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 managers 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.