Building Healthier Communities:
Response to an Aging Community

A Kansas City Northland Aging in Place Collaborative Demonstration Project
<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86%</td>
<td>Want to stay in their current residence for as long as possible</td>
</tr>
<tr>
<td>85%</td>
<td>Want to remain in their local community for as long as possible</td>
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<tr>
<td>65%</td>
<td>Want to stay in their home because they like what the community has to offer</td>
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</table>
What is the scope of the Issue?

• According to the Robert Wood Johnson Foundation, one in five elderly patients wind up back in the hospital within 30 days of leaving, creating a “revolving-door” affect.

• Major barriers to living independently
  – Changing healthcare needs
  – Loss of mobility
  – Home accessibility
Readmissions rate high among older adults

Social, Environmental and Behavioral Contributing Factors

- Inadequate discharge planning and discharge home
- Persons living alone without a sufficient social support system
- Having unmet functional need
- Inadequate follow-up or self-management skills
- Noncompliance with medications and diet
- Failure to seek medical attention promptly when symptoms recur
What is the scope of the issue?

<table>
<thead>
<tr>
<th>County</th>
<th>2007</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>% Change 2007-2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson</td>
<td>52,399</td>
<td>57,748</td>
<td>90,113</td>
<td>129,327</td>
<td>146.81%</td>
</tr>
<tr>
<td>Wyandotte</td>
<td>16,312</td>
<td>17,622</td>
<td>23,570</td>
<td>29,636</td>
<td>81.69%</td>
</tr>
<tr>
<td>Platte</td>
<td>8,045</td>
<td>8,950</td>
<td>13,840</td>
<td>18,970</td>
<td>135.79%</td>
</tr>
<tr>
<td>Clay</td>
<td>22,094</td>
<td>23,352</td>
<td>34,898</td>
<td>48,228</td>
<td>118.29%</td>
</tr>
<tr>
<td>Jackson</td>
<td>81,075</td>
<td>82,644</td>
<td>113,035</td>
<td>146,450</td>
<td>80.63%</td>
</tr>
<tr>
<td>Total</td>
<td>179,925</td>
<td>190,318</td>
<td>275,455</td>
<td>372,611</td>
<td>107.09%</td>
</tr>
</tbody>
</table>
Successful Partnerships in the Community

• They are possible!
• Require:
  – Committed, strong leadership
  – Buy-in from all the partners
  – Regular communication
  – Involvement!
• Look beyond costs
• Studies show
  – Improved health for community participants
  – Real cost savings from prevention benefits
Northland Kansas City Aging In Place

Northland Shepherd’s Center
YMCA of the Northland
Clay County Public Health Department
Clay County Senior Services

Public/Private Partnership

Rebuilding Together
K2 Consulting Solutions
LifeWise Renovations
Cerner
Aging in Place Demonstration Project

Identify a cohort of ~50 Clay and Platte County residents aged 65+ hospitalized and at high risk of readmission

Care management
Community engagement
Service enriched housing

Demonstration of participation and patient outcomes
Roles within the Demonstration Project

- Care Management
- Community Engagement
- Service Enriched Housing
Program Case Manager – North KC Hospital

- Recruitment and consent
- Coordinate with Primary Care Physician and Community Programs Specialist
- Assisting with transition of care from the hospital to home
- Post-discharge home visit and subsequent follow-up phone calls
- Ensuring educational modules are available
- Coordinating patient wellness plan and home health monitoring
Perform a full home safety assessment

Create prioritized list of suggested modifications
Home Assessment Specialist (Rebuilding Together)

- Work with participants to make low cost and simple modifications
- Assist in determining appropriate home modifications
- Schedule and oversee home modifications
Community Programs Specialist – Northland Shepherd’s Center

- Coordinate with Program Case Manager to identify all participants
- Conduct an assessment of individual community-based needs upon discharge
- Conduct an assessment of current state community resources available on an individual basis
- Connect participants to services for which they qualify
- Identify barriers to patient engagement and receptivity
Coordinated Aging Programs and Services

Step 1: Identify
- Stakeholders
- Funding opportunities
- Project goals

Step 2: Design
- Tailor programs to aging
- Demonstration objectives and expectations

Step 3: Implement
- Enroll participants
- Provide services
- Communicate
- Coordinate

Step 4: Demonstration
- Participation
- Patient outcomes

Aging Population Health Management
Evaluation

Process Measures
• Number participants enrolled
• Number home assessments conducted
• Number of home modifications made
• Number and type of community programs for which participants qualify and enroll in
• Number of meals delivered

Outcome Measures
• Knowledge and satisfaction
• Functional independence
• Quality of Life
• Depression
• Rate of falls
• Rate of hospital readmission
• Return on investment
Final Results March 2018

• 76% Clay County Residents/24% Platte County Residents

• Age breakdown for study participants:
  – 57% - 70-80 years old
  – 42% - 80-90 years old
  – .03% - 90 +
Final Results March 2018

- Twenty-four hospital admissions to the hospital in the year prior to entering the program (six participants had more than one admission to the hospital making up this total).
- Four of the 50 participants (.08%) had readmissions after discharge within 30 days (one participant had two readmissions for a total of five readmissions within 30 days).
- Five of the 50 participants (.10%) had readmissions within 60 days of discharge (one participant had two readmissions for a total of six readmissions within 60 days).
- Four of the 50 participants (0.8%) had a readmission rate within 90 days (there were no participants who had multiple readmissions at 90 days).
Final Results March 2018

• Twenty-seven of the 50 participants reported improved quality of life – physical (54%).
• Twenty-three of the 50 participants reported improved quality of life – psychosocial (46%)
• Nineteen of the 50 participants reported improved quality of life – social (38%)
• Sixteen of total 50 participants (32%) self-reported improved overall quality of life after exiting the program
• Twenty-two out of 50 participants (44%) self-reported improved overall health after exiting the program.
Final Results March 2018

- 50% of participants had improved FIM scores when compared pre/post participation in the program (Functional Independence Measure)
- 38% of participants had increased improvement in their TUG scores when compared pre/post participation in the program (Timed Up and Go)
- Forty or the 50 participants agreed to and had at least one grab installed in their home (Majority of participants had more than one grab bar installed).
- Twenty-seven of the 50 participants agree to and had at least hand-rail installed in their home (of those receiving hand-rails multiple participants had more than one installed).
Questions?

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