



SCHOOL OF PUBLIC HEALTH

UNITED WAY OF TARRANT COUNTY

Healthy Aging and Independent Living Initiative

Annual Evaluation Report

July 1, 2010 – June 30, 2011

Executive Summary



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HEALTHY AGING AND INDEPENDENT LIVING INITIATIVE

2013 BOLD Goal:

5% (10,850) more older adults with chronic disease will be living at home.

For the 10,850 served, there will be:

- A **20% reduction** in hospital admissions 6 months after completion
- A **10% reduction** in Emergency Room visits 6 months after completion

HAIL Strategies

Respite care

Allows caregivers regular opportunities to relax and take care of themselves, which lowers the risk of care recipients being placed in nursing homes.

Education and Counseling

Like Resources for Enhancing Alzheimer's Caregiver Health (REACH II), an evidence-based program, can help caregivers reduce stress and depression, and improve their capacity for self-care. Of the 2,000 served, **80%** will still be living at home after 6 months

Stanford Chronic Disease Self-Management Program

This evidence-based program teaches those with chronic health problems, like diabetes, how to deal with pain and isolation; use proper medications, exercise and nutrition; and communicate clearly with family and health professionals.

Diabetes Screening and Intervention

Identifies at-risk individuals and helps them spend fewer nights in the hospital, with fewer visits to the emergency room.

Clients Served/Targets/Percent of Target

| Strategy | Agency | Year 1 Target | Actual (%) |
|---------------------------------|-------------------------|---------------|-----------------------------|
| Caregiver Respite | Easter Seals | 242 | 180 (74%) |
| Caregiver Education and Support | Alzheimer's Association | 417 | 381* (91%) |
| Disease Management Education | Senior Citizen Services | 500 | 314 (63%) (495 Enrolled) |
| Diabetes Screening | Senior Citizen Services | 2,000 | 2,040 (104%) |
| Nutrition Screening Counseling | Meals on Wheels | 3000 500 | 3,204 (107%) 513 (103%) |

*This includes 164 clients served through the Area Agency on Aging's Community Living Program

Demographics

| | Caregiver Respite | Caregiver Education/ Support | Diabetes Self-Management | Diabetes Education/ Counseling |
|------------------------------|----------------------|------------------------------------|-----------------------------|-----------------------------------|
| | (%) | (%) | (%) | (%) |
| <u>Race/Ethnicity</u> | | | | |
| American Ind. | 0% | <1% | 2% | <1% |
| Asian | 0% | 1% | 2% | 0% |
| Black | 25% | 20% | 18% | 12% |
| Hispanic | 12% | 15% | 16% | 8% |
| White | 63% | 63% | 58% | 80% |
| Not Reported | 0% | <1% | 3% | <1% |
| <u>Gender</u> | | | | |
| Male | 44% | 23% | 24% | 33% |
| Female | 96% | 75% | 76% | 67% |
| Not Reported | 0% | 2% | 0% | 0% |
| <u>Median Age</u> | 62.5 | 80 | 70 | 79 |

Key Findings Year-to date:

- All services were implemented as proposed by the agencies. Although enrollments were slow to start they have significantly increased in the last two quarters.
- Alzheimer caregiver families who received Education and Counseling and/or Respite services achieved the goal of 80% of Alzheimer's clients remaining in the community. However, 12 persons were deceased before the end of the program which may indicate that services were provided to "end stage" Alzheimer's clients, rather than the "mid-stage" target population.

- Clients receiving Diabetes and Nutrition Education and Counseling were at moderate risk of hospitalizations or emergency room visits, a total of 39 in the pre-service period. Of these clients only 11 had reached 6 months after their start of service. Inpatient admissions for these clients increased from 1 to 2. However emergency room visits decreased from 23 to 10 in the post service period. Numbers are too small for conclusions at this time but are encouraging.
- Clients participating in the Senior Citizen Services Diabetes Self Management Workshops are at relatively low risk of diabetes related hospitalizations or emergency room visits (total of 11) in the 6 month pre-service period. Of these only 3 have reached 6 months after start of services.
- Focus group findings showed very positive receipt of services by clients.

Successes:

- Implementation of all services in Tarrant County funded by the HAIL initiative.
- The Alzheimer's Association has been invited by the Rosalynn Carter Institute to present the REACHII program at the RCI National Summit Capital Training in October 2011.
- Senior Citizens Services and Don Smith made a presentation to the Texas Conference on Aging regarding implementation of best practices programs.

Areas of Concern:

- The start up period prior to enrollment of clients in most services was greater than anticipated. This resulted in lower than expected enrollments in the first two quarters.
- The proportion of Hispanic, Asian, and male clients served by agencies was low.
- Completion rate of Diabetes Self Management Workshops was lower than anticipated.
- Interaction between agencies to optimize client receipt of appropriate services can be improved.
- Alzheimer's patients whose families received services were at a later "stage" of the disease than anticipated.

Continuous Improvement Efforts and Plans moving forward:

- Increase outreach activities for all services to meet 2011-2012 increased targets.
- Expand the number of service agencies to compare effectiveness of different approaches to diabetes self management and Alzheimer's caregivers education and support.
- As numbers of clients who reach 6 months after start of diabetes education and self management services increase, more information will be available for analysis of reductions in hospitalizations and emergency room visits.
- Meals on Wheels has recently purchased and implemented software developed by the American Association of Diabetes Educators to track achievement of client behavior goals.


Comments for Further Exploration:

- Explore the use of nutrition risk and diabetes assessment data to determine short term, and intermediate outcomes in Stanford Chronic Disease Self-Management Program and Diabetes Screening Intervention.
- Due to the low risk of hospitalization Identified for the Senior Citizen Services' Diabetes Education population an alternative outcome measure should be explored.
- Have Alzheimer's Association and Easter Seals conduct and report a telephone contact with caregiver families 6 months after service ends to determine if the Alzheimer client continues to live in the community.

Recommendations:

- Continue to increase outreach to Hispanic, African-American, Asian, male and other under-served populations among all agencies.
- Increase referrals/intakes to respite services for Alzheimer caregiver families as appropriate.
- Utilize outreach funds to increase numbers served and target Hispanic and Asian communities.
- Increase outreach to male population for diabetes education and self management. For example through more workshops at the Veteran Administration sites.
- Utilize incentives to increase completion of Diabetes Self Management Workshops.
- Enhance assessment and intake process to target "mid-stage" Alzheimer's patient families for caregiver education and respite.
- Revise reporting procedures to maximize capture of data for diabetes self management clients.
- Improve interaction between service agencies to optimize client receipt of appropriate services.
- Explore strategies to provide transition of Alzheimer's families from the United Way funded respite services as service limits are reached.
- Clarify what will constitute achievement of Bold Goal.

Live Well: Healthy Aging and Independent Living Initiative

| On target for bold goal | Health Strategies | Targets Reached | Results Achieved |
|---|--|-----------------|---|
|  | Caregiver Respite for Alzheimer's families | B- | A- |
| | Diabetes & Nutrition Screening | A | A |
| | Caregiver Education and Training | A- | A- |
| | Diabetes Self-Management Training | B | Pre-service hospitalizations and ER visits to date not adequate for determination |