Community Innovations for Aging in Place

Project Summary

Grantee Organization: Coordinating Center for Home and Community Care, Inc.

State: Maryland

Project Title: Community Innovations for Aging in Place Project

Project Period: September 30, 2009 to September 29, 2012

Contact: Karen-Ann Lichtenstein, kalichtenstein@coordinatingcenter.org

Project Summary:
The Coordinating Center proposes a three year Community Innovations for Aging in Place project in collaboration with the Howard County Department of Aging (ADRC). The approach integrates innovative case management expertise with existing community-based services to sustain independence of older individuals.

Goals and Objectives:
Actualizing aging in place principles, the project goal is to establish a partnership between an experienced case management entity and a local ADRC creating a model for supporting elderly individuals with specialized health concerns to age in their own homes or sites of their choice and avoid costly re-hospitalizations and inappropriate facility placement. Objectives of the project are to: 1) Provide outreach to identify individuals living in a Naturally Occurring Retirement Community (NORC)/surrounding area and in danger of spending down to Medicaid and nursing home placement 2) Work with Howard County General Hospital to implement a comprehensive discharge plan for participants that includes follow-up community-based case management. 3) Develop comprehensive community living plans that encompass the medical, social, educational and recreational supports individuals need to age in place, honoring the individual's strengths and choices. 4) Provide on-going case management ensuring that as the individual's needs change they have access to needed care and community supports including community housing alternatives 5) Establish a Community Development Council, comprised primarily of participants

Outcomes and Products:
Expected outcomes include: hospital readmissions will be significantly reduced; greater use of community-based services will be realized; individuals will remain in the community longer, and a replicable model of comprehensive care coordination will be implemented. Final products include: a final report to include a case management replication model, a refined needs assessment, and a plan for sustainability.