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 and Planning accepting our Letter of Intent to establish a PACE program here in Allen County. PACE, Programs for All-Inclusive Care implementing statewide contract with Managed Care Organizations.”

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.

As AIHS strives to stand at the forefront of innovative care for our populations, we have discovered best practices for traditional all Case Management staff certified in Person-Centered Planning” — “First community-based organization in Indiana to support resources/pace/pace-news/ in independence, dignity and advocacy for all older adults, persons with disabilities and their caregivers.

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

https://agingihs.org/programs-clinical services for complex patients. Our efforts to prepare for PACE can be followed on...
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 Indiana 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
President & CEO

COMING 2020
PACE OF NORTHEAST INDIANA
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!

In-Home Assessment
Review Activities of Daily Living (ADLs) and acknowledge your needs.

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

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.

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

**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.

**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.

By reviewing Activities of Daily Living (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**

**HEALTHY. HAPPY. HOME.**

**Evaluation complete: resources provided**
OUR CLIENTS
- Age of oldest client: 102
- Age of youngest client: <1
- Female: 65%
- Male: 35%
- Minority: 28%
- Living alone: 36%
- Below poverty level: 55%

Living alone: 28%
Minority: 35%
Age of youngest client: <1
Age of oldest client: 102

TOP 3 REFERRALS
- In-Home Services
- Family Caregiver Program
- Home Delivered Meals

REVENUES FY 19 BY FUNDING
Total Revenue: $10,519,574

EXPENSES FY 19 BY PROGRAM
Total Expenses: $10,328,707

Our Clients support, and future care planning.

Our clients living alone struggle with the gaps – gaps from lack of targeted solutions for immediate needs, ongoing sources. Custom Care offers individualized and services on a fee-for-service basis to those who regardless of their income. Custom Care provides adults, persons with disabilities, and their caregivers established to be responsive to the needs of older adults

Custom Care, our private pay service model, was Custom Care, a person-centered care model, was designed to address the needs of older adults with complex health conditions who are able to remain in the community with loved ones rather than be institutionalized.

CustoM CAre
- Medicaid Waiver
- Federal funds
- Total revenue: $10,519,574

Other revenue
- In-Kind
- Client Contributions
- Other revenue
- Total expenses: $10,328,707

Top 3 referrals
- In-Home Services
- Family Caregiver Program
- Home Delivered Meals

Population Health focuses on the Social Determinants of Health by meeting people where they are. These programs see a significant reduction in hospital readmissions!

Our Nutrition Program is funded by the Older Americans Act (OAA). The Older Nutrition Program is based on the Social Determinants of Health (SdOH) and the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, work and age.

Geriatric & Disability Case Management is a comprehensive approach to promote health and safety in a community-based setting through continuity and support, and future care planning.

Through nutrition and nutrition-related services, the Older Nutrition Program sees a significant reduction in hospital readmissions!
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