

FY11 United Way Mid-Year Report

Program: Adult Care Centers and Health Services

Agency: JABA

Date: February 4, 2011

1. For the current funding period, please highlight your program's goals, activities and results, noting any changes to your original plan/proposal. Include any relevant budget and/or financial information. Limit your response to no more than one page.

Program: Adult Care Centers—(ACC)—Hillsdale and Louisa

JABA's Adult Care Centers provide a safe, protected daytime environment for adults with special needs who are unable to be alone during the day. Most of our members live at home with family who must work during the day or who need respite from the responsibility of caring for their loved ones 24 hours a day. Our members are treated with dignity and are engaged in a service which offers healthcare, purposeful therapeutic activity and vital socialization within an informal group setting.

The staff in the centers is dedicated and committed to offering a caring environment with a culture that promotes quality person centered care utilizing an interdisciplinary team approach. Services include healthcare screening; health promotion; therapeutic recreation; speech, occupational and physical therapy; exercise and leisure programs; companionship and socialization; assistance with activities of daily living (personal care); enhanced nutrition (featuring local foods when available) and medication management. To date 116 clients have attended JABA's two Centers during FY 11.

While day care is the least expensive of the community based services, there are many families who need financial support to participate. Without the funds available through the United Way, caregivers and members would face long days at home. At our current level of funding, there are still unmet needs. There are approximately eight members who would attend more days during the week if there was more scholarship funding.

Highlights of program enhancements which will assist us in surpassing our goals include but are not limited to:

- Care plan goals for all members are monitored by staff on a monthly basis;
- Over 60% of our members are currently part of the "Walking Club" to increase mobility;
- Our support group participation continues to expand;
- Half-day and drop-in services continue to be available for members;
- Saturday service continues from 9 AM to 3 PM, serving an average of 8 clients per day;
- Intergenerational activities occur on a daily basis with the Montessori School at the Hillsdale Center and JABA's new Shining Star Pre-School at the Louisa Center. (JABA opened the Shining Star Pre-School in October, 2010, and as of this report, we are fully enrolled to our licensed capacity of 32 children.)

Program: Health Services

From July through December, 2010, JABA Health Services has provided direct health services to 447 clients. Services are provided at 8 community centers and 5 senior living sites. In spite of the funding challenges, the Westhaven Clinic has been brought fully under JABA management. The clinic staff include a registered nurse, 8 hours per week and an outreach coordinator, 25 hours per week. The Health Services program continues to provide health screenings, minor treatment, health promotion and counseling, as well as care coordination to the elderly, thereby providing an opportunity for more active, healthy lifestyles. The ultimate goal is to assist older adults to age in the places of their choice.

2. Please share a success story from your program. We are especially interested in stories that show a long-term impact on a person or family, and stories that show collaborations or referrals with other community programs in meeting a client's multiple needs.

Hillsdale ACC:

Mr. P is a 69 year old Caucasian man with Frontotemporal dementia. Prior to retiring, he was a car salesman and a drug and alcohol counselor. From an early age, he played the saxophone and the clarinet. His ready smile and musical talent helped him find a niche in the ACC program fairly soon. He plays along with anyone who wants him to and has even gone to a nursing home with one of our volunteer groups. His clarinet adds just the right touch to round out the songs from yesteryear. Another of Mr. P's talents is that he is an excellent dancer, which is quite a hit with many of the ladies who attend the ACC. Mr. P has become the Ambassador of our program and befriends all the newcomers. He happily told his wife that he now has friends with dementia and they understand what he is going through. Being part of a group of his peers and being able to give back has given new meaning to Mr. P and has allowed his wife to continue working.

Louisa ACC:

Ms. B is an 84 year old women who has been attending our ACC program for 9 years. She started out at the Hillsdale center then moved to the Louisa center when we opened. Her daughter worked full time in Charlottesville but their home is in Louisa. Ms. B's daughter sent her mother here with people that she knew, and went to work with her mind at ease that her mother was well taken care of. Over the years Ms. B has had a decline in her health so her days have been cut back. She now attends the center two to three days a week and is on oxygen. Her daughter has since retired and has become a wonderful volunteer at our Community Center. Ms. B's daughter said that we had given her so much by taking such great care of her mother that she felt it was time for her to give back to us. She said that if it wasn't for places like our Adult Care Centers, people like her would not be able to keep their loved ones at home like she has been able to do.

Health Services:

Mrs. A.N., 93 year old widowed black female, lives alone in Esmont with nearby siblings and devoted neighbors who check in on her daily. She is treated for hypertension, diabetes and recent slight changes in mental status. Her blood pressure and diabetes were well-managed until she experienced an unintentional 12-pound weight loss during the past year. Her longtime physician is at Southern Albemarle Family Practice. When her BP dropped because of her weight loss, two of her three anti-hypertensive meds were discontinued. She was referred to JABA's ACC at Hillsdale, and the JABA nurse practitioner ordered Ensure supplements through JABA's meals program. She has regained 8 pounds, is thriving at ACC three days a week and continues to attend the Esmont center on Tuesdays and Thursdays.

Mrs. M.A., 69 year old widowed white female, lives in Mineral and attends the JABA Louisa Community Center. In 2003, she underwent a heart transplant at UVA and is now able to participate fully in all of the activities and programs at the Betty J. Queen Center. She is a gracious patient for the many UVA nursing and medical students who have received clinical experiences at the center. In the fall of 2010, she approached the JABA nurse practitioner for help in constructing a letter of gratitude to the family of her heart donor, and this long-desired project was completed before Thanksgiving. While it will be delivered anonymously by the

transplant coordination agency, the completion of this happy task has been a source of great satisfaction to the client and a truly humbling experience for the JABA nurse practitioner.

3. Complete the following Outcome Measurement update (based on your application for funding) for the fiscal year to date.

Projected Number of Intended FY11 Primary Beneficiaries:	<u>161</u> Adult Care Centers <u>555</u> Health Services	Actual Number of Primary Beneficiaries:	<u>116</u> Adult Care Centers <u>447</u> Health Services
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Projected FY11 Outcomes	FY11 Indicators Tracked	FY11 Outcome Results (provide specific numbers and percentages)
Adult Care Centers (ACC): At-risk elderly live as independently as possible in their chosen residences.	Caregivers report being able to continue with life responsibilities and leisure activities due to the respite provided through ACC.	-The annual survey will be distributed in February, 2011. -To date, staff has provided 315 hours of support group, individual counseling and assistance with paperwork for Social Services and Veteran's Administration to caregivers.
	ACC clients who meet the criteria for institutionalization (needing assistance with 2 or more activities of daily living and qualify for nursing home placement) are able to remain at home.	For 6 months, 31 clients who need assistance with 2 or more activities of daily living and qualify for nursing home placement remained at home for 5,489 days.
	All assessed clients will have completed care plans that include measurable personal goals.	116 clients (100%) have completed care plans including measurable goals which are monitored by staff on a monthly basis.
Health Services: At-risk elderly with chronic diseases like high blood pressure and diabetes manage their illnesses and maintain their health, thereby avoiding exacerbation of their diseases(s) that result in the need for tertiary levels of care.	Clients whose blood pressure and/or blood sugar was monitored demonstrate positive outcomes in managing their chronic disease(s).	91% of the 220 clients whose blood pressure was monitored and 79% of the 78 clients whose blood sugar was monitored demonstrated positive outcomes in managing their chronic diseases (showed improved, stable or normal levels).

	Through group education, one-on-one health education and health counseling, clients learn to manage their chronic disease(s) and maintain their health.	542 clients improved their knowledge of their disease(s) and general health issues. (This includes clients who attend sessions at three senior living sites, two public housing sites and receive one-on-one counseling or who attend health promotion sessions at the community centers.)
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4. Impact Report. We are looking for issues and statistics specific to our local area; you are also welcome to include some general issues that set the framework for the local statistics. Under the Actual Results heading, we are looking for impact, especially long-term results, not just numbers served. For the Financial Impact section, have each example highlight a different thing (in other words, don't just multiply the first answer three more times).

Community Needs or Issues Your Program Addresses -- please include at least 3 local issues/statistics and cite your source

Based on 2000 Census data for the Planning District, 12% of the population is 65 years of age and older. Forty-three percent are male and 57% are female, of which, 33% live alone. Of those 65 and older, 36.96% have a disability or chronic illness.

The Alzheimer's Association reports there are 5,937 individuals in the Planning District with Alzheimer's disease. This is projected to increase to 8,847 by 2010. Based on the national population statistics, one-in-ten of those 65 and older are affected and one-in-two of those over 85 years of age have some form of dementia. By the year 2050, the number of persons with Alzheimer's or a related dementia is projected to triple locally as well as nationally.

Based on 2005 Census data and the Virginia Atlas of Community Health, the following is a picture of the health of seniors in Planning District 10.

	Albemarle	Charlottesville	Fluvanna	Greene	Louisa	Nelson
Population 65+	9,905	4,490	2,729	1,382	3,202	2,352
# With Physical Disability	2,019	1,090	202	149	305	264
# With Mental Disability	708	441	22	10	43	37
% With Hypertension	27%	21%	29%	25%	30%	31%
% With Diabetes	8%	6%	9%	7%	9%	9%

Demographic forces are reshaping how our health delivery and caregivers' support systems must operate. Between 2004 and 2010, the number of people 65 and older in the population is projected to grow 25%, while the total population is projected to grow only 10%. Between 2010 and 2030, the 65+ population will double. The fastest growing segment of the adult population is among people over the age of 65, particularly that segment over the age of 85. In our area, this group is expected to increase by 50% between 2010 and 2020. More than one third of those age 85 and older need regular care to remain in their homes. Almost half of those age 65 and older are limited in some way, and one out of every five persons needs assistance with major activities of daily living.

Meeting the needs of those cited above is currently being addressed by caregivers who often must also maintain employment or who themselves are elderly. The combination of working and providing care to those in need has a profound impact on the well-being of the caregiver. Currently, approximately one-in-four local full-time employees provides some level of eldercare. Without support, caregivers are at risk for losing their employment, disrupting family life and stability and/or experiencing significant illnesses that make it difficult or impossible for them to continue to provide care. There is an increasing need for adult day care services. Furthermore, elder caregivers often have their own health issues, putting them at risk for further illness or injury.

Compounding the problems of caregivers is that as the aging population grows, the number of professional and family caregivers is shrinking. Baby boomers are the first generation to outnumber their children's generation. Twenty percent of boomers have no children, and 25% have only one child. There will be fewer adult children to help provide the care of their aging parents.

At-risk elderly need assistance with basic activities of daily living, without which they are at risk for institutionalization. Health care monitoring is critical to manage serious, chronic conditions. Monitoring leads to access to medical care that is preventative, not emergent, which is costly and without good follow-up.

Many elderly are at-risk due to minority status and/or low income. They are increasingly at-risk for malnutrition, social isolation, displacement due to a lack of affordable housing, premature institutionalization, and any number of ailments commonly associated with advancing age and a lifetime of inadequate access to healthcare and other services.

Your Program's Solutions that United Way Community Impact Funds Support

Adult Care Centers:

- The annual survey will be distributed in February, 2011.
- To date, staff has provided 315 hours of support group, individual counseling and assistance with paperwork for Social Services and Veterans Administration to caregivers.
- For 6 months, 31 clients who need assistance with 2 or more activities of daily living and qualify for nursing home placement remained at home for 5,389 days.
- 116 clients (100%) have completed care plans, including measurable goals which are monitored by staff on a monthly basis.

Health Services:

- 91% of the 220 clients whose blood pressure was measured and 79% of the 78 clients whose blood sugar was monitored demonstrated positive outcomes (improved, stable or normal levels) in managing their chronic diseases.
- 542 unduplicated clients improved their knowledge of their disease and general health and wellness issues—330 clients attended health promotion sessions held at the community centers and senior living sites. 212 unduplicated clients received individual counseling and medication management.

Financial Impact of Donations -- (i.e., \$3/week provides...; \$5/week provides...; \$10/week provides...; \$20/week provides....)

\$3/week (\$156) provides: Seven hours of training for family caregivers of members attending Adult Care Centers, providing support, education and counseling to ease the burden of around-the-clock caregiving.

\$5/week (\$260) provides: One hour a month of disease prevention education at one of JABA's eight senior community centers and three senior living sites or two public housing sites, benefiting all of the clients who attend.

\$10/week (\$520) provides: Two hours a month of nursing services in one of JABA's senior community centers or senior living sites to monitor the health of the clients attending the center.

\$25/week (\$1300 per year) provides: Thirty-two days of care at JABA's Adult Care Centers through a part-time scholarship which directly benefits the individual attending and one or more family members and/or caregivers.

\$30/week (\$1560 per year) provides: One hour a week of in-home follow-up by the nurse practitioner for clients in their homes. This can be a result of a primary care physician referral or a condition identified by the nurse or other staff member while the client is attending the senior community center.