Aging and Disability Resource Centers
Implementing the Affordable Care Act:
Making it Easier for Individuals to Navigate Their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access
Evidence Based Care Transition Program

State Agency: Indiana Family and Social Services Administration

Name of ADRCs and Healthcare Partners:
ADRC of CICOA, Indiana University Geriatrics Program, Wishard Memorial Hospital and the Indianapolis VA Medical Center

Project Period: September 30, 2010 to September 30, 2012

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Evidence Based Care Transitions Model: Geriatric Resources for Assessment and Care of Elders (GRACE)

Project Summary:
This grant will build upon the GRACE model, which currently exists at Wishard and the Indianapolis VA, and integrate the ADRC care mangers component that will not only complement the GRACE services but also build a stronger relationship between veterans and the ADRCs.

Goal/Objectives:
The goals of this project are: 1) to integrate of CICOA care managers into the hospital discharge planning process at the Indianapolis VA and to provide timely, on-site access to comprehensive Options Counseling, care management and when appropriate, Preadmission Screening; 2) to more effectively coordinate hospital/ADRC planning process to support a more complete consumer/family discharge planning process; 3) to support, at the consumer's/family's option, access to high quality community-based long-term care supports with increased discharge to community-based settings and reduced reliance on nursing home care; and 4) when a consumer elects to reside in the community, to ensure linkage with physicians and other health care supports with a goal of preventing hospital readmission or nursing home admission.

Anticipated Outcomes/Results:
Key system outcomes are: 1) supporting information to aid in replication of the model across the state; 2) a reduction in nursing home admissions and long-stay placements, defined as greater than 90 days, and hospital readmissions, measured on a per person, admission, and days basis; and 3) an enhanced ADRC program that achieves more timely and effective person centered discharge planning and care transitions through collaboration with hospital and physician partners.