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# ***Aging in Community*** Initiative: Supportive Housing to Supportive Living

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## ICL Mission

Assist individuals and families affected by or at risk of mental illness or developmental disabilities with integrated comprehensive care designed to improve their wellbeing, recovery and participation in community living.



## ICL Core Principles: TRIP

- **T**RAUMA-INFORMED: sensitive to an individual's past experiences and how they may impact current choices and behaviors.
- **R**ECOVERY-ORIENTED: concentrates on the four major dimensions of recovery; home, health, purpose and community
- **I**NTEGRATED: addresses physical health, mental health and substance use issues using a coordinated multidisciplinary team.
- **P**ERSON-CENTERED: focuses on the goals and values of the individual as primary determinant of services provided.

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## ICL: Types of Services

- Supportive Housing Programs
- Assertive Community Treatment (ACT) Teams
- Personalized Recovery Oriented Services (PROS)
- Outpatient Mental Health Clinics
- Shelters
- School-based Programs
- Family Resource Center



## Aging in Community

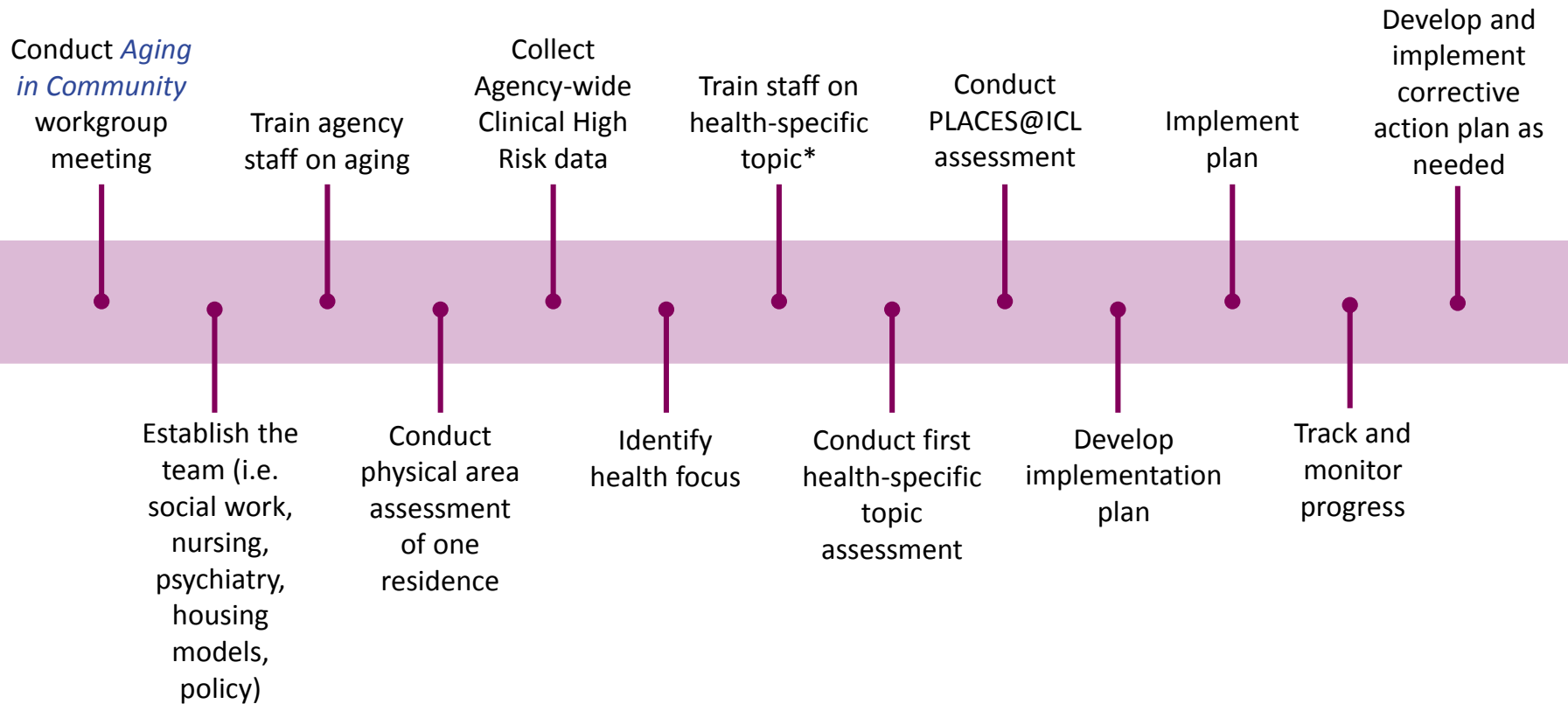
***Aging in Community*** is an initiative that focuses on addressing older adults whole health needs to remain in supportive housing and in their community while reducing health costs associated with aging

### Approach:

- To understand the breakdown by age groups that lives in supportive housing
- To assess the individuals and their environment
- To determine what aspect of health to focus on
- To develop a plan for improvement
- To track and monitor progress

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## Model Basics: *Aging in Community*



\* Training is dependent on data findings

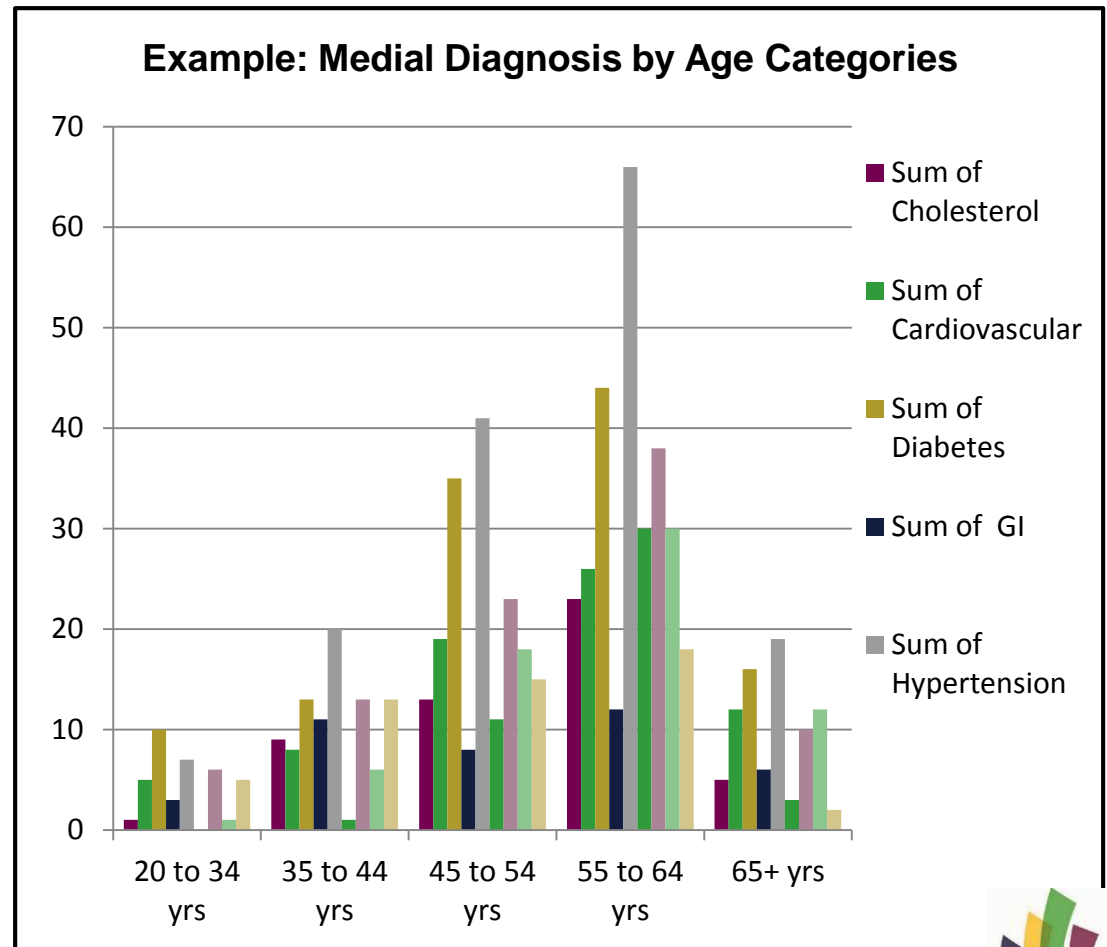
## Conduct Physical Area Assessment of One Residence

- Identify areas that can be modified and/or improved to better fit the aging population
- Assess the space usage and make up of a house
  - Type of flooring
  - Type of lighting
  - Safety equipment (i.e. railings installed in the bathroom)
- Findings are utilized and integrated into home assessments across housing programs



## Collect Agency-Wide Clinical High Risk Data

- Each program is responsible for completing and updating their clinical high risk data periodically
- Use a clinical risk algorithm to identify program individuals as clinical high risk
- Identify most prevalent health issues and health-specific focus for the *Aging in Community* initiative





## **Conduct Health-Specific Focus Assessment**

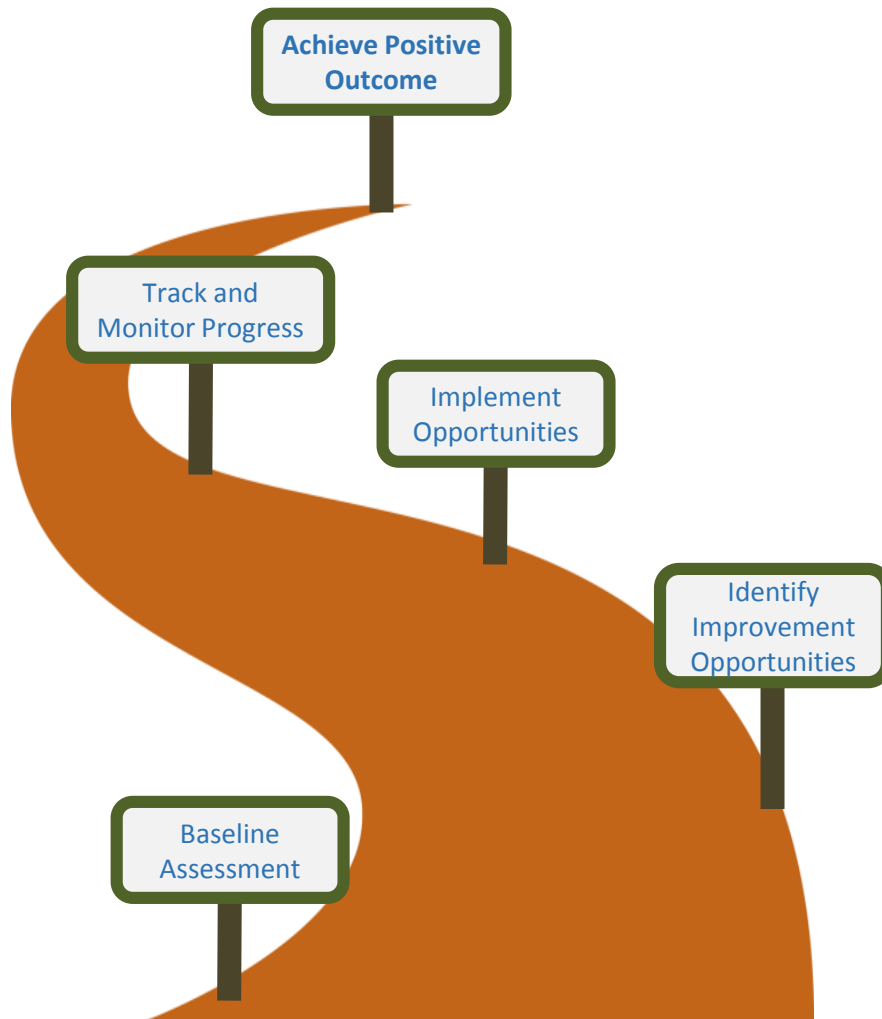
- Identify multiple parties (i.e. nurses and case managers) that can be trained to administer health assessments
- All parties are trained and provided with the proper equipment to administer the assessment
- Create multiple opportunities to conduct health assessments in efforts to collect as much data as possible, including:
  - Creating centralized locations, where individuals can visit
  - Conducting assessments during home visits
- Develop standardized intervention protocols to address at-risk individuals to be used

## Conduct ICL's People Living and Aging in Community Experience Success (PLACES) Assessment

- PLACES evaluates a person's **quality of life**, including social environmental factors that would impact his/her **physical** and **mental health**:
  - Housing
  - Transportation
  - Interpersonal relationships
  - Food security
- Developed using several standardized tools, focusing on various aspects of a person's life
- Assessments are conducted by their case manager, during home visits, and with the individual

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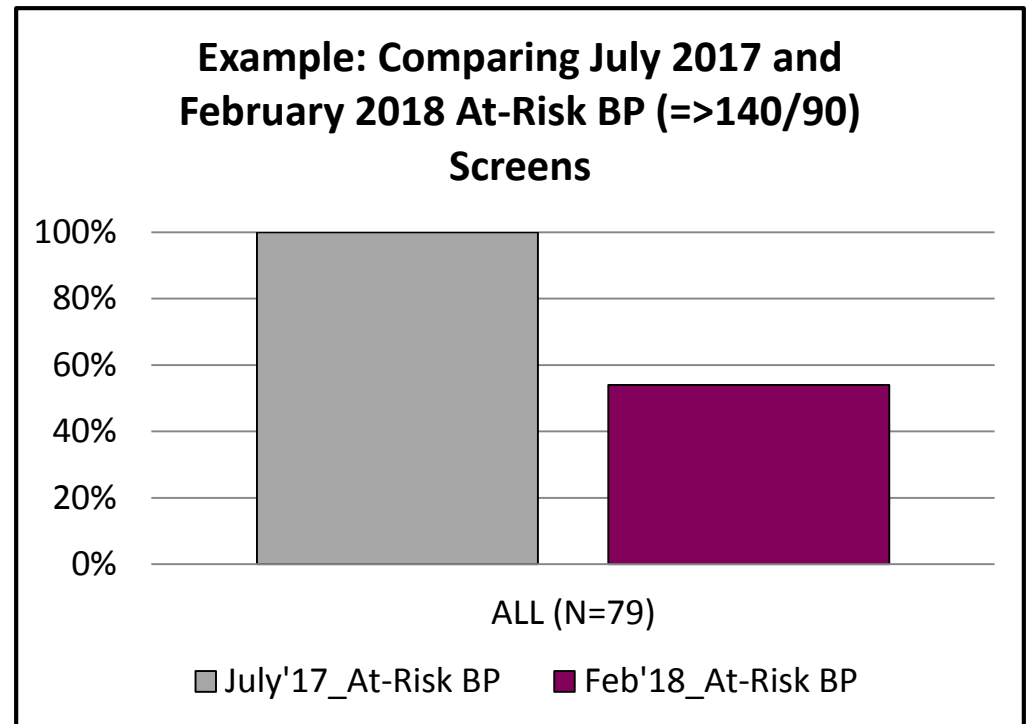
## Develop and Implement Opportunities to Achieve Positive Outcomes



- Utilize evidence-based practices and models, as well as ICL programs to create optimal treatment-to-target solutions
- Once implemented, track and monitor ongoing performance to ensure a positive outcome is achieved

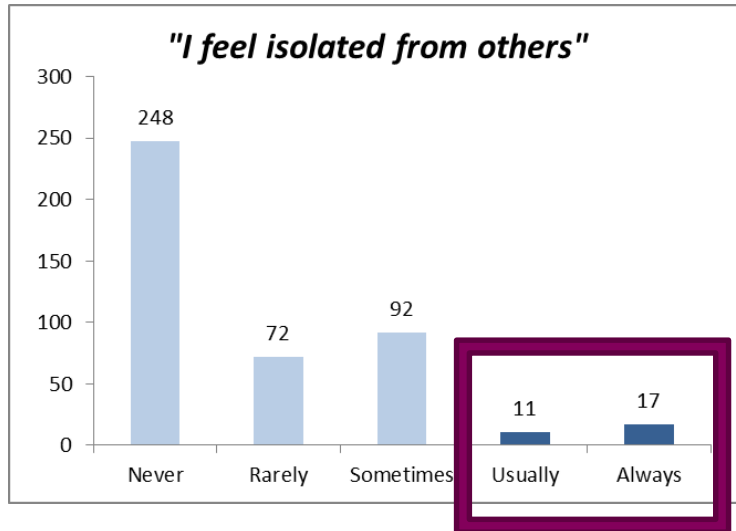
## Outcomes - Track and monitor progress

- Track and monitor progress to:
  - Determine if the program is achieving positive outcomes
  - Identify additional opportunities for improvement
  - Identify need for corrective action plans
  - Use data for lessons learned

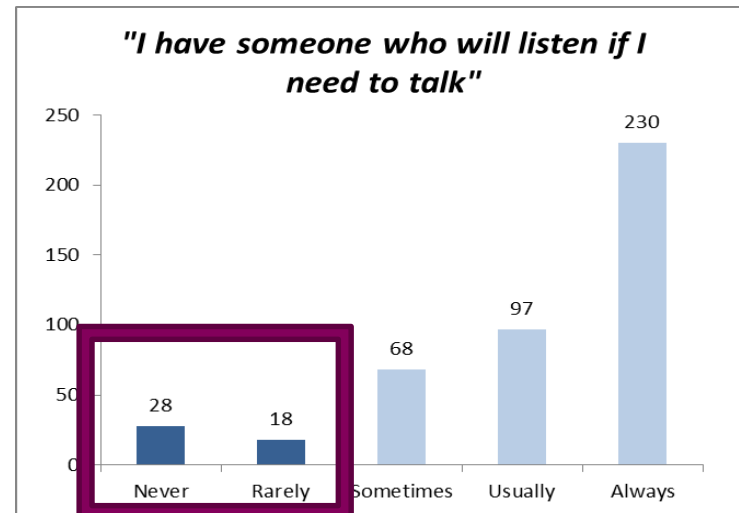
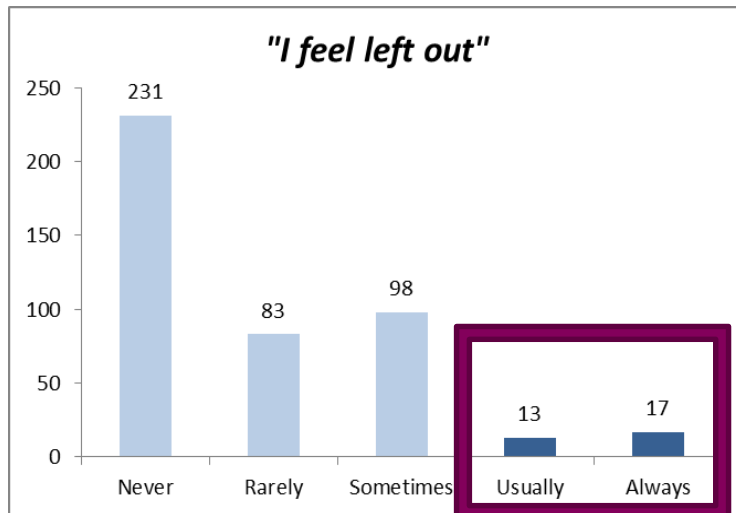


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## Example: Using ICL's PLACES Assessment



Focus on social isolation of adults living independently in supported housing (SH) and treatment apartments (TAP)



## **Example: Treatment-to-Target Solution to Address Social Isolation**

- Aging in Community's Social Isolation Pilot Program:
  - Designed to increase social support and decrease social isolation of individuals who responded they felt isolated “all the time” or “usually”
  - Each individual receives a call 1-2 times a week from the Aging in Community implementation team
  - Communicated pilot program to case managers and administration for collaboration



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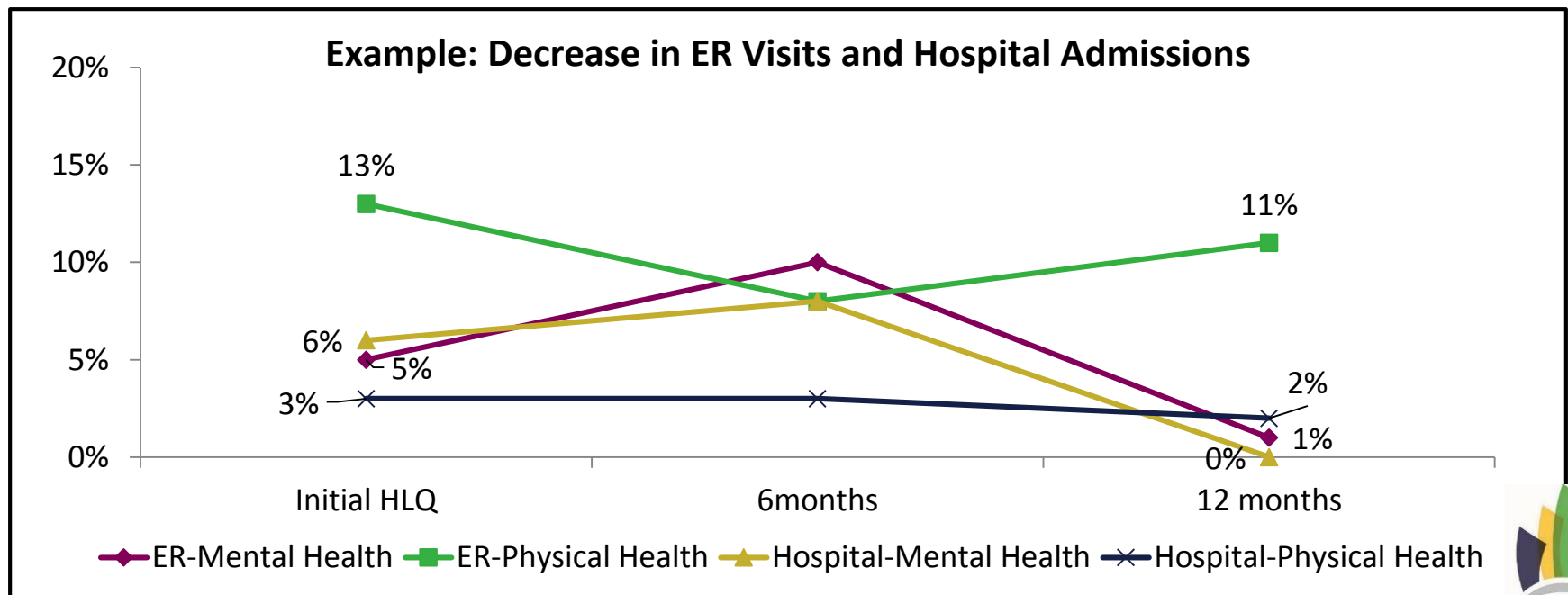
## **Example: Next Steps – Track and Monitor Efforts Made To Address Social Isolation**

- Reassessment of loneliness, isolation, and social support using PLACES



## Future work

- Connect individuals eligible for HARP with behavioral health HCBS services
- Increase partnerships within the community
- Expand healthy living groups in home programs
- Include peer support for aging individuals
- Refine the Aging in Community model





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**Thank You!**

