Eldercare & Aging in Place: '24-'25 Committee Report

(Committee Chairs: Rev. Maria Campbell, Rev. Eileen Stulak, Vicki Love)

Hearing the Concerns of Our People

Concerns related to seniors and aging in our community were identified during the fall 2024 Listening Process. Network members shared concerns such as:

- "Can we continue to live in our house if we can't drive? We would need some kind of transportation for groceries, doctors, shopping, etc. We don't want to have to move to a senior facility"
- "I worry about burdening my family and my wife [as I age]. I want to stay independent as long as possible."
- She has been in her home for 50 years, and has to be realistic about staying and maintaining it. Alternatives are extremely expensive.
- Concern for the high cost of a nursing home, but the cost of home health care is even higher.
- Recently browsed for a long term care facility. One was $11k/month. One is $3k to just be put on a waiting list.
- "Aging in place is a battle."

Selecting the Priority of Eldercare & Aging in Place

At our annual Community Problems Assembly on November 3rd, members of the Good Faith Network confirmed eldercare as the next priority for the organization. The Eldercare Committee formed at our annual Research Kick-Off on November 18th, and Network Members from many congregations volunteered to learn more about the issue and dig deeper. Further review of the stories shared in the Listening Process and initial research meetings led the committee to specify four sub-themes: healthcare, community services, care facilities, and aging in place. Through additional study, the theme of aging in place was determined to be the path where our work would be most fruitful.

Researching the Problem and Viable Solutions

The Eldercare Committee held the following meetings leading up to the 4/6/25 Solutions Briefing:

- 11/25/24 - **Dan Goodman, Barb Conant** - KS Advocates for Better Care
- 12/04/24 - **Commissioner David Anderson** - KS Dept of Aging and Disability Services (KDADS)
- 12/06/24 - **Kevin McGuire, Liz Worth** - Johnson County Mental Health Center
- 12/16/24 - **Kathy Greenlee** - ADvancing States, former Asst. Secretary for Aging, US Dept of Health and Human Services
- 12/18/24 - **Tim Wholf, Cindy Green** - Johnson County Aging and Human Services, Area Agency on Aging (AAA), and Board of County Commissioner's Commission on Aging
- 01/03/25 - **Lauren Schaumburg, Cathy Boyer-Shesol** - Mid-America Regional Council
- 01/09/25 - **Chris Osborne** - Evergreen Community/Evergreen Hospice Care
- 01/16/25 - **Shawn Sullivan** - Midland Care Connection, PACE program
- 01/17/25 - **Rita Cortes, Kim Lewis** - Menorah Heritage Foundation
- 01/20/25 - **Hector Rodriguez** - Regional Long Term Care Ombudsman
- 01/23/25 - **Rachel Ohlhausen, Jana Fielder** - Jewish Family Services
- 03/04/25 - **Hannah Albers** - Workshop with the National Center for Reframing Aging

- 03/10/25 - **Emily Jensen, Monica Cissell** - Sedgwick County AAA and Aging Mill Levy programs
- 03/14/25 - **Study Session** - CAPABLE model
- 03/14/25 - **Deputy Secretary Andy Brown, Commissioner David Anderson** - KDADS
- 03/17/25 - **Tricia Ford** - CAPABLE National Center, Care Synergy
- 03/21/25 - **Aimee Tilley** - CAPABLE program at North Kansas City Hospital
- 03/26/25 - **Stephanie Bonham, Amanda Goodenow** - CAPABLE program at Colorado VNA
- 03/31/25 - **Jeremy Wiltz** - CAPABLE program at Midland Care Connection
- 04/01/25 - **Andrea Bozarth** - KS AARP State Advocacy Director
- 04/03/25 - **Tina Uridge, Kay Findlay** - Clay County Senior Services and North KC Hospital

The Problem Statement *(adopted by Good Faith Board of Directors 1.28.25)*

Census data tells us there are over one hundred thousand people in Johnson County above the age of 65.[1] Most of these seniors want to age in place and live in their homes for as long as possible.[2,3]

However, Kansas is one of the worst states in the nation for “low-care” residents in long term care facilities, meaning that more people end up in professional care institutions than need be according to their actual level of need.[4]

The most important factors that affect one’s ability to age in place include, but are not limited to:

- The affordability, functionality, accessibility, and safety of the home
- Planning ahead for healthcare decisions
- Social connections/supports for both seniors and caregivers
- In-home skilled caregivers for assistance with Activities of Daily Living (ADLs)
- Nutritional support and wellness programming
- Transportation to and from aforementioned community programs and social events, as well as medical appointments

Without the adequate scaling and coordination of the factors and community resources listed above, we will continue to see an unnecessarily high number of people enter into institutional care.

The Solution Statement *(adopted by Good Faith Board of Directors 3.16.25)*

The Good Faith Network seeks a solution that focuses not only on the clinical needs, but also the functional needs of the elderly residents of our community, empowering people to safely and independently live in their own homes for as long as possible. This includes enabling them to complete Activities of Daily Living (ADLs) with greater ease and remain meaningfully engaged in the community. Because the needs of older adults are highly individualized, effective solutions to aging in place must prioritize dignity and self-determination.

To address our community’s desire to age in place, we must scale resources for older adults to reach the level of demand and optimize coordination across service delivery systems to ensure people are able to navigate and access the resources they seek.

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[1] Census data, 2023. Accessible via: https://www.census.gov/quickfacts/fact/table/johnsoncountykansas/PST045224
[2] Committee interview with Kathy Greenlee, Dec 16, 2024.
[3] “"I'd prefer to stay at home but I don't have a choice': Meeting Older People's Preference for Care: Policy, but what about practice?” Page 22. Accessible via: http://hdl.handle.net/10197/7670
[4] Kansas Advocates for Better Care interview, Nov 25, 2024. Accessible via: https://www.kabc.org/kansas-struggles-with-low-care-nursing-home-residents-ranking-among-the-worst-in-the-nation

Narrowing and Selecting a Solution

The Solution Statement above specified the features we were seeking in a solution, but left us additional room to narrow down which model would be best suited to the problem at hand: aging in place successfully. The functional needs of older adults are often ignored by our health care system because they are “beyond the scope” of typical medical care. But in many ways, a functional lens is key to an older adult’s ability to engage meaningfully in the community and keep living independently in one’s own home.

Additional research in the following weeks would lead us to CAPABLE, a model originating from the Johns Hopkins School of Nursing. CAPABLE stands for: Community Aging in Place, Advancing Better Living for Elders.

The committee was impressed with CAPABLE’s inter-disciplinary approach, addressing both the clinical and functional needs of older adults in flexible and creative ways. Because of the academic origins of the model, there is a robust body of research to support its effectiveness. There are also support structures in place through the CAPABLE National Center available to communities looking to implement the model locally, which paves the way for the model’s adoption and expansion into Johnson County.

The CAPABLE Model: Participants and Home Visits

Participants in CAPABLE are older adults over the age of 50, with some degree of functional limitation when it comes to performing Activities of Daily Living (ADLs), who are cognitively intact and have a desire to keep living in their house or apartment. While it depends on the organization that is implementing the model, CAPABLE is frequently provided to the client free-of-charge. In some programs, there is a sliding scale based on annual income.

CAPABLE is delivered in the home during 10 visits, spanning the course of 3-5 months, through an inter-disciplinary team including an Occupational Therapist (OT), a Registered Nurse (RN), and a handy-worker.

During the first home visit, the OT guides the client through an interview where they assess their current needs, set goals, and develop an action plan. Over the next few months, the OT conducts 4-6 more visits where they work on functional/mobility needs, assess the home risk and determine modification and equipment needs, and discuss fall prevention.

The handy-worker receives a work order and confers with the client on installation before making the necessary home repairs/modifications. These are highly individualized to the client’s needs, but could include items such as ramps, grab bars or railings, flooring thresholds, toileting assistance devices, or exercise equipment.

The RN will conduct 3-4 visits with the participant during this time period, collaborating with the OT and working from the same action plan, but addressing other participant needs such as healthcare coordination, key health issues/risks, pain, and a review of current medications.

Outcomes and Research on the Effectiveness of CAPABLE[5]

Improved Physical Function

- 74.8% participants had less difficulty with ADLs. Participants had difficulty with an average of 3.9 out of 8.0 Activities of Daily Living (ADLs) at baseline, compared to 2.0 after five months.

Improved Motivation & Home Safety

- The change in physical environment (home modifications) further motivates the participant. Addressing both the person and the environment in which they live allows the person to thrive. 77.6% of participants had less home hazards.

Reduced Symptoms of Depression

- 52.9% of participants had less depressive symptoms and reported a greater ability to do important tasks. 65% of participants improved such tasks as grocery shopping and managing medications.

6-7x Return on Investment

- Roughly $3,000 in program costs yield more than $30,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures.
- A reduction in healthcare costs reflects not only a savings in cost to the healthcare system, but also savings to the client from suffering from those medical events.

Implementation of a CAPABLE Program

Many types of organizations are implementing CAPABLE around the country, including:

- Health care systems
- Accountable Care Organizations
- Area Agencies on Aging
- Medicare Advantage health plans
- Insurance companies
- PACE programs
- State/county/city Departments of Aging
- Home and Community Based Services providers
- Skilled nursing facilities
- Nursing homes
- Veterans Administration centers
- Home healthcare agencies
- Nonprofits
- Start-up for-profits (self-pay model)

The handy-worker component of CAPABLE is frequently a partnership with a separate community organization, such as a local Habitat for Humanity chapter or similar nonprofit.

The funding sources for CAPABLE can vary widely, and can be braided from multiple public, private, and philanthropic sources to build sustainability. Some states are working towards incorporating CAPABLE into their Medicare waiver eligibility for additional funding.

[5] Ruiz, et. al, 2017. Accessible via: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1305 and Szanton et. al, June 2016. Accessible via: https://doi.org/10.1093/ppar/prw014