LIVING WELL!
CIAIP PROGRAM
AUSTIN, TEXAS

Administration on Aging

Living Well!
A Partnership in Public Housing

Grantee: Family Eldercare

Project Manager: Joyce Hefner, LMSW

About Family Eldercare

Mission: Family Eldercare provides essential services to seniors, adults with disabilities and caregivers.

Vision: Elders and adults with disabilities live in a supportive community with dignity and as much independence as possible.

Established 1982

Family Eldercare's Programs and Services

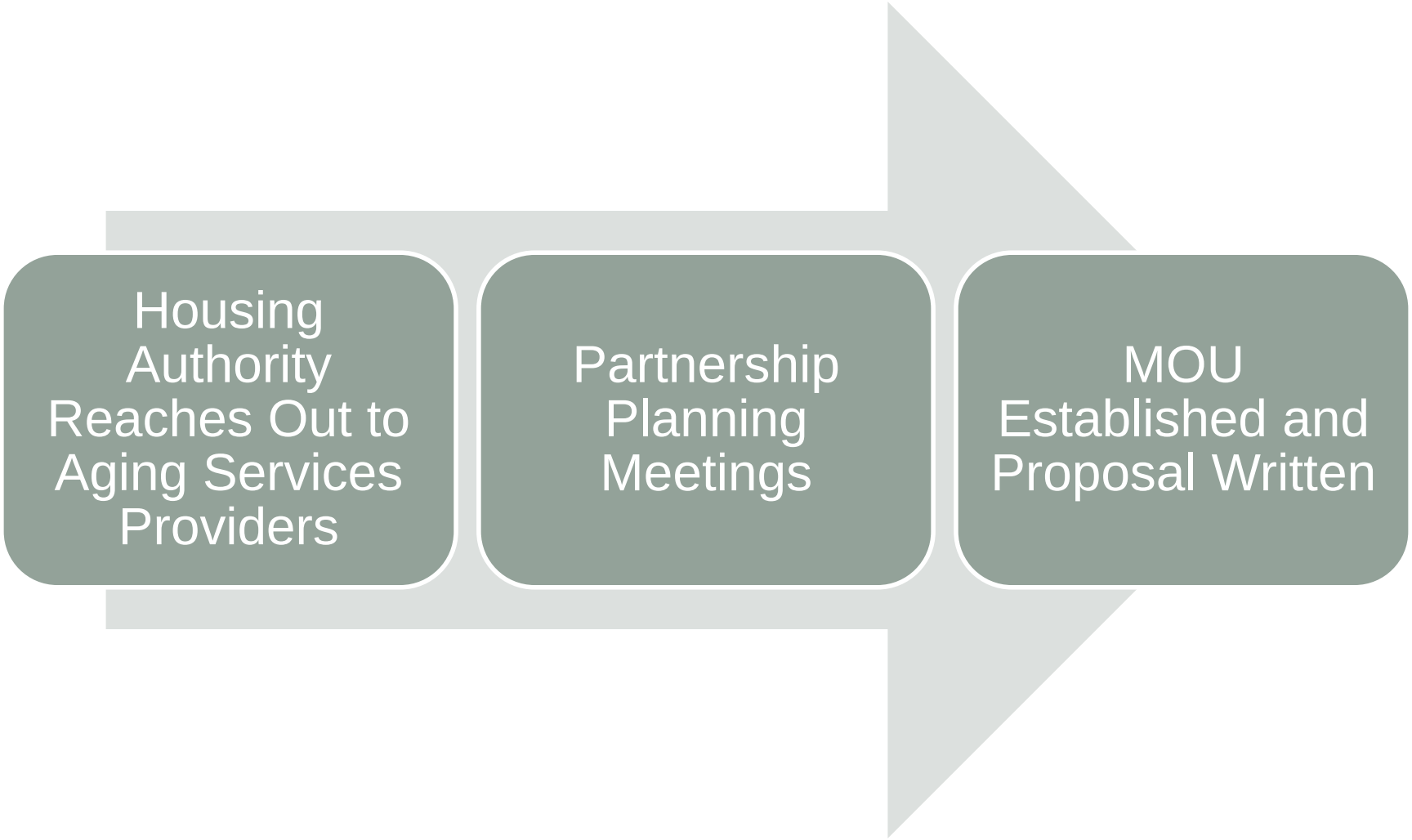
Family Eldercare carries out its mission through a variety of programs. Priorities are to:

- Prevent abuse, neglect, self-neglect and financial exploitation
- Prolong independent living in the least restrictive environment
- Promote the health, well-being and dignity of elders, adults with disabilities and their caregivers.

Family Eldercare provides a continuum of services on a sliding fee scale to more than 6,000 elders, people with disabilities and their caregivers annually in Travis, Williamson and Hays counties.

- In Home Care and Caregiver Services.
- Geriatric Consultation
- Guardianship
- Money Management
- Lifetime Connections Without Walls
- Service Coordination
- Living Well! Aging in Place Initiative
- Lyons Gardens Senior Housing (HUD 202)
- Summer Fan Drive (serving 11 counties)

How did our CIAIP Project Develop?



Project Goal:

Promote a community where older adults are active and engaged.

Provide on-site services to support aging in place.

Promote healthy aging.

Target Population:

We work with residents in 5 public housing properties with a total of 456 units occupied by residents who are elderly (age 60+) or disabled.

Partnership:

We are a partnership in public housing. Our partners are governmental and non-profit agencies.

Family Eldercare H.A.N.D WeViva

Housing Authority, City of Austin

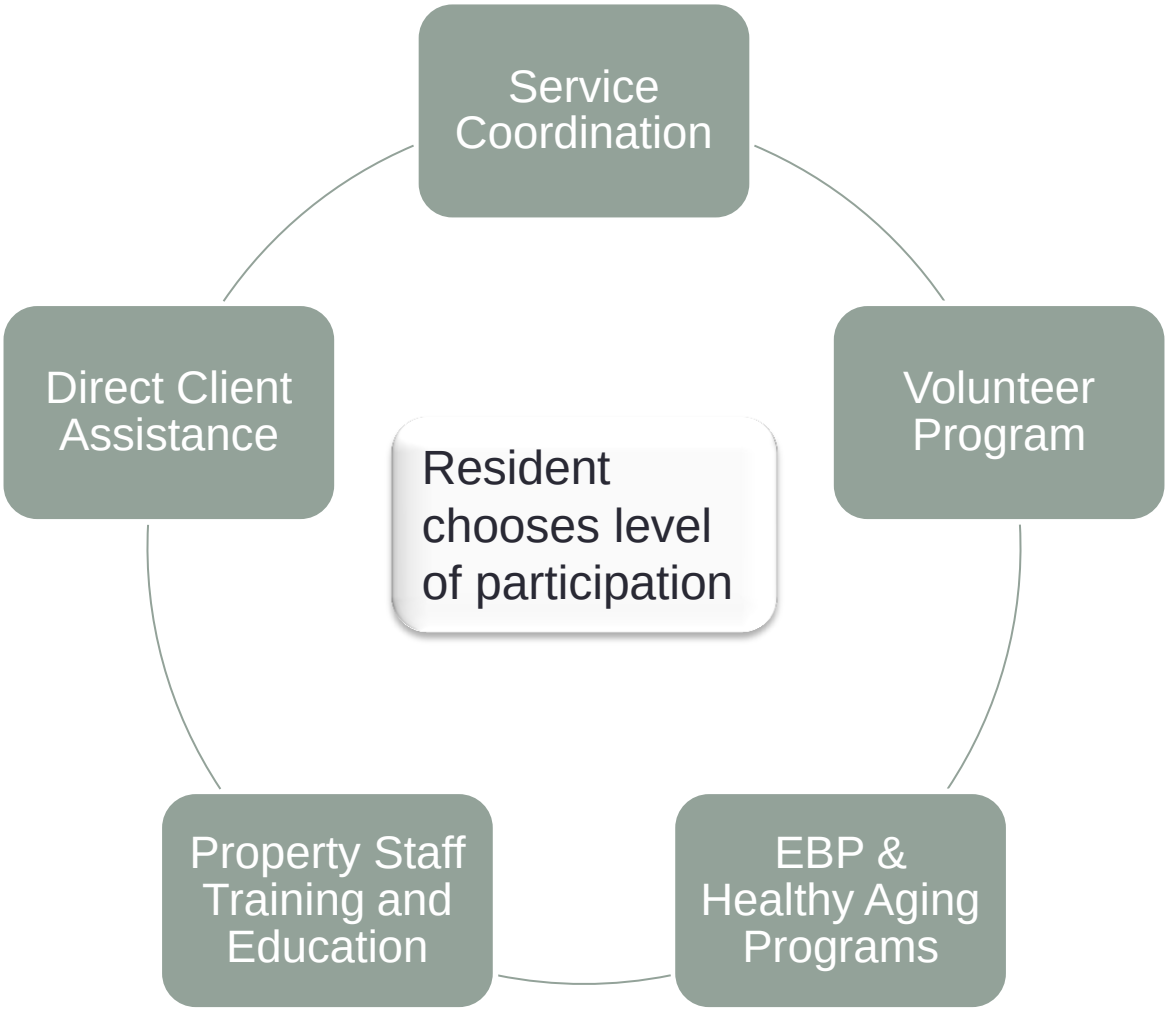
Area Agency on Aging of the Capital Area

New Connections at AGE

Coming of Age

Georgetown Housing Authority

Components of Program Model



Role of Service Coordinator

Traditional Role

- Intake and Assessments
- Information and Referral
- Case management
- Linkage to Services
- Emotional Support
- Advocacy
- Crisis Intervention
- Conflict Resolution
- Caregiver Support and Education

Enhanced Role

- Project Ambassador
- Link Residents to onsite programs and activities
- Connect residents to direct client assistance
- Program Development
- Partner Relations
- Project Evaluation

Partners and Programming

Evidenced Based Practices	Healthy Aging Programs	Direct Client Assistance	Volunteerism & Engagement	Property Staff Training & Education
Medication Management (MMIS)-AAACAP	Nutrition Education-CAFB	Personal Assistance-HAND	Structured program developed	Focus Groups
Problem Solving Therapy-UTSSW	Writing Workshops-BadgerDog	Homemaker Services-FE	Integrated with HACA positions	Aging Sensitivity
Matter of Balance-AAACAP	Brain Boosters-New Connections	Transportation	Resident Volunteerism	Assessment skills and Resources
SeniorWISE (Memory Improvement)-UTSN	Fitness Classes-We Viva	Durable Medical Equipment	Community volunteers	Boston University Certificate Program
CDSM/DSM-Central TX AAA	Yoga-Community Yoga	Basic Needs	Recognition Activities	Advise Administration

Measureable Results

Program	Measure	Results	Related Data
CDSM/DSM 6 weekly classes	Understanding Problems Understanding Mgmt. Tools Knowledge of Healthy Behaviors	Self rating ↑ from 1.8 to 2.8 Self rating ↑ from 1.4 to 2.8 Self rating ↑ from 1.4 to 2.8	40 unduplicated 20 attend 3+ classes 10 complete both evals.
Brain Boosters Weekly classes Class size limit=15	Warning signs of memory loss Steps to maintain brain health Ways to cope with memory loss	Self rating ↑ from 2.2 to 2.8 Self rating ↑ from 1.2 to 3.8 Self rating ↑ from 1.5 to 3.7	81 unduplicated Average class size=7 10 complete both evals.
SeniorWISE 8 weekly classes	Confidence about memory Understanding of memory Anxiety about memory	↑ 81% ↑ 88% ↓ 80%	31 attended 2 + classes 18 completed evals.
Healthy Choices Nutrition- 4 classes	Knowledge of healthy foods, importance of exercise, disease risk and food choices	Overall ↑ of 60% (goal: 40% increase)	41 unduplicated Average 2 classes
Medication Screening/Flu shots	Take 10 or more medications= 27 On site flu shots provided	# accepting referral= 6 ↑ from 35 to 63	Combined pharmacist provided flu shots and medication screenings.

Measureable Results

Program	Measure	Results	Related Data
Personal Assistance Homemaker Services	Medically fragile are stabilized At risk for eviction stabilized	5 of 6 remain in housing 23 of 23 remain in housing	1 resident moved to hospice 10 of these had lease violations
Service Coordination	Residents engaged in program	↑ by 32% in one year (from 319 to 420)	Change from 2010 to 2011
Resident Volunteerism	# of volunteers # of hours of service # of resident led activities	↑ 32% (31 to 41) ↑ 140% (1,536 to 3,691) 9 new resident led activities	Change from 9/10–3/11 to 4/11-9/11.

Stories to Tell….

Mrs. S.
age 73

Assisted resolving medical bills.
Supported after financial exploitation by a friend
Provided support and transportation to visit another resident who was hospitalized and dying.
Linked with housekeeping following lease violation.
Attended CDSM, Nutrition, and Brain Booster classes. Volunteers at events and leads sewing group. Interviews show she reports that socialization has increased from several times a week to daily. Her overall status of well-being has increased from “Fair” to “Good.”

Assisted with organizing bills and papers and renewing Medicaid and SNAP benefits that lapsed due to her disorganization. She was assisted with housekeeping due to a lease violation. She was referred to the bill payer program at FE. She participates in most activities and classes (CDSM, nutrition, exercise, writing, computer). Linked with a volunteer job at a local hospital. Assisted with joining the YMCA. She uses her computer skills to research nutrition information, materials for writing, etc. She has lost significant weight

Mrs. P.
age 70

New Chapter: Williamson County Project Expansion

Timeline

Community Assessment

- -Focus Groups
- -AdvantAGE Initiative

Partnership with Georgetown Housing Authority

- -Health Indicators
- -Medication Screening
- -CDSM Classes

Report and Release AdvantAGE survey results

Key Accomplishments

- Engagement of residents in Program
- Development of effective incentives program
- Increased access to health services on site
- Increased knowledge and skills of program participants
- Prevention of eviction or pre-mature institutionalization
- Promotion of volunteerism and meaningful activities
- Williamson County expansion and AdvantAGE initiative

Lessons Learned

Implementation though Multiple Partners	Engaging Residents in Activities and Programs
Great Way to share workload and Resources	Takes time to build trust with residents (and staff)
Increases complexity of project management and communication	Seek resident feedback and respond to feedback
Requires structure, dedicated staff, regular check-in and evaluation	Residents not always receptive of evidenced based programs or “Cadillac” models.
Look beyond “usual suspects” to meet goals and address needs	Design an incentive program to build participation and volunteerism

What's Next?

- Partners working on sustainability plans
- Marketing project to new communities
- Release of Georgetown AdvantAGE survey & publicity campaign

Recommendations

- It is essential to support policies and prioritize programs that support aging in place.
  - The AASC estimates savings of $4,283 for every month a low income senior lives independently
- Allow for flexibility in interventions and programming to be selected.
  - Strong evaluation program and best practices can give great results!

This is a beautiful home to come to every day. I have lived here nearly 20 years and intend to stay 20 more and enjoy my golden years.

Quote from Optimistic 80+ Resident

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