

Breaking Down Silos and Creating Bridges: Innovative Partnerships to Reach Vulnerable Populations

Wednesday, December 9, 2020
4:35 – 5:35 PM Eastern Time



Introductions

- **Matthew Jones**, Care Coordinator Manager, Senior Connections (Richmond, Virginia)
- **Terri Lawson**, Homeless Crisis Line (HCL) Coordinator, Homeward (Richmond, Virginia)
- **Lynn C. Vidler**, BSW, MBA, Director of Home and Community Programs, Massachusetts Executive Office of Elder Affairs
- **Molly Evans**, Senior Policy Manager and EMHOT Program Manager, Massachusetts Executive Office of Elder Affairs

The Need for Behavioral Health Support is Significant



- One in four older adults experiences some mental disorder such as **depression, anxiety, and dementia**. This number is expected to double to 15 million by 2030.¹
- **Older men have the highest suicide rate of any age group**. Men aged 85 years or older have a suicide rate of 45.23 per 100,000, compared to an overall rate of 11.01 per 100,000 for all ages.²
- In the last two decades, the proportion of the **homeless population in the United States age 50 years or older has increased dramatically**. In 1990, only 11% of adults experiencing homelessness in the United States were age 50 years or older; however, by 2003 one-third of these adults were older than age 50 years.³
- Three-quarters of family caregivers cited their caregiving responsibilities as stressful, and **more than half found caregiving to be overwhelming**. Depression affects 20 to 40% of all caregivers.⁴
- 1 million adults aged 65 and older live with a **substance use disorder (SUD)**.⁵

¹ NCOA. *Behavioral Health*

² CDC. *The State of Mental Health in America*

³ Brown, R. and Kushel, M. *Current Diagnosis and Treatment: Geriatrics. Understanding the Effects of Homelessness and Housing Instability on Older Adults*

⁴ *Aging in Place: Caregiver Burnout*

⁵ National Institute on Drug Abuse: *Substance Use in Older Adults Drug Facts*

Breaking Down Silos and Creating Bridges: Innovative Partnerships to Reach Vulnerable Populations in Greater Richmond Area, VA



Senior Connections
Matthew Jones, MSW
Care Coordination Manager



Homeward
Terri Lawson
Coordinated Entry System
Administrator



Innovations in Housing for Older Adults

Senior Connections
The Capital Area Agency on Aging

Richmond, VA

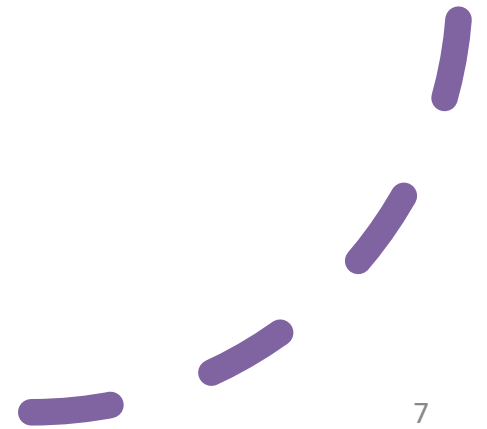
Matthew Jones, MSW

Care Coordination Manager

Housing Issues in the Richmond Area

- The fastest growing segment of people experiencing homelessness is people over 55 years of age
- Nearly half of this cohort experiencing homelessness are experiencing it for the first time
- Richmond, VA has the 2nd highest rate of evictions in the country
- Lack of accessible housing has caused a crisis
 - Accessible housing is: low-cost, located in the community, near services and transportation, built for people of all abilities, does not have a waiting list
- Shelters and other safety net providers are often unprepared for the needs of older adults and people with disabilities

Building Bridges





Implementing the Social Isolation Risk Index

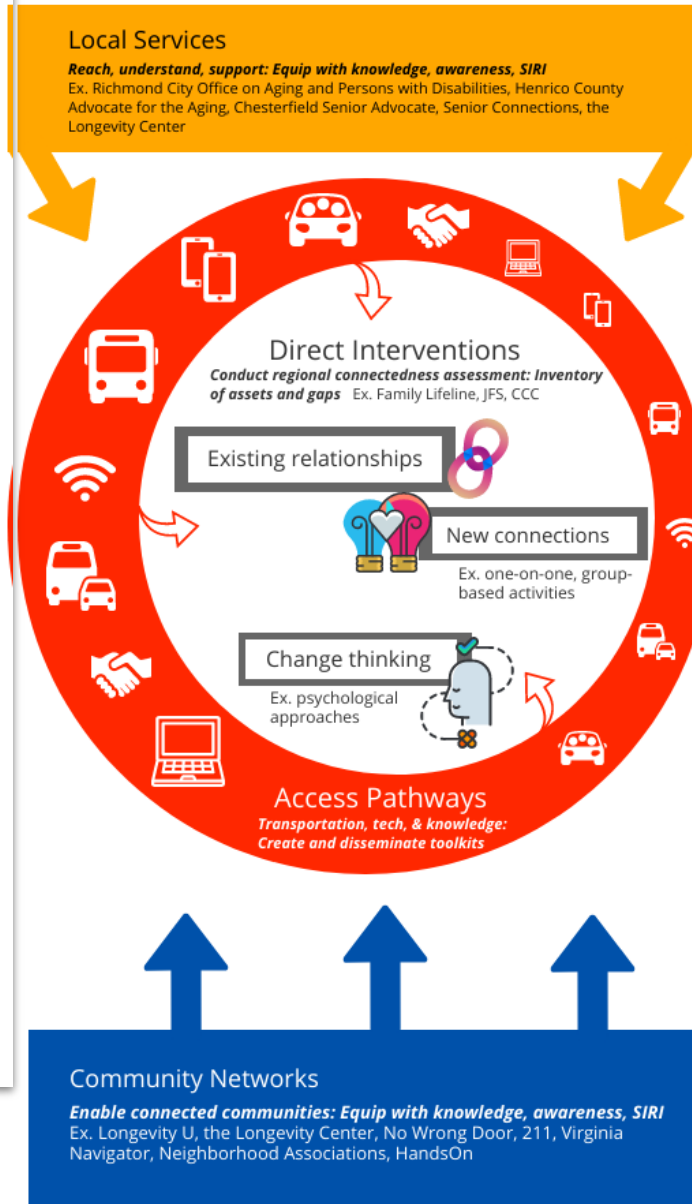
The demographic shift known as the age wave signals unprecedented change and unprecedented opportunity, beckoning us to transform the practices and policies, systems and structures existing in our region that have created inequities in life chances of reaching longevity.

The Longevity Project for a greater Richmond (previously called Greater Richmond Age Wave) provides systems-level changemaking, education, and advocacy to increase longevity equity and access to services, in order to help the region become engaged, livable, stable, and well.

Social connectedness is a critical protective factor for people of all ages. However, social isolation among Richmond's elders is rising, resulting in higher risk for chronic disease, depression, and premature death.

By approaching social isolation consequences proactively instead of reactively, we can make Richmond a better, healthier and more sustainable place for everyone to grow old.

This connectedness framework is based on Age UK's Campaign to End Loneliness.



Goals:

- Develop productive relationships between homeless services and aging services leading to structural system changes within these organizations designed to increase housing stability among older adults.
- Introduce homeless services providers to No Wrong Door, a state-run database, for effective, electronic information exchange between aging and housing services.



Commonwealth Council on Aging 2020 Best Practices Award – Honorable Mention



Older Adult Housing Stability: Strategic Partnerships, Technology, Operational Improvements Project

Educational opportunities provide interactive training to a balanced audience of housing and aging services providers. Topics include:

- Oral Housing Histories (once in March and once in June 2019)
- Trauma-informed approaches to serving older adults
- Ageism and Elderhood: Reconnecting to Strengths
- Compassion Fatigue, Resilience, and Self-Care
- Person-centered approaches to serving older adults
- Disrupt Ageism



Housing Stability Learning Labs

Housing Stability Learning Labs: Feedback

"Please share a takeaway of professional value to you:

Insight into the experience and idea of housing of others

It was good to be reminded of the diverse backgrounds we all come from.

Experience of home is critical to our identity.

I appreciated being connected to those outside of my traditional bubble in homeless services.

Having not worked in the field or housing, I learned about how different life experiences can affect your idea of home.



Changing the language of aging and serving older adults.

How to think and approach aging differently.

Recognizing the barriers and the privilege that comes with race and housing.

Today's session was valuable because everyone at our table came from different backgrounds, and had diverse answers and thoughts about housing. There were some core shared beliefs but we came to those beliefs and values differently.

Aging = living = development (not aging = pathology)

The model of the brain and how it affects so many things with fear etc. It was a very relaxing time of learning and I will take a lot away from what I have learned.

Being able to network and get different perspectives on various topics that can influence a positive impact on the people that we service

That change begins with me and that I can make a change within my agency to begin organizational change.

Being mindful of my own lived experience and not allowing it to interfere with the services I provide to our members

The inventory slide for the levels of a trauma-informed workplace for clients and staff- ie safety, transparency, empowerment etc for taking an inventory as a supervisor, very helpful format to do so. Also the hand model for the brain. Thank you!

Homeless Housing Preference

- Senior Connections Partners with:
 - Richmond Health and Wellness – Community Based Health Care in partnership with Virginia Commonwealth University
 - Homeward – Richmond area homeless services coordinating agency
 - Dominion Place – Senior Affordable Housing (249 units, 62+)
 - The Longevity Project – Advocacy, education, and community engagement centered around issues impacting older adults
- Provides 5 dedicated units at Dominion Place
- Requires HUD waiver

- Women homeowners, 60+, whose partner has passed in the last year
- Provides financial education, advice, and assistance
- Assists with settling the estate and determining assets and liabilities
- Avoids crisis before it happens

Rural Housing Intervention for Older Women

Eviction Diversion Program



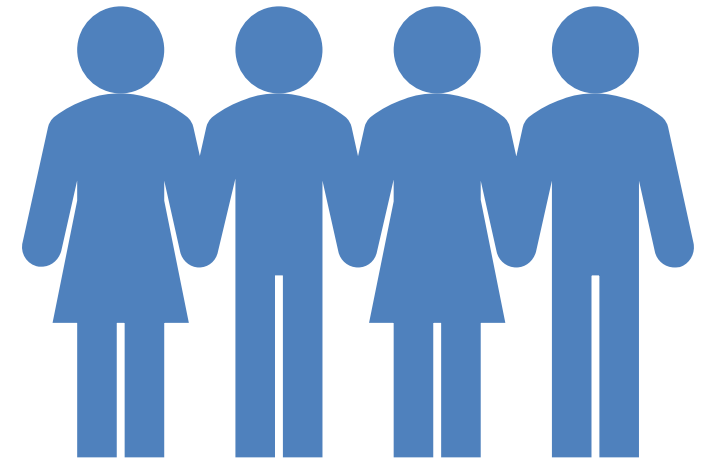
- Fund established to assist older adults from being evicted from their homes
- Collaboration with Central Virginia Legal Aid Society to provide pro bono legal assistance to tenants who have received notice to vacate
- Clients must have received a written notice to remedy
- Assistance has been provided for clients being evicted for a variety of reasons, e.g. failure of payment, improper maintenance, fire hazards, etc.

Chore Services and Residential Repair & Rehab

- Crisis home repair – condition of the home is dangerous or uninhabitable
- Home modification – to make the home more accessible
- Bulk removal of large items, junk, or trash both inside the home and out that may impact safety or cause fines or removal orders
- Heavy duty housecleaning – including hoarding*, preparation for in-home care, and transition from hospital or rehab to home
 - * We work with an agency dedicated to a respectful and considered approach to handling sensitive hoarding situations

Homeless Crisis Line

- Dedicated staff member from Senior Connections
- Works in partnership with Homeward
- Multi-agency collaborative effort





Coordinated Entry System Continuum of Care

Homeward

Richmond, VA

Terri Lawson

Coordinated Entry System Administrator

Continuum of Care



A Continuum of Care (CoC) is a broad group of stakeholders coming together to end homelessness in a community

- Required by the U.S. Department of Housing and Urban Development (HUD) in order to receive funding targeted for homeless services
- The HUD program was established in 1995
- Not required to be a legal entity

Greater Richmond Continuum of Care (GRCoC)



Map retrieved from
<http://www.richmondregional.org/>

- Established in 1997
- Homeward was created in 1998 to facilitate and support the GRCoC.
- More than \$4.6 million in HUD funds targeted to homelessness each year; \$1.6 million in state funds
- 2020 Point-in-time count = 547 (down from 1150 in 2007 & 2009)
- Region = approx. 1.3 million individuals (560K households)
- Poverty rate > 20%
- Area Median income= \$69K

Access for people experiencing homelessness

Homeless
Crisis Line

804-972-0813

.....
If you are homeless or will lose housing within the next three days, call the Homeless Crisis Line for help and alternatives to emergency shelter.
.....

Partners Include:

- ACTS
- HomeAgain
- Homeward
- Housing Families First
- Senior Connections

Monday – Friday, 8am to 9pm; We have expanded hours for evening and weekend which operates 1pm to 9pm
More than 4,000 phone calls each month

Record needs for emergency shelter and provide problem-solving supports

Literally Homeless Clients by Age (N = 4867): July 1, 2019 - June 30, 2020



Homelessness and Housing Instability



Unsheltered;
nowhere safe to
stay



Fleeing sexual or
domestic violence



No longer able to
stay where they
are



"Doubled Up" or
living with family
or friends



Living in a hotel



Paying too much
for rent; getting
behind on bills



Homeless Services in the Richmond Region

8/17/20

Access Points

Coordinated entry points into the region's network of homeless services

- Homeless Crisis Line
- Domestic Violence Hotlines
- Coordinated Outreach: RBHA, Daily Planet Health Services, Commonwealth Catholic Charities, Richmond DSS, St. Joseph's Villa (youth)

Connection Points

Light-touch assistance and connection to Access Points

- Chesterfield DSS
- Goochland CARES
- OAR
- Powhatan Free Clinic
- REAL Life Community Center
- Richmond Public Library, Main Branch
- Virginia Career Works Centers

Connected Agencies and Groups

Mainstream resources provided to community members including persons experiencing homelessness

- Departments of Social Services
- Public School Systems
- Community Services Boards
- Police Departments/Sherrifs
- Community Meal Programs/Congregations
- Free Clinics

Community-based outreach & services

Additional agencies providing homeless services

- Moments of Hope Outreach
- Focused Outreach Richmond
- Veteran Affairs Medical Center
- VETLINK

Pandemic Response Programs

- Daily Planet (COVID-19 testing)
- Homeward (non-congregate shelter)
- RUMI (residential workforce program)

Shelter

Emergency shelter for families and individuals experiencing homelessness. Families and individuals are referred to emergency shelter through Access Points.

- CARITAS (men, & women)
- Daily Planet (Medical, Mental Health)
- Hanover Safe Place (domestic violence)
- HomeAgain (men, family, vets)
- Housing Families First (family)
- Goochland Cares
- Liberation Veteran Services
- Safe Harbor (domestic violence)
- RBHA Transitional Units
- Salvation Army (men, family)
- YWCA (domestic violence)

Homeward

Lead agency for Greater Richmond Continuum of Care

- Collaborative applicant for federal & state funding
- Provides technical support and best practices to CoC member organizations
- Manages Homeward Community Information System (HCIS)
- Coordinates bi-annual Point-in-Time Counts
- Hosts Best Practices Conference & Project Homeless Connect
- Coordinates 15+ local workgroups and committees
- Cross-sector partnership development

Rapid Rehousing

Permanent housing for families/individuals who need assistance in securing and maintaining stable housing

- Hanover Safe Place
- HomeAgain
- Housing Families First
- St. Joseph's Villa
- Virginia Supportive Housing (for veterans)

Permanent Supportive Housing

Permanent housing for families/individuals who need long-term housing that is connected to on-going supportive services

- HomeAgain
- HUD-VASH (for veterans)
- Richmond Behavioral Health Authority
- Virginia Supportive Housing

Targeted Recovery Services

Substance Use Disorder recovery providers with an emphasis on persons experiencing homelessness

- The Healing Place
- Good Samaritan Ministries
- Daily Planet Health Services
- Salvation Army ARC

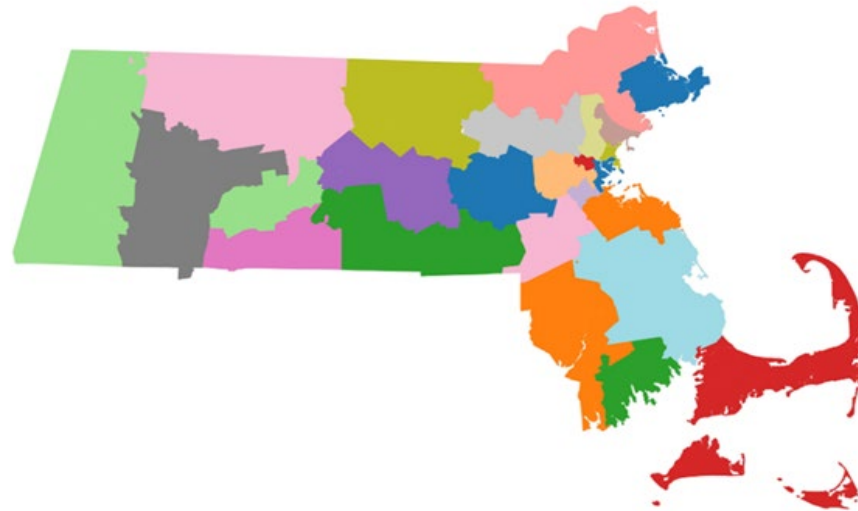
Agencies represented here participate in the GRCoC through the point-in-time count, the Housing Inventory Count, or a committee. If your agency is not shown, please contact Michael Rogers at mrogers@homewardva.org. If you are experiencing homelessness and need help, call the **Homeless Crisis Line at 804-972-0813**.

Massachusetts State Home Care Program & Behavioral Health Support

Overview of MA State Home Care Program/services & supports for people with behavioral health conditions:

- Expanded eligibility
- Existing Behavioral Health Services – Therapy
- Supportive Home Care Aide – Coping Mechanism/Interventions (ADRD/BH)
- Chore & Home Modification
- New Behavioral Health Services/Programs Added in CY2019 (e.g., Evidence-Based, COAPS, ANCHOR)
- Tenancy Preservation Project (TPP)
- Buried in Treasure/Hoarding Support Groups
- Elder Mental Health Collaborative

Massachusetts AAA/ASAP Network



- | | |
|--|---|
|  Baypath Elder Services, Inc. |  Highland Valley Elder Services, Inc. |
|  Boston Senior Home Care |  LifePath, Inc. |
|  Bristol Elder Services, Inc. |  Minuteman Senior Services |
|  Central Boston Elder Services |  Montachusett Home Care Corporation |
|  Coastline Elderly Services, Inc. |  Mystic Valley Elder Services, Inc. |
|  Elder Services of Berkshire County, Inc. |  Old Colony Elder Services, Inc. |
|  Elder Services of Cape Cod and the Islands, Inc. |  SeniorCare, Inc. |
|  Elder Services of Merrimack Valley and North Shore, Inc. |  Somerville/Cambridge Elder Services, Inc. |
|  Elder Services of Worcester Area, Inc. |  South Shore Elder Services, Inc. |
|  Ethos |  Springwell, Inc. |
|  Greater Lynn Senior Services, Inc. |  Tri-Valley, Inc. |
|  Greater Springfield Senior Services, Inc. |  WestMass ElderCare, Inc. |
|  HESSCO Elder Services | |



Massachusetts State Home Care Program

– **Expended Eligibility for Home Care**

- **5 pillars of eligibility are:**
 - Age, Residence, Income for contribution sharing, Functional Impairment Level, Need
- **Age:**
 - 60 years of age **OR** under 60 with a diagnosis of Alzheimer’s or related disorder
 - People Living with Dementia (PLWD) or Alzheimer’s Disease behavioral issues
- **Functional Impairment Level (FIL):**
 - Standard minimum of 1 Activity of Daily Living (ADL) **OR** at least 6 Instrumental Activities of Daily Living (IADL)
 - Exception
 - at least 4 IADLs **AND** at risk factors including, but not limited to substance abuse, behavioral health or cultural and linguistic barriers

Therapy, Evaluation & Emergency Health Supports

EVALUATION

Case Consultation

Diagnostic
Services

Reevaluation

THERAPY

Individual

Couple/Family

Group

Emergency

24 /7

Immediate
face-to-face
Intervention

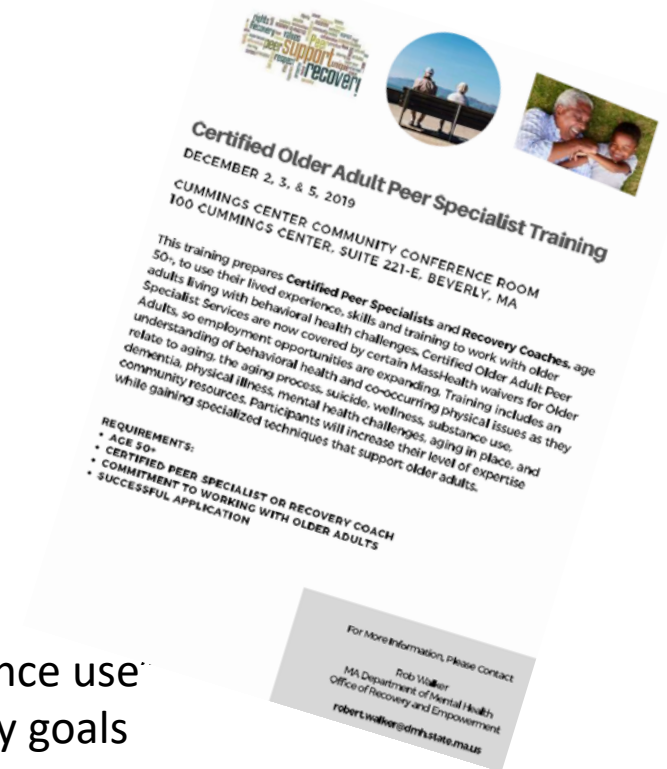
Supportive Home Care Aide (SHCA), CHORE, & Home Modifications

- **Supportive Home Care Aide =**
 - specialized service for consumers with Alzheimer’s Disease/Dementia or emotional and/or behavioral concerns
 - SHCA provider staff complete a total of 87-hours of training (75 hours Home Health Aide Training & 12 hours additional training)
 - Personal Care and/or Homemaking
 - Coping Mechanisms, re-direction, de-escalation techniques
 - Emotional Support/Socialization
 - Medical Escort to appointments
- **CHORE =** environmental cleanout, specialization in working in hoarding removal
- **Home Modifications =** pest removal, infestation, home repairs, such as wall, floor repairs, ramps



New Initiatives in Massachusetts Behavioral Health Support

- CY2019 New Behavioral Health Services/Programs Added (e.g., Evidence-Based, COAPS, ANCHOR)
 - AAA experience
 - ACL/CMS
 - DMH
 - PS, COA, Housing, ASAP
- Certified Older Adult Peer Specialist (COAPS):
 - targeted recovery services
 - mentoring about self-advocacy
 - provided in small groups or 1:1
 - trained peers as coaches
 - “who have lived experience - behavioral health, trauma, &/or substance use”
 - promote person-centered care & attainment of personalized recovery goals
 - Department of Mental Health cooperative relationship



Initiatives in Behavioral Health Supports

- Evidence Based Education Programs (EBP):
 - Education & tools manage chronic conditions
 - Caregiver education, diabetes, heart disease, arthritis, HIV/AIDS and depression, to better manage/prevent falls
 - Peer-facilitated self-management workshops or 1:1 interventions w/ a trained coach
 - Promotes consumer's active engagement
 - Two EBP Examples:
 - Enhance Wellness
 - Health action plan is developed by the consumer with support from the Enhance Wellness coach
 - Goal is to promote positive behavior change and minimize health risks
 - Healthy IDEAS (Identifying Depression Empowering Activities for Seniors)
 - Empowers older adults to manage their depression through a behavioral activation approach that encourages involvement in meaningful activities
- Developing service in Home Care
 - Healthy Living Center of Excellence <https://healthyliving4me.org/>
 - Department of Mental Health



HEALTHY IDEAS

Ethos has a new, **FREE** program that can help you feel happier! If you have felt down, low, or blue in the past few weeks or months, we want to help!

Healthy IDEAS is an evidence-based program that offers face-to-face, in-home counseling services to elders. An Ethos staff member will work with you to find meaningful and positive activities to enhance your mood.

Each Ethos staff member is trained by the LGBT Aging Project in Lesbian, Gay, Bisexual, Transgender cultural competency.

Program benefits:

- Fewer symptoms of depressive symptoms
- Decreased physical pain
- Better ability to recognize and self-treat symptoms
- Improved well-being through achievement of personal goals

If you are interested in learning more about the Healthy IDEAS Program or have a friend who may benefit, please contact:
Claribette Del Rosario, Mental Health Services Program Manager
617-522-6700 x344
cdelrosario@ethocare.org
www.ethocare.org

ETHOS IS A BOSTON BASED NOT-FOR-PROFIT AGENCY that has served the elderly and disabled since 1973. We help elders stay at home as long as possible by ensuring that they—and their caregivers—have access to continuum of life-enhancing support services. Each service we provide makes a real difference in the every day lives of our clients.





Advocacy & Navigating Care in the Home with Ongoing Risks (ANCHOR) Pilot Program

High
contact
focused
interaction

Goal
Oriented

Older Adults with Behavioral Health Needs
at risk of

homelessness

Institutionalization

Rigorous & Time Intense Delivery of

Advocacy

Support



ANCHOR



Development

- Varied from past endeavors (Intense Case Management, Case Management Only)
- Individuals in need of in-home services
- Unable to engage or commit
- Conversations, meetings and collaboration
- ASAP, Housing Programs, Protective Services, Council On Aging, Elder Mental Health Specialists

Designed - support older adults whose behavioral health diagnoses impede or reduce their ability to accept services

- Anxiety, suspicion, paranoia
- Substance use
- Chronic behavioral health concerns
- Chronic homelessness or history of housing instability
- Family dynamics that impact service delivery
- A constant level of risk in their lives that may impact service utilization
- Consumer is “pre-protective” or receiving “Protective Services Ongoing Services” and ANCHOR can help transition the consumer to Home Care Services



Anchor Consumer Profile



Consumer's Goals:

- 1) Acceptance of services-unmet personal care & house cleaning needs
- 2) Getting a hearing aid
- 3) Determine if can get back on Medicaid
- 4) Visit PCP

Progress On Goals:

Received medical attention from PCP (3-4 mo), prior had not seen a PCP or any medical professional for 5 years

Can apply for Medicaid with spend-down, has no wishes to spend down her assets

Progress On Goals:

Has agreed to and accepted a total of 12 hrs of heavy chore, home remains cluttered with safety concerns.

In process of obtaining Hearing Aides

Additional Advocacy & Support Needed:

Provide emotional support & encouragement for untreated mental health concerns

Decline of memory affecting day/time

Additional Advocacy & Support Needed:

Intensive encouragement to accept heavy chore

Threat of eviction still potential



ANCHOR



- Program began 2/2019
- 708 unduplicated persons assisted within program
- COVID-19 still enrolling individuals
- Slower pace of enrollment

Gender		
Female	447	63.6%
Male	256	36.4%
Average Age	75.4	
Under 60	0	0.0%
60-69	234	32.9%
70-79	243	34.2%
80-89	172	24.2%
90+	62	8.7%
Diagnoses		
Alzheimer/Dementia (1209-1210)	111	19.2%
Any psychiatric diagnosis (1220)	329	57.0%
Stroke (1203)	73	12.7%
Diabetes (1226)	161	27.9%
Emphysema/COPD/asthma (1227)	142	24.6%
Renal Failure (1228)	37	6.4%

Tenancy Preservation Program (TPP)

- **The Tenancy Preservation Program (TPP):**
 - homelessness prevention program
 - works with tenants, including families with children with disabilities,
 - facing eviction as a result of behavior related to a disability (e.g. mental illness, mental retardation, substance abuse, aging related impairments)
 - neutral party to the landlord and tenant
 - works in consultation Housing Court Dept. with the property owner & tenant to determine whether the disability can be reasonably accommodated and the tenancy preserved
- <https://www.mass.gov/info-details/tenancy-preservation-program>

Elder **M**ental **H**ealth **O**utreach **T**eam (EMHOT) Program



Services provided:

- Referrals
- Counseling
- Wellness checks
- Case management
- Provider collaboration
- Family support
- Resource management

EMHOT Consumer Profile

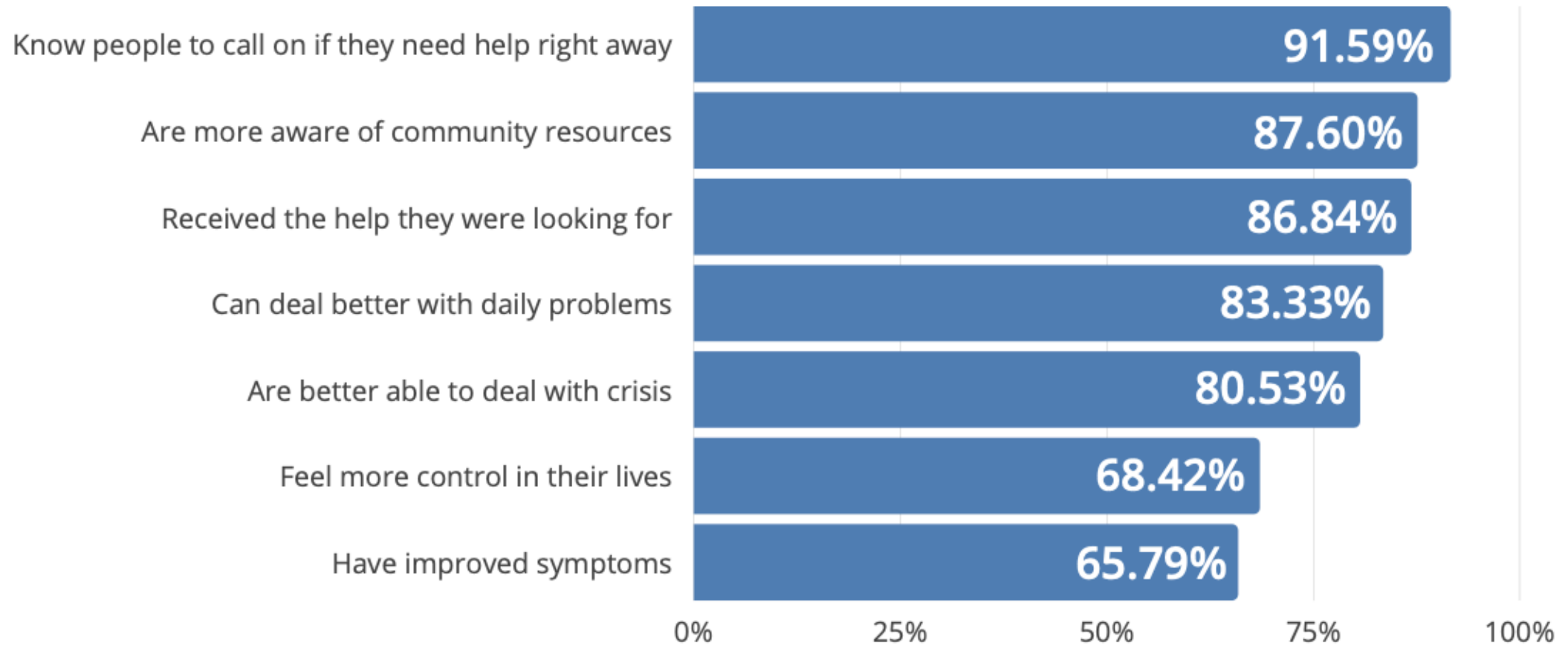
- **58.6%** Depression
- **31.4%** General Anxiety Disorder
- **33.9%** Co-Morbid Psychiatric Illnesses

- **15.5%** Recent Behavioral Health Crisis

- **78.9%** Referred by a Community-Based Organization

Outcomes

By receiving EMHOT services, older adults report they:



What is the value of the EMHOT Program, according to consumers?

“The social worker helped me so much, she found me a place to live and connected me to so many resources. I was homeless and I don’t know where I would’ve been without this program. She also got me a therapist I enjoy working with. I can’t tell you how much I appreciate this program.”

“I prayed for someone to help me, and my prayers were answered when you called.”

“In working with the social worker, she has helped me with my self-esteem and positivity, connected me with resources, helped with crisis, and provides me with a listening ear and feedback.”

“Everyone has been so empathetic especially when I was in survival mode. I am convinced that they are here to help and that they care.”

EMHOTs during COVID-19

Service Delivery

- ✓ Counseling services
- ✓ Provider collaboration
- ✓ Referrals

Adaptations & Accomplishments

Remaining Challenges

Thank You!

Questions?

Panelist Contact Information

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Terri Lawson, tlawson@homewardva.org

Lynn C. Vidler, lynn.vidler@mass.gov

Molly Evans, molly.r.evans@mass.gov