDITIONS OF CARE MANAGED CLIENTS BY PRIMARY CLASSIFICATION

Condition	Percent
Cardiac/Circulatory	19%
Muscular	15%
Blood Disorders & Diabetes	12%
Nervous System (Parkinson's, Alzheimer's, MS & others)	19%
Mental Health	10%
Respiratory	9%
Cancer	3%
Other (congenital, digestive, infections)	13%



OUR AREA AGENCY SERVICE AREA



Health Happens Here

- Home
- Community

Aging & Disability Resource Center

To inform, empower, connect

- Information & Assistance
- Options Counseling
- Benefits Enrollment
- State Health Insurance Program (SHIP)
- Money Follows the Person (MFP)
- Advance Care Planning

INCONNECT ALLIANCE

Programs for Productive Aging

Health, wellness, and community engagement

- Health Education Specialist
- Preventive Health
- Chronic Disease Self Management
- Community Education Programs
- Retirement Planning
- Nutrition Counseling

Family Caregiver Center

Helping you care for the ones you love

- Caregiver Assessments
- Caregiver Consultation
- Support Groups
- Respite Care
- Men as Caregivers Initiative

Our Goal: Healthy. Happy. Home.

Home & Community Services

Supporting you where you live

- Senior Dining/Wellness Café
- Meals on Wheels
- Transportation
- HandyChore
- Legal Services

Care Transitions of Eastern Indiana

From hospital or skilled nursing facility to home to reduce readmissions across care settings.
Eligibility requirements apply.

Custom Care (Private Pay)

Individualized and targeted solutions

- Individual Care Coordination (LSW or RN)
- Corporate On-Site Services
    - Lunch & Learn
    - Individualized Employee Consultations
- Nutrition Counseling (RD)

Geriatric & Disability Case Management

Easing the burden of long term care

- Comprehensive Assessments
- Care Planning, Referral & Monitoring
- Enrollment Assistance for State & Federal Programs
- Consumer-Directed Care Management
- Pre-Admission Screening for Nursing Home Care

If you know someone in need of assistance,

just call us.

1-800-552-3662 • 1-260-745-1200
www.agingihs.org

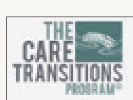
Health Happens Here

: Home
: Community

Over the past several years, the AIHS Board of Directors and CEO established Strategic Organizational
traditional social services agency to a bold, innovative nonprofit business leading its industry to better se
needs of a growing population of older adults, individuals with disabilities and their family caregivers.

Strategic Organizational Priorities — Ready. Se

Elevate professional practice models and standards to ensure quality outcomes in all programs:



Implemented evidence-based programming in multiple programs including Care Transitions and Family Caregiver Center

Implemented Person-Centered Care model in Case Management program protocol

Implemented Money Follows the Person (MFP) assessment in Aging & Disability Resource Center (ADRC) Designated by state FSSA as "Hub" supporting four Area Agencies on Aging "Spokes"

Selected by NCQA (National Committee for Quality Assurance) to participate in new Long Term Services & Supports (LTSS) product development and national standards committee. Stepped forward as NCQA LTSS Early Adopter. Achieved first-in-nation Area Agency on Aging to receive NCQA LTSS accreditation

Continue to grow opportunities in integrated medical and social healthcare contracts:

Developed Care Transitions pilot program with Parkview Hospital to reduce hospital readmissions

Selected by the Centers for Medicare and Medicaid Services (CMS) as part of national demonstration for Community-based Care Transitions Program (CCTP) to reduce hospital readmissions with Medicare high-risk patients

Secured contract with regional health insurer to provide care transition and care coordination to complex members, all ages

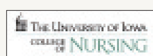
Provided leadership in the conceptualization of first in the nation statewide network of Area Agencies on Aging and the negotiation of first statewide managed care contract continuing today to reach and better serve high-risk Medicaid population

Developed joint venture to customize Health-IT platform for community-based organizations to track the Social Determinants of Health and communicate electronically with health care electronic medical records and statewide health care exchange

Achieved national recognition as "Innovator in Linking Health Care with Community" from The John A. Hartford Foundation through their Business Innovation Awards program

Partner effectively on translational research that will positively impact the populations we serve:

Research partner to Northwestern University School of Medicine under two funded PCORI (Patient-Centered Outcome Research Institute) grants to develop and disseminate PlanYourLifespan.org materials



Research partner to University of Iowa College of Nursing and Lutheran Medical Group to test the impact of diabetes self-management education on the health of community-dwelling older adults with diabetes

Research partner with National Institute on Aging (NIA), the Centers for Disease Control and Prevention (CDC), and the Administration for Community Living (ACL) in the ROAR project – Recruiting Older Adults into Research, to encourage them and other underrepresented populations to consider participating in research

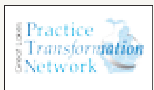
Priorities to transform our organization from a
erve the health and long term service and support

t. Achieved!

Achieve Medicare provider status and develop multiple Medicare-billable services:

Achieved Medicare provider designation

Developed qualified Medicare-billable "Diabetes Self-Management Education and Training" accredited by American Association of Diabetes Educators



With Great Lakes Practice Transformation Group, developing model for Primary Care Physicians to partner with Community-Based Organizations to accomplish Care Transitions and Complex Care Management

Develop enhanced model of nutrition interventions

Expanded Meals on Wheels and congregate dining to offer disease-specific meal options based on person-centered assessment of nutritional need

Integrated wellness programming into congregate dining including evidence-based Chronic Disease Self-Management Program (CDSMP)

Expansion of Wellness Café concept with vouchers for meal purchase to hospital-based cafeterias

Provide leadership in the development and distribution of Advanced Care Planning (ACP) information and materials

Established and supported local, and statewide coalition of organizations in integration process with nationally-recognized ACP organization – Honoring Choices

Received Achievement Award for our ground-breaking work in ACP at National Area Agency on Aging annual conference

Community-Anchored Integrated Health Care

Leveraging the Social Determinants of Health

Community-based Care Transitions Program 2013–2017

Value Proposition Community-Based Care Transitions

- Contact with patients/members extended beyond the walls of health care setting
- Real time check on patient understanding & support following episode of care
- Increased patient safety (after discharge) and patient satisfaction
- Addressing full range of psycho-social issues impacting health outcomes
- Reduced ED visits and hospital readmissions

CCTP Coverage Area

Bluffton Regional Medical Center
Community Hospital of Anderson & Madison Counties
DeKalb Memorial
Henry County Memorial Hospital
Indiana University Health Ball Memorial Hospital
St. Vincent Anderson Regional Hospital
Parkview Huntington
Parkview Hospital Randallia
Parkview Noble
Parkview Regional Medical Center
Parkview Whitley

Our CCTP Results

Patients served:	**15,730 High Risk Medicare**
Net Medicare Savings:	**$5.5 Million**
Program Outcomes:	**43% reduction in hospital readmission**

"CCTP was wildly successful"

Making a Market: The Case for Community-Based Care Transitions, Greg Johnson, DO, Chief Clinical Integration Officer, Parkview Health

INDIVIDUAL & ORGANIZATIONAL RECOGNITION

Special thanks to those individuals and organizations whose financial commitment was accompanied by extraordinary personal commitment, including members of our Staff, our Board of Directors, and the following:

DONORS

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Derrick Jackson - AFLAC
Dr. Carol Sue Johnson & PEO Members
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Epiphany Lutheran Church Congregation
Greatbach Medical
Guardian Medical Monitoring
Help at Home
Kroger Community Rewards
Lamplight Inn
Maxim Healthcare
Miller's Merry Manor
MKM architecture + design
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USI Insurance Services
Windows Doors and More

Thank you to all those who made possible our 42st Annual Meeting & Awards Ceremony, Wednesday, October 7, 2016

Featuring
Dr. Nancy Snyderman

"There is something very special happening here in Fort Wayne."

GRANTS

Community Foundation of Greater Fort Wayne
Council on Senior Services
Hospice Foundation of America
Indiana Association of Area Agencies on Aging
Indiana State Department of Health & University of Indianapolis Center for Aging & Community
Lincoln Financial Foundation
Meals on Wheels America
Northwestern University
Plymouth Congregational Church
United Way of Allen County
University of Iowa

IN MEMORY OF LYNN BROWN

Ms. Margaret L. Pierce

IN MEMORY OF RICHARD HOFFMANN

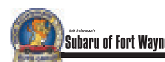
Mr. John Hoffmann

IN MEMORY OF PEGGY DUVALL

Mr. Richard E. Swan
Mr. & Mrs. David & Joann Kramer
Ms. Marilyn Rupright & Mr. Ron Alspaugh
Ms. Kathy Smar
Ms. Susan Thomas
Mr. & Mrs. Mark & Beverly A. Franken

SPECIAL THANKS

Bob Rohrman Subaru of Fort Wayne



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Aging & In-Home Services
OF NORTHEAST INDIANA