Supporting Aging in Place Through IWISH:

Second Interim Report from the Evaluation of the Supportive Services Demonstration

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Foreword

The Supportive Services Demonstration rigorously tests the place-based, Integrated Wellness in Supportive Housing (IWISH) model of service delivery that HUD launched in 2017. The demonstration leverages HUD's properties as a platform for the coordination and delivery of services to better address the health and supportive service needs of older residents. The goal of the demonstration is to help older adults living in HUD-assisted housing age in place by improving their housing stability and health outcomes.

The IWISH model funds a full-time Resident Wellness Director and part-time Wellness Nurse to work in 40 HUD-assisted housing developments that either predominantly or exclusively serve households headed by people aged 62 or over. The Resident Wellness Director and Wellness Nurse proactively engage with residents and implement a formal strategy for coordinating services to help meet residents' health and wellness needs.

The evaluation is among the first rigorous randomized-controlled trials to assess the housing and health outcomes of a place-based, supportive services coordination model. This report is the second in a three-part series. The first report, *Supporting Aging in Place Through IWISH: First Interim Report from the Supportive Services Demonstration*, provided an overview of residents' characteristics and described the first 18 months of the implementation of IWISH. The second report, *Supporting Aging in Place Through IWISH: Second Interim Report from the Evaluation of the Supportive Services Demonstration*, provides a comprehensive analysis of implementation over the three-year demonstration period, including fidelity to the IWISH model and the experiences of staff, property owners, and residents. While the report documents the generally successful early implementation of the demonstration, it also includes recommendations for improving core aspects of the IWISH model, including, but not limited to, strengthening training and support for IWISH staff and revising guidance on partnerships with healthcare providers. Expected in 2022, the third report will provide a quantitative analysis of the causal impact of the IWISH model on residents' healthcare utilization and housing stability for the three-year implementation period.

The onset of the COVID-19 pandemic had dramatic effects on many facets of IWISH model implementation at the demonstration properties. The pandemic required IWISH staff to change the way they interacted with residents, but the assistance provided generally remained the same.

Originally slated to end in September 2020, the demonstration has been extended for two years by Congress. The extension will enable the research team to analyze the impact of the IWISH model over a full five-year demonstration period and to determine whether the long-term outcomes, such as fewer unplanned hospitalizations, greater use of primary care and other nonacute health care, and longer stays in housing and delayed transitions to long term care facilities, were achieved.

Todd Richardson
General Deputy Assistant Secretary for Policy Development and Research
U.S. Department of Housing and Urban Development

About This Report

This report is the Second Interim Report on the Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing. The U.S. Department of Housing and Urban Development (HUD) sponsored the Supportive Services Demonstration to test the impact of housing-based supportive services on the healthcare utilization and housing stability of low-income adults ages 62 and older living in HUD-assisted multifamily properties.

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Executive Summary

The U.S. Department of Housing and Urban Development (HUD) sponsored the Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing to learn whether structured health and wellness support can help older adults living in affordable housing successfully age in place. The model tested through the demonstration is called *Integrated Wellness in Supportive Housing* (IWISH). The Supportive Services Demonstration provided grants to fund health and wellness staff in HUD-assisted multifamily properties to better address the health, housing, and social service needs of older adults. Core components of the IWISH design include onsite wellness staff, proactive engagement with residents, structured assessment of residents' health and wellness needs, supplemental funding to make high-quality programming available to residents, and training and technical assistance for IWISH staff.

The demonstration is designed to produce evidence about the IWISH model's impact on the housing stability and health outcomes of HUD-assisted elderly residents. The demonstration is to test whether IWISH will affect (1) unplanned hospitalizations and the use of other types of acute care with high healthcare costs, (2) the use of primary and nonacute care, and (3) the length of stay in housing by reducing transitions to long-term care facilities.

This report is the second of three reports on the evaluation of the Supportive Services Demonstration. The First Interim Report[1] described the demonstration properties' characteristics and their implementation of the first 18 months of the IWISH model (October 2017 through March 2019). This Second Interim Report documents the implementation during the entire 3-year demonstration period (October 2017 through September 2020). It describes the experiences of staff, property owners, and residents in IWISH and documents how IWISH differs from what is offered at a comparison group of HUD-assisted properties for older adults. The third and Final Comprehensive Report, expected in late 2022, will examine whether the IWISH model has any effect on participants' health and well-being and their ability to remain in their homes (that is, age in place).

Integrated Wellness in Supportive Housing (IWISH)

The Supportive Services Demonstration will test whether onsite services will affect residents':

- Unplanned hospitalizations and use of other types of acute care with high healthcare costs.
- Use of primary and nonacute care.
- Length of stay in housing.

The IWISH Model

The IWISH model funds two health and wellness staff positions in HUD-assisted multifamily properties to better address the health, housing, and social service needs of adults ages 62 and older. A full-time Resident Wellness Director coordinates health and wellness programming for the property and connects residents to supportive services in the community. An onsite Wellness Nurse monitors residents' health and wellness and facilitates access to primary and preventive health care.

The demonstration provided funding for onsite services staff that goes beyond the resources usually available to HUD-assisted multifamily properties. The demonstration funded two onsite wellness staff positions for the 3-year duration of the demonstration: a full-time (40 hours a week) Resident Wellness Director and a part-time (20 hours a week) Wellness Nurse for every 100 to 115 residents living at a property; thus, each IWISH property could have one or more Resident Wellness Directors and Wellness

[1] https://www.huduser.gov/portal/publications/IWISH_FirstInterimReport.html.

Nurses depending on its number of residents. The people filling those two IWISH positions are intended to work together to support residents' health and wellness.

The Supportive Services Demonstration builds on what HUD learned from the Support and Services at Home (SASH) model and earlier studies to advance the knowledge base on the impact of housing-based services on healthcare use and housing stability for older adults.[2]

Evaluating IWISH Model Implementation at 40 Properties

The Supportive Services Demonstration evaluation has a cluster randomized controlled trial design, in which HUD randomly assigned 124 HUD-assisted properties that predominantly or exclusively serve seniors ages 62 or older to one of the following three groups:

- The 40 **treatment group** properties received funding to support the Resident Wellness Director and Wellness Nurse positions for 3 years, plus supplemental funding to support health and wellness programs for residents and training and technical assistance for staff.[3]
- The 40 **active control group** properties did not implement the IWISH model and form part of the overall control group for the impact analysis.
- The 44 **passive control group** properties did not implement the IWISH model and form the other part of the overall control group for the study's impact analysis, along with the active control group.

The control group properties serve as a comparison for the IWISH properties in measuring the impact of the IWISH model on residents and provide context to inform those findings. The study will compare outcomes for residents living in the 40 treatment group properties with outcomes for residents living in the 84 active and passive control group properties.

The evaluation consists of two main analyses: an implementation analysis of the extent to which the 40 treatment properties implemented the demonstration with fidelity to the IWISH model and to identify model strengths and weaknesses, and **an impact analysis** to assess the effect of IWISH on resident tenancy and healthcare use outcomes compared with resident outcomes in the 84 control group properties that did not implement IWISH. This Second Interim Report presents the results of the implementation analysis; the impact analysis will be the subject of the Final Comprehensive Report.

Main Findings of the Implementation Analysis

By and large, the study team found that the treatment properties implemented the Supportive Services Demonstration with fidelity to the IWISH model. Through interviews with program staff and analysis of program data and reports from the implementation team, the study team analyzed whether the demonstration properties implemented all the core components of the IWISH model. Core components of the IWISH model include the onsite staffing of the Resident Wellness Director and Wellness Nurse, proactive one-on-one engagement with residents, structured assessment of residents' health and wellness needs, and health and wellness programming that addresses resident needs.

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[2] The SASH model consists of a full-time service coordinator and a quarter-time wellness nurse assigned to 54 panels of approximately 100 older adults, most of whom are living in affordable housing developments. The SASH evaluation was funded by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and by HUD. The evaluation has produced multiple reports, which are available at https://aspe.hhs.gov/.

Although we determined that most IWISH properties implemented the program with fidelity to the model, we observed substantial variation in how properties implemented the core components of the program.

Exhibit ES-1 at the end of this Summary describes the rating system used by the study team to measure fidelity to the IWISH model and the distribution of fidelity ratings into categories of high, medium, and low levels of implementation. Across all IWISH properties, 33 properties were rated as high or medium on overall fidelity of core IWISH components.[4]

Not All IWISH Properties Implemented All the Core Components of the IWISH Model to a High Degree

As described throughout this report, staff reported some challenges in meeting the intentions of the IWISH model at their properties. As a result, not all the 40 properties implemented all the core components of IWISH program or implemented them to a high degree. Most properties were rated high in enrollment and participation, person-centered interviews, and health and wellness assessments. Most properties were also rated high or medium in areas of enhanced service coordination that are not typically part of the service coordinator's role: medication self-management, transitional care, and family and caregiver interaction.

No IWISH properties were rated high in healthcare partnerships because no properties reported developing partnerships with healthcare providers at the property level, as was intended in the model. Only one-half of the IWISH properties reported implementing specific evidence-based health and wellness programs identified by the implementation team, but all IWISH properties regularly offer onsite programming related to health and wellness that have similar goals as the recommended evidence-based programs.

The Resident Wellness Director Position Was Fully Staffed at Most Properties for Most of the Demonstration Period

The IWISH staffing team is integral to the implementation of the IWISH model; the model cannot be implemented without staff filling these important roles. Most IWISH properties (30) were funded for one full-time Resident Wellness Director, and 10 properties were funded for two to four Directors based on the number of units of the property. The position of Resident Wellness Director was staffed at most properties for most of the 3-year demonstration period. Five properties had less than full staffing for 6 months or longer. At most IWISH properties, the Resident Wellness Director role replaced the service coordinator role, and the person who was in the position of onsite service coordinator before the start of IWISH transitioned into the Resident Wellness Director role. IWISH staff reported that the implementation of IWISH was not substantially affected by the vacancies in the Resident Wellness Director position.

The Wellness Nurse Position Was At Least Partially Staffed at Most Properties for Most of the Demonstration Period

On average, across all IWISH properties, the Wellness Nurse position was fully staffed for 76 percent of the demonstration period and partially staffed for 90 percent. Interviews with IWISH and property staff suggest that the presence of at least one Wellness Nurse enabled what they saw as the most important IWISH activities to continue in large part. At properties with staffing vacancies, IWISH staff and residents report that vacancies in IWISH staffing affected resident enrollment and engagement and eroded the trust that had been built in the program.

The Average Enrollment Rate Was Satisfactory, but Engagement Varied Across Properties

The IWISH implementation team encouraged IWISH staff to aim for an 80-percent enrollment rate, considered to be the highest likely enrollment rate. Across all IWISH properties, 70 percent of eligible residents had enrolled in IWISH as of March 2020. Forty percent of the IWISH properties met the 80-percent enrollment goal set by the implementation team, including three properties that enrolled 100 percent of residents. One-fourth of properties had enrollment rates of less than 60 percent, however.

Once enrolled, resident participation in IWISH activities varied widely among properties. Only about one-fourth of residents met with IWISH staff at least every 3 months while enrolled, and approximately 10 percent of participants did not meet with IWISH staff at all after the first month of enrollment. IWISH staff and residents report that speaking a different primary language than IWISH staff, a desire for privacy, and vacancies and turnover in IWISH staffing were factors that limited resident enrollment and engagement. Over time, IWISH staff were able to build relationships with residents and develop trust, which supported resident enrollment and engagement in IWISH.

Almost All IWISH Participants Completed an Assessment, but Privacy Concerns Were a Barrier

A core component of IWISH is a two-part resident assessment process consisting of a person-centered interview and a health and wellness assessment to help staff identify resident needs and to determine where to target supportive services. Most IWISH staff reported that the formal assessments are essential components of the IWISH model and said that they used the data collected through those tools to support residents both individually and collectively.

Across the 40 properties, 89 percent of those residents who had enrolled in IWISH participated in the health and wellness assessment, and 96 percent participated in person-centered interviews. The rates of participation varied somewhat across properties. Although most IWISH staff did not see major barriers to completing the interview or assessment, resident concerns about privacy were cited as the most common reason for residents not participating in the assessment process.

Using the information gathered in the assessment process, IWISH staff are expected to work with residents to set personal health and wellness goals and develop a plan for achieving those goals. As of March 2020, some 61 percent of residents who had enrolled in IWISH set at least one goal with IWISH staff—far less than had participated in a person-centered interview or an assessment.

IWISH Staff Reported Challenges Using Required Case Management Software

IWISH staff were required to use a case management software program, Population Health Logistics (PHL), to record resident assessment data and staff interactions with residents. Many IWISH staff reported difficulties using the system. In addition to technical and training problems, staff reported that collecting and entering data into the system was time consuming and took away from time they thought would be better spent interacting with the residents directly.

Staff at Most IWISH Properties Reported Engaging in Enhanced Service Coordination Activities

In the IWISH model, service coordination is "enhanced" because of its distinct focus on resident health and wellness beyond the help in accessing community resources that service coordinators typically provide in HUD-assisted multifamily properties. The study team found that enhanced service coordination was implemented with varying approaches and to varying degrees across IWISH properties:

- **Transitional Care.** Staff at all IWISH properties reported providing some level of transitional care to their residents. IWISH staff at the majority of IWISH properties conducted in-home visits with residents after in-patient stays. About one-half reported coordinating in-home services for residents when they returned home, and about one-half reported visiting residents during their in-patient stay.

- **Emergency Events.** IWISH staff at most treatment properties reported playing a role in resident emergency events—such as a fall—including providing support during events that occur at the property, providing support and service coordination after an emergency event, and educating residents on how to prevent future emergency events. Staff from one-third of IWISH properties gave examples of when their active intervention prevented the unnecessary use of emergency care or services.
- **Medication Self-Management.** Wellness Nurses at most IWISH properties helped IWISH participants manage their medications. Wellness Nurses most commonly assisted residents with their medication by directly communicating with doctors and pharmacists and by educating residents about the purpose of the medication, the appropriate dosage, and potential interactions.

When compared with service coordinators in the active control properties, IWISH staff reported providing more enhanced service coordination to residents. IWISH staff reported greater interaction with families and caregivers on behalf of residents than did service coordinators in the active control group. IWISH staff and active control service coordinators reported providing similar levels of assistance to residents transitioning home from a hospital, nursing home, or long-term care facility. Most service coordinators at the active control properties had little or no involvement in helping residents self-manage their medication.

All Properties Offered Programs Focused on Health and Wellness, but Only One-Half of IWISH Properties Implemented Evidence-Based Programs

The demonstration grant provided supplemental funding for evidence-based programming and other activities that help residents perform the instrumental activities of daily living and health, wellness, and preventive care to support their aging in place. IWISH staff at only one-half of the properties reported implementing the specific evidence-based programs that were recommended by the IWISH model. However, most properties implemented programs that focused on the same goals as the recommended programs. Staff reported that programming related to exercise, nutrition, balance, and chronic disease management had the most impact on residents' health and well-being.

Developing Property-Wide Healthcare Partnerships Was a Challenge

IWISH staff reported that the model component that was most challenging to implement was developing property-wide partnerships with healthcare providers or facilities to help facilitate transitional care and assist residents. Although many staff reported developing relationships with individual providers or facilities, no IWISH properties were able to develop formal partnerships with healthcare providers for the whole property, citing the relatively small number of residents compared with the population the providers serve and bureaucratic barriers.

However, 60 percent of properties report that healthcare providers come onto the property to provide services to residents on a regular basis. Those providers include podiatrists, elder care specialists, dentists, and physical therapists, who were onsite from once a week to once a year. In addition, several properties reported property-wide partnerships with other types of organizations that focus on health and wellness or serve older adults, such as nursing schools, local Area Agencies on Aging and senior centers, and community health organizations.

COVID-19 Required Staff to Change the Way They Interacted with Residents but Not the Assistance They Provided

The onset of the COVID-19 pandemic had dramatic effects on every facet of IWISH at the demonstration properties. IWISH staff had to change not only the way they implemented health and wellness activities but also how they engaged with residents, changing to mostly telephone rather than in-person interactions. In some instances, IWISH staff reported that the pandemic helped reinforce the value of the IWISH model for residents. Appendix A provides a detailed description of how IWISH staff adapted their work during the pandemic.

Final Evaluation Report Will Analyze the Impact of the IWISH Model as Implemented in the Demonstration

The Final Comprehensive Evaluation Report, expected to be made available in late 2022, will assess whether IWISH led to any changes in outcomes related to resident tenancy and acute and nonacute healthcare use. Although we do not yet know what the outcomes data will show, IWISH and property staff and residents who participated in the program reported numerous benefits from implementing the IWISH model. Residents reported changes to their health and well-being as a result of having IWISH at their properties, including better self-management of their chronic health conditions and of the medication they were taking. Staff from one-third of IWISH properties reported examples of when the interventions prevented unnecessary use of emergency services. Property managers and owners also reported seeing benefits from the program. At some properties, property managers attribute a reduction in tenant turnover to the services provided under IWISH.

Staff and residents also reported an increased feeling of safety and security, better awareness of residents' medical diagnoses and the medication they were prescribed, and a greater understanding of their own health. Residents attribute those positive changes to IWISH staff and programming. They appreciate having a medical professional and designated point of contact for health and wellness on site, and they described how programming provides an opportunity for social interaction and education.

Exhibit ES-1. IWISH Fidelity Measures and Ratings for the 40 IWISH Properties

IWISH Component	Fidelity Rating Definition	Ratings of High, Medium, and Low Implementation	IWISH Properties Rated High	IWISH Properties Rated Medium	IWISH Properties Rated Low
ONSITE SERVICES STAFFING					
Resident Wellness Director (RWD) Staffing	Presence of onsite RWD during 36-month demonstration period	**High:** At least one RWD for all 36 months **Medium:** No RWD for 1–6 months **Low:** No RWD for 6 months or longer	28 (70%)	9 (23%)	3 (8%)
Wellness Nurse (WN) Staffing	Presence of onsite WN during 36-month demonstration period	**High:** At least one WN for all 36 months **Medium:** No WN for 1–6 months **Low:** No WN for 6 months or longer	3 (8%)	30 (75%)	7 (18%)
RESIDENT ENROLLMENT					
Resident Enrollment	Percentage of residents at property that enrolled and consented to participate in IWISH	**High:** ≥80% of residents enrolled in IWISH **Medium:** 60–79% enrolled in IWISH **Low:** <60% enrolled in IWISH	16 (40%)	14 (35%)	10 (25%)
RESIDENT ASSESSMENTS, INTERVIEWS, AND HEALTHY AGING PLANS					
Health and Wellness Assessments	Percentage of IWISH participants with completed health and wellness assessments	**High:** ≥80% of IWISH participants completed assessments **Medium:** 50–79% of IWISH participants completed assessments **Low:** <50% of IWISH participants completed assessments	31 (78%)	4 (10%)	5 (13%)
Person-Centered Interviews	Percentage of IWISH participants with completed person-centered interviews	**High:** ≥80% of IWISH participants completed interviews **Medium:** 50–79% of IWISH participants completed interviews **Low:** <50% of IWISH participants completed interviews	31 (78%)	8 (20%)	1 (3%)
Development of Individual Healthy Aging Plans (IHAPs)	Development of Individual Healthy Aging Plans (IHAPs)	**High:** ≥80% of IWISH participants developed IHAPs **Medium:** 50–79% of IWISH participants developed IHAPs **Low:** <50% of IWISH participants developed IHAPs	13 (33%)	15 (38%)	12 (30%)
ENHANCED SERVICE COORDINATION					
Transitional Care	Extent to which onsite services staff provided and coordinated care for residents returning home from a hospital or nursing home stay, as reported by staff	**High:** Formal process for providing transitional care to residents, and staff report doing so on a regular basis as requested by residents **Medium:** No formal process, but staff provide these services as requested by residents **Low:** No formal process for providing transitional care, and staff do not provide any type of transitional care or do so rarely	20 (50%)	17 (43%)	1 (3%)
Medication Self-Management	Extent to which onsite services staff engaged	**High:** IWISH staff report doing all three activities on a regular basis	12 (30%)	16 (40%)	7 (18%)

IWISH Component	Fidelity Rating Definition	Ratings of High, Medium, and Low Implementation	IWISH Properties Rated High	IWISH Properties Rated Medium	IWISH Properties Rated Low
	in medication self-management services described in the *IWISH Operations Manual**	**Medium:** IWISH staff report doing one or two of these activities on a regular basis or all three infrequently **Low:** IWISH staff report doing one of these activities or doing any of the activities infrequently			
Family and Caregiver Interaction	Extent to which onsite services staff interacted with IWISH participants' families and caregivers to help residents obtain needed services and support	**High:** Staff often interacted with residents' families and caregivers **Medium:** Staff sometimes interacted with residents' families and caregivers **Low:** Staff rarely or never interacted with residents' families and caregivers	22 (55%)	12 (30%)	5 (13%)
HEALTHCARE PROGRAMMING AND PARTNERSHIPS					
Community Healthy Aging Plan (CHAP)	Completion of the Community Healthy Aging Plan (CHAP) based on identified needs of residents	**High:** Completed a CHAP and reported using the CHAP to inform needed programming **Medium:** Completed a CHAP but did not use the CHAP to inform needed programming **Low:** Did not complete a CHAP	32 (80%)	3 (8%)	5 (13%)
Evidence-Based Programming	Availability of evidence-based group programming recommended by the IWISH model and included in the IWISH *Evidence-Based Catalog*	**High:** Made available evidence-based programs included in the IWISH *Catalog* and that meet identified resident needs **Medium:** Made available health and wellness programs that meet identified needs of residents but were not included in the IWISH *Catalog* **Low:** Did not make available any health and wellness group programming	20 (50%)	20 (50%)	0 (0%)
Healthcare Provider Partnerships	Extent to which site staff developed property-wide partnerships with healthcare providers or interacted with providers on behalf of individual residents.	**High:** Staff developed property-wide partnership and individual interactions with healthcare providers **Medium:** No property-wide partnerships, but staff interacted with healthcare providers on behalf of individual residents **Low:** Staff did not interact with healthcare providers	0 (0%)	40 (100%)	0 (0%)

* Educating residents on medications, helping residents reconcile their medications with their prescriptions, and helping residents establish medication reminder systems.

Notes: Due to insufficient or unclear interview data, the transitional care rating was not determined for two properties; the medication self-management rating was not determined for five properties; and the family and caregiver interaction rating was not determined for one property.

Sources: Abt Associates analysis of program data in PHL; IWISH staffing data from implementation team monthly reports; responses of interviews with IWISH staff in 2019 and 2020; and analysis of monthly implementation team reports.

1. Introduction

The U.S. Department of Housing and Urban Development (HUD) sponsored the Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing to learn whether structured health and wellness support can help older adults living in affordable housing successfully age in place. The model tested through the demonstration is called *Integrated Wellness in Supportive Housing* (IWISH). The Supportive Services Demonstration provided grants to fund health and wellness staff in HUD-assisted multifamily properties to better address the health, housing, and social service needs of older adults. Core components of the IWISH design include onsite wellness staff, proactive engagement with residents, structured assessment of residents' health and wellness needs, and supplemental funding to make high-quality programming available to residents.

What Are the Goals of the Demonstration?

The Supportive Services Demonstration, which tests the IWISH model, is designed to provide rigorous evidence of whether a structured program of housing-based health and wellness supports can help older adults successfully age in their homes and communities.

The demonstration is designed to produce evidence about the IWISH model's impact on the housing stability and health outcomes of HUD-assisted elderly residents. The demonstration is to test whether IWISH will affect (1) the number of unplanned hospitalizations and use of other types of acute care with high healthcare costs; (2) the use of primary and nonacute care; and (3) the length of stay in housing by reducing transitions to long-term care facilities.

The First Interim Report described characteristics of the demonstration properties and implementation of the first 18 months of the IWISH model (October 2017 through March 2019). This Second Interim Report documents the implementation during the entire 3-year demonstration period (October 2017 through September 2020). It describes the experiences of staff, property owners, and residents in IWISH and documents how the IWISH model differs from what is typically offered at HUD-assisted properties for older adults. The third and Final Comprehensive Report, expected in late 2022, will examine whether the IWISH model has any effect on participants' health and well-being and their ability to remain in their homes.

HUD contracted with Abt Associates and its partner L&M Consulting to document IWISH model implementation and to measure IWISH's impact on residents' housing stability and healthcare utilization.

1.1 The IWISH Model

The IWISH model funds two health and wellness staff positions in HUD-assisted multifamily properties to better address the health, housing, and social service needs of adults ages 62 and older.

The Supportive Services Demonstration builds on what HUD learned from the Support and Services at Home (SASH) program[5] and earlier studies to advance the knowledge base on the impact of housing-based services on healthcare use and housing stability.

The IWISH model is different from the supportive services available at a typical HUD-assisted multifamily property serving older adults. The biggest difference is that a typical HUD-assisted property does not have an onsite Wellness Nurse. Some properties have an onsite service coordinator who fills

[5] SASH is an ongoing, multi-year evaluation of a program that was launched in Vermont in July 2011 that, as of December 2016, had served 6,064 individuals (Kandilov et al., 2019). The SASH model consists of a full-time service coordinator and a quarter-time wellness nurse assigned to 54 panels of approximately 100 older adults, most of whom are living in affordable housing developments. The SASH evaluation is funded by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) and by HUD.

components of the Resident Wellness Director role, such as helping residents gain access to services and programs they may need to live independently. However, not all properties have service coordinators, and generally, service coordinators do not focus as strongly on health and wellness. Finally, a typical property might neither conduct a detailed assessment of residents' health and wellness needs nor receive supplemental funding for health and wellness programming.

The demonstration provided funding for onsite wellness staff that goes beyond the resources usually available to HUD-assisted multifamily properties. The demonstration paid for the two onsite wellness staff positions for the 3-year duration of the demonstration: a full-time (40 hours a week) Resident Wellness Director and a part-time (20 hours a week) Wellness Nurse for every 100 to 115 residents living at a property. Thus, each IWISH property could have one or more Resident Wellness Directors and Wellness Nurses depending on its number of residents. The two IWISH positions are intended to work together to support residents in achieving their health and wellness goals.

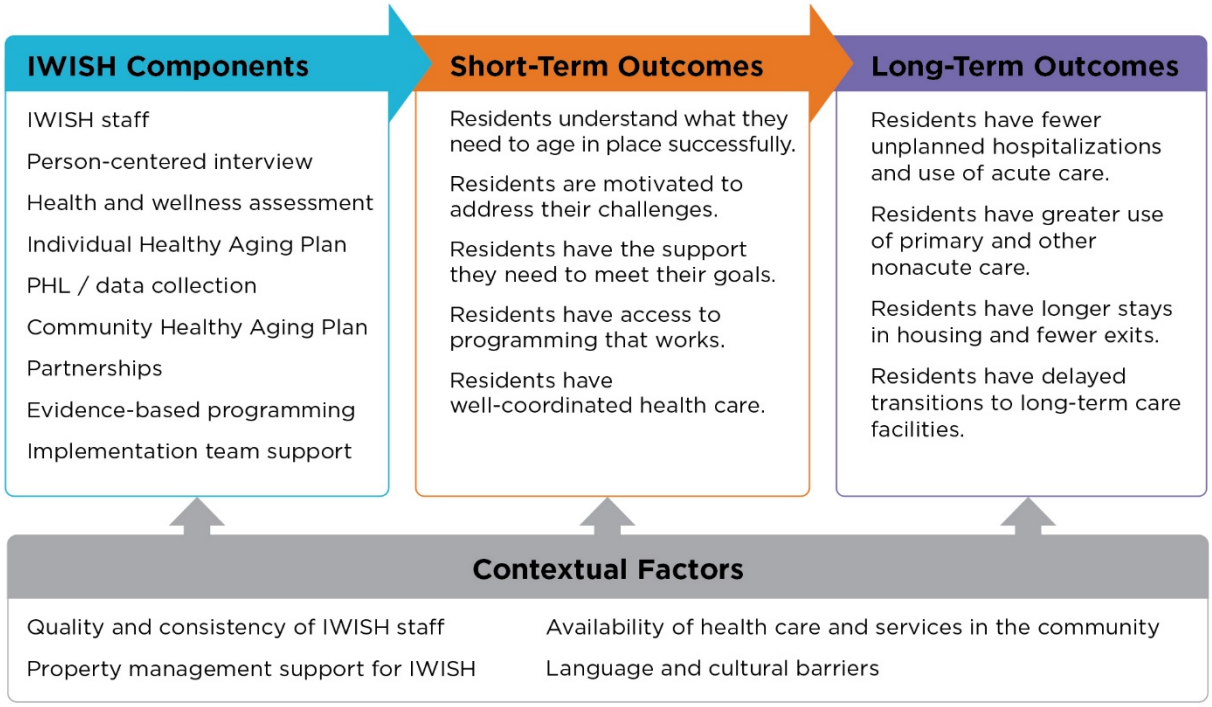
IWISH model components include the following:

- A Resident Wellness Director(s), who proactively engages with residents for the needs assessment and individual goal setting, coordinates health and wellness programming for the property, and builds partnerships with healthcare and social services partners in the community.
- A Wellness Nurse(s), who provides health education and coaching to residents, offers basic health and vital signs monitoring, helps residents work effectively with their healthcare providers, and assists with residents returning from hospitals, nursing homes, or rehabilitation centers.
- A structured approach to engaging with residents that includes (a) indepth interviews to learn about residents' needs and goals and (b) health and wellness assessments to collect standardized information from all residents, which can inform individual and group programming to help residents achieve their health and wellness goals.
- The use of a case management data system to collect and store information on IWISH participants' health and wellness needs and service engagement.
- A Community Healthy Aging Plan (CHAP) that identifies appropriate partnerships and programming for the property.
- Supplemental funding of $15 per unit per month for programming and other activities that help residents that help residents meet their health, wellness, and preventive care needs.
- Partnerships with healthcare facilities and other provider types to better coordinate health and wellness services for residents and transitional care following hospitalizations.
- Support from an implementation team (under contract to HUD) that provides staff training, technical assistance, and monitoring during the demonstration.[6]

Exhibit 1-1 shows the model's expected short- and long-term outcomes and contextual factors for the IWISH model.

[6] HUD's IWISH implementation team consists of The Lewin Group and its partners, LeadingAge and the National Well Home Network. The Lewin Group is a national healthcare and human services consulting firm. LeadingAge is a nonprofit membership organization that helps older adults successfully age in place. The National Well Home Network is a nonprofit organization that develops housing-based service models across the country.

Exhibit 1-1. IWISH Model's Components, Expected Outcomes, and Contextual Factors



PHL = Population Health Logistics.

1.2 Evaluating the Supportive Services Demonstration

In anticipation of the demonstration grant awards, HUD contracted with Abt Associates and its partner L&M Consulting in 2016 to evaluate the implementation and effectiveness of the Supportive Services Demonstration. This section summarizes the study's methodology, focusing on data collection and analysis for this interim report. Appendix B (Research Methodology) provides additional detail.

In 2017, HUD awarded 40 properties funding to support Resident Wellness Director and Wellness Nurse positions for 3 years, supplemental funding for health and wellness programming for residents, and training and technical assistance for staff.[7] The 40 IWISH properties agreed to implement the model fully for a 3-year demonstration period.

[7] The specifics of the funding arrangement vary by property. Properties that had a traditional HUD service coordinator grant at the time of applying for the Supportive Services Demonstration received funding for the Wellness Nurse and to supplement the salary for the Resident Wellness Director position that was already funded through the service coordinator grant. Project Rental Assistance Contract (PRAC) properties that had a service coordinator funded from the property's operating budget had the same type of funding arrangement, with the Supportive Services Demonstration supplementing existing monies budgeted for the service coordinator and funding the Wellness Nurse outright. Properties without a service coordinator received demonstration funding for the Wellness Nurse and Resident Wellness Director positions in their entirety. The technical assistance and training provided by the implementation team was funded separately. In addition, PRAC properties already had some funding available for programming and other activities that help residents perform activities of daily living, although those properties may not have been aware of the funding.

Randomized Controlled Trial

The Supportive Services Demonstration evaluation has a randomized controlled trial design, in which HUD assigned 124 properties and their residents to one of three groups.[8] The study will compare outcomes for residents living in the 40 properties that implemented IWISH (the "treatment" group) to outcomes for residents living in 84 similar properties that did not implement IWISH (the "control" group). The control group is composed of an "active" control group of 40 properties and a "passive" control group of 44 properties.[9]

The main purpose of the control group properties is to make possible a comparison of outcomes for the IWISH properties to outcomes for HUD-assisted properties that do not have access to the additional resources associated with the IWISH model. In considering the impact results that the evaluation will ultimately provide, policymakers must understand how different the IWISH model is from business as usual at HUD multifamily properties serving older adults. The bigger the difference between the level of support offered to residents of the IWISH properties compared with the level offered to residents of the control properties, the larger the expected impact.

Exhibit 1-2 shows the 124 properties by state and their approximate locations. Most treatment and control properties in a given state are in the same metropolitan area, and many are in the same neighborhood. Refer to appendix B or to the Impact Study Research Design for additional details on random assignment and the study sample.

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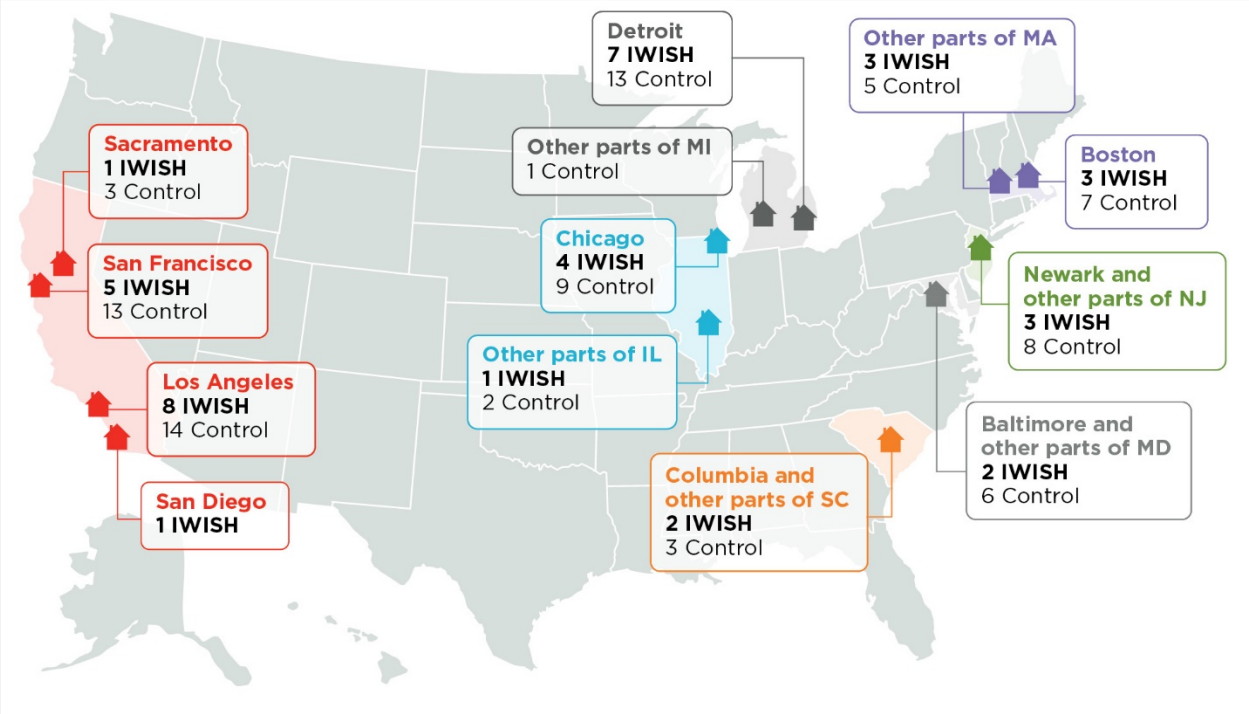
[8] Active control properties in this demonstration are not necessarily representative of HUD-assisted properties nationwide. Although a previous study found that about one-half of HUD-assisted properties employed service coordinators, about 95 percent of active control properties employed a service coordinator by the end of this demonstration. Properties first applied to participate in this demonstration before being randomly assigned into the treatment, active control, or passive control groups. Properties that applied to participate in the demonstration may be different from properties that did not apply. As demonstrated in the First Interim Report, treatment properties are similar to control group properties across a range of characteristics.

[9] This design uses clustered random assignment. Impacts will be estimated at the resident level, but individual residents are not randomly assigned to treatment and control properties. Instead, random assignment occurs at the property level, with multifamily properties of varying sizes randomly assigned to the treatment and control groups.

Exhibit 1-2. Map of Demonstration Properties



The evaluation consists of two main analyses:

- **An implementation analysis** documenting how the 40 treatment properties implemented the IWISH model, identifying challenges to implementation, assessing fidelity to the IWISH model among treatment properties and variations in implementation, and describing the extent to which active control properties were implementing similar services.
- **An impact analysis** assessing the effect of IWISH on residents' tenancy and healthcare use.

This Second Interim Report presents the results of the implementation analysis. The impact analysis will be the subject of the Final Comprehensive Report.

Implementation Analysis Research Questions and Data Sources

The research questions and data sources for the implementation analysis are shown in exhibit 1-3. The research questions address IWISH implementation across the 40 properties, the experiences of staff and residents, and how the resident supports provided at these IWISH properties differ from those provided at the active control properties. The study team conducted site visits and interviews with IWISH Resident Wellness Directors and Wellness Nurses; service coordinators at active control properties; and property managers and owners of both IWISH and control properties. The study team also led focus groups with residents at six active control properties and analyzed data collected through PHL, the case management software used by IWISH staff.

Exhibit 1-3. Implementation Analysis Research Questions and Data Sources

Research Question	Interviews (staff)	Focus Groups (residents)	PHL (program data)
What are the experiences of resident wellness and property management staff with implementing the IWISH model?	✔		
What are the perceived benefits, strengths, and weaknesses of the IWISH model?	✔	✔	
Within the treatment group, did residents' perceptions of their health, well-being, and satisfaction with housing and services change?	✔	✔	
Was the demonstration implemented with fidelity to the IWISH model across the treatment properties?	✔		✔
What factors explain or contribute to the observed variation in fidelity to the IWISH model across the treatment properties?	✔	✔	✔
How does the service coordination and health and wellness programming provided at the IWISH properties differ from that provided at active control properties?	✔	✔	

PHL = Population Health Logistics.

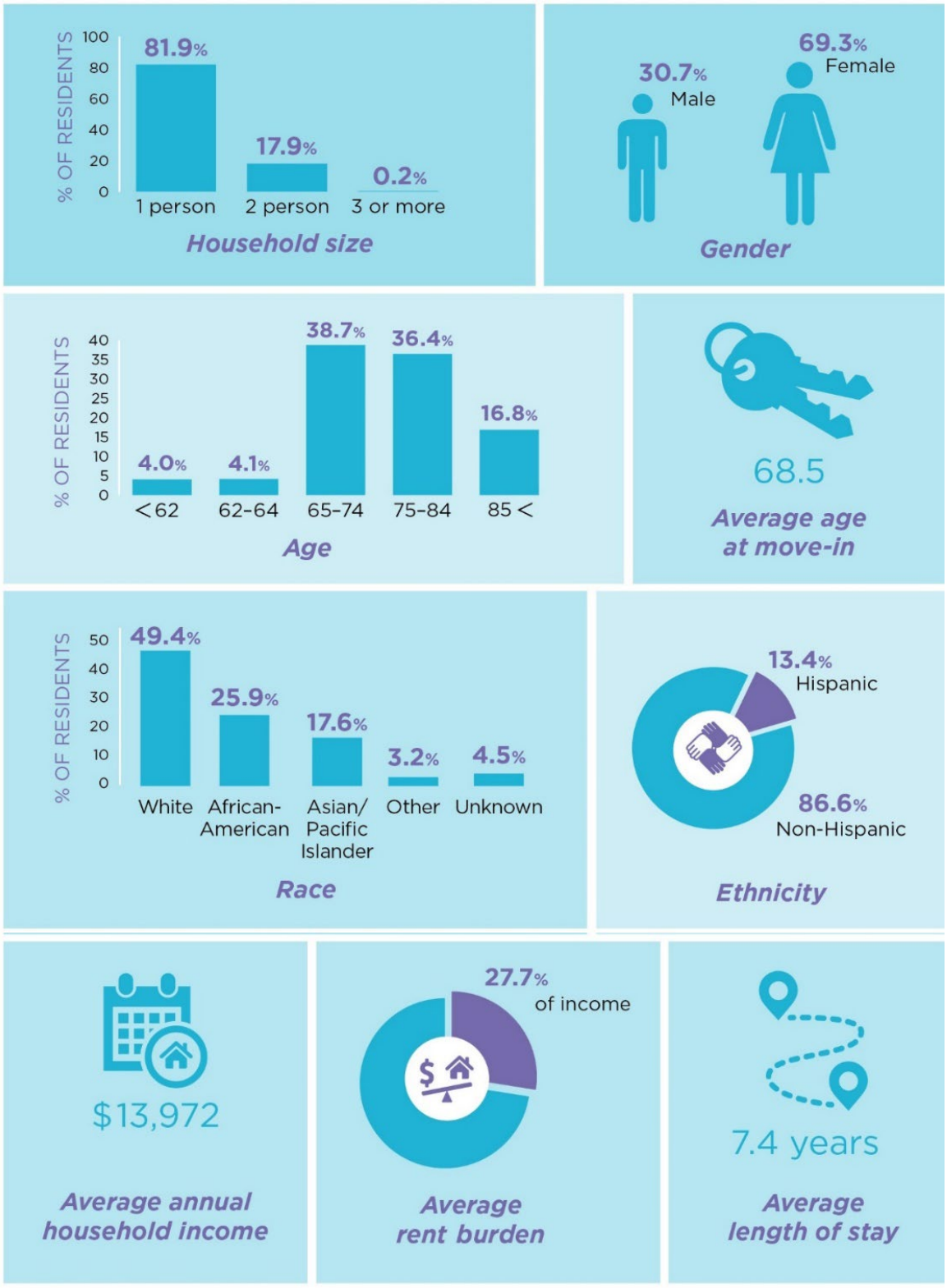
To use interviews and focus groups to answer the research questions, the study team used NVivo software to identify themes, code interview transcripts, and summarize findings. Refer to appendix B for more information on the approach.

1.3 IWISH Properties and Their Residents

The First Interim Report presented the characteristics of 4,274 residents living at the IWISH properties (the evaluation treatment sample) in October 2017, which can be found in exhibit 1-4.

The typical HUD-assisted resident of an IWISH property as of October 2017 was a 76-year-old woman who lived alone and had resided at the property for about 7 years. Most residents were between 65 and 84 years old; the number of residents was about evenly divided between those from 65 through 74 and those from 75 through 84.

Exhibit 1-4. Characteristics of Residents Living at IWISH Properties, October 2017



Notes: *N* = 4,274 residents in 40 properties. Age calculated as of October 1, 2017. Average rent burden calculated as rent as a percentage of adjusted income and capped at 100 percent. Average length of stay calculated from move-in date until October 1, 2017.

Overall, the resident population of IWISH properties was racially and ethnically diverse: 49 percent White, 26 percent African American, 18 percent Asian or Pacific Islander, and 8 percent other or unknown. 13 percent identified as Hispanic. The average household income at baseline was $13,972—about one-third of the median income for the U.S. population ages 65 and older.[10]

The IWISH properties varied appreciably in resident population and neighborhood characteristics. For example, some properties had lengths of stay averaging 5 years; others had lengths of stay averaging 12 years. Some properties were almost all White, including properties with sizable European immigrant populations; others had almost all African American residents; and still others were racially mixed. At some properties, a sizable share of residents were ages 85 or older, whereas at other properties, the share was quite small.

The properties did not vary substantially in physical condition, based on HUD inspection data, but the neighborhoods where they were located were highly diverse. The neighborhoods ranged in poverty rate (at the census-tract level) from 4 to 53 percent and varied in educational attainment and racial and ethnic composition.[11]

1.4 Reports from the Evaluation of the Supportive Services Demonstration

This **Second Interim Report** describes the experiences of staff and residents with implementing IWISH during the entire 3 years of the demonstration, October 1, 2017 through September 30, 2020. The report assesses to what extent the 40 treatment properties implemented all core components of the IWISH model. It also describes the differences in experiences and contexts across the treatment properties and the extent to which services differed between treatment and control properties.

The **First Interim Report** (November 2019) describes the baseline characteristics of residents living at IWISH properties, drawing on HUD administrative data, Medicare claims data, and public use data sources. It describes the first 18 months of IWISH implementation (October 2017–March 2019). The report focuses on the process of hiring and retaining IWISH staff and implementing key startup IWISH activities, such as enrolling residents in the program and initially assessing their health and wellness needs. Find it here: https://www.huduser.gov/portal/publications/IWISH_FirstInterimReport.html.

The **Research Design and Analysis Plan for Impact Study** describes the research design and analysis plan for the impact study component of the evaluation of the Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing, including the research questions, outcome measures, data sources, analysis approach, and limitations of the impact study. Find it here: https://www.huduser.gov/portal/sites/default/files/pdf/Impact-Study-Research-Design.pdf.

The **Final Comprehensive Report** (planned for late 2022) will provide quantitative analysis of IWISH impacts on residents' healthcare use and housing stability. The study's third and final report will examine whether IWISH had any effect on participants' health and well-being or their ability to remain in their homes (age in place). The study team will use HUD administrative data and Medicaid and Medicare claims data to compare resident outcomes in the IWISH properties to those in the control properties. Specifically, the Final Comprehensive Report will measure the IWISH impact on the following resident outcomes:

- Unplanned hospitalizations and use of other acute care.
- Use of primary care and other nonacute care.
- Length of stay in HUD multifamily housing and exits from housing.

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[10] See exhibit 3-1 in Turnham et al. (2021).

[11] Refer to the First Interim Report for more on this topic.

- Transitions to long-term care facilities.

The Final Comprehensive Report will also analyze the impact of IWISH on total costs, including those for health care, inpatient, outpatient, and pharmacy. The report will use information collected for the First and Second Interim Reports to contextualize its quantitative findings.

1.5 Second Interim Report Purpose and Organization

This Second Interim Report is based primarily on qualitative research at the IWISH and active control group properties. Based on conversations the study team had with IWISH staff and focus groups with residents, we report on how IWISH staff and support team members work together to implement the IWISH model, which aspects of the model staff and residents find the most beneficial, and which ones they find the most challenging. We discuss how thoroughly the treatment properties implemented the demonstration with fidelity to the IWISH model and how fidelity varied across properties. Finally, we discuss how the IWISH model—as implemented in the 40 treatment properties—differs from service coordination in the 40 active control properties.

Second Interim Report Data Sources

This report draws mainly from in-person site visits and in-depth interviews conducted with property and services staff and from focus groups with residents in the summer and fall of 2019, with followup telephone interviews conducted in late 2020. The interview data are supplemented with resident and property data from HUD's administrative data system, IWISH program data collected in PHL, and data collected directly from the demonstration properties and resident focus groups. Exhibit 1-5 presents the main data sources.

Although the demonstration officially operated through September 30, 2020, we chose to end the analysis of IWISH program data for this report in March 2020, as the work of IWISH staff with residents changed substantially and data entry was less reliable as a result of the COVID-19 pandemic (see appendix A). However, the Population Health Logistics (PHL) data obtained after March 2020 indicate that enrollment rates did not change substantially between March and September 2020, when the demonstration period ended.

Exhibit 1-5. Data Sources for Second Interim Report

Source	Timeframe	Description
Site visits (in-depth interviews, focus groups)	April–December 2019	In-person site visits, in-depth interviews, and focus groups at all 40 IWISH properties and all 40 active control properties: ▪ Interviews with Resident Wellness Directors, Wellness Nurses, and property managers at IWISH properties. ▪ Interviews with service coordinators and property managers at active control properties. ▪ Focus groups with residents at IWISH and active control properties.
Follow-up telephone interviews	August–December 2020	Telephone interviews at 39 IWISH properties and 21 active control properties: ▪ Interviews with Resident Wellness Directors and Wellness Nurses at IWISH properties. ▪ Interviews with service coordinators at active control properties. ▪ Telephone interviews with 5 owners of IWISH and active control properties.
Telephone surveys	November 2018–January 2019	▪ Telephone survey of Resident Wellness Directors at each IWISH property.

Source	Timeframe	Description
Implementation team materials	October 2017–September 2020	▪ *IWISH Operations Manual*, training presentations, and other resources developed by HUD's implementation team for IWISH property staff. ▪ Monthly progress reports. ▪ Bimonthly reports generated from PHL data. ▪ Start and departure dates for IWISH staff. ▪ Discussion with HUD's implementation team.
IWISH program (case management) data	March 2018–September 2020	▪ Extraction of person-level PHL data provided by HUD's implementation team.

PHL = Population Health Logistics (data system).

Organization of This Report

The content of this report is organized into eight chapters (including this introduction) and two appendixes:

- **Chapter 2. IWISH Staffing and Support** discusses whether the IWISH properties met the model's core staffing requirements during the demonstration period and how property management and training and technical assistance from HUD's implementation team supported staff implementing the IWISH model.
- **Chapter 3. Resident Enrollment and Engagement in IWISH** discusses whether the IWISH properties met the resident enrollment goals of IWISH and IWISH staff perceptions of what factors affected enrollment and resident participation in IWISH programs and activities. The chapter also provides data on how often residents met with IWISH staff throughout the demonstration period and the reasons for the visits.
- **Chapter 4. Resident Participation in Interviews, Assessments, and Goal Setting** assesses the extent to which IWISH properties conducted health and wellness assessments, person-centered interviews, and Individual Healthy Aging Plans with residents enrolled in IWISH. The chapter also presents IWISH resident experiences and perspectives regarding these core IWISH components.
- **Chapter 5. Enhanced Service Coordination in IWISH** presents IWISH staff experiences with and perspectives on implementing areas of enhanced service coordination that are intended to be part of the IWISH model, including transitional care for residents returning home from a hospital or healthcare facility stay; helping residents self-manage the medication they are taking; and interacting with healthcare providers, family, and caregivers on behalf of residents.
- **Chapter 6. Health and Wellness Programming and Partnerships** discusses how IWISH staff implemented health and wellness programming in line with the intent of the IWISH model. The chapter also presents IWISH staff experiences in developing evidence-based programs and partnerships and identifies challenges with developing partnerships with local healthcare providers.
- **Chapter 7. Resident and Staff Perceptions of IWISH** offers the perspectives of IWISH staff, property management, and participating residents on what they think are the benefits of IWISH. The chapter presents information learned through interviews with Resident Wellness Directors, Wellness Nurses, property managers, and property owners and through focus groups with residents at a sample of IWISH properties.
- **Chapter 8. Conclusion** summarizes how the properties participating in IWISH implemented and experienced the IWISH model during the 3-year demonstration. The chapter also offers the study team perspective on the practicality of the IWISH model and offers some suggestions for modifications should the demonstration be continued or expanded.

- **Appendix A. How the COVID-19 Pandemic Affected IWISH Implementation** describes how COVID-19 limited staff ability to implement IWISH as designed during the demonstration period and describes how IWISH staff changed their procedures to continue to provide services and maintain communication with residents.
- **Appendix B. Research Methodology** describes the research methodology and data sources the study team used to develop this report.

2 IWISH Staffing and Support

Core components of the IWISH model include proactive one-on-one engagement with residents, structured assessment of residents' health and wellness needs, and health and wellness programming that addresses those needs. The primary responsibility for implementing these components lies with the two resident wellness staff positions that are funded through the Supportive Services Demonstration grant—the Resident Wellness Director and the Wellness Nurse. [12]

This chapter is based on interviews conducted with Resident Wellness Directors, Wellness Nurses, and property managers at the 40 IWISH properties and resident service coordinators and property managers at the active control properties; and on an analysis of staffing vacancy data provided by HUD's implementation team.

Key Findings on IWISH Staffing and Support

- Across all sites, IWISH properties were fully staffed with Resident Wellness Directors for most of the demonstration period.
- Across all sites, the Wellness Nurse position was at least partially staffed for most of the demonstration period.
- Overall, property managers were minimally involved in implementing the IWISH program, with most spending less than 5 hours a week on IWISH activities. Despite the limited time commitment, IWISH staff reported the relationship with property management staff to be important in helping to identify and meet resident needs.
- Overall, IWISH staff reported satisfaction with the training and technical assistance provided by the implementation team.
- All but two active control sites had a full-time service coordinator who performed a role similar to the Resident Wellness Director in IWISH.
- No active control site had onsite healthcare services comparable to those provided by the Wellness Nurse. One-third of active control sites had regular visiting healthcare providers—such as nurses, podiatrists, elder care specialists, dentists, and physical therapists—but they did not provide the same type of services as the Wellness Nurse. Two-thirds of active control sites did not offer these services.

2.1 IWISH Staffing During the Demonstration

The Resident Wellness Director and the Wellness Nurse are integral to IWISH implementation; the model cannot be implemented without staff filling these important roles. Resident Wellness Directors, as described in chapter 1, provide enhanced service coordination to residents at the property where they live, and Wellness Nurses provide health and wellness education and support to residents on site. Exhibit 2-1 presents a more detailed overview of staff responsibilities.

Exhibit 2-1. Overview of IWISH Staff Responsibilities

Resident Wellness Director Primary Responsibilities	Shared Responsibilities	Wellness Nurse Primary Responsibilities

[12] The First Interim Report goes into greater detail about the division of labor between the Resident Wellness Director and the Wellness Nurse and how vacancies in the first 18 months of the demonstration affected resident enrollment in the IWISH program.

• Coordinate outreach and education efforts with residents about IWISH, with input and involvement from the Wellness Nurse and property management staff. • Enroll residents and schedule person-centered interviews and resident health and wellness assessments. • Conduct person-centered interviews. • Oversee completion of resident needs assessments, with the Resident Wellness Director and the Wellness Nurse each completing specified parts. • Ensure development of IHAP, with input from the Wellness Nurse and the resident. • Ensure development of CHAP, with input from the Wellness Nurse and community partners. • Oversee implementation of IHAPs and the CHAP, with the Resident Wellness Director and the Wellness Nurse each fulfilling designated activities. • Oversee a followup with residents returning from a hospital or nursing facility, collaborating with the Wellness Nurse as appropriate. • Oversee development and coordination of onsite programming, with input and assistance from the Wellness Nurse and community partners. The Resident Wellness Director, Wellness Nurse, or community partners may deliver programming. • Serve as liaison to the IWISH implementation team.	• Assist residents with implementing and following through on activities and goals identified in IHAPs. • Support residents with addressing ongoing and new health and wellness needs. • Assist residents with addressing any transitional care needs. • Develop partnerships and collaborate with community partners and service providers for greater efficiency in delivery of care and well-being. • Input and maintain information in PHL on resident status and service encounters.	• Educate and coach residents on understanding and managing their chronic health conditions. • If authorized by the resident, communicate with residents' healthcare providers to assist residents with relaying health information to their providers and coordinating their health-related services. • Monitor vital signs as necessary or as requested. • Assist residents with self-management of medications (e.g., review medications with the resident or help establish a system for remembering to take medications). A Wellness Nurse may assist a resident with preparing medications only on an emergency or short-term basis. • Host health and wellness group activities, such as blood pressure clinics or health education sessions. • Provide nursing expertise upon a resident's return from a hospital or nursing facility to promote a safe transition and minimize readmissions.

PHL = Population Health Logistics.
Source: Abt Associates adaptation from the *IWISH Operations Manual* (February 6, 2019)

Larger IWISH properties were funded for additional Resident Wellness Directors and Wellness Nurses, other than the one of each provided to every property, as shown in exhibit 2-2.

Exhibit 2-2. Number of Resident Wellness Director and Wellness Nurse Positions, in Full-Time Equivalents

Number of Units per Property	Resident Wellness Director FTEs	Wellness Nurse FTEs	Number of Properties
Up to 115	1.0	0.5	30
116 to 215	2.0	1.0	7
216 to 315	3.0	1.5	2
More than 315	4.0	2.0	1

FTE = full-time equivalent.
Source: Abt Associates adaptation from the *IWISH Operations Manual* (February 6, 2019)

Overall, the IWISH properties were largely able to fill IWISH staff positions, although most experienced at least some stretches when one or more positions were vacant.

In this analysis, we use the term fully staffed to indicate that the IWISH property had filled all the full-time equivalents (FTEs) for which it was funded. We use the term not staffed to describe periods when a property lacked a Resident Wellness Director or Wellness Nurse. We employ those two measures to provide a more complete understanding of the staffing picture across properties. From interviews, we understand that full staffing is important to ensure that all program components can be implemented fully without overtaxing staff. However, we also learned that with at least one person in a given role, staff were able to continue (but not fully implement all) what they considered to be the most meaningful IWISH activities by filling in for missing staff.

We use the concept of "demonstration days" to quantify the amount of time that IWISH positions were fully staffed and not staffed in a given property. Demonstration days are calculated as the number of calendar days between the start of the demonstration on October 1, 2017 and its conclusion on September 30, 2020. The demonstration period consists of 1,095 total demonstration days, which, for ease of interpretation, are presented in terms of months in this report (30 demonstration days = 1 demonstration month).

As discussed in the First Interim Report, delays in hiring the first Wellness Nurses at IWISH properties played a large part in early staffing shortages. Factors delaying initial hiring included a lack of experience among property owners in contracting for healthcare services (Wellness Nurses were not employees of the property[13]), a reported lack of urgency on the part of third-party contractors responsible for identifying the nurses, and the nationwide nursing shortage. Properties faced fewer challenges filling the Resident Wellness Director position, in part because many properties already employ service coordinators, who are usually direct employees of the housing development, who were able to transition to this role. Resident Wellness Directors also were paid more than regular service coordinators in control properties.

Ongoing turnover in both positions also contributed to the number of vacant positions across properties. For every Resident Wellness Director and Wellness Nurse position available, properties on average needed to hire 1.5 times the required staff and, even so, experienced periods without full staffing.

Resident Wellness Director Positions Were Fully Staffed for Most of the Demonstration

As a whole, IWISH properties were fully staffed with Resident Wellness Directors for 94 percent of the demonstration and had at least one Resident Wellness Director for 97 percent of the demonstration. Staffing levels varied by property, but only a few properties had no Resident Wellness Director for a substantial period of time (exhibit 2-3).

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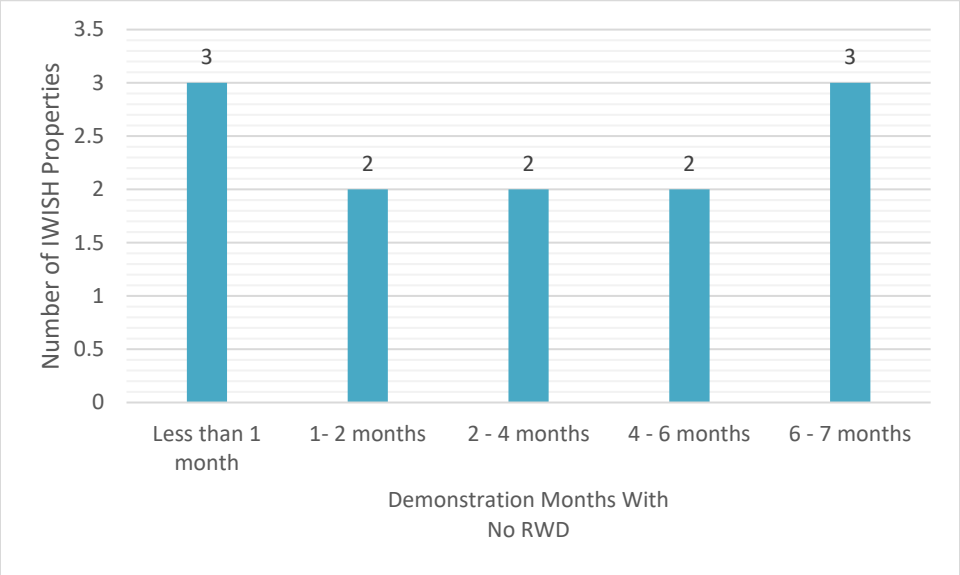
[13] Recognizing that property owners would not have experience hiring and overseeing nurses and might not have the level of insurance needed to have a healthcare provider on site, HUD required IWISH properties to contract for the Wellness Nurse through a certified provider. Those certified providers included assisted-living residences, hospitals, home health agencies, and Federally Qualified Health Centers.

Exhibit 2-3. Properties with No Resident Wellness Director on Staff

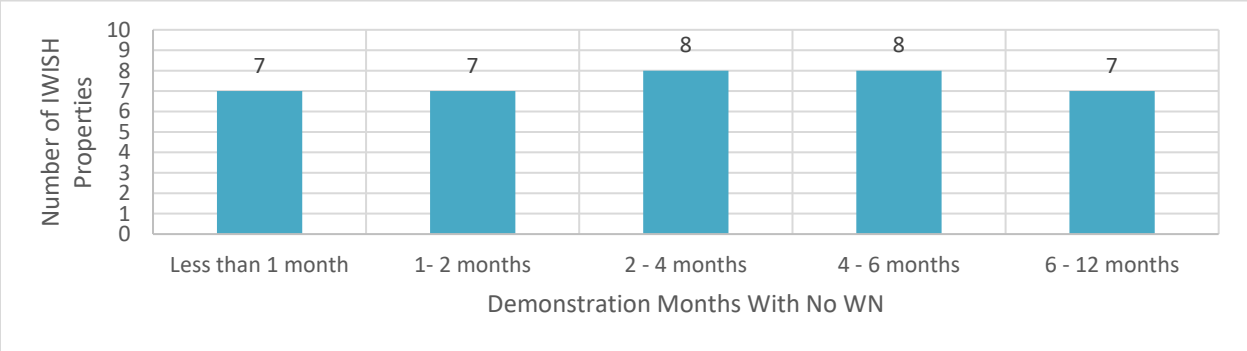


RWD = Resident Wellness Director.
Note: Demonstration months refers to a 30-day period during the time of the demonstration.
Source: Abt Associates analysis of staffing data in the implementation team's IWISH implementation reports

Despite Challenges, IWISH Properties Had at Least One Nurse on Site for Most of the Demonstration Period

Across all IWISH properties, at least one Wellness Nurse position was on site for 90 percent of the demonstration. The Wellness Nurse position was fully staffed for 74 percent of the demonstration. Some demonstration properties were without any Wellness Nurse for substantial periods of time; at seven properties, the position was not filled for at least 6 months (exhibit 2-4).

Exhibit 2-4. Properties with No Wellness Nurse on Staff



WN = Wellness Nurse.
Note: Demonstration months refers to a 30-day period during the time of the demonstration.
Source: Abt Associates analysis of staffing data in the implementation team's IWISH Implementation reports

Staffing Vacancies Affected IWISH Implementation

IWISH staff at 28 of the 40 IWISH properties discussed staffing vacancies in interviews with the study team. Only one-third reported that staffing vacancies or turnover affected program implementation and that those effects were caused by the reduction of program activities or resident trust. At several properties, IWISH staff from the same or another property stepped in to fill the IWISH role. One property manager described how a Resident Wellness Director from another nearby property agreed to visit the

property once per week while the property manager sought a replacement hire. The two worked together to support residents as best they could, but the property manager noted that due to the staffing shortage, not every IWISH activity or resident need and request could be addressed.

Not having fully staffed IWISH positions sometimes meant that assessments or individual goal-setting activities were temporarily put on hold. One Director discussed how not having a dedicated Wellness Nurse for a year delayed full implementation of the program:

> *We weren't able to launch as much health-focused programs. We had a nurse come from another site once per month for 6 hours, but we weren't able to launch health-focused processes and programs without a regular nurse. We had to keep saying, "We will soon be getting a nurse!" Every month we said that, for a whole year.*

Our analysis of information provided by the implementation team, the study's Expert Panel, and interviews with property and IWISH staff suggests that staff departures from both Resident Wellness Director and Wellness Nurse positions were largely for personal reasons and were not directly related to the IWISH model.

2.2 Technical Assistance and Training Provided to IWISH Staff

To support the Resident Wellness Director and the Wellness Nurse in implementing IWISH core components, HUD contracted with an implementation team consisting of The Lewin Group and its partners LeadingAge and the National Well Home Network.

The implementation team provided formal in-person and virtual training to staff on IWISH procedures and policies before the start of resident enrollment and throughout the demonstration period. Formal training included a number of special topics relevant to working with older adults, such as memory conditions, bullying, and trauma-informed care. In addition, the implementation team provided day-to-day support through dedicated site liaisons assigned to each property and convened in-person and virtual opportunities for staff from all the IWISH properties to learn from one another.

We learned from interviews with IWISH staff and implementation team members that a great deal of the technical assistance provided centered on using the required case management system and assessment tools and on enrolling residents in the first 18 months of the demonstration. Technical assistance in the second half of the demonstration focused more on special topics of interest to staff and continued one-on-one support between the implementation team and IWISH staff. The text box that follows summarizes the special topic webinars that staff found most valuable.

IWISH Staff Found the In-Person Training, Special Topic Webinars, and Individual Site Liaison Support Valuable

Although responses varied depending on preferred ways of learning and prior experience, IWISH staff reported some training and technical assistance to be especially helpful:

- **The 2-day in-person training held in September 2017.** This training was held about 6 months before staff could officially begin enrolling residents. It focused more on the foundation of the IWISH model and building relationships than on day-to-day IWISH activities. In addition to the value of in-person learning, several IWISH staff reported that it was useful to understand the overall IWISH model, the goals of the demonstration, and how their role fit into the model. Wellness Nurses reported that learning about the IWISH model was especially important because the nursing role in IWISH is different from clinical nursing positions.

- **Virtual webinars on special topic areas.** The implementation team held monthly webinars throughout the 3-year demonstration (37 webinars in all) on topics particular to working with older adults. IWISH staff reported that the training expanded their knowledge in areas related to their work with residents. Staff reported that the live aspect of the webinars was especially beneficial and that it was helpful to be able to talk with staff at other properties, ask questions, and get answers in real time. Webinars were also recorded and made available to all IWISH staff through a shared website.
- **One-on-one consultation about issues specific to individual properties.** IWISH staff reported that regularly scheduled calls with their site liaison helped them focus their activities and obtain feedback from the implementation team on working with residents. The staff found the site liaison calls helpful because they addressed concerns specific to their property, whereas the webinars did not.

Special Topic Webinars Most Appreciated by IWISH Staff

- Assisting residents with mental health issues.
- Motivational interviewing.
- Understanding dementia.
- Bullying.
- Older adults experiencing trauma.
- Areas of importance to the LGBTQ community.
- Medicare and Medicaid and resident eligibility.
- HUD housing programs and policies.
- Elder legal rights.

Several IWISH staff reported that they would have liked to receive more one-on-one assistance from their assigned liaison. Some also noted that the liaison could not always answer their questions about their day-to-day work or the demonstration grant's requirements. In particular, Wellness Nurses reported that they would have liked to have another nurse or other medical professional as a peer or supervisor to bounce ideas off, ask questions, and shadow them when they first started working.

IWISH Staff Identified Additional Training Needs

Some IWISH staff reported that the training and technical assistance did not add much to their previous experience and education; however, we identified training and support areas that IWISH staff thought should be strengthened.

- **Training for staff who joined after resident enrollment started.** Six months before the start of the demonstration, a number of the demonstration properties had already experienced turnover in the IWISH positions. Staff who joined after the initial onboarding period reported more challenges with learning the responsibilities of their positions. Several noted that they wished they had received the same level of training that earlier hires had. Staff starting later said that watching prerecorded webinars was not the most effective way for them to learn a lot of information at one time.
- **Training on PHL and completing assessments.** Training on the case management system represented a large share of the work that the implementation team carried out with the demonstration properties. Still, many IWISH staff reported needing more support with using PHL. IWISH staff requested more hands-on training and more opportunities to work in a test environment before having to use those tools with residents (see section 4.4 on IWISH staff use of PHL).
- **How to assist residents with mental health issues such as depression and grief.** Many staff reported that they did not feel they had sufficient training or experience to assist residents with mental health needs. They also noted feeling inadequately prepared to deal with the psychological aspect of the job. A Resident Wellness Director described this experience:

> *Delving into one's background for some residents has trauma. For us listening, we also have secondary trauma. We aren't clinicians. And then by asking these questions, we open trauma up and not being a clinician, how do we close it up? Because residents are sharing very personal details of their lives, we wanted them to understand we aren't going to see them differently. Because some residents may walk away and they wonder if you aren't going to treat them any differently.*

A few staff reported that the amount of training and technical assistance offered by the implementation team was more than they needed or was repetitive, and the time would have been better spent directly assisting residents. Some reported that they simply did not have time to attend all the recommended training or read all the provided materials or that training was offered at times when they were unavailable to attend.

Training and Support Provided by the Properties' Owner Organizations Were Considered Effective

Several IWISH staff pointed to the training and assistance provided by the owner organization of the property as critical support for their roles. At most properties, the Resident Wellness Director is an employee of the housing development and overseen by a service coordinator supervisor who works for the ownership entity.

For example, one property owner had several properties in the demonstration in one state and convened regular meetings of the IWISH staff to discuss the demonstration. These meetings were an opportunity for staff to discuss their understanding of their roles, help identify services and programs available in their areas, and brainstorm ways to address resident concerns. Several IWISH staff reported shadowing or working with existing staff as the most effective way to learn their roles. Staff noted the importance of having someone more experienced or even a peer to act as a sounding board when trying to resolve specific resident issues.

Resident Wellness Directors Often Relied on Previous Experience and Training

For work related to serving older adults more generally and not specific to the IWISH model, Resident Wellness Directors relied more on their previous experience and guidance from their employer or service coordination supervisor than on any training they received as part of IWISH, according to those interviewed. Many of the Resident Wellness Directors pointed to their regular service coordinator training as their most useful support. HUD service coordinators are required to have annual training, and several Resident Wellness Directors noted attending the training during the demonstration period. Resident Wellness Directors trained as social workers also are required to obtain continuing education credits to remain accredited in their field. Several Wellness Nurses noted that their previous nursing experience and training were important resources in preparing them for their IWISH role.

2.3 Property Management Involvement in Implementing IWISH

Each IWISH property already had the usual property management team, consisting of a property manager, maintenance staff, and, in some cases, security staff. IWISH staff are expected to distinguish their roles from the property management team's role. For example, the Resident Wellness Director and the Wellness Nurse do not engage in property management functions such as rent collection and evictions. The IWISH staff may not share any health and wellness information about individual residents with property management staff unless the resident gives permission. However, property managers and IWISH staff are expected to communicate regularly to help identify and address resident needs.

Most Property Managers Were Minimally Involved in IWISH Activities

Property managers at three-fourths of the IWISH properties described their involvement in day-to-day activities of IWISH as "minimal" or "somewhat" involved. Resident Wellness Directors and Wellness

Nurses described the involvement of property managers in their work similarly. Four property managers reported no involvement with IWISH, whereas two property managers reported being "very involved" in IWISH activities at their properties.

Those property managers who reported little day-to-day involvement in IWISH nonetheless described their role as being a resource for the IWISH staff. All property managers we interviewed said they were willing to work with the IWISH staff to help solve resident problems when they arose and to refer residents to the IWISH staff if they saw or learned something concerning about a resident.

Property Managers Support IWISH Through Resident Referrals and Assistance with Program Logistics

Most property managers estimated that they spent less than 5 hours a week on IWISH activities, including two property managers who reported not spending any of their work time on activities related to IWISH. Five managers reported spending between 5 and 9 hours a week on IWISH, and four managers reported spending more than 10 hours a week on IWISH-related activities.

How often the property managers communicated with IWISH staff varied. Two-thirds of property managers reported communicating with IWISH staff in person, via telephone, or via email, either daily or a few times a week. The remaining one-third of managers reported mostly communicating with IWISH staff weekly or a few times a month.

The frequency of communication between property and IWISH staff was influenced by how often property managers and IWISH staff are on site at the property at the same time. Some property managers oversee multiple properties and might be on site at each property only 2 or 3 days a week. Most Wellness Nurses worked at IWISH properties 20 hours a week, so their time at the property might not always coincide with other site staff's schedules.

Property managers report that the following IWISH activities took the most time:

- **Referring residents to IWISH staff for services.** Property managers often referred residents to the IWISH staff for questions about their benefits or if they saw that the resident had needs for services. Conversely, IWISH staff might refer residents to the property manager for questions about their rent or tenancy.
- **Consulting with Resident Wellness Directors when residents had potential lease violations,** such as when a resident was late on rent, had a housekeeping issue, or had other issues with tenancy compliance. Resident Wellness Directors can connect residents to services to help address any underlying issues.
- **Collaborating with IWISH staff during emergency situations,** such as when a resident fell, needed emergency room care, or was transitioning to or from a hospital, rehabilitation facility, or nursing home stay.
- **Supporting the logistics of health and wellness programming.** Property managers often supported IWISH by ensuring that common spaces were available and ready for IWISH activities.
- **Supporting budgeting for onsite programming.** As managers of the property's operating budget, some property managers reported a role in developing or managing the property's budget for onsite programming. That effort included approving the use of supportive services grant funds or communicating with HUD about the use or expenditure of funds.
- **Being an advocate for IWISH.** A common way that management staff reported advocating for IWISH was by providing accurate information about the program to residents—in particular, assuring residents that the information they provide to IWISH staff is kept confidential. Several

property managers noted that simply being present or participating in IWISH programs and activities showed support for the program and encouraged resident participation.

2.4 Onsite Wellness Staffing Fidelity to the IWISH Model

If the Resident Wellness Director and Wellness Nurse positions are not fully staffed, as defined earlier, we would expect less effective implementation of the other core components of the IWISH model. We assessed fidelity to IWISH in onsite wellness staffing by measuring how many months the site had no Resident Wellness Director or Wellness Nurse staffing during the demonstration period and categorizing properties into low, medium, and high levels of staffing implementation. Exhibit 2-5 presents the onsite wellness staffing fidelity ratings for the 40 IWISH properties.

Exhibit 2-5. IWISH Staffing Fidelity Measures for the 40 IWISH Properties

IWISH Component	Fidelity Rating Definition	Ratings of High, Medium, and Low Implementation	IWISH Properties Rated High	IWISH Properties Rated Medium	IWISH Properties Rated Low
Resident Wellness Director (RWD) Staffing	Presence of onsite RWD during 36-month demonstration period	**High:** At least one RWD for all 36 months **Medium:** No RWD for 1–6 months **Low:** No RWD for 6 months or longer	28 (70%)	9 (23%)	3 (8%)
Wellness Nurse (WN) Staffing	Presence of onsite WN during 36-month demonstration period	**High:** At least one WN for all 36 months **Medium:** No WN for 1–6 months **Low:** No WN for 6 months or longer	3 (8%)	30 (75%)	7 (18%)

Sources: Abt Associates analysis of IWISH program data in PHL; IWISH staffing data from implementation team monthly reports; responses of interviews with IWISH staff in 2019 and 2020; analysis of monthly implementation team reports

Most properties (28) had at least one Resident Wellness Director on staff for the entire demonstration. Three properties had no Resident Wellness Director on staff for less than a month, six had no Director on staff for more than a month but less than 6 months, and three had no Director for 6 to 7 months. We rated the three properties with no Resident Wellness Director for at least 6 months as having low levels of implementation for this position.

Only 3 properties were able to fill the Wellness Nurse position for the entire 36-month demonstration; the remaining 37 properties had no nurse for at least some period of time ranging from less than 1 month (7 properties) to between 6 months and 1 year (7 properties). We rated the 7 properties that had no Wellness Nurse for at least 6 months as having low levels of implementation for the Wellness Nurse position. Only one site had low levels of implementation for both the Resident Wellness Director and the Wellness Nurse positions.

2.5 How IWISH Services and Wellness Staffing and Support Compare with Those at the Active Control Properties

The level of supportive services staffing in IWISH properties contrasts in two main ways with what is typical at HUD-assisted multifamily properties serving older adults. The IWISH Resident Wellness Director role is intentionally different from that of a typical service coordinator. The Resident Wellness Director focuses specifically on residents' health and wellness and provides enhanced service coordination activities. Typical HUD-assisted properties also do not have an onsite Wellness Nurse.

For properties that had a HUD-funded service coordinator, the demonstration grant funded the difference between the Resident Wellness Director-level salary and the salary previously budgeted for the service coordinator, who typically earned less.

We compared the level of onsite service coordinator staffing at the active control properties to that of IWISH and found the following distinctions:

- **Most properties in both groups had a service coordinator before the start of the demonstration in October 2017.** In both IWISH and active control groups, 33 of the 40 properties had an onsite service coordinator when the demonstration period started in October 2017. Many of those properties had recently begun a service coordinator program. At the time they applied to the demonstration, 27 active control properties and 33 IWISH properties reported employing a service coordinator. Several of the active control properties also added service coordinator positions during the demonstration period. By August 2019, all but two active control properties had service coordinators on site.

- **More active control properties than IWISH properties had staffing vacancies in the service coordinator position.** At least 40 percent of active control properties had vacancies in the service coordinator position between when the demonstration started in October 2017 and when the study team conducted site visits in August 2019. The average length of vacancy was just shy of 5 months during that period. By contrast, only 20 percent of IWISH properties experienced a vacancy in the Resident Wellness Director position during the entire demonstration period (October 2017 through September 2020), and the average length of vacancy was 1 month. In addition, consultation with members of the study's Expert Panel suggests that the turnover of Resident Wellness Directors at IWISH properties is in keeping with turnover patterns observed among service coordinators at large.

- **None of the IWISH properties had a regular onsite nurse before IWISH, and none of the active control properties had an onsite nurse during the demonstration period**. A proportion of properties in both groups have regular visiting healthcare providers, such as nurses, podiatrists, elder care specialists, dentists, and physical therapists; however, those services were not typically similar to those provided by the onsite Wellness Nurse. The frequency of the providers' visits varied from once a week to once a year, compared with the ongoing presence of the Wellness Nurse, who is at the property for several days each week. In addition, most of the services provided by the visiting healthcare providers were specialty clinical services—not the more general nonclinical care that the Wellness Nurse provides.

The Level of Property Management Involvement in Service Coordination Was No Different Between IWISH and Control Properties

The level of support and involvement that the property manager and owner provide may affect the implementation and effectiveness of supportive services; therefore, the study team also compared the level of involvement of property management in onsite services between the IWISH and active control properties.

We did not find any substantial differences between property managers' and owners' involvement at IWISH properties and control properties. The study team characterized most IWISH and active control properties as having either no (2 IWISH and 4 active control) or low (25 IWISH and 20 active control) involvement of the property manager in onsite services. The study team characterized slightly more IWISH properties as having high property manager involvement in onsite services (4) compared with the active control properties (2). In both groups, more than half of property managers said they spent five hours or less related to service coordination activities weekly.

In both groups, the onsite property management's involvement in IWISH and the regular service coordination program varied and was generally based on a combination of the structure and requirements of the owner organization and the individual work style of the property manager. Many of the properties in both groups have similar organizational structures and, for some properties, the same owner. From interviews with property managers and owners, we learned that they did not change the way they interacted with onsite services staff whether they were involved in IWISH or not.

3 Resident Enrollment and Engagement in IWISH

Describing resident enrollment and participation in IWISH activities is foundational to understanding the implementation of the demonstration. IWISH property residents must be enrolled in IWISH to take advantage of services that differentiate the IWISH properties from the control group properties, such as one-on-one support from the Wellness Nurse. Knowing the status of IWISH take-up and engagement and the factors that influence participation rates is important in understanding IWISH's potential reach or impact on the resident population.

This chapter provides an overview of enrollment across the 40 treatment properties that implemented the IWISH model between March 2018, when program enrollment began, and September 2020, when the demonstration period officially ended. It describes the status of resident enrollment and consent to the demonstration and provides data on how often residents met with IWISH staff. The chapter also discusses factors that IWISH staff report affected enrollment or resident participation in IWISH programming and activities. This chapter is based on IWISH program data and on interviews conducted with Resident Wellness Directors and Wellness Nurses at the 40 IWISH properties and with service coordinators and property managers at the active control properties. Following chapters will describe IWISH activities, such as assessments and programming, in greater detail.

Main Findings on Enrollment and Engagement

- Almost 3,000 residents enrolled in IWISH at the 40 treatment sites, or 70 percent of eligible residents. At three sites, 100 percent of eligible residents enrolled.
- On average, residents enrolled in IWISH met with one or both IWISH staff a little less frequently than once per month. The number of visits per participant varied widely, ranging from a single visit to enroll in the program to 14 visits per month.
- Privacy concerns were named by IWISH staff as the most significant reason for residents to not participate in IWISH or in the health and wellness assessments.
- Language barriers may have hindered program engagement, with non-English speakers meeting slightly less frequently with IWISH staff compared with English speakers. Hiring delays and confusion over allowable costs exacerbated this challenge.
- Engagement in service coordination at the active control sites was less formal than in IWISH properties, and participation in service coordination varied more widely in the active control sites than in IWISH properties. At one-fourth of active control properties, service coordinators reported meeting with fewer than 40 percent of residents at their property.

3.1 IWISH Enrollment

IWISH staff could officially enroll residents of the 40 treatment properties in IWISH beginning March 19, 2018. For residents wanting to participate in the demonstration, enrolling in IWISH only required signing an informed consent form. By enrolling, residents agreed that information they provided to IWISH staff might be shared with HUD's implementation team and our study team. Enrolling did not require residents to complete or attend specific IWISH components or activities, such as the health and wellness assessment. Residents did not have to change healthcare providers or anything about their living arrangements.

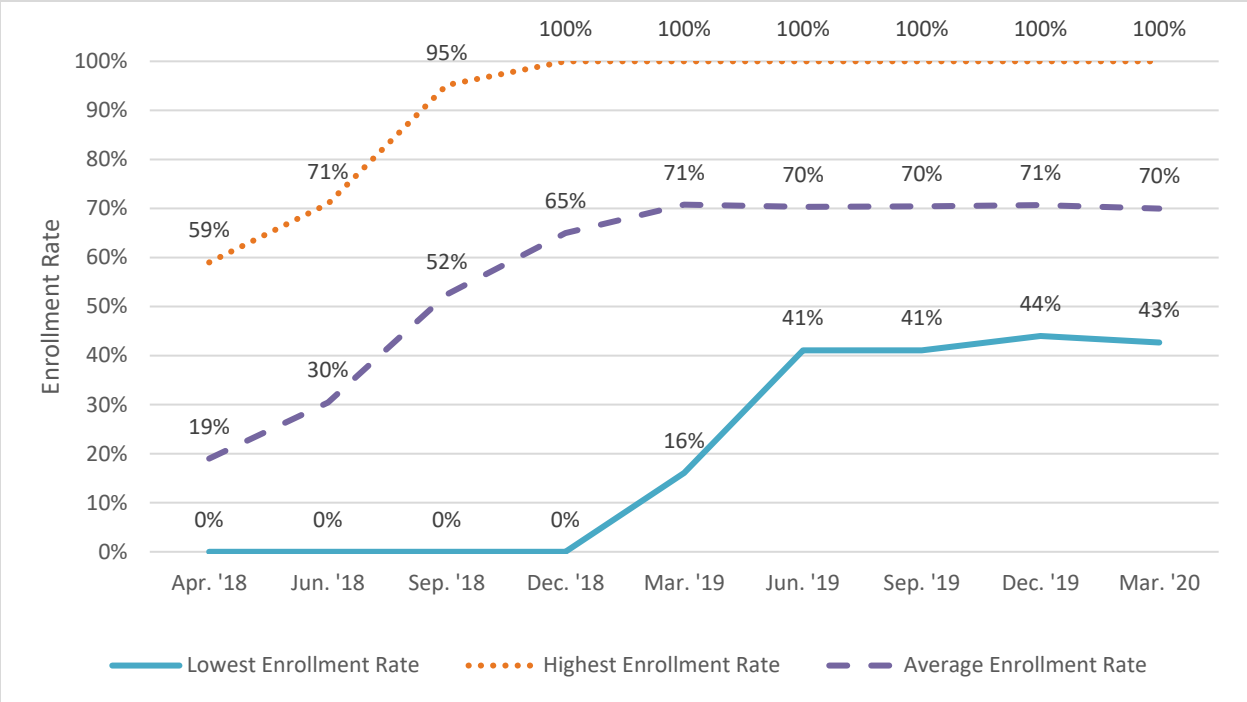
Residents who did not enroll in IWISH still had access to traditional service coordination (such as general information and referrals from the Resident Wellness Director) and any group wellness programs and activities. Non-enrolled residents did not receive enhanced service coordination support, nor did they receive one-on-one assistance from the Wellness Nurse. For example, non-enrolled residents did not

receive annual assessments or healthy aging plans, one-on-one coaching, and support to follow through on goals. Further, Wellness Nurses did not monitor non-enrolled residents' vital signs outside group events, review their medications, communicate with their medical providers, provide individual health education, or monitor them following return from a hospital stay, for example.

As of March 2020, 2,927 residents were enrolled in IWISH across the 40 treatment properties—a 70-percent enrollment rate overall. Exhibit 3-1 shows the trajectory of enrollment over time, from April 2018 (when IWISH staff recorded the first enrollments in PHL) through March 2020 (the start of the COVID-19 pandemic).[14] Most properties had a steady upward trajectory in enrollment for about a year, and then enrollment growth tapered off around June 2019. The properties with the lowest enrollment (solid line) got off to a slow start in enrolling residents and never achieved more than 50-percent enrollment. By contrast, the properties with the highest enrollment (dotted line) enrolled all or nearly all their residents within the first 6 months of the program. The implementation team supported enrollment efforts across IWISH properties, especially through March 2019,[15] when enrollment began to stabilize. After that point, the implementation team focused on properties with the lowest enrollment, while continuing to encourage others to enroll residents who may have been more difficult to enroll.

Exhibit 3-1. IWISH Enrollment Rates by Month, April 2018–March 2020

Notes: *N* = 40 IWISH properties. Enrollment at some properties exceeded 100 percent because the number of residents exceeded the number of units, but the enrollment rate is capped at 100 percent for the purposes of this chart.



Source: Abt Associates analysis of IWISH implementation team program reports

Seventy Percent of Eligible Residents Enrolled in IWISH, but Rates Varied by Property

The IWISH implementation team encouraged IWISH staff in the summer of 2019 to aim for an 80-percent enrollment rate—considered the highest likely rate of enrollment. Exhibit 3-2 shows the

[14] As explained further in appendix B: Research Methodology, the research team determined in consultation with HUD that the research team would not include data entered in PHL after March 2020 for this report.

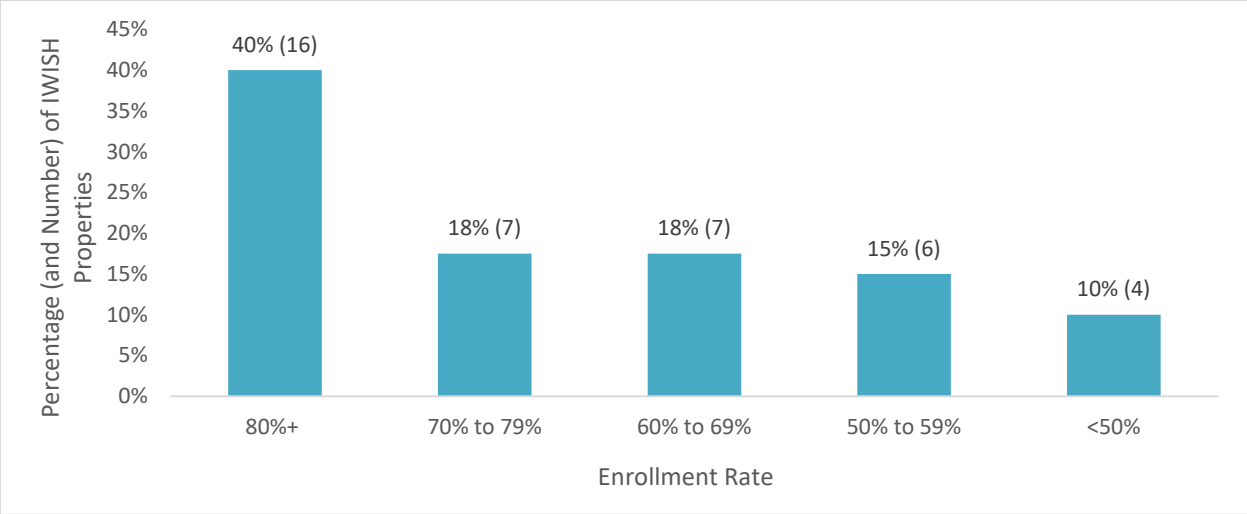
[15] See the First Interim Report for discussion on how the implementation team supported IWISH enrollment.

distribution of IWISH properties by their enrollment rates in March 2020. As of March 2020, enrollment rates at 16 of the 40 treatment properties (40 percent) were at or above 80 percent.

Among those 16 properties, 3 achieved 100-percent enrollment. Among the 24 properties with enrollment rates below 80 percent, 7 properties had enrolled 70–79 percent of their residents, 7 properties had enrolled 60–69 percent, 6 properties had enrolled 50–59 percent, and 4 properties had enrolled fewer than 50 percent. The distribution of properties by enrollment rate changed little between the end of data collection for the First Interim Report in March 2019 and the end of data collection for this report in March 2020.[16]

Residents enrolled in IWISH were largely similar in age, race, and ethnicity to all HUD-assisted residents living at IWISH properties. Of residents enrolled in IWISH,[17] most were between the ages of 65 and 74 (37 percent) or 75 and 84 (38 percent) when they enrolled. Eighteen percent of participants were ages 85 and older, 4 percent were younger than age 62, and 3 percent were between the ages of 62 and 64.

Exhibit 3-2. Distribution of IWISH Properties by Enrollment Rate, March 2020



Notes: *N* = 40 IWISH properties.
Source: Abt Associates analysis of IWISH quarterly management of information technology reports created by the implementation team using PHL data

Nearly All IWISH Participants Stayed Enrolled as Long as They Were at the Property

Once enrolled, nearly all residents were willing to stay in IWISH as long as they remained at the property. As of March 2020, some 349 IWISH participants (11 percent of those ever enrolled in the program) were no longer enrolled in IWISH (exhibit 3-3).[18] The most common reason was the participant moving out of the property (49 percent), followed by the resident dying (36 percent). Only 16 IWISH participants (less than 1 percent of those enrolled) were reported as choosing to stop being enrolled in IWISH.

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16 See exhibit 5-5 in Turnham et al., 2021.

17 Based on an analysis of IWISH participant data in Population Health Logistics

of 3,358 enrolled IWISH participants as of January 2020.

18 Where possible, the IWISH staff collected and recorded the reasons that residents were no longer part of IWISH. Of the 349 IWISH participants who exited the program between March 2018 and March 2020, staff had entered a disenrollment reason in PHL for 320.

As shown in exhibit 3-3, some 156 participants moved out of the property voluntarily. Of those 156 participants, 62 moved to other independent housing without HUD assistance, and another 62 moved to housing with a higher level of care. The remaining 32 participants moved to another HUD-assisted property. In addition to the 156 participants who voluntarily moved out, another 13 (4 percent of program exits) were reported as having been evicted. According to the property managers interviewed for the study, evictions are rare occurrences; residents who fall behind on their rent or have other lease violations typically move out before being evicted.

Exhibit 3-3. Reasons for Exiting IWISH

Reason	Number of Participants	Percentage of Participants
Moved from the property	156	45
Moved to other independent housing with HUD assistance	62	18
Moved to a higher level care setting	62	18
Moved to other independent housing without HUD assistance	32	9
Evicted from IWISH property	13	4
Died	114	33
Chose to stop participating in IWISH	16	5
Other reason	21	6
No reason given	29	8
Total	**349**	**100**

Notes: *N* = 349 people who enrolled in IWISH and later exited the program across 40 IWISH properties.
Source: Abt Associates analysis of IWISH quarterly management of information technology reports created by the implementation team using PHL data, March 19, 2018 through March 18, 2019.

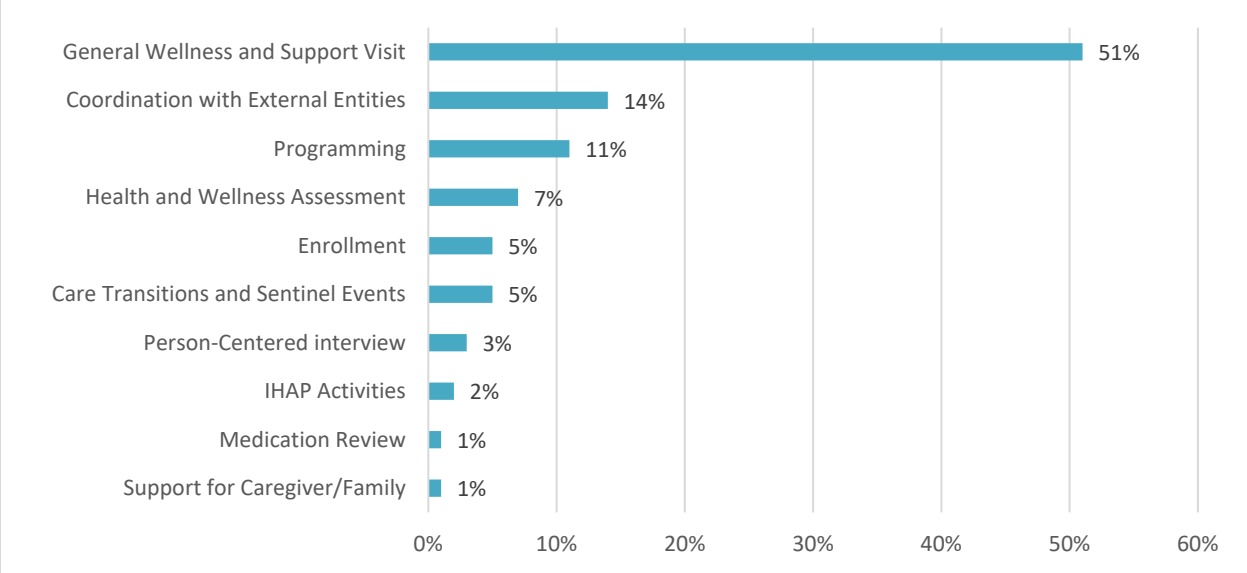
3.2 Resident Visits with IWISH Staff

Across the 40 treatment properties, from March 2018 through March 2020, IWISH staff logged more than 50,000 visits with residents enrolled in IWISH. The PHL User Guide defines a visit as an interaction that meets the following criteria. First, the communication must be "bilateral," meaning that the staff person communicates something to the resident and the resident communicates to the staff person. Leaving a message or voicemail does not count as a visit, for example. The exception to this requirement is the recording of a "sentinel event," such as a fall or hospitalization. The second requirement is that the visit is an "intentional engagement to address a social or health-related need."

Resident Visits with IWISH Staff Focused on Health

IWISH staff classified more than one-half the visits with residents in the PHL category of "General Wellness and Support Visit." We infer that those visits also included more specific purposes, such as medication review (exhibit 3.4). Visits concerning person-centered interviews, health and wellness assessments, and IHAPs typically occurred only once or twice per resident during the demonstration period.

Exhibit 3-4. Distribution of Visits by Reason Identified in PHL, All Visits March 2018 Through March 2020



IHAP = Individual Healthy Aging Plan. PHL = Population Health Logistics.
Notes: *N* = 40 IWISH properties, 51,557 visits with reasons identified in PHL. Percentages were rounded to the nearest decimal. Rounding accounts for the difference in bar size between Support for Caregiver/Family and Medication Review.
Source: Abt Associates analysis of PHL data

Sentinel events, as defined in the *IWISH Operations Manual,* could include hospitalizations, skilled nursing or rehab facility stays, readmissions within 30 days of discharge from a hospital, emergency department visits, ambulance or emergency medical technician visits, permanent moves to assisted living or nursing homes, permanent moves to other locations (new apartment, family, etc.), evictions, falls, attempted suicides, and deaths. Only 5 percent of all visits recorded were in this category (see exhibit 3-5).

Exhibit 3-5. Distribution of Visits by IWISH Staff, All Visits March 2018 Through March 2020

Visit Category	With Resident Wellness Director Only (%)	With Wellness Nurse Only (%)	With Resident Wellness Director and Wellness Nurse (%)
General Wellness and Support Visit	37	59	4
Enrollment	54	11	34
Health and Wellness Assessment	20	50	29
Person-Centered Interview	84	7	9
IHAP Activities	41	33	26
Coordination with External Entities	60	31	9
Programming	41	21	38
Support for Caregiver/Family	52	42	6
Care Transitions and Sentinel Events	32	49	19
Medication Review	3	92	5
All Visit Types (%)	**41**	**45**	**13**

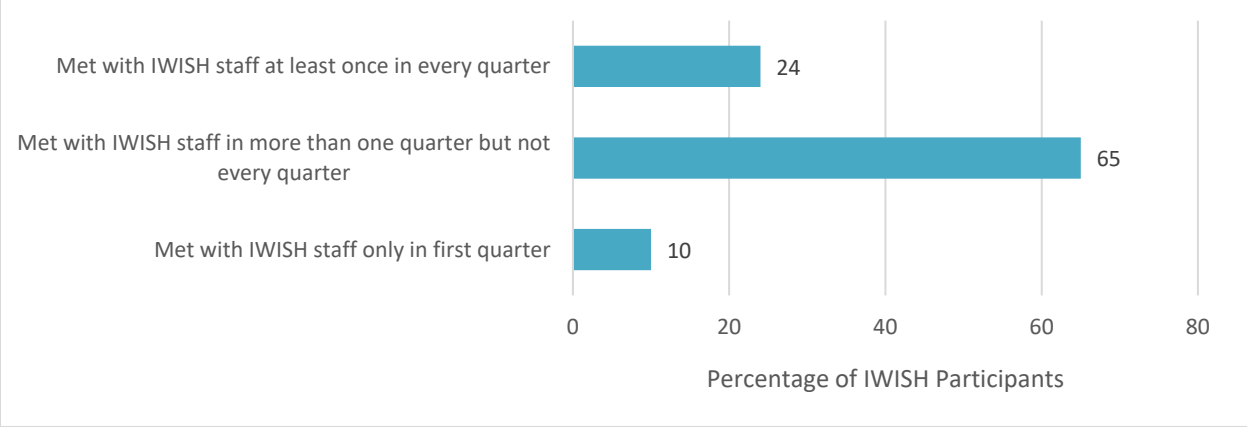
IHAP = Individual Healthy Aging Plan.
Notes: *N* = 40 IWISH properties, 51,557 visits with reasons identified in PHL. Percentages may not add to 100 due to rounding.
Source: Abt Associates analysis of PHL data provided May 2020

Most Residents Met with IWISH Staff a Few Times per Year

As of March 2020, residents enrolled in IWISH had met on average with one or both IWISH staff 16 times since enrolling in the program. Visits averaged a little less than one visit per month of enrollment per resident, but the number of visits per participant and the timing of visits varied tremendously. Visits tended to occur earlier in the participant's enrollment period and then taper off.

Ten percent of IWISH participants had one or more visits in the first quarter of enrollment—presumably to complete the person-centered interview and health and wellness assessment—and then never met with IWISH staff again. Another 24 percent of IWISH participants met with IWISH staff at least once every 3 months while they were enrolled (through March 2020). Two-thirds of IWISH participants (65 percent) met somewhat less frequently—in more than one quarter but not every quarter.

Exhibit 3-6. Distribution of Visits by IWISH Staff by Number of Visits per Quarter, All Visits March 2018–March 2020



Note: *N* = 40 IWISH properties, 3,278 IWISH participants (includes all participants ever enrolled as of March 2020).
Source: Abt Associates analysis of PHL data provided May 2020

3.3 Factors that Could Affect Resident Engagement with IWISH

Many factors could affect whether a resident enrolled in IWISH and participated in IWISH activities. We asked IWISH staff whether they believed that certain resident characteristics made residents more or less likely to enroll and participate in the program. We also reviewed program data to identify enrollment trends.

With respect to enrollment, the study team found the following:

- **Enrollment increased over time as staff gained trust and residents saw peers enrolling.** Staff that took time to build relationships with residents in the early months of the demonstration, including before enrollment was permitted, were able to leverage those relationships to facilitate enrollments. Residents also were more likely to enroll over time, as they witnessed their peers benefiting from the program.
- **Findings were mixed on the relationship between IWISH enrollment and residents' health needs.** IWISH staff provided two conflicting observations regarding the link between residents' likelihood of enrolling and health needs. Some staff reported that residents with serious medical conditions, low literacy levels, or lack of family support were more likely to enroll in IWISH than those with fewer or less critical needs. Those staff believed that residents who had the most immediate need for IWISH services tended to enroll. Other IWISH staff believed that "younger, more active" residents were more health conscious and more likely to enroll and participate. More information is needed to understand this relationship.

- **Racial or ethnic similarities between residents and staff might affect enrollment.** The study team examined the share of participants who either met with staff frequently (at least once a quarter) or rarely, and we observed no variation by race or ethnicity. However, IWISH staff provided anecdotal observations on this subject. Staff at some properties reported that it seemed to help enrollment if IWISH staff were of the same racial, ethnic, or cultural background and that it helped when they spoke the same language as residents. Residents in focus groups noted that differences in background between staff and residents were exacerbated if staff did not take the time to build a relationship before soliciting residents' enrollment.
- **General lack of trust is a deterrent to resident enrollment.** Staff described that resident privacy concerns and distrust hindered program enrollment. Certain residents were reluctant to share personal information because of perceived stigma, embarrassment, or an overall preference for privacy. Others feared that they might lose their housing or other HUD benefits. Some residents held a misconception that IWISH would bill them for services.

The study team analyzed PHL data to learn of any differences in the frequency of meetings based on race and ethnicity, age, gender, marital status, and primary language and found several small but statistically significant differences. Hispanic, American Indian/Alaskan Native, and White residents had higher rates of visits with IWISH staff than did African American and Asian residents. Divorced or widowed residents met more frequently with IWISH staff than married and other non-married residents. Residents younger than 60 had far fewer visits than all other residents. Residents ages 60 to 64 and residents 85 or older met with IWISH staff slightly more often than those ages 65 to 84. We did not find any differences in visitation rates by gender. For complete results, please refer to appendix B, exhibit B-6.

Residents whose primary language is English met more frequently with staff than those whose primary language is not English—another small but statistically significant difference. This variation might reflect what we learned in the site visits and interviews about the challenges that some IWISH staff experience working with non-English speakers. Finding bilingual staff to serve residents was challenging, especially in diverse properties where multiple languages are spoken. Some property and IWISH staff expressed uncertainty about what translation services were allowable costs for IWISH, leading to delays in obtaining assistive services and devices.

3.4 Fidelity to the IWISH Model in Resident Enrollment

Properties were encouraged to try to enroll at least 80 percent of residents at the property—considered the highest likely rate of enrollment. Overall, the IWISH properties fell short of this goal. Although the average enrollment rate across all sites was 70 percent of all eligible residents, the rate varied across properties. The study team rated the enrollment level of IWISH properties into three categories: high for properties meeting the goal of enrolling at least 80 percent of all residents living at the property; medium for an enrollment rate of between 60 and 79 percent; and low for an enrollment rate of less than 60 percent. The ratings are shown in exhibit 3-7.

Exhibit 3-7. IWISH Enrollment Fidelity Ratings for the 40 IWISH Properties

IWISH Component	Fidelity Rating Definition	Ratings of High, Medium, and Low Implementation	IWISH Properties Rated High	IWISH Properties Rated Medium	IWISH Properties Rated Low
Resident Enrollment	Percent of residents at property that enrolled and consented to participate in IWISH	**High:** ≥80% of residents enrolled in IWISH **Medium:** 60-79% enrolled in IWISH **Low:** <60% enrolled in IWISH	16 (40%)	14 (35%)	10 (25%)

SOURCE: Abt Associates analysis of IWISH program data in PHL, IWISH staffing data from implementation team monthly reports, and responses of interviews with IWISH staff in 2019 and 2020, and analysis of monthly implementation team reports.

Forty percent of properties (16) were rated as having high enrollment rates, 35 percent (14) were rated as medium, and 25 percent (10) were rated as low. Of the 10 properties with low enrollment rates, 3 had enrollment rates of less than 50 percent. Two of those properties had vacancies in both the Resident Wellness Director and Wellness Nurse positions.

3.5 IWISH Resident Engagement Compared with Active Control Properties

The study team compared enrollment and participation in IWISH to the level of engagement in service coordination activities in the active control properties.

Measuring resident enrollment and engagement in service coordination activities in the active control properties was more complicated than in the treatment properties. Although it varied by property, residents did not typically need to formally enroll in service coordination programs to take advantage of any programs and services that the coordinator helped make available to residents. In properties where health and wellness assessments were conducted, residents may have been required to complete a release-of-information form that dictated how their data would be shared and with whom. In addition, service coordinators may not always have kept records of whom they assisted or who attended their programs. Service coordinators at several control properties simply reported that they worked with all the residents at the property. Even if they may not have been assisting a resident one day, they may have been serving that resident the next day.

To compare resident engagement in active control properties with enrollment and participation in IWISH properties, we asked service coordinators to approximate the percentage or number of residents they worked with on a regular basis. The study team identified the following distinctions in resident engagement between the IWISH and active control properties:

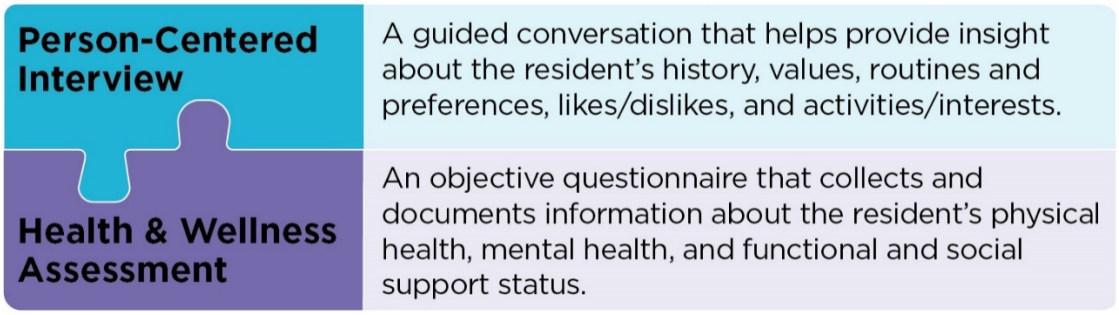
- The control properties displayed more variation in the number and proportion of residents who actively obtained services from the service coordinator. One-third of service coordinators in control properties (14/40) reported that 80 percent or more of residents regularly participated in services or programs. At one-fourth (10/40) of active control properties, service coordinators reported meeting with fewer than 40 percent of residents at their property. By comparison, no IWISH properties had enrollment rates of less than 60 percent.
- Interviews with service coordinators at the active control properties point to the lack of formal enrollment and engagement procedures and lack of training as some reasons that resident engagement rates may be highly variable across control properties. Although all service coordinators said that their services were available to all residents who requested them, the level to which they actively sought out residents differed, and most service coordinators did not have a formal process for engaging residents in service coordination activities.
- The training and support provided to staff on engaging residents in the active control properties were also highly variable and dependent on both the resources of the properties' ownership entities and how proactive individual service coordinators were in seeking out training resources. We learned from interviews with a sample of property owners in both the IWISH and active control groups that training and support made available by the owner organization were the same for service coordinators in the active control properties as they were for IWISH Resident Wellness Directors.

4 Resident Participation in Interviews, Assessments, and Goal Setting

A core IWISH component is a resident assessment process to help staff identify resident needs and to determine where to target supportive services. IWISH staff used information collected about residents to help those residents identify and meet individual health and wellness goals and to develop programs and partnerships that promote well-being among all residents who live at the property.

After residents enrolled, they were asked to participate in a two-part assessment process that included a person-centered interview and a health and wellness assessment (exhibit 4-1). The intent of the IWISH model was that Resident Wellness Directors and Wellness Nurses use the interview and assessment data to work with residents to set personal health and wellness goals and develop a plan for achieving those goals.

Exhibit 4-1. Components of Resident Assessment Process



Source: Abt Associates adaptation from the *IWISH Operations Manual* (February 6, 2019)

This section describes resident participation and IWISH staff experiences with these activities on the basis of IWISH program data and interviews conducted with Resident Wellness Directors and Wellness Nurses at the 40 IWISH properties and active control properties.

Key Findings on Interviews, Assessments, and Goal Setting

- IWISH staff were successful in completing the two-part assessment process with most IWISH participants. By March 2020, some 96 percent of IWISH participants had participated in a person-centered interview, and 89 percent had completed their health and wellness assessments.
- Fewer participants set goals related to health and wellness than completed the assessment process or participated in the person-centered interview. As of March 2020, just 61 percent of residents enrolled in IWISH had one or more goals recorded.
- Although staff appreciated the benefits of a centralized system for resident health and wellness data, they reported technical challenges using PHL, the specific system selected for the Supportive Services Demonstration.
- Resident participation in assessments and goal setting in the active control properties was similar to that in IWISH properties. Service coordinators conducted resident assessments at three-fourths of the active control properties and helped residents develop IHAPs at slightly more than one-half. The assessment tools in the active control properties typically included health and wellness assessment questions and tools similar to those in IWISH.

4.1 Using Person-Centered Interviews and Health and Wellness Assessments to Help Understand Assistance Needs

The person-centered interview was a conversation between the Resident Wellness Director and the resident, guided by a series of predetermined questions. The interview provided IWISH staff insight into the resident's history, values, routines and preferences, likes and dislikes, and activities and interests. It was intended to provide IWISH staff with insight into what was important to residents and what motivated them. IWISH staff used that information to help understand what assistance residents needed.

The person-centered interview had four domains of questions:

1. Background and life history.
2. What a typical day is like for the resident.
3. Relationships and social support.
4. Impact of health on function for daily life.

The health and wellness assessment was a structured survey to collect information on a resident's self-reported physical health, mental health, and functional and social support status and identify supportive service needs and gaps in health care. The assessment also included screening tools that tested residents' cognitive ability, memory, and fall risk. The First Interim Report's appendix A provides a copy of the health and wellness assessment.

4.2 Completing Interviews and Assessments with IWISH Participants

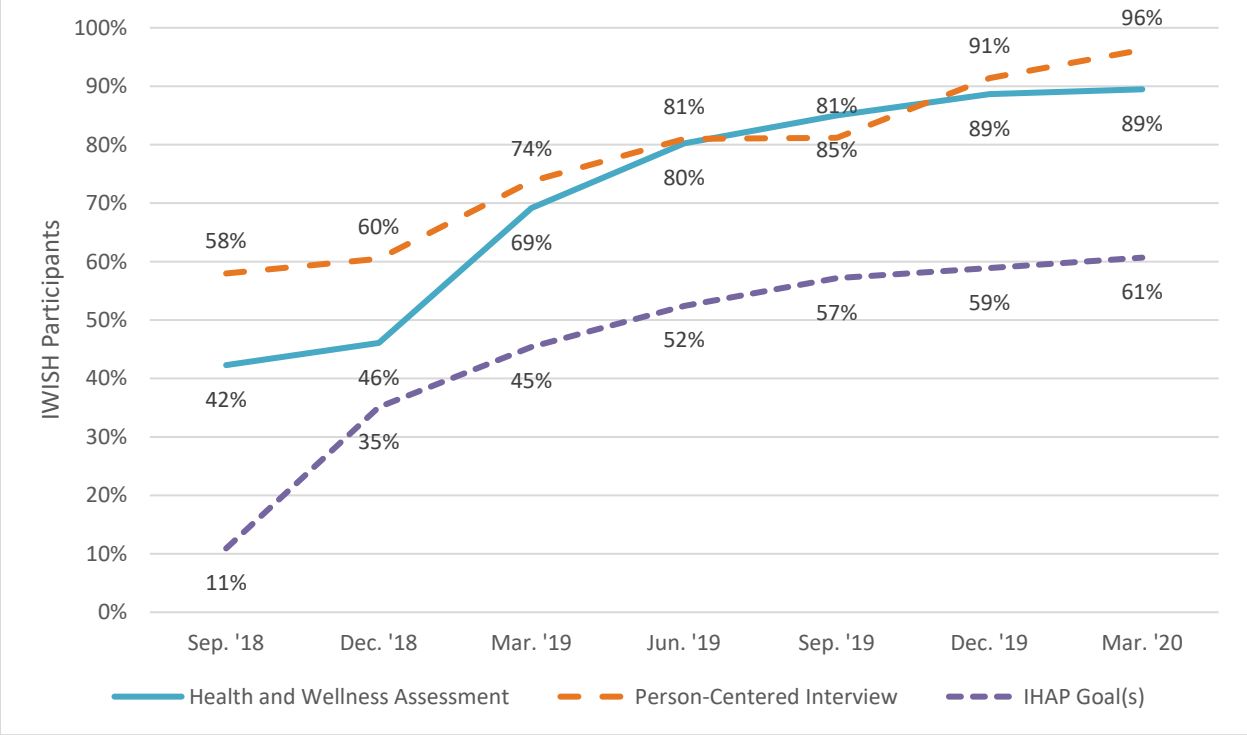
HUD's implementation team strongly encouraged IWISH staff to complete both the person-centered interview and the health and wellness assessment with all residents enrolled in IWISH. The implementation team provided training and technical assistance on how to conduct interviews and assessments in the months leading up to the start of enrollment in March 2018, as documented in the First Interim Report. However, as with all aspects of IWISH, participation was optional for enrolled residents. Residents could refuse to participate in either discussion or skip particular questions and components of the assessment.

> *After we use the assessment, I have a very good picture of what's going on with the resident. It's not just the assessment but all of the conversation and followup that comes along with the assessment questions. You get a good background on what is happening concerning the resident's health, family system, and all of their life. I get a better understanding of where I can tailor what they want to get out of working with the nurse. This helps all of us to plan and figure out what we want in terms of programming and what would benefit residents. We start to see trends across residents.*
> *—Wellness Nurse*

The Resident Wellness Director and the Wellness Nurse each typically complete portions of the IWISH health and wellness assessment, with the Wellness Nurse focusing on the health-oriented elements.

Exhibit 4-2 shows the percentage of IWISH participants who participated in person-centered interviews and health and wellness assessments over time. The chart begins with September 2018, about 6 months after enrollment began. Within the first 6 months of enrollment, 58 percent of IWISH participants had taken part in a person-centered interview. That percentage steadily increased over time.

Exhibit 4-2. Share of IWISH Participants with Person-Centered Interview, Health and Wellness Assessment, or Individual Healthy Aging Plan (IHAP) Goal Recorded, September 2018–March 2020



IHAP = Individual Healthy Aging Plan.
Notes: *N* = 2,927 IWISH Participants.
Source: Abt Associates analysis of IWISH quarterly management of information technology reports created by the implementation team using PHL data

Most IWISH Participants Took Part in the Person-Centered Interviews and Health and Wellness Assessments

By March 2020, some 96 percent of IWISH participants had participated in a person-centered interview and 89 percent in a health and wellness assessment. Most person-centered interviews and health and wellness assessments took place within the first 30 days of enrollment, so completion of the interviews and assessments roughly tracks with enrollment. Six months after the start of enrollment, only 42 percent of IWISH participants had received a health and wellness assessment, but that proportion had increased to 80 percent by June 2019, when enrollment was largely completed, and ultimately reached 89 percent in March 2020. The increases in completion rate after June 2019 suggest that staff continued to work on those activities with existing and new residents.

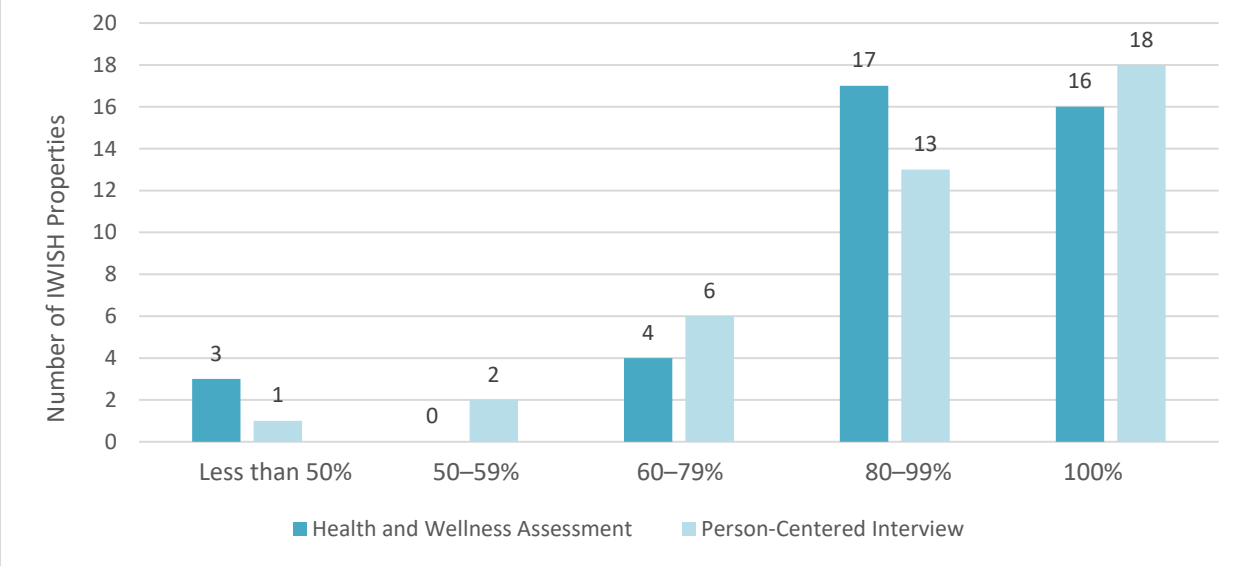
The IWISH model calls for annual reassessments of participants. PHL data suggest that as of March 2020, about one-third (36 percent) of IWISH participants had met with the Resident Wellness Director or the Wellness Nurse for a reassessment, based on an analysis of recorded reasons for resident visits with staff.

Resident Participation in the Assessment Varied Among IWISH Properties

Participation in the IWISH assessment process varied somewhat across the 40 treatment properties. As shown in exhibit 4-3, most properties had conducted assessments with at least 80 percent of IWISH participants as of March 2020, including a substantial share that had conducted those activities with all their participants. However, a handful of properties completed those activities with a smaller share of

IWISH participants, including three properties where less than 50 percent of participants had a health and wellness assessment. All three of those properties experienced turnover in the Wellness Nurse position.

Exhibit 4-3. Distribution of IWISH Properties by Percentage of IWISH Participants with a Person-Centered Interview or Health and Wellness Assessment



Note: *N* = 40 IWISH properties.
Source: Abt Associates analysis of IWISH quarterly management of information technology reports created by the implementation team using PHL data

IWISH Staff Considered Assessments and Interviews Important and Split Primary Responsibilities

In most instances, Resident Wellness Directors focused on completing the person-centered interviews, and Wellness Nurses focused on administering the health and wellness assessments. Resident Wellness Directors solely conducted the person-centered interviews most of the time. In a few instances, Wellness Nurses participated in the interviews or conducted the interviews alone. IWISH staff attribute that variation to language barriers, staff vacancies, or IWISH staff availability.

By contrast, Wellness Nurses were primarily responsible for conducting the health and wellness assessments. In some cases, Resident Wellness Directors helped collect some nonmedical portions of the assessment, such as basic demographics, insurance information, and emergency contact information. The division of responsibilities often was attributed to the limited time Wellness Nurses were on site because of their part-time schedule and the length of the assessment.

IWISH staff reported large variations in how long the interviews and assessments took to complete. Person-centered interviews often took less time than health and wellness assessments; however, some IWISH staff noted that some residents liked to talk at length about their lives and that interviews could take anywhere from 15 minutes to 3 hours. Assessments often took about 90 minutes, but a few IWISH staff noted that they could also take as long as 3 hours.

IWISH staff also reported updating the assessments—or planning to update the assessments—on an annual basis. Through March 2020, program data show that one-third of IWISH participants met with IWISH staff to update their health and wellness assessments.

Staff Believed that Interviews and Assessments Benefited Residents

IWISH staff reported that they found the person-centered interview helpful. Most said that the interviews gave them an opportunity to understand a resident as a person and sometimes helped them see the resident more empathetically. Some IWISH staff also noted that interviewing helped them build trust with the residents. Others said that the interviews helped them personalize care for the resident and informed programming and resource needs as a whole for the property.

> *The interviews are useful in understanding why a resident may or not do something. The IWISH staff understand the resident's childhood, which speaks volumes. Without doing such an indepth interview, you can't know the residents or understand the services they need. This interview helps the [Resident Wellness Directors] adjust how they interact with residents and build trust. This makes the residents feel like they care. Sometimes this interview is the only time someone asks questions about who they are and their past experiences.*
> *—Resident Wellness Director*
>
> *[The health and wellness assessment] is the best tool ever because you find out [from] chronic conditions to "Do you have a podiatrist?" It also covers mental health, memory issues, if the person drinks or smokes.... I will make recommendations and appointments at the end of the assessment.*
> *—Wellness Nurse*

Most Wellness Nurses reported that the formal health and wellness assessments were an essential component of the IWISH model. They reported learning about important aspects of residents' health from conducting the assessments. Many also noted that they used the assessments as the starting point for conversations on health and wellness, goal setting, and medication self-management.

Wellness Nurses reported using information from the assessments to inform programming or to determine what resources residents needed. A few staff noted that they used information from the assessment as a reference to interact with healthcare professionals in emergency situations or with primary care physicians. A few Wellness Nurses also noted that they used the assessment as a chance to get to know the residents better and to build a rapport with them.

Common Barriers to Completing Assessments with Residents Included Privacy and Trust Concerns

Although most IWISH staff did not see major barriers to completing the interview or assessment, others described the challenges they encountered. More IWISH staff reported challenges to completing the health and wellness assessment with residents than the person-centered interview. Of those staff who described barriers, the most common reasons for both the interview and the assessment concerned privacy and trust issues.

- **Privacy.** IWISH staff reported that some residents were concerned about their privacy. About one-half of IWISH staff who mentioned privacy concerns attributed them to the residents' desire to keep aspects of their physical or mental health private because of the potential for stigma or embarrassment or because residents felt that the questions in the assessment were too personal or intrusive. Some staff reported that "people are private" without elaborating on why. Only a few IWISH staff reported that privacy concerns stemmed from resident mistrust of government entities, healthcare providers, or other institutions. Similarly, only a few IWISH staff reported that privacy concerns were the result of residents' fear of losing their public benefits or housing on the basis of information they might be asked to share.

> *Getting information from residents – sometimes they want to give you little or nothing because they are concerned about privacy in spite of all the assurances we give them. Mental health is one issue people are sensitive about.*
> *—Wellness Nurse*

- **Language barriers** were a challenge when English was not the resident's primary language and none of the IWISH staff spoke the resident's primary language.
- **Challenges with specific parts of assessments.** A few Wellness Nurses reported that some of the residents found the exercises in the assessment frustrating (e.g., drawing a clock or remembering three words) and suggested they be removed. Some Wellness Nurses stated that this section is best suited for a clinical setting, whereas others reported that it helped them see which residents were experiencing declines they otherwise would not have noticed. The conversational part of the interviews with residents sometimes brought up feelings of trauma or grief that some Resident Wellness Directors said they felt unequipped to deal with or respond to.
- **Time-consuming.** Although most staff felt that all parts of the assessment were useful, some IWISH staff said that the assessment took too long to administer and gave examples of sections that might be condensed or deleted.
  - Some residents told staff that the mini-cognitive screen repeated similar tests administered by primary care physicians.
  - Some staff thought that the medication adherence section and the depression and anxiety screen could be condensed.
  - Some staff thought that the nutrition screen could be improved to better assess residents' health risk.
  - Some staff thought that residents were not answering the questions on the substance abuse screen honestly.

To a lesser extent, IWISH staff reported issues with case management software, challenges scheduling interviews and assessments, a lack of general interest from residents, and residents' health problems—such as dementia—that prevented them from participating.

IWISH Staff Offered Tips for Conducting a Successful Resident Assessment

Some IWISH staff reported that they made the following slight modifications to the way they conducted the interview and assessments to increase the rate at which residents completed them:

- During the person-centered interview, they kept the conversation casual and avoided bringing up memories that could elicit a resident's grief, trauma, or pain.
- They focused on the resident during the interview and waited until afterwards to enter information into the case management system.
- If possible, and with the resident's permission, they conducted the assessment and interview in the resident's apartment to help the resident feel more comfortable.
- For residents who might find the assessment process too long, they broke it up into parts and conducted it over time.

4.3 Helping Residents Set Personal Health and Wellness Goals

Using the information gathered in the assessment process, Resident Wellness Directors and Wellness Nurses were expected to work with residents to set personal health and wellness goals and develop a plan for achieving those goals. In the IWISH model, the plan that residents developed to help them achieve their health and wellness goals was called the Individual Healthy Aging Plan, or IHAP. For each need or barrier the resident wanted to address, staff and the resident specified one or more goals, actions to achieve the goals, the timeline for achieving the goals, the person responsible for taking action (typically the resident), and the person who would assist (typically IWISH staff).

Residents Did Not Engage in Personal Goal Setting at the Same Rate as They Participated in Assessments

As of March 2020, some 61 percent of residents enrolled in IWISH had at least one goal recorded in the Population Health Logistics (PHL) system, many fewer than had participated in a person-centered interview (96 percent) or an assessment (89 percent). As shown in exhibit 4-1, the share of residents with at least one recorded goal increased steadily over time, with the rate of growth slowing after September 2019—about 18 months after the start of enrollment in March 2018.

Completing the IHAP typically followed and built on the person-centered interview and the health and wellness assessment. The finding that IWISH staff conducted fewer IHAP discussions with residents than interviews or assessments likely reflects that sequencing.

The most common personal goals set by IWISH participants through the goal-setting process were to—

- Increase levels of activity and exercise.
- Improve nutrition or eat healthier.
- Obtain healthcare services, social services, or public benefits.
- Increase socialization.

Dissatisfaction with the IHAP Tool and Lack of Resident Interest in Setting Goals Hampered its Use

Interviews with IWISH staff suggested that staff dissatisfaction with the IHAP tool hampered its use. IWISH staff at some properties said that formal goal setting in the IWISH model did not suit their needs for assisting the residents nor the desires of residents. Staff perceived some elements of individual goal setting or planning as beneficial, but resident concerns, the structure of the tool, and time limitations kept formal goal setting from being more widely used during the demonstration.

IWISH staff reported the following barriers to getting residents to set goals:

- **Many residents were not interested.** IWISH staff offered several hypotheses. Residents could have been disinclined to take on the IHAP because of their advanced age and wanted to simply live their lives. They might have seen no pressing need for change at that time. They might have been afraid of feeling disappointed or of letting down IWISH staff if they did not meet or continue to pursue their goals. Finally, staff reported general antagonism with some of the terms used in the IHAP such as "goal" and "barrier."
- **Although IHAP made sense as a concept, it did not function well as a tool in practice.** Some IWISH staff said that the IHAP format was rigid and confusing, its questions were redundant, and it took too long to complete. Furthermore, an important strategy for goal achievement is monitoring progress, and the required case management software lacked a system for followup reminders. The lack of a dedicated place for the IHAP in the case management system and a lack of clarity on when staff should consider a goal "complete" further limited support for the plan.

IWISH Staff Recommended Strategies for Helping Residents Set and Meet Health and Wellness Goals

IWISH staff described some successful strategies for goal setting. They reported that residents are interested in meeting objectives that matter to them, such as getting health insurance or connecting to other benefits. Those staff found that customizing their approach to the IHAP was an effective strategy. For example, staff reported better success rates when developing suggested goals on the basis of information residents shared with them in the meeting and weaving the goal setting into the conversation naturally rather than just asking the resident to set a goal and completing the IHAP form step by step. Because words such as "goal" and "barrier" did not resonate with residents, staff found that customizing their language improved results.

> *I tried to do an official IHAP for everyone when I first started in the job, but people are very much "over" the idea of setting goals for themselves. It's a pressure they don't want to have—to have to set and meet a goal. I got rid of the language of goals, and it started to work better because everyone wants to work on something. The problem is that PHL does not reflect that—you need to have specific barriers entered. So I work with everyone on "goals" but don't always enter [them] into PHL.*
> *—Resident Wellness Director*

Some properties tried to incorporate doing the IHAP into the interview or the health and wellness assessment but found it to be too much to do at one time.

4.4 Use of Case Management Software to Collect Resident Data

The demonstration required staff to collect and store resident information in the PHL online case management system. The system was adapted for the Supportive Services Demonstration and was used by all 40 properties to track residents' health and wellness needs and engagement in the demonstration. Asked about their experiences with PHL, IWISH staff described varying experiences.

Although Staff Reported Benefits of a Centralized System, They Experienced Technical Challenges and Provided Recommendations

IWISH staff appreciate having a centralized system for confidentially storing participant data collected in the interview and the assessment, and a shared electronic system facilitates collaboration between the Resident Wellness Director and the Wellness Nurse.

> *[Data in PHL] gives the staff so much information about the person that they can follow up on....I like the resources tab, to see what resources have been used for which resident.*
> *—Resident Wellness Director*

Other staff noted technical challenges, a steep learning curve, and substantial time commitments for data entry. IWISH staff described the system as somewhat more complicated than other case management systems they had used previously or used to support non-enrolled residents of the property. Staff said that challenges using the new software could have been mitigated through continued access to the testing platform and a real-time support hotline for technical challenges.

> *PHL was more of a headache. They should have stuck with [other case management system]. People were already familiar with that, and the new documentation system wasted a lot of time and resources. Even to this day, PHL freezes up.*
>
> *—Resident Wellness Director*

A testing platform in which staff could practice with sample data was a beneficial training tool for IWISH staff who joined early in the demonstration. IWISH staff who joined later did not have access to that resource or the chance to practice entries in the system.

Technical challenges included difficulty obtaining passwords, logging into the system, and remaining logged into the system. Some of those problems were addressed by updates to the system or staff education as implementation continued. When the study team followed up with IWISH staff in the fall of 2020, several staff noted that the challenges with the software program had diminished over time.

> *In the beginning, there were challenges, but it has gotten better....Every now and then [PHL] freezes, but it has otherwise improved in this regard.*
> *—Wellness Nurse*

IWISH staff reported frustration in not being able to run their own reports in PHL. Accessing information through a reporting function on a regular basis would have allowed IWISH staff a more comprehensive view of resident needs and health conditions. One Resident Wellness Director reported being "blind" to the information placed in the system. Several staff elaborated on how they would make use of the PHL data if they had access to a reporting function. One Wellness Nurse said they would run a report to keep track of when it was time to re-engage and reassess each resident. Another Wellness Nurse would have liked to generate a report on the health conditions of residents to help her organize programming rather than keep informal lists of "who has what ailments." Several noted that running a report or receiving a pop-up notification in PHL would have been helpful for keeping track of next steps on resident IHAPs.

> *HUD pulled information from PHL and gave it to us. It would be nice if we could access that information and pull reports ourselves. With PHL, you cannot run reports.*
> *—Resident Wellness Director*

Staff also reported the loss of previously entered resident information. To address that issue, several IWISH staff maintained paper records of the information entered into PHL at a later time. That workaround of dual documentation was noted as time consuming, reducing the time staff could have spent providing direct service to residents. Staff at a few IWISH properties reported documenting in both PHL and another data system as a "failsafe" in case PHL deleted information.

> *The PHL software needs to be more user friendly. The system erases the information being entered too quickly, resulting in frustration for IWISH staff.*
> *—Wellness Nurse*

To address some of the barriers they faced in working with PHL, IWISH staff recommended providing IWISH staff with ongoing access to the training site and giving staff the ability to run reports from PHL that will summarize resident data for the property.

4.5 Fidelity to the Resident Assessments in the IWISH Model

A rigorous assessment process is important for uncovering residents' needs and health and wellness goals. The IWISH model process combined a standardized health and wellness assessment with a person-centered interview that built rapport and was likely to identify more concerns and goals. The IWISH model also encouraged the development of written IHAPs with concrete steps to help residents identify and meet their health and wellness goals.

Health and wellness assessments were conducted at all 40 IWISH properties, but resident participation in IWISH assessments was highly variable across properties. Most properties had high ratings in conducting person-centered interviews and health and wellness assessments, but only one-third of IWISH properties had high ratings in the development of IHAPS (exhibit 4-4). Only one property was rated low in the implementation of interviews, and three properties were rated low in assessments.

Exhibit 4-4. IWISH Assessments Fidelity Ratings for the 40 IWISH Properties

IWISH Component	Fidelity Rating Definition	Ratings of High, Medium, and Low Implementation	IWISH Properties Rated High	IWISH Properties Rated Medium	IWISH Properties Rated Low
Health and Wellness Assessments	Percent of IWISH participants with completed health and wellness assessments	**High:** ≥80% of IWISH participants completed assessments **Medium:** 50-79% of IWISH participants completed assessments **Low:** <50% of IWISH participants completed assessments	31 (78%)	4 (10%)	5 (13%)

Person-Centered Interviews	Percent of IWISH participants with completed person-centered interviews	**High:** ≥80% of IWISH participants completed interviews **Medium:** 50-79% of IWISH participants completed interviews **Low:** <50% of IWISH participants completed interviews	31 (78%)	8 (20%)	1 (3%)
Development of Individual Healthy Aging Plans	Percent of IWISH participants who developed Individual Healthy Aging Plans (IHAPs)	**High:** ≥80% of IWISH participants developed IHAPs **Medium:** 50-79% of IWISH participants developed IHAPs **Low:** <50% of IWISH participants developed IHAPs	13 (33%)	15 (38%)	12 (30%)

Source: Abt Associates analysis of IWISH program data in PHL, IWISH staffing data from implementation team monthly reports, and responses of interviews with IWISH staff in 2019 and 2020, and analysis of monthly implementation team reports.

4.6 Comparison of Assessments and Service Plans in the Active Control Properties

The study team identified a few differences between IWISH and active control properties in health and wellness assessments and goal setting.

Service coordinators at three-fourths of active control properties conducted some type of health and wellness assessment with residents, compared with all IWISH properties. One additional active control property was in the process of starting to conduct resident assessments when we interviewed staff in 2019. The data collected by service coordinators at active control properties included much of the same resident demographic and health and wellness information that was collected through the IWISH assessment tool, however, the IWISH assessment tool may have been more comprehensive and more proactive than other tools commonly used. For instance, the IWISH assessment tool encouraged staff to proactively assess needs related to mental health, food insecurity, and social isolation. Service coordinators at non-IWISH properties may have gathered that information but rarely as systematically or proactively as in IWISH.

For the properties that conducted assessments, resident participation in those assessments varied greatly in both groups. Although service coordinators who reported conducting resident assessments noted that their goal was to conduct assessments with all residents, reported participation rates among residents ranged from a low of 30 percent at one control property to a high of 100 percent at another.

Both groups reported updating wellness assessments at similar frequencies. Similar to the situation at IWISH properties, almost all the service coordinators at control properties who conducted assessments reported that they typically did so when the resident first moved into the property, with an update every year, every other year, or after a major health change or event. One factor that seemed to affect whether assessments were conducted at the active control properties was whether assessments were required or encouraged by the owner organization. Other factors included whether staff had access to case management software that included assessment questions and screening tools and the workload and schedule of the onsite services staff. The assessments in the active control properties typically included questions and tools that focused on health and wellness, similar to the IWISH assessments. About one-half of properties reported working with residents on their personal health and wellness goals but typically not through a formal process, as is intended in IWISH.

Similar to IWISH, staff at most active control properties used a centralized case management system to store resident information and service data. Service coordinators at active control properties reported updating information in the system at relatively the same frequencies and for the same reasons as the

IWISH properties: to keep track of resident interactions and service provisions and to update assessment data annually or after sentinel events.

5 Enhanced Service Coordination in IWISH

Ongoing wellness and service coordination to IWISH participants is a core IWISH component. In the IWISH model, this coordination is "enhanced" because of its distinct focus on resident health and wellness—beyond helping residents access community resources, which is what service coordinators typically do in HUD-assisted multifamily properties.

This chapter presents the extent to which IWISH staff engaged in enhanced service coordination activities with residents: assisting residents with transitioning back to their homes from a hospital, nursing home, or rehabilitation facility; providing support in cases of health emergencies or near-emergency events; assistance with medication self-management; and interaction with resident families and caregivers. This chapter is based on interviews conducted with Resident Wellness Directors, Wellness Nurses, and property managers at the 40 IWISH properties and the 40 active control properties.

Key Findings on Enhanced Service Coordination

- Staff at all IWISH properties reported providing some level of transitional care to their residents. IWISH staff at 33 IWISH properties conducted in-home visits with residents after in-patient stays. About one-half reported coordinating in-home services for residents when they returned home, and about one-half reported visiting residents during their in-patient stay.
- IWISH staff at most treatment properties reported playing a role in resident emergency events, including providing support during those that occur at the property, providing support and service coordination after an emergency event, and educating residents on how to prevent future emergency events. Staff from one-third of IWISH properties gave examples of when their support averted the unnecessary use of emergency care or services.
- Wellness Nurses at most IWISH properties helped IWISH participants manage their medications. Wellness Nurses most commonly assisted residents with their medication by directly communicating with doctors and pharmacists and by educating residents about the purpose of medication, the appropriate dosage, and potential interactions.
- In contrast to IWISH, most service coordinators in the active control properties had little involvement in helping residents self-manage their medication. IWISH staff reported greater interaction with families and caregivers on behalf of residents than did service coordinators in the active control group.

5.1 Transitional Care

Transitional care helps vulnerable residents transition back home safely after a hospital stay, nursing home stay, stay in a rehabilitation center, or emergency room visit. Transitional care provided by the IWISH team is intended to supplement the transitional care coordinated by the discharge staff of the hospital or nursing home. The IWISH model encourages staff to track and document a resident's transition, work with the resident's healthcare team, and periodically check in with and visit the resident after the return home.

Staff at All IWISH Properties Reported Providing Transitional Care to IWISH Residents

Staff at all IWISH properties reported providing transitional care to their residents. Typically, IWISH staff reviewed a resident's discharge papers or communicated directly with the resident's hospital or nursing home case manager, discharge planner, or social worker to discuss the discharge plan. The IWISH staff then helped the resident and sometimes the resident's family understand the plan, helped set up followup appointments, reviewed changes in medication with the resident, and recorded the event and discharge details in PHL. It was mainly the Wellness Nurse who took on those responsibilities.

Staff at most IWISH properties (33 of 40) reported conducting home visits with residents once they returned to the property. At 19 of those properties, the Resident Wellness Director and the Wellness Nurse visited together, at 10 properties only the Wellness Nurse visited, and at 4 properties only the Resident Wellness Director visited. IWISH staff described home visits as an opportunity to review discharge plans with the resident and ensure that the services, follow-up appointments, and medications outlined in the discharge plans were established. They also said that home visits helped them set up a follow-up schedule, with the amount of follow-up visits by IWISH staff depending on the extent of residents' needs and the level of support they would be receiving from family or other caregivers. IWISH staff said that a home visit with the resident within the first 24 to 48 hours helped ensure that the resident had the proper supports and services in place to transition back into the home setting successfully. Staff—usually the Wellness Nurse—at about one-half of IWISH properties coordinated home health care or other medical services for residents upon return to their homes. Some IWISH staff also coordinated nonmedical services, such as meal delivery or maintenance for the resident's apartment to address the cause of the sentinel event (e.g., installation of grab bars in the shower in the case of a fall). Coordination of nonmedical services was largely done by the Resident Wellness Director.

> *We had someone who fell down here in a snowstorm and broke his ankle. Residents told me about it, and I knew about it, and I got him home health care. In the old days, he would have just been sitting in the apartment. We are also getting him chore assistance. Anytime that happens to someone, we offer chore assistance and home health care.*
> *—Resident Wellness Director*

Staff at about one-half of IWISH properties reported visiting the resident in the hospital or nursing home. The staff at those properties described such visits as an opportunity to introduce themselves to the resident's doctor or hospital case manager. In that conversation, IWISH staff could inform the healthcare team of the resident's housing setting and understand the plan for the resident to return to the property.

Barriers to Providing Transitional Care Included Difficulty with Information Sharing and Lack of an Efficient Notification System for Resident Sentinel Events

Some IWISH staff reported wanting to assist residents transitioning back from a hospital or nursing home, but they reported challenges associated with HIPAA protections on sharing information when working with residents' healthcare providers or discharge planners. Even when residents signed a release of information, hospital staff could be hard to reach and might not understand the role of the IWISH staff.

IWISH staff also reported the lack of an efficient notification system for a fall or other sentinel event. If an event happened outside the Resident Wellness Director's and Wellness Nurse's working hours, they might only hear about it from other residents, the resident's family, or maintenance or front desk staff. Some properties had 24-hour staff coverage, which enables more consistent reporting of such events. When IWISH staff joined the property, they were integrated into the notification chain and could therefore offer to provide follow-up care and resources to the affected resident.

> *If we don't know, we can't help. If we know, we can follow up with service and keep them on track with a plan of care.*
> *—Wellness Nurse*

IWISH staff often fill a gap in care between a resident's hospital stay and their follow-up services. The support provided by IWISH staff is particularly important for residents without involved or nearby family. Several IWISH staff described residents who returned from a hospital stay and were too overwhelmed, confused, or weak to coordinate their own home health services or manage medications. In a few cases, the transitional care provided by IWISH staff identified a medication error or a change in a

resident's health status. IWISH staff helped to address such issues and, in doing so, may have prevented potentially fatal health conditions.

5.2 Assistance with Health Emergencies

Two hypothesized outcomes of the IWISH model are reduced incidence of unplanned hospitalizations and emergency room visits and increased use of primary and other nonemergency sources of care. How IWISH staff handle potential emergency events and proactively address health concerns can support or impede those outcomes. Interviews with Resident Wellness Directors and Wellness Nurses suggest that IWISH staff took an active role in assisting residents during health emergencies.

IWISH Staff Assisted Residents in a Variety of Ways During Healthcare Emergencies

Residents might seek emergency care for a wide array of reasons, from a fall or serious injury to elevated blood pressure or generally feeling unwell. IWISH staff at 38 of the 40 treatment properties (95 percent) reported assisting residents during healthcare emergencies. That assistance included providing support during emergency events that occurred at the property, providing support after an emergency event, and educating residents on how to prevent future emergency events or promote earlier identification of disease.

If 911 was called, IWISH staff often waited with the resident until the ambulance arrived. During that time, their presence could comfort the resident and keep the resident calm. Some staff are CPR certified and could be allowed to respond in the event of an emergency, in accordance with property-specific emergency protocols. Staff said that it was easier to support residents in emergencies when the residents were enrolled in IWISH and had consented to sharing their health information. IWISH staff could then share that information with the emergency response team.

IWISH Staff Reported That Preventive Measures by the Wellness Nurse Helped Avert Unnecessary Emergency Care

Staff from one-third of IWISH properties gave examples of when they believed their support averted the unnecessary use of emergency services. In those cases, the resident was prepared to go to the emergency room, but the Wellness Nurse was able to assess the resident and provide information on an alternative, nonemergency source of care that was more appropriate. Staff also described some residents as frequent emergency care users and said they learned to seek more appropriate avenues of care with the help of IWISH staff.

- During a regular visit, the Wellness Nurse determined that a resident's blood pressure was very low. The nurse gave the resident's daughter a detailed account of her mother's symptoms, and the daughter made her mother an appointment with the cardiologist. Provided with such detailed information, the doctor was able to discontinue one medication and prescribe a different one.
- A resident's heart rate was low. The Wellness Nurse and the resident called the doctor together, and the doctor gave them instructions over the phone to address her condition. The resident did not need to go to the emergency room; instead, she scheduled a follow-up appointment with her doctor within a few days of the phone call.
- A resident wanted to go to the emergency room for a stubbed toe. The Wellness Nurse was able to offer patient education that convinced the resident that it was not necessary. The nurse was able to make an appointment with the resident's primary care provider the next day.
- Whenever he needed a new inhaler, a resident used to go to the emergency room because he did not want to make an appointment at his doctor's office. With information from the IWISH staff, he understood that he needed to visit his primary care provider instead.

Staff at eight IWISH properties reported that the Wellness Nurse's preventive services probably helped prevent unnecessary use of emergency care. IWISH staff reported that preventive or early intervention measures helped residents avoid future emergency care for untreated conditions. For example, one resident showed the Wellness Nurse a rash during a visit, and the Nurse recommended that the resident speak with her doctor. The next day, the resident was diagnosed with shingles. Early diagnosis and treatment of the shingles meant that her case was less severe than it might have been otherwise.

About one-fourth of IWISH staff reported trying to understand the circumstances surrounding emergency events and supporting the resident to take preventive measures. For example, IWISH staff reported assessing the environment and identifying what changes needed to be made in a resident's home to reduce the risk of falls. Other examples included reviewing a resident's medications to see whether any might predispose the resident to a fall, procuring a pendant or call button, or setting up physical therapy. IWISH staff also supported reasonable accommodation requests to property owners for safety-related modifications, such as a walk-in shower.

> *When I first got here, residents were calling EMS for everything. Now I [haven't] seen EMS in a long time. Residents will call me first before calling EMS—before they would go to the ER for anything.*
> *—Wellness Nurse*

Although staff at most IWISH properties reported assisting during emergency events, several IWISH staff said that they might not always be notified when an event occurs. IWISH staff reported instances of hearing about emergency events a day, a week, and even a month afterward. Staff found it easier to support residents in emergencies when residents were enrolled in IWISH and consented to sharing their health information because staff can then share that information with the emergency response team.

5.3 Assisting with Medication Self-Management

Under the IWISH model, Wellness Nurses are expected to help residents understand what medication they are taking and for what purpose, as well as to discuss potential side effects and interactions. Wellness Nurses might also help the resident establish systems for medication adherence, such as pill packs for each day of the week or reminder alerts to take medication. Wellness Nurses are prohibited from dispensing medications or recommending any medication to residents. A Wellness Nurse who has medication concerns is instructed to support residents in talking with their doctors. Only Wellness Nurses can support medication self-management because it requires a clinical background and medical knowledge.

Wellness Nurses Helped IWISH Participants Manage Their Medication Through Education and Communication with Healthcare Providers

Most of the Wellness Nurses reported that they engaged in medication self-management with the residents. The number of residents they assisted varied across IWISH properties. For example, one nurse reported that she helped two or three residents on a regular basis, whereas another nurse said she helped most of her IWISH participants. At least seven Wellness Nurses told the interviewer that medication self-management was one of their most impactful activities. Two said that medication self-management was especially important for residents transitioning back from a nursing home or hospital stay.

Wellness Nurses reported helping residents self-manage their medication in the following ways:

- **Communicating with primary care physicians or pharmacists about medication that residents were taking.** Residents sometimes receive prescriptions from different doctors or take many medications at the same time. Wellness Nurses reported that if they had concerns about drug interactions or residents feeling ill because of their medication, they would call the resident's doctor together with the resident or else encourage the resident to make an

appointment. Some Wellness Nurses also noted that they sometimes would call pharmacists together with residents for questions about refills or medications.

- **Educating residents about the medicines they are taking.** Several Wellness Nurses reported that the health and wellness assessment helped facilitate conversations on managing medications. Some nurses found it helpful to ask residents to bring all their medications to the assessment meeting.
- **Assisting with medication adherence.** Wellness Nurses reported that pill packs were an important tool to help residents remember to take medications at the right time and in the correct dosage. Some Wellness Nurses noted that they helped residents fill their pill packs, whereas other nurses just helped residents obtain the pill packs. A few IWISH staff worked with local pharmacy schools or other partners to provide residents with programming around medication self-management (e.g., how to dispose of medication properly, the importance of taking medicine as prescribed).

Although most of the Wellness Nurses did not report major challenges to helping residents manage their medications, a few noted that workload issues prevented them from doing more in this area**.** Because many of the Wellness Nurses were on site part time, workload was cited as the most common challenge. A couple of Wellness Nurses reported that residents' willingness to have their medications managed also plays a role. One nurse believed that other sources of similar services, such as pharmacy staff, were available and that Wellness Nurses doing more would take away from residents' independence.

When we enter medication into the PHL, I ask the resident about those medications, "What is the name of the medication that you take? Do you know the purpose of it? What is the dose?" A lot of residents do not know. And I notice that residents need help with adherence. With adherence, I can help them with the pill packs. For some residents, their usual system of medication management does not work because of their memory problems and [how] the pill packs work.
—Wellness Nurse

As I do the assessments, we talk about the areas that may be an issue. They come and give me their meds, we review them. I use it as a teaching tool itself. "These are your meds, do you know why you are on these meds?" We match them, I teach them. If they are on blood pressure medication, "Do you have heart issues? Hypertension?" If they say no but they are on those meds, we talk about it.
—Wellness Nurse

5.4 Interacting with Residents' Families and Other Caregivers

The IWISH model is intended to promote direct engagement and collaboration of IWISH staff with a resident's family and other caregivers to address issues related to the resident's health and safety. In reality, this collaboration is not always possible, and IWISH staff experiences working with families varied greatly. Some IWISH staff reported that they interacted with family frequently, and others reported that they did so only as needed. Most seemed satisfied with their level of interaction with family and other caregivers, but a sizable minority indicated that they would prefer more interaction.

IWISH Staff Faced Emotional and Structural Challenges to Interacting with Family and Caregivers

IWISH staff reported many challenges to interacting with family and other caregivers. Because IWISH operates in independent living properties, staff may not talk to family without the resident's permission unless the resident is in danger. That was the most common challenge reported. IWISH staff reported that some residents wanted their families to be involved, but others did not. Staff attributed that reluctance to residents not wanting to bother or burden their family—especially if the family lived far away.

IWISH staff also reported that some families did not want to or could not be involved with the resident's living situation or care because of their own life circumstances. A barrier reported by some staff was that most family visits occurred in the evening, after IWISH staff had left for the day, which prevented them from interacting.

> *I try to, as much as I can, work especially with the vulnerable older people. [But] I have had occasion where residents get upset that I talk to the family—but it is because the family member came to me with a question and I just recommend they talk to the doctor. It's a struggle [getting caught in the middle]. It's a goal to build a relationship with [family], too, because they are an ancillary support and they are a part of IWISH, too, in my opinion.*
> *—Resident Wellness Director*

IWISH Staff Reported Benefits of Active Engagement with Family and Caregivers

IWISH staff reported many benefits of working with residents' families and caregivers, and many staff said that they would like to do more in this area. To build trust with the family and caregivers over time is important. One Resident Wellness Director described her open-door policy with caregivers, providing them her email address so they could contact her whenever needed. Other IWISH staff said that they always made a point to introduce themselves to family when possible and to make sure they understood IWISH, the roles of the Resident Wellness Director and the Wellness Nurse, and the assistance they could provide to residents.

IWISH staff reported that family support was especially important during a resident's transitions or when a resident was declining in health and might require additional services to live independently. Family involvement helps residents stay healthy and helped IWISH staff find and access proper care for the resident when needed. IWISH staff also reported interacting with family when language barriers were present and they needed the family's help to communicate with a resident. A few IWISH staff reported that family members helped deal with issues related to residents as tenants, such as cleaning the apartment.

Although there were some instances in which families were actively involved with their loved ones and declined assistance from IWISH staff, there were more instances of residents who had no family or whose family was not available. IWISH staff reported that IWISH has been especially important for those residents.

5.5 Enhanced Service Coordination Fidelity to IWISH

The study team rated the extent to which IWISH properties engaged in enhanced service coordination activities. As shown in exhibit 5-1, most properties were rated as providing high or medium levels of assistance in areas of enhanced service coordination that are not typically part of the service coordinator's role: medication self-management, transitional care, and family and caregiver interaction.

Exhibit 5-1. IWISH Enhanced Service Coordination Fidelity Ratings for the 40 IWISH Properties

IWISH Component	Fidelity Rating Definition	Ratings of High, Medium, and Low Implementation	IWISH Properties Rated High	IWISH Properties Rated Medium	IWISH Properties Rated Low
Transitional Care	Extent to which onsite services staff provided and coordinated care for residents returning home from a hospital or nursing home stay, as reported by staff	**High:** Formal process for providing transitional care to residents and report doing so on a regular basis as requested by residents **Medium:** No formal process for providing transitional care but staff provide these services as requested by residents **Low:** No formal process for providing transitional care and staff do not provide any type of transitional care or do so rarely	20 (50%)	17 (43%)	1 (3%)
Medication Self-Management	Extent to which onsite services staff engaged in the three medication self-management services described in the *IWISH Operations Manual*	**High:** IWISH staff report doing all three activities on a regular basis. **Medium:** IWISH staff report doing one or two of these activities on a regular basis or all three activities infrequently **Low:** IWISH staff report doing one of these activities or doing any of the activities infrequently	12 (30%)	16 (40%)	7 (18%)
Family and Caregiver Interaction	Extent to which onsite services staff interacted with IWISH participants' families and caregivers to help residents obtain needed services and support	**High:** Staff often interacted with residents' families and caregivers **Medium:** Staff sometimes interacted with residents' families and caregivers **Low:** Staff rarely or never interacted with residents' families and caregivers	22 (55%)	12 (30%)	5 (13%)

Source: Abt Associates analysis of responses of interviews with IWISH staff in 2019 and 2020. Note: Due to insufficient or unclear interview data, transitional care rating was not determined for 2 properties; medication self-management rating was not determined for 5 properties; and family and caregiver interaction rating was not determined for 1 property.

Providing transitional care and support to residents when they return home from a stay in a hospital, rehabilitation facility, nursing home, or other long-term healthcare setting is a core component of the IWISH model. On the basis of information learned from interviews with staff, the study team rated the level of transitional care provided by onsite staff for all IWISH properties and rated almost all properties as having either high (20) or medium (17) levels of providing transitional care to residents.

Helping residents self-manage their medication is one of the core activities of the Wellness Nurse and a key distinction between what wellness services were available in the IWISH properties compared with the active control properties. For each of the 40 IWISH properties, we examined the extent to which onsite services staff engaged in activities that promote medication self-management among residents in any of the three medication self-management activities described in the *IWISH Operations Manual:* educating residents about what medications they are taking, helping residents reconcile their medications with their prescriptions, and helping residents establish systems to help them remember to take their medications as prescribed. We found greater variation in the level of medication self-management support than in the

other areas of enhanced service coordination we examined. We rated one-third of properties as having high levels of medication self-management assistance, 40 percent as medium, and 18 percent as low.

Although not a core component in the IWISH model, onsite services staff are expected to work as a team with residents' family and caregivers to help residents. During our interviews with staff, we asked about the frequency and circumstances of their interactions with family and caregivers and whether staff feel they are interacting with those individuals as much as they should. On the basis of their responses, we rated 22 properties as having high levels of family and caregiver interaction, 12 as medium, and 5 as low.

5.6 How Enhanced Services in IWISH Compare with Services in the Active Control Properties

The study team compared the extent to which service coordinators who work at the control group properties provided enhanced service coordination in three areas that are intended to be a focus of the IWISH model: supporting residents when they transition home from long-term healthcare facilities, helping residents self-manage the medications they take, and interacting with healthcare providers on behalf of residents.

Transitional Care

The transitional care that the service coordinators in active control properties described was similar to the transitional care provided at IWISH properties, but this type of support was provided only at some control properties. In comparison to IWISH, where staff at all properties provided some level of transitional care, service coordinators in less than one-half of the active control properties reported having a formal process for providing transitional care to residents, and another one-third reported providing this type of care but only when requested by residents. Staff at the remaining properties said they did not provide any type of transitional support to residents when they returned home from a hospital or nursing home stay.

Medication Self-Management

We found that service coordination staff at the active control properties did not engage in activities to help residents self-manage their medication at the same level as did IWISH staff. At more than one-half of the active control properties, onsite staff did not provide any assistance to residents to help them self-manage their medication. At the remaining properties, service coordinators reported supporting residents by asking about their medication as part of regular wellness assessments or by recommending that they contact their healthcare providers if they had questions about the medications they were taking.

Interaction with Families and Other Caregivers

In the IWISH model, onsite services staff are expected to work as a team with residents' family and other caregivers to help residents. We asked service coordinators at the active control properties about the frequency and circumstances of their interactions with family and other caregivers and whether they felt they were interacting with those individuals as much as they thought they should.

In general, we found that IWISH staff had higher levels of involvement with residents' family and other caregivers than did onsite staff in the active control properties. Staff at more than one-half of IWISH properties reported high rates of involvement with residents' family and caregivers compared with about one-fourth of the active control properties. Several service coordinators at properties said they would like to interact more with family and caregivers but that either time or needing to maintain resident confidentiality prevents them from doing more.

6 Health and Wellness Programming and Partnerships

In the IWISH model, onsite wellness staff are encouraged to develop health- and wellness-related programming and, specifically, to offer programs that are evidence based and address resident needs identified through the resident assessment and goal-setting processes. Evidence based means that the program has been found to be effective through rigorous evaluation. Health and wellness programming includes ongoing onsite programs on topics such as fall prevention and chronic disease management and one-time events such as a health fair or an invited speaker.

With the assistance of HUD's implementation team, IWISH staff at each property were encouraged to form partnerships with local health and social service providers to coordinate services and resources for their residents. As part of the demonstration, IWISH properties received supportive services funding to support evidence-based programming and other activities and resources that helped meet residents' health and wellness needs.

This chapter presents information on the types of health and wellness programming made available to residents at the IWISH properties and how properties used the supportive services grant funds. It also presents the perspectives of IWISH staff on which programs are most beneficial to helping older adults remain in their homes and which programs are most needed. This chapter is based on interviews conducted with Resident Wellness Directors and Wellness Nurses at IWISH properties and with service coordinators at active control properties. The chapter also uses data on programs reported to the IWISH implementation and study teams.

Key Findings on Health and Wellness Programming and Partnerships

- IWISH staff reported that exercise, health education, and fall prevention programs are most beneficial to residents' health and well-being.
- Staff at a few IWISH properties reported difficulty accessing the supportive services funding provided under the demonstration grant.
- Although staff at many properties reported relationships with social service and health agencies in their areas, IWISH staff reported challenges in trying to develop property-wide partnerships with healthcare providers.
- Service coordinators at the active control properties did not report using resident data to develop programming to the same extent as staff at IWISH properties. In addition, services programming at active control properties included fewer health and wellness programs that have been shown to be evidence based.

6.1 Using Resident Data to Develop Programming and Partnerships

IWISH staff are expected to analyze the information on residents' health and wellness collected through assessments and to use the analysis to identify and develop programming and partnerships that meet the residents' needs. As part of that process, staff are expected to create a Community Healthy Aging Plan, or CHAP, for the property that identifies the most common needs of residents and how the needs will be addressed through programs or services.

As part of the demonstration, IWISH staff were expected to develop the CHAP from community profiles that the implementation team prepared and that provided aggregate data on residents' characteristics and needs for services. The implementation team prepared those profiles after at least 50 percent of residents

enrolled in IWISH participated in the assessment process and their data were entered into PHL; therefore, IWISH properties developed their CHAPs at different times throughout the demonstration.

As of August 2019, 32 of the 40 properties had developed a CHAP and reported using it to inform or develop needed programs. Of the remaining properties, three completed a CHAP but did not report using it, and five had not yet completed a CHAP. Of the five properties, staff at three were unsure of what a CHAP was or whether the implementation team had developed the community profiles for their property. The remaining two properties did not complete resident assessments with at least 50 percent of enrolled IWISH participants and therefore did not have sufficient data to complete the CHAP.

Most IWISH Staff Used Aggregate Assessment Data to Identify Resident Needs

IWISH staff shared largely positive feedback about the CHAP, a tool they found helpful in guiding programming and partnership decisions. Resident Wellness Directors described how they used CHAP's aggregate resident data to develop programming:

> *We look at the feedback and also identify diagnoses. For example, we saw a lot of high blood pressure, so we started Tai Chi, yoga, and Zumba classes. We also saw a lot of arthritis, so we started a fall risk prevention program. We tie it all back using the CHAP.*
>
> *—Resident Wellness Director*
>
> *Usually you see anxiety and depression run pretty high in this population. We can tailor presentations and activities for residents based on their needs. For instance, art therapy for mental health. Blood pressure management and measurement classes because that was one of the top health conditions. Many members here are at risk for [poor] nutrition, so we have several programs on cooking: learn how to cook, learn how to read nutrition facts, learn how to eat healthy. Another health system came out to do a fall class. We really do use the community profile so that we can find the right programming for residents.*
>
> *—Resident Wellness Director*

IWISH Staff Desired Greater Access to Data Reporting

Several IWISH staff reported limitations in the process for developing the CHAP. During interviews with the study team, some staff reported that they were unfamiliar with the CHAP process, and others reported that they did not receive their property's community profile as early in the demonstration period as they would have liked. Several IWISH staff said they would have preferred to be able to run aggregate reports from PHL themselves at the frequencies they chose rather than having to rely on the implementation team to provide the community profiles.

6.2 Providing Evidence-Based Programming

The IWISH model emphasizes the use of evidence-based programming to meet residents' health and wellness needs. In December 2018, the implementation team provided the IWISH properties with a catalog of evidence-based programs to help IWISH staff identify evidence-based programs. The catalog defines evidence-based programs as "initiatives that have been rigorously evaluated and found effective in improving health and well-being or reducing disease, disability, or injury among older adults."[19] The catalog lists more than 30 evidence-based programs addressing chronic conditions, general health and

[19] IWISH *Evidence Based Program Catalog*, p. 1.

mental health, nutrition, physical activity, and medication management. The catalog includes guidance to help IWISH staff identify and select programs to offer. The implementation team also provided staff with training and technical assistance on how to develop programming at their property.

IWISH staff at one-half of the demonstration properties reported implementing evidence-based programming included in the catalog. Among IWISH staff we interviewed, the most common of those evidence-based programs implemented at IWISH properties were the following:

- A Matter of Balance, STEADI (Stopping Elderly Accidents, Deaths and Injuries), and other fall prevention programs.
- Diabetes Self-Management, Diabetes Empowerment Education program.
- Tai Chi for Arthritis, Qigong, Walk with Ease, and other exercise and arthritis interventions.
- Chronic Disease Self-Management (chronic disease intervention).
- Eat Better & Move More (nutrition intervention).
- PACE (All-Inclusive Care for the Elderly program).
- Clear Horizons (smoking cessation).

IWISH staff were not required to implement only the specific programming identified in the catalog. In fact, most of the programming offered to residents during the demonstration was not in this catalog. Not all cataloged programs are available near all IWISH properties, and property staff might prefer providers and programming different from what the implementation team prefers. However, many of the health and wellness programs offered to residents address the same needs that the evidence-based programs in the catalog address.

Several Health and Wellness Events were Offered Each Month

IWISH staff reported offering an average of six health and wellness events each month, including both evidence-based and non-evidence-based programs. The number of health and wellness programs and events offered at IWISH properties varied widely across properties, from a low of about 20 separate events a year to more than 200 separate events a year. A "program" is typically ongoing, with regularly scheduled meetings or classes, such as a weekly exercise class or a monthly health education presentation. An "event" takes place only once or infrequently—for example, an annual health fair. Most of the health and wellness programming reported by IWISH staff were ongoing exercise or physical fitness classes. Participation rates in individual events also varied by property, ranging from a property-wide average of 3 residents to 20 residents per event. The average participation rate across all properties was 9 residents per event. [20]

The Most Popular Programs and Events are Interactive, Social, and Personalized

Information reported by services staff indicates that most programs were attended by 10 or fewer residents for each class or event. The activities that had the largest attendance were not focused on health and wellness and included social activities that appeal to a wide audience, such as monthly resident parties, tea times, musical performances, food distributions, and gatherings for meals. Events that drew the largest number of participants often were explicitly social events, such as ice cream socials or birthday celebrations.

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[20] IWISH staff reported participation in group programming to the implementation team between January 2019 and September 2020, although not all properties reported programming for all months and not all properties chose to report group programming. This information was available for 31 of the 40 IWISH properties. As reported in appendix A, virtually all group programming was suspended beginning around March 2020 because of COVID-19 restrictions on resident gatherings.

Of health and wellness-focused events, the most widely attended events were fitness activities, cooking classes, and workshops on chronic conditions. IWISH staff were generally satisfied with the level of participation in group programming and reported that the most popular events embodied some of the following characteristics:

- Residents preferred programs that allowed them to move instead of workshops in which they sat and listened. The most popular programs at many sites were fitness classes.
- Healthy cooking or nutrition classes were very popular and were often filled to capacity. Participants sometimes received a bag of food to help replicate the recipe at home.
- Residents seemed to participate in events in larger numbers when they included personalized attention, such as blood pressure clinics, and screenings and assessments for various health issues.
- Workshops that integrated a social aspect, such as a health topic workshop with discussion and coffee, were extremely popular among residents.
- IWISH staff considered demonstrations, games, and hands-on activities a draw for residents. These types of events included brain games, art therapy, and Jeopardy.

Some staff reported a variety of challenges with participation in group programming. One issue noted by many staff was space limitations. Event capacity was sometimes capped at 20 people or fewer because of the size of a property's community space, especially for events such as cooking demonstrations or fitness classes that require more space than a seated workshop. Some IWISH staff also mentioned that it was difficult to get people to commit to events that are more than one day or required doing "homework." Other staff mentioned challenges such as resident discord, residents' preference for certain instructors, language barriers, scheduling, and residents' dislike of lectures as barriers to participation.

Individual participation in programming is not recorded in PHL, so the study team is not able to verify whether a larger group of IWISH participants took part in at least one program or whether a smaller group of IWISH participants attended many programs. Given the volume of programs offered at each property, a larger exposure to programming may have occurred than the average attendance per program might suggest. However, interviews with staff suggested that some residents engaged with multiple events, some attended select events on the basis of their health needs and interests, and some never attended any group program or event, regardless of the subject matter.

6.3 Use of Supportive Services Funding

The demonstration provided IWISH properties with grant funding to develop supportive services and programming for residents. Each IWISH property received $15 per unit per month to help meet IWISH participants' health and wellness needs and to support IWISH goals. For example, a 100-unit IWISH property would receive $18,000 per year, or $54,000 during the 3-year demonstration period.

The funds were to be used to deliver evidence-based programming and supports that could benefit multiple IWISH participants. The funds also could be used to address individual needs or provide services to individual residents—provided the funds did not duplicate resources or funds available from another program or the participant's own resources.

Staff reported that program funding enabled them to offer useful services to residents, such as fitness programs, art therapy, gardening, and nutrition workshops. IWISH staff reported using their services funds to support program fees and materials and the equipment (e.g., exercise machines, blood pressure monitors, pedometers) needed to deliver the programming.

A few staff also reported using the funds to lease space to hold events and to pay for transportation for residents to attend programs at locations outside the property. Staff at two properties discussed using the funds to train Resident Wellness Directors to provide a health and wellness program themselves after the

demonstration ended and IWISH funds were no longer available. IWISH staff reported that the amount of funding through the grant was generally considered adequate for the demonstration period.

IWISH Supportive Services Funding Could Be Challenging to Use

Some IWISH and property management staff reported challenges in trying to use the supportive services funding. Some staff described a lack of clarity on program rules—coupled with restrictions on how the funding could be used—as barriers to accessing all their awarded services funding. Staff also had some misconceptions regarding funding rules. For example, some staff mistakenly thought that the funding would cover only evidence-based programs. At many properties, IWISH staff were unfamiliar with how the supportive services funds were allocated at their properties because funding decisions were made by the owner or property management organization.

Differences between types of multifamily properties in the way HUD provided supportive services funds added to staff confusion. Project Rental Assistance Contract (PRAC) properties received services funding in increments throughout the demonstration, whereas other types of properties received services funding as one lump sum at the start of the demonstration. In addition, some properties already had access to existing per-unit supportive services funds from HUD, and those properties did not receive additional funding under the demonstration.

One Resident Wellness Director reported that the way the grant funds were released to their property as reimbursable costs prevented them from using all their allocated funds during the demonstration:

> *IWISH staff aren't able to access the funds. The funds are complicated to use: the building has been told they should buy things out of their own funds, to then be reimbursed. However, the building doesn't have the budget to front these expenses, so these funds are tied up.*
>
> *—Resident Wellness Director*

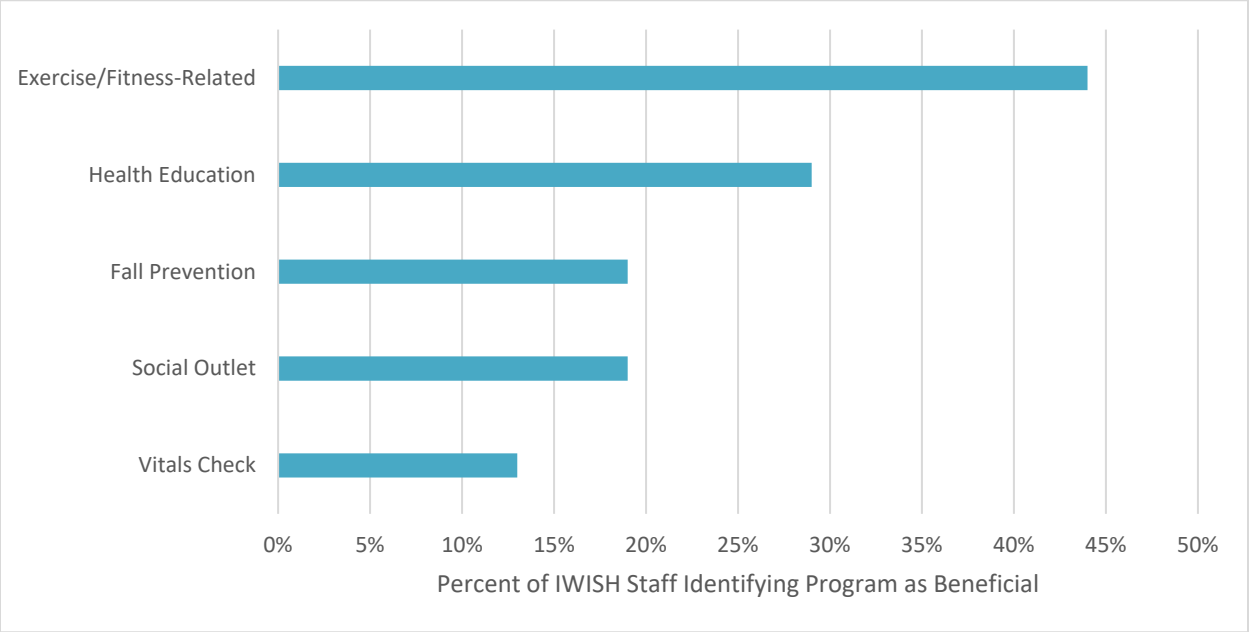
Several IWISH staff reported wanting to use the funds for activities that were not allowable grant expenses. IWISH grant funds cannot be used for social activities or outings or for food at programs and events, both of which are big draws for residents. In addition, staff believe that both social activities and food can help to alleviate residents' feelings of isolation and depression. One Wellness Nurse noted—

> *There are some activities residents would like that aren't covered, like music or bringing in a local band. Social isolation and depression are a big deal, and IWISH funds don't cover them adequately.*
>
> *—Wellness Nurse*

IWISH Staff Reported That Exercise, Health Education, and Fall Prevention Programming Had the Most Impact on Residents' Health and Well-Being

The evaluation team asked Resident Wellness Directors and Wellness Nurses about their perceptions of the programming and partnerships at their properties. Exhibit 6-1 shows the programs that staff saw as having the most impact on residents' ability to age safely and successfully in place.

Exhibit 6-1. Most Beneficial IWISH Programs According to Staff



Notes: Percentages sum to greater than 100 percent. Up to the first two programs cited by a respondent are counted.
Source: Abt Associates analysis of responses of interviews conducted with Resident Wellness Directors and Wellness Nurses in 2019 and 2020

Exercise and fitness-related activities were by far the most cited programs (44 percent). Because fitness classes are also social activities, IWISH staff said they supported residents' mental and physical health. The second most common category of programming mentioned was health education on topics such as chronic disease management. Fall prevention programs, along with any sort of program that also allowed for some social interaction (such as a healthy cooking workshop), were the next most common category, followed by vitals monitoring (such as blood pressure).

IWISH Staff Would Have Liked to Offer More Mental Health Supports and Transportation Services

We asked IWISH staff whether there were any types of partnerships or programs they wished to have but had not been able to implement at their property for any reason. In addition to social activities and refreshments, the most common responses were the following:

- Support for grief or depression.
- Mental health resources.
- Transportation to grocery shopping, pharmacy trips, and other errands.

Aside from transportation, IWISH staff did not report that the cost of programming prohibited them from offering a particular program or resource to residents. More commonly, staff had challenges finding a qualified service provider in their area.

6.4 Partnerships

Developing partnerships with healthcare facilities, primary care providers, local agencies serving seniors, and community agencies is an important part of the IWISH model. The goal is for these IWISH partnerships related to health and wellness to add to the resource and referral partnerships typical of traditional service coordination. The IWISH model encouraged properties to enter into formal partnership agreements to strategize on how best to serve residents with agencies such as Area Agencies on Aging, mental health agencies, home health agencies, and other agencies that serve the resident population. The model design anticipated that those entities might meet monthly to coordinate services and support to residents. Properties were also encouraged to develop partnerships with healthcare facilities (e.g., hospitals, nursing homes, and rehabilitation facilities). Facility-based partnerships were intended to enable the facility and the IWISH property to work together to assist participants—from admission to the facility to discharge back to the property. Those partners might also work on developing new and mutually beneficial policies, such as establishing data sharing agreements between hospital discharge teams and Wellness Nurses.

I pray that IWISH stays here and in the other senior buildings. This is the best program they could come up with as far as seniors.

Before, a lot of seniors didn't come out unless it was check day, food stamp day, or grocery shopping. But now that [the] Wellness Nurse is here and there are activities, you see them more. They come out of their apartment now. Especially at lunch time (the Salvation Army brings hot lunch twice a week), they get together and socialize.

I think the most beneficial programs to residents are all of them. More people come out for lunch, for Zumba, and eye examinations and hearing aids, lawyers, and so on. People come out more since IWISH.
— Property Manager

IWISH Staff Reported Challenges in Developing Partnerships with Healthcare Providers Because of Scale and Lack of Interest from Healthcare Providers

According to IWISH staff, challenges in developing partnerships with healthcare facilities were largely associated with issues of scale. First, it was not feasible for IWISH staff to establish relationships with the large number of doctors and hospitals visited by residents at their property. That was especially the case for larger properties and in larger metropolitan areas. Second, hospitals and facilities did not express interest and did not have the time to develop a partnership with the IWISH property (or any individual property). Further, the bureaucratic requirements triggered by putting anything in writing, which may require review by the hospital's legal department, can be an appreciable barrier to establishing partnerships with care facilities.

Regarding efforts to establish relationships with hospitals and nursing home facilities in the community, one Resident Wellness Director said—

> *It doesn't work. The departments are so compartmentalized, and there needs to be high-level agreements put in place, otherwise it is person to person. IWISH staff can't communicate with CEOs of these hospitals.… There are 200 clients in this building, there are so many doctors that people are working with. There isn't one particular doctor or group of doctors. Everyone goes to different doctors. Physically impossible to form all those partnerships.*
>
> *—Resident Wellness Director*

Most IWISH staff were aware of the training materials developed by the implementation team to assist them with partnership development, but most either had not read the materials or did not find them

particularly useful. Several IWISH staff did not think it was appropriate for them to conduct conversations to facilitate a partnership with an entire healthcare facility or organization or did not feel well equipped to manage that type of conversation. Two interviewees suggested that having an IWISH administrator or a higher level HUD representative develop and broker relationships would have been helpful.

IWISH Staff Found Greater Success Developing Relationships with Individual Healthcare Providers

IWISH staff found building informal relationships with individual providers or staff members easier than attempting to develop a formal partnership with an entire organization or healthcare system. IWISH staff, particularly Wellness Nurses, worked with primary care and sometimes specialty providers on behalf of IWISH participants to coordinate care, schedule appointments, and clarify questions. Nurses sometimes helped residents prepare for office visits with their physician by providing a list of questions for the resident to ask, a summary of recent blood pressure readings, or other information. In addition, nurses sometimes attended office visits with the IWISH participant to help interpret issues for residents and to build a relationship with the provider. Some properties also had a visiting physician or medical group who offered in-home services to residents.

Other Health and Wellness Partnerships

IWISH staff also successfully expanded their resource and referral networks to include new partners who could deliver health and wellness offerings at the property and help support residents' ability to successfully age in place. The following are several examples of new partnerships brokered during the demonstration.

- Two IWISH properties formally partnered with a private company to provide wellness programs using their supportive services grant funds. They selected this company because it offered a wide selection of evidence-based programs, as recommended by the IWISH model. Each program lasted approximately 4 to 8 weeks and covered topics such as the following:
    - "Brain fitness" classes to improve focus, function, creativity, and mental clarity.
    - Walking programs, which included a fall risk assessment.
    - Chronic disease self-management courses, such as diabetes management and prevention.
- IWISH staff at one property formally partnered with a local hospital to deliver evidence-based programming and education once a week at no cost to the property. During the partnership, the hospital provided programs such as A Matter of Balance, tai chi, and classes on cooking safety.
- IWISH staff at another property partnered with a local university's nursing school to provide programming and services to the property's residents. Students from both the undergraduate and graduate nursing degree programs visited the property once per week for approximately 10 weeks each semester. They offered weekly workshops covering wellness topics such as fall prevention and medication management. In addition, the student nurses assessed residents and provided IWISH staff with their notes at the end of their weekly visits. The IWISH staff used those notes and conversations with the student nurses to help address residents' health and wellness needs. IWISH staff report that the student nurses often spoke a variety of languages and were able to develop strong relationships with residents who came from different ethnic backgrounds.

6.5 Programs and Partnerships' Fidelity to the IWISH Model

Properties need strong partnerships with health and social service providers in the community to give residents access to the services they need and to provide effective support during transitions from hospitals and other inpatient facilities. The study team examined the extent to which properties used data to develop programming through the development of a CHAP, whether they made evidence-based health and wellness programming available to residents during the demonstration period, and whether they

developed partnerships with healthcare providers to jointly assist their residents. Exhibit 6-2 shows the fidelity ratings categorized into high, medium, and low levels of fidelity.

Exhibit 6-2. IWISH Programs and Partnerships Fidelity Ratings for the 40 IWISH Properties

IWISH Component	Fidelity Rating Definition	Ratings of High, Medium, and Low Implementation	IWISH Properties Rated High	IWISH Properties Rated Medium	IWISH Properties Rated Low
Community Healthy Aging Plan	Completion of the Community Healthy Aging Plan (CHAP) based on identified needs of residents	**High:** Completed a CHAP and reported using the CHAP to identify needed programming **Medium:** Completed a CHAP but did not use the CHAP to identify needed programming **Low:** Did not complete a CHAP	32 (80%)	3 (8%)	5 (13%)
Evidence-Based Programming	Availability of evidence-based group programming recommended by the IWISH model and included in the IWISH *Evidence-Based Catalog*	**High:** Made available evidence-based programs included in the IWISH *Evidence-Based Catalog* and that meet identified needs of residents **Medium:** Made available health and wellness programs that meet identified needs of residents but were not included in the IWISH *Evidence-Based Catalog* **Low:** Did not make available any health and wellness group programming	20 (50%)	20 (50%)	0 (0%)
Healthcare Provider Partnerships	Extent to which site staff developed property-wide partnerships with healthcare providers or interacted with providers on behalf of individual residents.	**High:** Staff developed property-wide partnership and individual interactions on behalf of individual residents **Medium:** No property-wide partnerships, but staff interacted with healthcare providers on behalf of individual residents **Low:** Staff did not interact with providers	0 (0%)	40 (100%)	0 (0%)

Source: Abt Associates analysis of responses of interviews with IWISH staff in 2019 and 2020, and programming data collected from IWISH properties.

Most (32) IWISH properties had completed a CHAP as of August 2019 and reported using aggregated resident assessment data to identify and develop health and wellness programming; those properties were rated as high in developing a CHAP. Three properties reported completing a CHAP but not using it to inform programming; those properties were rated as medium. Five properties reported not having completed a CHAP and were rated as low.

One-half of properties were rated as high in evidence-based programming for offering at least one program identified in the catalog of evidence-based programming recommended by the implementation team. The other half of properties implemented health and wellness programming that focused on many of the same goals as the evidence-based programs but that were not identified in the catalog of recommended programs; these properties were rated as medium in evidence-based programming. Within those categories, IWISH properties varied widely in the average resident participation in group

programming and in the number of health and wellness programs and individual events offered during the demonstration, both evidence-based and non-evidence-based. As part of the impact analysis, the study team will analyze the extent to which the number of programs and average participation affect healthcare use and tenancy outcomes.

No properties were able to develop partnerships with healthcare providers to mutually assist residents, therefore no properties were rated as high in this category. Instead, all were rated as medium because all properties reported interacting with healthcare providers on behalf of individual residents. Those interactions were most common when providing transitional care to residents or assisting residents with their medication.

6.6 Programs and Partnerships in IWISH Compared with Active Control Properties

The study team also examined the extent to which service coordinators who worked at the control group properties used data to develop programming and the extent to which their programming placed a focus on health and wellness. The study team found the following similarities and differences between programming made available in active control properties and in IWISH properties:

- **Service coordinators at most active control properties did not develop formal community services plans.** Service coordinators at two-thirds of the active control properties reported that they did not develop any property-wide services plans for their residents, in contrast to the three-fourths of the IWISH properties that developed a CHAP. Staff at the remaining third of active control properties reported that they had not developed property-wide services plans or were in the planning stages of developing such plans at the time the evaluation team interviewed them in the fall of 2019. Although few service coordinators reported using a formal process to do so, almost all reported that, to help determine what programming to offer at the property, they used some type of resident data, such as those collected through annual resident surveys.
- **IWISH properties implemented more evidence-based programs, although active control properties were increasingly making those programs available.** We learned from interviews with representatives of owner organizations of properties in both the IWISH and the active control groups that some organizations had been making health and wellness programming available in all of their properties for older adults in recent years. In addition, although programs offered in active control programs may not have been the specific ones recommended in the IWISH model, many of them focused on the same health and wellness goals
- **IWISH properties reported more visiting healthcare providers.** Sixty percent of IWISH properties reported a healthcare provider visiting the property to provide services to residents on a regular basis, compared with one-third of active control properties. The specific types of healthcare providers and the frequencies of visits in the IWISH properties were not meaningfully different from those in the active control properties. Two active control properties were colocated with healthcare service providers because they rented space in the same location; however, eligibility for those services was no different among control property residents than for the general public.
- **Service coordinators at one-half of the active control properties said that they engaged with local healthcare providers in some way,** most commonly through the development of onsite services or through interactions on behalf of individual residents. Service coordinators at about one-third of properties said that they only interacted with healthcare providers on behalf of residents on an as-needed basis when specifically requested by residents. Service coordinators at seven properties said they had never had interactions with healthcare providers for any reason. By comparison, IWISH staff at all properties reported that they tried to engage with healthcare providers even if they were not always successful in their efforts.

7 Resident and Staff Perceptions of IWISH

The IWISH model was designed to positively affect residents' health and well-being and to improve their ability to remain in their homes as they age. The third and final report of this evaluation will compare HUD-assisted residents at IWISH properties with control group residents in terms of unplanned hospitalizations and use of other types of acute care, use of primary and nonacute care, and ability to stay in their homes longer.

During our interviews with IWISH staff, we asked Resident Wellness Directors and Wellness Nurses to identify what they thought were the most impactful aspects of IWISH. We also conducted focus groups with enrolled residents at 11 IWISH properties to hear about any changes they perceived in their health and well-being and changes to their satisfaction with housing and services resulting from their IWISH participation. The information in this chapter is based on those interviews and conversations.

Key Resident and Staff Perceptions of IWISH

- Staff at more than three-fourths of IWISH properties said that the presence of an onsite Wellness Nurse was one of the features of IWISH that had the most impact on residents' health and well being. The second most commonly cited feature was the programming available as a result of the supportive services funds.
- Staff perceived that the IWISH model reduced unplanned hospitalizations and increased the use of preventive and nonacute care by residents.
- Residents said that IWISH contributed to improvements in their health and overall well-being. Residents reported feeling that they had more control over their health in terms of both chronic and acute needs. They also said that they felt more secure and safe, emotionally supported, more positive, and more prepared to advocate for themselves.
- Residents attributed positive improvements in their health and well-being to IWISH staff and programming. They appreciated the counseling of the Resident Wellness Director and having the Wellness Nurse as a medical professional and designated point of contact for health and wellness at the property. They described how programming provided an opportunity for social interaction as well as education.

7.1 Effects on Residents' Health and Well-Being: Staff Perceptions

Wellness Nurse and Health-Focused Programming Were Noted by Staff as Most Impactful

Staff at more than three-quarters of IWISH properties reported that the presence of an onsite Wellness Nurse was one of the benefits of the IWISH model that had the most impact on residents' health. IWISH staff discussed several components of the Wellness Nurse role as contributing to that impact, including the following:

- Medication self-management.
- Education about chronic conditions and chronic condition management.
- Working with doctors.
- Triaging questions from residents to identify the appropriate level of care.

IWISH staff identified onsite availability as a key beneficial feature of the Wellness Nurse. Residents with limited or no access to transportation or who had limited physical mobility were able to make full use of the Nurse's services without having to leave the property.

IWISH staff at about one-half of properties reported that the programming available as a result of IWISH was one of the most impactful program features. The educational programming that was offered helped

residents learn about their own health and better manage chronic conditions. At a couple of properties, staff specifically mentioned that CHAPs enabled them to closely tailor programs to resident needs. IWISH staff said that the programming also helped keep the residents engaged, got them out of their homes, promoted socialization, and reduced isolation. In particular, they cited the programs on health education, such as diabetes management, along with a wider range of programs that support resident wellness and socialization, from yoga and tai chi to art therapy and exercise classes.

> *The most impactful part of the IWISH program has been the opportunity to teach residents how to advocate for themselves and how to better take care of themselves, with the hope that they can stay in their homes longer.*
> *—Wellness Nurse*

Staff at several IWISH properties reported that the main source of benefit for residents was the complementary skill sets of the Wellness Nurse and the Resident Wellness Director. The background and knowledge base of the two positions allowed them to comprehensively address many aspects of residents' needs, from social to medical.

IWISH staff at several properties discussed how the program promoted residents' taking better control of their own health. The availability of one-on-one support from the IWISH staff taught residents how to better navigate the healthcare system, bring questions up with their healthcare providers, and become their own health advocates. The focus on health and well-being and the ability to age in place also motivated and empowered residents. Stated one Wellness Nurse—

> *The goal is for residents to participate in their own health as much as possible and to prevent hospitalizations and nursing home [admissions] if they do not need it. Other residents are losing weight because they know how their food choices influence their weight. And they are less depressed. All of it ties in together—the health, the psychosocial. We have empowered residents to do this. IWISH contributes to this through coaching and education provided by the Wellness Nurse. Residents also come down more because there are so many more activities, and that is so good for their mental health.*
>
> *—Wellness Nurse*

Staff at a minority of IWISH properties described the supportive services funding as particularly important in affecting residents' health and well-being. The funding allowed IWISH staff to choose what programming to bring in, whereas formerly they might have been limited to programs available at no cost to the property. The funds enabled the purchase of exercise equipment and other health equipment, such as pedometers, which helped residents exercise more often, both in group classes and on their own time. IWISH staff were also able to contract for individualized services for specific residents. For example, they used IWISH funds in several cases to hire decluttering services when issues of hoarding and unit cleanliness arose during apartment inspections.

7.2 Effects on Residents' Health and Well-Being: Resident Perceptions

In this section, we summarize perceptions of the effects of IWISH from enrolled residents and, in a few cases, their family or other caregivers at 11 IWISH properties. The relationships presented in this section are those identified by residents and should not be interpreted as causal claims by the research team.

Residents Agree That Onsite Nursing, IWISH Staff, and Programming Improve Their Sense of Well-Being

Residents reported that IWISH contributed to improvements in their health and overall well-being. Not only did residents report that they feel they have more control over their health in terms of both chronic and acute needs, but they also feel more secure and safe, emotionally supported, positive about life, and

empowered as advocates for their own health. Moreover, residents tied reported improvements in their health and well-being to specific IWISH interventions.

Participants identified six components of the Wellness Nurse role as contributing to improvements in their health and well-being:

- **Monitoring vital signs.** The Nurse's ability to monitor residents' vital signs, such as weight or blood pressure, was mentioned by several focus group participants. In one case—also described in IWISH staff interviews—a Wellness Nurse checked a resident's blood pressure, which was high, and the resident went to the hospital right away. The hospital treated the resident and then prescribed regular medication. The regular vitals checks conducted by Wellness Nurses and checks in response to ad hoc requests from residents, can help manage important indicators of health.
- **Assessing and triaging treatment.** Although the Wellness Nurses did not play a clinical role at IWISH properties, they were still able to meet with residents and assess their health status by reviewing their symptoms and checking their vital signs. One participant was grateful to have a nurse on site who could let them know if something *"looked infected or if I needed to call the doctor."* The nurse also was a knowledgeable source of guidance when residents were faced with a possible medical issue. Said one resident, "*If you are feeling some type of way and don't understand it, you can go to the IWISH people and they will help you understand. The Wellness Nurse can look at you and make a suggestion to see the [primary care physician] or a specialist."* The Wellness Nurse can check vital signs and advise proper medical treatment in real time if an abnormal result is identified.
- **Presence in emergency situations.** The Wellness Nurse was valued as an important source of support during emergency situations. At times, the nurse might identify an emergency and advise immediate treatment. Some residents recounted times when the nurse had stepped in during an emergency, one noting that "*it helps with the nurse, in case there is an emergency. She can run down to the unit before the [emergency medical technicians] get there."*
- **Coaching.** Some interviewed Wellness Nurses described their role as a "coach," and residents echoed that description in some of the focus groups. One resident described how the Wellness Nurse could "plant a seed" when a resident might be putting off or ignoring a possible health concern, encouraging them to seek an assessment or intervention. Another participant described uncontrolled blood pressure and having a habit of smoking. Regular gentle prompts from the nurse helped to keep that issue front of mind for the resident.
- **Care coordination.** Wellness Nurses also coordinated care and mediated complex discussions between residents and their various healthcare providers, as discussed at some of the focus groups. One participant stated, *"One hundred percent, they have helped with everything. My doctor sends everything to the director—my exam results, etc. I gave the authorization. She gets everything from my doctor and then she talks to me about it, tells me what doesn't look good."* Another also found the support of the Wellness Nurse invaluable in that role, describing how *"the nurse was vital in helping [her] with complicated health issues—finding doctors, coordinating paperwork, etc."* That support can reduce the friction of interactions with medical providers and reduce unnecessary visits, as reported by one resident: *"[The Wellness Nurse has] access to medical records, so they can help with things. It takes the place of having to go to the doctor all the time."*
- **Medication self-management.** Onsite support from the Wellness Nurse with medication self-management was cited at a small number of the focus groups. For one participant, that meant coordinating with medical providers to get more information, and the resident appreciated that *"[The Wellness Nurse] took the time to get notes about medication… She was very thorough and very helpful."* It could also mean routinely reviewing residents' medications: *"The new nurse*

checks my meds, and that's a big help. Sometimes I make a mistake and I don't know I'm making a mistake. But she calls the pharmacy and catches that."

Residents Reported Feeling More Secure and Safe

Residents reported that having a medical professional and a designated point of contact for health and wellness at the property was an added source of security and safety. For instance, one resident said, *"It is safer, more comfortable. There is trust. In an emergency, they are there."* Focus group participants also described the trusting relationships they had with IWISH staff, from which came peace of mind and a sense of comfort knowing that someone is there for them if they need it. Of the IWISH staff, one resident stated, *"They are family and look out for me."* Another summed a perspective: *"They are here for us, and they both helped me a lot. Before, there was no one, and now we have them."*

Residents Reported Feeling Emotionally Supported by IWISH Staff

At some focus groups, residents discussed how counseling from IWISH staff and simply having someone to talk with are healthy outlets and sources of emotional support. One participant recounted the support of the Resident Wellness Director when she experienced a death in her family: *"The police came with the Resident Wellness Director to tell me. It was wonderful to have [the Director] there."* Another described how residents were comfortable talking to IWISH staff about any of their concerns—physical or mental—especially because they could trust that their conversations would remain private. A different focus group participant noted, *"[The Resident Wellness Director's] patience is a blessing.… He will stop what he is doing and give you attention. It doesn't matter what time it is."*

Residents Reported that IWISH Programming Helps Them Develop a More Positive Outlook

Some focus group residents reported that programming organized by IWISH staff helped them to increase their social interactions and engagement with other people and reduced their isolation. An added benefit noted by one participant was that *"all those activities stimulate our mind, and you got to keep your mind sharp."* IWISH activity calendars were cherished and appreciated by some residents: *"As far as health goes, I push myself to go to all the activities. They do make a difference, definitely. I really look forward to them. You're getting out of the house, you're socializing, and you're engaged."* Those events also helped to bring together the community of residents. One said that the program affected their entire quality of life—that IWISH had introduced services and programs that encouraged people to participate and to get together; and that they are a "stronger community" as a result.

Residents Reported that IWISH Programs Helped Them Become More Informed Advocates for Their Health and Well-Being

IWISH staff provided numerous educational programs and sessions. Residents at some focus groups reported that those offerings helped them become more informed and more confident advocates for themselves. One resident reported learning about the importance of advanced directives in healthcare from the Resident Wellness Director and the Wellness Nurse. Another said that because "*residents don't always want to talk to their family or are not getting the information they need to get a good decision; to be able to talk to a qualified nurse to help inform the residents [is beneficial]."* That statement underscores the perceived value of having a resource at the property focused on health and well-being who is knowledgeable and accessible.

7.3 Effects on Housing

Staff Reported that IWISH Helps Residents Stay Longer in Their Homes

Potential long-term outcomes of the IWISH model are fewer housing exits, longer stays in housing, and delayed transitions to long-term care facilities. Staff at most IWISH properties identified a reduction in evictions and reduced unit turnover as a result of IWISH.

IWISH staff further attributed the reduction in unit turnover to the individualized housing support and services the IWISH staff provided for residents. Several staff identified issues that arose around apartment inspections—such as hoarding—that ultimately would have led to eviction if not addressed. In those instances, IWISH staff were able to hire cleaning and decluttering services using supportive services funding, which allowed the resident to stay in the unit. Most onsite staff reported that residents were better connected to public benefits—such as Medicaid, Supplemental Nutrition Assistance Program (SNAP), and cash assistance—as a result of IWISH. Through the interview and assessment process, the Resident Wellness Director learned more about residents and could identify additional benefits for which they might qualify.

Resident Feedback on IWISH was Either Positive or Neutral

Residents' feedback on the effect that IWISH had on their satisfaction with housing and services was a mix of positive and neutral. Residents who participated in focus groups at eight properties reported that IWISH improved their satisfaction level, whereas residents at another three properties reported no effect or that it was too soon to say. No participants reported that IWISH had a negative effect. Residents who said that IWISH improved their perception of their housing and services reported improvements in resident morale; in the consistency and quality of building maintenance; and in services that made it easier to live at the property, such as transportation options.

Findings from focus groups with IWISH residents *not* enrolled in the program or who lived at active control properties suggest that residents enrolled in IWISH could be underestimating or missing IWISH impacts on housing quality and stability. The study team conducted focus groups at two IWISH properties with residents who were not enrolled. Those residents reported no change in their satisfaction with housing and services since the start of the demonstration, whereas enrolled residents at the same property reported increased satisfaction with housing and services but did not attribute it to IWISH. Those reported but unattributed increases in satisfaction could thus be the result of positive feelings and effects related to participation in IWISH.

The study team conducted focus groups with residents of active control properties, whose participants largely reported satisfaction with the quality of their housing. They valued the same qualities of their housing as did IWISH residents—a convenient location, a feeling of safety, and a clean and well-maintained building. They appreciated conventional features, such as prompt repairs, and special amenities, such as a shared TV room, exercise room, or landscaped grounds.

In contrast to residents at IWISH properties, active control residents did not experience higher morale or engagement with their peers during the demonstration period. Furthermore, when an issue arose—such as poor heating or a lack of transportation—active control properties did not report the same level of support from service coordinators to help residents resolve the issue or find alternative solutions.

8 Conclusion

This Second Interim Report presented the results of the implementation analysis of the Supportive Services Demonstration, which tests the Integrated Wellness in Supportive Housing (IWISH) model. The report describes how the model was implemented in 40 properties for older adults that received grants to implement IWISH during a 3-year period, between September 2017 and September 2020, and the perceptions of IWISH by onsite services staff, property staff, and residents. For context, the report also describes how onsite services were provided at 40 active control properties.

8.1 Summary of IWISH Implementation Analysis

In this final chapter, we revisit the research questions this report was intended to address.

Was the demonstration implemented with fidelity to the IWISH model across the treatment properties, and what factors explain or contribute to the observed variation in fidelity across the treatment properties?

Through interviews with program staff and analysis of program data and reports from the implementation team, the study team analyzed whether the demonstration properties implemented IWISH with fidelity to the IWISH model, examining each of the core components of the model. Core components of the IWISH model include the onsite wellness staffing of the Resident Wellness Director and the Wellness Nurse, proactive one-on-one engagement with residents, structured assessment of residents' health and wellness needs, and health and wellness programming that addresses resident needs.

By and large, the study team found that the treatment properties implemented the Supportive Services Demonstration with fidelity to the IWISH model. Thirty-three of the 40 sites were rated as having medium or high levels of implementation overall. Still, staff at the IWISH properties reported some challenges in meeting the intentions of the IWISH model. Not all the 40 properties implemented all the core components of IWISH or implemented them fully. The components for which certain IWISH properties had the lowest levels of implementation were developing partnerships with healthcare providers beyond helping individual residents, developing IHAPs, enrolling residents, keeping the onsite Wellness Nurse position fully staffed throughout the demonstration period, and conducting medication self-management. Of those components, Wellness Nurse staffing was considered by study participants to be the most significant indicator of successful implementation. Seven properties were rated as having low levels of implementation in that component. Such vacancies were considered by IWISH staff, property managers, and residents to create challenges for meeting the intended goals of IWISH. Across all 40 IWISH properties, 7 properties were rated as having low levels of implementation in at least three core IWISH components.

Exhibit ES-1 is a summary of the fidelity ratings in each of the IWISH core components.

What are the experiences of resident wellness and property management staff with implementing the IWISH model?

IWISH staff reported high levels of support for the IWISH model and, on the whole, described satisfaction with their ability to implement the demonstration. Staff largely felt that they had the resources to conduct their work (in the form of meeting space, materials, and funds) despite challenges (such as issues with the case management system, confusion over allowable expenses). The relationships, skills, and systems that staff had established throughout the demonstration empowered them to continue supporting residents in new ways in the face of the COVID-19 pandemic.

Training and technical assistance offered through the demonstration—including the in-person IWISH training, the special topic webinars, and the individual site liaison—were valuable to IWISH staff. Staff also reported that their prior experience, professional education, and employer-based training were useful in their new roles.

For the specific IWISH model components, there was greater consistency in implementation of the structured interventions, such as the person-centered interview and health and wellness assessments, compared with IWISH staff responsibilities related to emergency events or transitional care. Nonetheless, the study found high or medium levels of fidelity to the IWISH model in the areas of enhanced service coordination: medication self-management, transitional care, and family and caregiver interaction. In addition, no IWISH properties reported developed partnerships at the property level, as was intended in the model. Only one-half of the IWISH properties reported implementing specific evidence-based health and wellness programs identified by the implementation team, but all IWISH properties regularly offered onsite programming related to health and wellness that had similar goals to the recommended evidence-based programs.

Workload was somewhat of an issue for staff, who reported wanting to do more to help residents than their time allowed. The assessments and reporting in the case management system were described as particularly time-consuming tasks. Medication self-management was one aspect of the model to which some Wellness Nurses were not able to devote as much time as they would have liked due to other responsibilities. Those issues were compounded by high staff turnover and vacancies. Although the Resident Wellness Director position was fully staffed and the Wellness Nurse position was at least partially staffed across all properties for most of the demonstration period, vacancies did have an impact on implementation at properties affected by short- and long-term vacancies.

Most property managers reported minimal involvement in IWISH—5 hours or less a week—and say that most of their interactions with IWISH staff related to concerns with individual residents. Some property managers also were involved in activities related to the demonstration grant funding or programming funds more generally or to assisting with the logistics of group programming. Several property managers that did not employ a service coordinator before the start of the demonstration reported that their workload had decreased as a result of having the IWISH staff there to respond to residents' service needs.

Overall, IWISH staff, property managers, and residents at IWISH properties reported support for the intent of the IWISH model and for helping older residents age in place and remain in their homes for as long as they are able.

What are the perceived strengths, benefits, and weaknesses of the IWISH model?

IWISH staff reported that the aspects that have the most impact on residents' health and well-being are the onsite positions of the Resident Wellness Director and the Wellness Nurse and the funding for supportive services and group programming. Residents who participated in the program identified six aspects of the Wellness Nurse role as having the most impact on their health: monitoring of vital signs, assessment of healthcare needs, support in emergency situations, wellness coaching, healthcare coordination, and medication self-management.

Perceived weaknesses of the model are the data collection and reporting requirements that many residents found intrusive and staff found time consuming and often frustrating to implement, as well as the strong reliance on individual staff to implement the model without necessary contingency plans in the case of staffing turnover. Staff at many properties did not find the formal structure of the IHAP to be useful in helping residents improve their health. In addition, the inability of staff to run their own reports from the required case management system meant that the development of the CHAP was not as helpful or as timely as intended.

How does the service coordination and health and wellness programming provided at the IWISH properties differ from those provided at the active control properties?

The main differences we found between the two groups were in the assistance and education the Wellness Nurse provided; a greater focus in the IWISH properties on providing enhanced service coordination, such as transitional care and support during emergency events; and available funding for supportive services.

All but two active control properties had a full-time service coordinator who performed a role similar to that of the Resident Wellness Director in IWISH. No active control property had onsite healthcare services comparable to those provided by the Wellness Nurse. In addition, 60 percent of IWISH properties reported having healthcare providers who visited the property, including nurses, podiatrists, elder care specialists, dentists, and physical therapists, compared with one-third of active control properties.

Engagement in service coordination at the active control properties was less formal than at IWISH properties, and participation in service coordination varied more widely in the active control properties than in the IWISH properties. However, service coordinators conducted assessments and worked with residents to set personal goals similarly to what is done at IWISH properties. Service coordinators conducted resident assessments at three-fourths of the active control properties and helped residents develop IHAPs at slightly more than one-half.

In contrast to IWISH staff, most service coordinators in the active control properties had little involvement in helping residents self-manage their medications, and IWISH staff reported greater interaction with families and caregivers on behalf of residents than did service coordinators in the active control properties. Services programming at active control properties included fewer evidence-based health and wellness programs and less focus on health and wellness than in IWISH.

Were there any changes in residents' perceptions of their health, well-being, and satisfaction with housing and services?

The demonstration intends to produce evidence about the impact of the IWISH model on the housing stability and healthcare use of HUD-assisted elderly residents. The demonstration is testing whether the IWISH model will affect (1) unplanned hospitalizations and the use of other types of acute care with high healthcare costs; (2) the use of primary and nonacute care; and (3) the length of stay in housing and transitions to long-term care facilities. The third and final report on this demonstration, expected to be made available in late 2022, will assess whether IWISH led to any changes in resident tenancy or healthcare use.

Although we do not yet know the results of the outcome analysis, staff who implemented IWISH and residents who participated in the demonstration said that the IWISH model has had a positive effect on residents' health and well-being. IWISH staff at most properties reported a decrease in unplanned emergency visits, and IWISH staff at about one-half of properties reported that residents more frequently used primary or specialty health care as a result of the demonstration. Staff at most IWISH properties also said that IWISH reduced evictions and people moving out of the property.

8.2 Policy Recommendations for Improvements to the IWISH Model

The Supportive Services Demonstration was extended by Congress in the Continuing Appropriations Act, 2021 and Other Extensions Act and the Consolidated Appropriations Act, 2021. Through those Acts, Congress appropriated funds for a 2-year extension of the Supportive Services Demonstration funding for the 40 participating properties.

Should the IWISH model be expanded or extended further, the study team offers the following recommendations for HUD and Congress to consider:

Recommendations for Staffing, Training, and Support of Onsite Wellness Positions

- **Consider expanding the time that Wellness Nurses spend on site.** Nurses are the keystone of the IWISH model. Under the current model, nurses experience workload issues that they report prevent them from providing as much assistance to residents as they would like. Because most properties do not employ a full-time nurse, often no nurse is on site when sentinel events occur during daytime hours. A full-time position may also alleviate some of the hiring and retention challenges for this role.
- **Strengthen training and support opportunities for Wellness Nurses and Resident Wellness Directors by providing more peer and supervisor support.** In particular, Wellness Nurses expressed a desire for more hands-on support and supervision from supervisors with similar experience. Staff in both positions said that they wanted more opportunities to learn from and collaborate with peers. Housing organizations that own many properties can build those structures within their organizations, and others can form coalitions with other owners.
- **Prioritize culturally competent staff hiring practices.** Many properties have a diverse resident make-up in terms of languages spoken, racial and ethnic composition, and cultural identity. Interviewees emphasized that the effectiveness of IWISH staff is determined at least in part by their ability to speak with residents in their preferred language and to identify with—or at least understand—their cultural background and preferences. Prioritizing those qualities could aid staff in gaining resident trust, thereby increasing program enrollment and engagement.

Recommended Modifications to Key Components of IWISH

- **Allow properties to use their own software programs to collect resident data.** Properties may already have systems in place that they wish to continue using or enhance. The learning curve, technical challenges, and reporting limitations encountered with PHL, the case management software used in IWISH, was a barrier to program implementation. HUD can determine which data points to collect uniformly across all properties and specify that properties must collect and report those data to HUD on a regular basis. Reporting could be done through HUD's Standards for Success framework, to which properties with service coordinator grant programs are already required to report data.
- **Address resident privacy concerns.** Consider reducing the extent of information collected from residents by reexamining whether all assessment tools and questions are needed for IWISH participants. A risk- or age-based determination of which assessment tools to deploy could be considered. Many staff and residents commented that the assessment took a long time to complete and that it asked questions that residents felt were intrusive, embarrassing, or unnecessary. Another option is to allow residents to consent to only the Wellness Nurse (and not the Resident Wellness Director) having access to their personal health and wellness information.
- **Develop new guidance for partnerships.** This demonstration found that developing partnerships with healthcare providers as intended by the IWISH model was not feasible at the property level. Instead, properties should continue to be encouraged to develop individual relationships with providers, provider staff, and small organizations that can help smooth transitional care delivery

for participating residents. In addition, property owners may consider participating in or creating regional coalitions with other properties, which could lead to developing relationships with hospitals, nursing homes, and other facilities and healthcare systems on a regional level rather than on a property-by-property basis.

- **Clarify guidance on the use of supportive services grant funds.** Confusion about allowable costs and the funding process delayed staff in pursuing material or programming opportunities for their properties. For instance, staff were interested in using funding for social events, which were not allowable costs of the grant, and translation services so that they could better communicate with residents who did not speak the same language as the staff. Providing meaningful access for persons with limited English proficiency is the housing provider's responsibility by law under Title VI of the Civil Rights Act of 1964 and should be paid for from operational funds. IWISH staff might benefit from closer relationships with property management staff to coordinate on funding-related questions and access to and clearer guidance from HUD on allowable costs and funding.
- **Reinforce the person-centered approach in the model and put less focus on developing formal goals with residents.** Residents and staff professed resistance to the specific tool used (IHAP) and structured format of goal setting in IWISH. Although some staff adapted the tool to fit individual resident needs and preferences, others felt constrained or restricted by the format and struggled to set goals with residents. Emphasizing a person-centered approach may empower IWISH staff to collaborate more effectively with residents in reaching their health and wellness-related objectives.
- **Expand the catalog of recommended evidence-based health and wellness programs beyond branded ones.** Some properties were not able to offer the specific IWISH-approved programs because they were not available in the area, but many properties offered health and wellness programs that addressed the same health concerns as the programs identified in the catalog.
- **Formalize systems within properties to notify IWISH staff in the event of emergencies and transitions,** particularly those that occur outside regular IWISH staff working hours. Limitations to the provision of transitional care support occurred when the nurse was not aware that a sentinel event had occurred. After-hours staffing, a resident system, or implementation of a notification process could ensure that the nurse is notified of all sentinel events at the property—regardless of whether they occurred during working hours—and enable the onsite staff to offer followup care and resources to the affected resident. Residents always have the opportunity to decline services from wellness staff and must consent to any sharing of their health information with others, including during emergency events. Residents can provide such consent when they enroll in IWISH.

Appendix A: How the COVID-19 Pandemic Affected IWISH Implementation and Active Control Properties

IWISH Implementation During COVID-19

The onset of the pandemic had drastic effects on every facet of IWISH at the demonstration properties. IWISH staff had to change not only the way they implemented health and wellness activities but how they engaged with residents. COVID-19 restrictions were similar across properties, but IWISH properties' responses to the pandemic varied. In some instances, IWISH staff reported that the pandemic helped reinforce the value of IWISH for residents. At the end of the demonstration, in the fall of 2020, the study team conducted followup interviews with IWISH properties to learn how they had fared and adapted the program in light of the pandemic.

COVID-19 Restrictions Changed the Way IWISH Staff Worked with Residents and Limited IWISH Programming

When the pandemic began, all IWISH properties made drastic changes to reduce the risk of virus transmission among residents. Group activities were canceled; common areas and community rooms were closed; and residents were asked to wear masks, keep their distance, and not congregate. Some IWISH staff reported that their properties initially did not allow visitors. One Resident Wellness Director said that, in the beginning, "it felt like residents were trapped in their house." A Wellness Nurse reported that the property's restrictions were so extreme that the IWISH staff had to advocate to ensure that residents had access to essential care, such as home health care. Most properties allowed caregivers to visit or residents to leave, albeit recommending that trips be minimized.

Most IWISH staff were asked by their property management companies or contract staffing agency to work remotely either part or full time. Other IWISH staff were classified as essential workers, and they continued to work full time on site, although other changes were made, such as requiring that residents book an appointment before coming to staff offices. Most properties began to require IWISH staff to check in on residents by phone in a systematic way. Some IWISH staff initially checked with each resident daily and then less frequently as time progressed. Staff at other properties reported checking in twice a week.

> *We called people when we couldn't be on site, and the residents said that it made them really happy and they appreciated that someone was out there checking up on them, especially those [who] didn't have family. The residents appreciate your time and effort and care, and that is rewarding. When we came back on site, they were so happy that we were back.*
> *—Wellness Nurse*

Initially, reaching residents by telephone was challenging because residents did not know who was calling and would not pick up. IWISH staff tried to work around that challenge in various ways, including asking staff at the property (e.g., maintenance staff) to check in or sending letters to residents.

As of the fall of 2020, most IWISH staff were working in their offices on site in some capacity. Some reported that they no longer had an open-door policy and that residents had to make appointments. Others said they made use of closed community rooms to meet with residents or used acrylic separators. Most noted that social distancing requirements were maintained and that everyone had to wear masks.

IWISH staff varied in whether they felt their interactions with residents had changed. Most staff reported changes in how much they engaged with residents, but staff were split between believing that interactions had increased due to the constant check-ins or decreased because they had less contact overall.

IWISH Staff Pivoted in How They Engaged Residents During the Pandemic

IWISH staff used various methods to engage residents after the pandemic began. The telephone became the primary format for engaging with residents. Not only did IWISH staff use it to check in and provide services for residents but they even offered some programming over the phone, including presentations on health and wellness and attempts at "group activities," such as phone bingo. Even for IWISH staff who were able to work on site at a property, phone use increased to offset reduced direct contact with residents.

When we conducted interviews in the fall of 2020, programming was still minimal compared with pre-COVID-19 programming. As weather permitted, at least one-third of properties tried to conduct some programming outdoors to adhere to COVID-19 precautions. A few IWISH staff reported moving exercise equipment outside and conducting classes there. Other IWISH staff said they created walking groups. One Resident Wellness Director was able to continue a music therapy program as an outdoor activity. Some areas experienced challenges to such outdoor activities due to poor air quality (e.g., smoke from wildfires) or excessive heat.

> *Upper management wanted our doors closed [to residents] and to only take calls.… We decided to be more realistic—we put a table together that blocked entry into the office and opened up the door, and we could talk through the door. We had a table…with a display of items that showed that we cared about them.… On the table we put essential items for residents—for example, toilet paper, hand sanitizers, face masks, word puzzles, weights, water bottles, protein snacks, etc.*
> *—Resident Wellness Director*

IWISH staff tried other ways to engage residents as well. At least one-third of properties reported that they distributed resources to residents, such as newsletters or handouts on health and wellness topics or packages that included activities to engage their minds, such as puzzles or coloring pages. On special occasions, a small number of IWISH staff brought residents treat baskets to make them feel remembered. Some properties reported that they tried virtual activities as well; however, many residents did not have access to the needed technology (e.g., smartphone or tablet) or did not know how to use it.

Less frequently, IWISH staff reported trying activities in the hallway, such as singing. A couple of IWISH staff lent out exercise equipment for use in the residents' apartments. One property tried partnering with an orphanage to solicit donations of small items from the residents to give them a sense of purpose.

Three-Fourths of IWISH Properties Increased Assistance for Accessing Food and Other Essentials

A number of IWISH staff reported that the individual services they provided to residents stayed the same, but at least three-fourths of properties said they increased assistance regarding masks, food, and other essentials. IWISH staff contacted organizations to solicit mask donations to make sure that residents had access to masks. Other properties began to coordinate with local stores or organizations to make sure that groceries were delivered to residents. IWISH staff also had to begin bundling up groceries from the food pantry and dropping them off at each apartment so that residents did not congregate in community space. One Resident Wellness Director said that she solicited donations for her property's pantry in posts on her Facebook page and reported receiving an abundance of donations in response.

Some properties reported that they increased assistance in helping residents access telehealth appointments. For residents who did not know how to navigate the technology, IWISH staff would set up the web meetings. In a few instances, IWISH staff located equipment in a space where residents had privacy to conduct their appointment. IWISH staff also reported strengthening relationships with pharmacies that delivered medications or organizations with physicians who would make onsite visits.

Most properties reported challenges working with some resident populations since the start of COVID-19. Some IWISH staff said that those residents who were already prone to feeling isolated and anxious became more so. Other IWISH staff reported that supporting non-English speakers became more challenging during the pandemic because of language barriers and translation issues exacerbated by pandemic conditions. Other populations that staff mentioned less frequently included residents who were hard of hearing or blind or who had severe mental illness or dementia.

> *We had a 96-year-old who keeps going to the ER because of anxiety, but with work, we've spoken to her on the phone and she now feels more secure. We facilitated telemedicine visits with her physician, and we worked on doing breathing exercises and using apps on her daughter's phone.*
> *—Wellness Nurse*

IWISH staff also reported challenges from some residents who did not want to follow COVID-19-related restrictions. Those residents might not wear masks properly or at all or might resent having to make appointments to see the IWISH staff.

The Pandemic Affected Residents' Mental and Physical Health

At least one-half of the properties reported that COVID-19 had negatively affected residents' health and well-being. Restrictions put in place to prevent the spread of COVID-19 made some residents depressed. Others were overtaken with anxiety, causing them to isolate themselves in an extreme manner, such as barring caregivers from their apartment or confining themselves there. One Resident Wellness Director even reported that the restrictions had aggravated some of their residents' mental health issues and increased drinking among others, purportedly resulting in a few serious incidents.

> *Before COVID it was a matter of keeping them engaged in community and more of a wellness focus. Now it is basically making sure they are OK and "keeping an eye" on their mental health and well-being, using proper precautions related to COVID while still making sure they get access to things they need. So the focus has changed—we are more in "crisis mode" or "protective mode" versus before, when we were more working to get them engaged in the community.*
> *—Wellness Nurse*

In certain properties, IWISH staff tried to develop closer relationships with residents who were expressing signs of depression. Staff at some properties reported that they increased program offerings related to mental health. For example, one organized a virtual class called "Intro to Deep Meditation." A few properties offered mental health programs over the phone, although staff noted that not all residents liked the idea of talking to strangers.

Changes Due to COVID-19 Had Little Effect on the Working Relationships of IWISH Staff

For the most part, IWISH staff believed that the changes due to COVID-19 did not greatly affect how they worked with family and caregivers, property managers, or one another. Most IWISH staff reported that, other than mode of communication, their relationships with property managers were about the same as they had been pre-COVID-19. Few IWISH staff reported that communication with property management had increased and that this helped them during the pandemic.

Similarly, most IWISH staff believed that family and caregiver interaction was about the same as pre-COVID-19—other than the format (e.g., phone versus in-person contact). Some staff reported that their interaction with family had increased and that this benefited the residents. One staff member noted how their own limited time on site required that family step up more. Staff reported that the pandemic has helped them develop stronger relations with families. A couple of Resident Wellness Directors even reported that families took residents to their homes but still kept in touch with the IWISH staff to let them know how residents were doing.

The relationship between the Resident Wellness Director and the Wellness Nurse is an important aspect in IWISH implementation success and continued to be so during the COVID-19 pandemic. About one-half of IWISH staff said that the relationship between the Resident Wellness Director and the Wellness Nurse had not changed significantly, other than in communication mode. For example, they might communicate more over the phone and via email than in person. Some IWISH staff reported that, following the pandemic declaration, they worked even more closely together to make sure the residents were safe and healthy. For some, however, the pandemic has caused significant strain among IWISH staff or has burdened one staff member more than others. In a few cases, Resident Wellness Directors reported that they were working less closely with Wellness Nurses, and that has caused frustration. For example, a Resident Wellness Director reported that the Wellness Nurse, who was working off site, had been difficult to get ahold of. The Director said that this situation has negatively affected residents' perceptions of the nurse and thus IWISH. In other instances, COVID-19 precipitated vacancies in the Wellness Nurse position. One Resident Wellness Director said that the turnover has caused residents to lose trust in IWISH at the property.

IWISH Program Benefited Residents During the COVID-19 Pandemic

We asked IWISH staff whether aspects of IWISH made weathering the pandemic easier for residents. IWISH staff reported that their presence on the property had an immense impact during COVID-19; staff said that residents felt a sense of "comfort" knowing they were on site and able to help. Staff continued to provide regular services during the pandemic, albeit sometimes in an altered format. Those regular supports that IWISH staff provided were even more valued by residents during a time of isolation. For example, although Wellness Nurses always acted as liaisons with primary care physicians and conducted medication self-management, those activities became particularly important during COVID-19 because residents had limited access to other resources, and seemingly minor tasks became quite overwhelming.

Examples of services that staff continued to provide that were particularly valued by residents during COVID-19 include the following:

- Assisting in connecting residents to supportive services and public benefits.
- Encouraging participants to maintain their health by attending important health screenings (e.g., colonoscopies), exercising, and monitoring their own vital signs.
- Accessing assistance with paying utilities that were not paid as part of their rent.
- Explaining regular lab results.
- Educating residents about their health condition.
- Communicating with residents' primary care physicians or pharmacies.

In addition, staff adapted to residents' varied needs during the pandemic by also providing new supports. With programming less of a focus, IWISH staff increased one-on-one assistance in response to residents' needs. Some of that extra assistance focused on residents' mental health as they experienced increased stress related to the COVID-19 pandemic. Others focused on making sure that residents had access to essentials needed to maintain their health.

New supports provided by IWISH include the following:

- Providing enhanced mental health supports, such as resources for residents who had lost loved ones due to COVID-19 or who felt anxious and depressed.
- Reassuring residents who had major anxiety about COVID-19 by checking temperatures and oxygen levels.
- Checking in with residents consistently and making sure that they felt that someone cared about them.

- Determining whether residents were experiencing a physical or mental health decline and then working with the resident, the resident's family, and the resident's doctor to help address it.
- Helping residents meet their basic needs for items such as groceries, masks and hand sanitizer, and other essentials.
- Assisting residents to access and navigate technology, such as smartphones, or making telehealth appointments.

Active Control Sites' Experience During COVID-19

The study team also spoke with service coordinators representing 23 active control properties about how COVID-19 affected their work and the residents at their properties. The active control site staff reported experiences similar to those of IWISH staff during the pandemic—with a few key differences.

Like IWISH staff, service coordinators pivoted in the way they worked with residents at their properties. Most staff reported that they continued to work on site at least part time. Other similarities between IWISH properties and active control properties include service coordinators doing the following:

- Canceling in-person programming and closing community spaces.
- Increasing telephone calls with residents to conduct wellness checks and making appointments to meet with residents when needed.
- Continuing to assist residents with social assistance program applications and recertifications.
- Creating partnerships and increasing efforts for meal or food delivery, including pre-bagging food donations.
- Helping residents cope with anxiety or depression associated with the isolation caused by the pandemic.
- Engaging residents through offering social or health and wellness programs outdoors, virtually, or via telephone; providing activity packets or newsletters to residents; and holding some socially distant programming indoors, such as bingo or voter registration.

> *My work is really more demanding—working more now than before COVID. With the meal program, [I] had to sign most of the residents up with that. They just need more help with appointments and paperwork; for a long time, I couldn't let them into my office, so it just took longer to do the work with them over the phone. More residents are needing my support. I do get my regulars, but recently we have had a lot of move-outs and move-ins. We have had a couple of violations, so I've had to help residents with that. That is a lot for me. The work is the same, but more people need my help.*
> *—Service Coordinator*

Activities at IWISH and active control properties during the pandemic differed in some ways, however:

- **Service coordinators had a limited role in providing health and wellness-related services.** For example, they did not coordinate with primary care physicians, remind residents to keep their regular medical checkups or appointments, or determine whether residents were experiencing cognitive declines. However, a few active control staff mentioned that they helped residents access telehealth appointments by lending tablets to residents and helping set up the virtual meetings.
- **Some service coordinators at active control properties mentioned feeling stressed, overworked, or burned-out more often than IWISH staff.** Service coordinators reported varied reasons for feeling so harried. Some said it was because they were short staffed, others said that residents needed more attention, and still others mentioned both issues. A few staff members said that they felt they had little control over decisions made by property management staff, such

as requiring staff to continue to work at the property full time. The IWISH staff that reported high stress most often described staffing vacancy issues.

Overall, active control and IWISH properties responded to the onset of the pandemic in similar ways. The pandemic led staff in both groups to adjust their work to address residents' most immediate needs, such as obtaining food and other essentials, applying for social programs, and coping with the effects of isolation. The main difference between the active control and IWISH properties during COVID-19—as well as at other times throughout the demonstration—was the presence of the Wellness Nurses and the specialized skills and knowledge they brought to residents.

Appendix B: Research Methodology

This appendix describes the study design, research questions, data sources, and analysis methods that formed the basis for this report.

Study Design

The study has a cluster randomized controlled trial design in which HUD assigned 124 properties to treatment and control groups: 40 properties that implemented the IWISH model and 84 control properties that did not.

Notice of Funding Availability and Random Assignment of Demonstration Properties

In January 2016, HUD published a Notice of Funding Availability (NOFA) announcing $15 million in demonstration funds and inviting owners of multifamily properties serving older adults to apply.[21] To be eligible for the demonstration, the properties (1) had to have at least 50 HUD-assisted housing units, with no more than 10 percent of units available for residents younger than age 62; (2) had to have passed the most recent physical inspection by HUD; and (3) had to have received satisfactory Management and Occupancy Review ratings from HUD. Properties could have an onsite service coordinator at the time of application but could not have an onsite Wellness Nurse.

HUD received more than 700 applications in response to the NOFA. From that pool, HUD identified 131 properties across seven states as eligible for random assignment. The seven states were California, Illinois, Maryland, Massachusetts, Michigan, New Jersey, and South Carolina. HUD engaged with Dr. Partha Deb, professor of economics at Hunter College, to assist with the random assignment. Before random assignment, HUD stratified the properties by Core-Based Statistical Area to help ensure that the treatment and control groups would be balanced on characteristics that could affect demonstration outcomes, such as access to and cost of health care and access to social services. HUD assigned weights to each property on the basis of the rate of Medicare fee-for-service participation for its county and the property's budget request in the response to the NOFA, using those weights to order the properties for random assignment.[22]

HUD conducted random assignment in January 2017, assigning properties to three groups: treatment, active control, and passive control. HUD randomly assigned 43 properties to the treatment group, 40 properties to the active control group, and 48 properties to the passive control group. Within the treatment group, HUD assigned three properties to a waiting list in the event that any of the other 40 declined to participate. After random assignment, HUD negotiated cooperative agreements with the owners of properties in the treatment group and active control groups. Two of the 40 properties assigned to the treatment group and one of the properties assigned to the treatment group waitlist declined to participate after random assignment. HUD replaced the two properties with the remaining two properties on the treatment group waitlist. In addition, four properties originally assigned to the active control group declined to participate. HUD replaced those properties with four from the passive control group, resulting in 40 properties in the treatment group, 40 properties in the active control group, and 44 properties in the passive control group.

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[21] The NOFA is available at https://www.hud.gov/sites/documents/2015SSDEMO-NOFA.PDF.

[22] HUD weighted for the level of fee-for-service participation to ensure that detailed healthcare use data would be available for the evaluation. HUD weighted for the budget requested to ensure that it would be able to fund 40 IWISH properties with the available resources.

Characteristics of Treatment, Active Control, and Passive Control Groups

The 40 **treatment group** properties received funding to support a Resident Wellness Director and a Wellness Nurse for 3 years, plus additional funding to support health and wellness programs for residents and training and technical assistance for staff.[23] Those 40 properties were required to offer IWISH for 3 years. The treatment group properties are called "IWISH properties" in this report.

The 40 **active control group** properties did not implement IWISH and form part of the overall control group for the impact analysis. They could continue their existing service coordination programs or even expand their supportive services offerings during the term of the demonstration if they chose, but they did not receive additional HUD funding for staff or services. However, unlike properties in the passive control group, the active control group properties received modest funding from HUD to participate actively in the data collection by the evaluation team. Data collection took the form of interviews, site visits, and focus groups.

The 44 **passive control group** properties did not implement IWISH and form part of the overall control group for the study's impact analysis. They could continue their existing service coordination programs or even expand their supportive services offerings during the term of the demonstration if they chose, but they did not receive additional funding for staff or services from HUD.

Characteristics of Demonstration Properties

The 124 demonstration properties were in mostly urban areas across seven states. Exhibit B-1 shows the distribution of the 124 demonstration properties by state. The column titled "Control" combines the properties in the active and passive control groups.

Exhibit B-1. Distribution of IWISH and Control Properties by State

State	IWISH	Control
California	15	30
Illinois	5	11
Maryland	2	6
Massachusetts	6	12
Michigan	7	14
New Jersey	3	8
South Carolina	2	3
Total	**40**	**84**

Source: HUD Supportive Services Demonstration Site List, December 4, 2017

Most of the properties were in large urban areas, reflecting the stratification of the applicant pool by Core-Based Statistical Area and the weighting by fee-for-service penetration. Most treatment and control properties within a given state were in the same metropolitan area, and many were in the same neighborhood.

Research Questions and Data Sources

[23] The specifics of the funding arrangement varied by property. Properties that had a traditional HUD service coordinator grant at the time of applying for the demonstration received funding for the Wellness Nurse and to supplement the salary for the Resident Wellness Director position that was already funded through the service coordinator grant. Project Rental Assistance Contract properties that had a service coordinator funded from the property's operating budget had the same type of arrangement, with the demonstration funding supplementing existing monies budgeted for the service coordinator and funding the Wellness Nurse. For properties without a service coordinator, the demonstration funded the Wellness Nurse and Resident Wellness Director positions in their entirety.

The study's research questions address IWISH implementation across the 40 properties, the experiences of staff and residents, and how the resident supports provided at the IWISH properties differed from supports provided at the active control properties. Exhibit B-2 presents the research questions and the data sources used to answer them. The data sources are described briefly below.

Exhibit B-2. Research Questions and Data Sources

Research Question	Interviews (staff)	Focus Groups (residents)	PHL (program data)
What are the experiences of resident wellness and property management staff with implementing the IWISH model?	✔		
What are the perceived benefits, strengths, and weaknesses of the IWISH model?	✔	✔	
Within the treatment group, were there any changes in residents' perceptions of their health, well-being, and satisfaction with housing and services?	✔	✔	
Was the demonstration implemented with fidelity to the IWISH model across the treatment properties?	✔		✔
What factors explain or contribute to the observed variation in fidelity to the IWISH model across the treatment properties?	✔	✔	✔
How do onsite services compare between the treatment and active control properties?	✔	✔	

Interviews with Staff at IWISH and Active Control Properties

We conducted three rounds of interviews with IWISH and active control property staff:

1. **Telephone Survey.** Between November 2018 and January 2019, Abt Associates conducted telephone interviews with Resident Wellness Directors at each IWISH property (n=40) and at each active control property with a service coordinator (n=38), for a total of 78 interviews (exhibit B-3).

2. **Indepth Interview/Site Visit.** Between April and December 2019, Abt Associates completed 209 interviews with property staff across the 40 IWISH properties and 40 active control properties. The interviews with staff at the IWISH properties were mostly conducted in person as part of a site visit to the property.

   - At each IWISH property, the team interviewed the Resident Wellness Director(s), Wellness Nurse(s), and property management representative(s). We completed 123 interviews across the 40 IWISH properties. Slightly more than one-half the interviews with staff at the active control properties were completed by telephone, and the others were conducted in person during site visits.
   - At each active control property, we interviewed the service coordinator (if the property had one) and property management representative(s). We completed 86 interviews across the 40 active control properties.

3. **Followup Telephone Interview.** Between August and December 2020, Abt Associates completed 92 interviews with property staff across the 40 IWISH properties and 40 active control properties. The interviews were all conducted by telephone.

   - At each IWISH property, the team interviewed the Resident Wellness Director(s) and the Wellness Nurse(s) where possible, although Resident Wellness Directors were not available at one property and Wellness Nurses were not available at 11 properties. We completed 68 interviews across the 40 IWISH properties.

– At each active control property, we attempted to interview the service coordinator at the 38 properties that had a service coordinator as of August 2020. We completed 22 interviews representing 23 active control properties.

Exhibit B-3. Summary of Surveys and Interviews

Respondent Type	Telephone Survey (Nov 2018–Jan 2019)		Indepth Interview / Site Visit (Apr–Dec 2019)		Follow-up Telephone Interview (Aug–Dec 2020)	
	IWISH	Active Control	IWISH	Active Control	IWISH	Active Control
Property Management	0	0	45	47	0	0
Resident Wellness Director	40	NA	40	NA	39	NA
Wellness Nurse	0	NA	38	NA	29	NA
Service Coordinator	NA	38	NA	39	0	23
Total	**40**	**38**	**123**	**86**	**68**	**23**

NA = not applicable.

Focus Groups with Residents and Caregivers

Between July and December 2019, the study team conducted 21 focus groups across 12 IWISH properties and 6 active control properties. We selected the focus group locations to reflect a diversity of property types, including smaller and larger properties and properties in high-, low-, and medium-resourced neighborhoods. As shown in exhibit B-4, we completed eight focus groups with English-speaking IWISH enrollees, three focus groups with Spanish-speaking IWISH enrollees, two focus groups with English-speaking residents of IWISH properties who did not enroll in IWISH ("non-enrollees"), two focus groups with caregivers of IWISH enrollees, and six focus groups with residents of active control properties.

Exhibit B-4. Number of Focus Groups Completed by Type

Focus Group Type	Completed	Planned
IWISH enrollees (English)	8	9
IWISH enrollees (Spanish)	3	3
Non-enrollees at IWISH properties (English)	2	3
Caregivers of IWISH enrollees (English)	2	3
Residents of active control properties (English)	6	6
Total	21	24

The final types and numbers of focus groups completed were somewhat different from the study's original research design. The original design called for 18 focus groups at 12 IWISH properties and 6 focus groups at 6 active control properties. We completed the focus groups at active control properties as planned. However, we were not able to complete one planned focus group with IWISH enrollees and one planned focus group with non-enrollees due to the onset of the COVID-19 pandemic.[24] We were not able

[24] At one property, we had delayed scheduling the focus groups until February 2020 in hopes of being able to add a focus group in Russian with the property's Russian-speaking residents. By the time planning for the focus group was complete, the pandemic had started. This property was also the planned location for a focus group with English-speaking IWISH enrollees and a focus group with IWISH non-enrollees. Pandemic restrictions prevented us from rescheduling those focus groups before the demonstration period ended in September 2020.

to recruit any caregivers to participate in one of the caregiver focus groups. Thus, we completed three fewer focus groups than originally planned.

A total of 180 people—about 8 to 10 per group—participated in the 21 focus groups. For the groups with residents (IWISH enrollees, IWISH non-enrollees, and residents of active control properties), we generated lists of residents at each property using HUD administrative data and IWISH program data collected through the Population Health Logistics (PHL) data system. We then pulled a random sample of residents to invite to each focus group and followed up with letters and telephone calls until we reached 8 to 12 people per group. Sometimes the staff at the properties (Resident Wellness Directors and service coordinators) assisted us by putting up flyers or otherwise communicating with residents about the focus groups. Before confirming residents for a focus group, we administered a brief cognitive screening to help ensure that the resident was capable of participating. The study team also asked the Resident Wellness Directors and service coordinators to identify any resident on the list of potential invitees for whom participation in the focus group might present a hardship.

For the caregiver focus groups, we worked with the Resident Wellness Directors to identify caregivers and family members who might be willing to participate in a focus group. We were not as successful in our recruitment efforts for this population because most family members said they did not have the time to participate.

All focus group participants—residents and caregivers—received a $40 gift card for attending the focus group. The focus groups lasted approximately 60 to 90 minutes and were held at the property, usually in a recreation room or other shared space. Participants signed a written consent form, provided in advance. We also explained at the start of the group that participants were free to leave if they needed to and could choose to not answer any given questions. The focus group moderators had nursing backgrounds and experience conducting focus groups with older adults. The focus groups with Spanish-speaking participants were held entirely in Spanish, and the notes from the groups were translated by native Spanish speakers on the study team.[25]

Interviews with Property Owner Representatives

At the start and end of the demonstration, we interviewed representatives of five property owners with properties in the demonstration. We selected the five owners to include the four owners with the most properties in the demonstration, plus one additional owner to ensure that we had broad geographic representation. Together, those five owners accounted for 21 IWISH properties and 21 active control properties. The purpose of the interviews was to learn the property owner's involvement in the implementation of the program and each owner's perspective on the IWISH model.

Information Provided by HUD's Implementation Team

Before the demonstration concluded, we met with the implementation team to capture their final thoughts on demonstration implementation. We also met with the implementation team regularly throughout the demonstration to keep abreast of their training and technical assistance activities and to learn about any major implementation challenges. In addition, we reviewed monthly reports provided to HUD by the implementation team on their activities and IWISH staffing changes.

IWISH Program Data

IWISH staff at the 40 IWISH properties used the PHL system to document their work with residents. The implementation team set guidelines for data entry and reviewed the data throughout the demonstration for

[25] The study team followed the guidance of Abt Associates' Institutional Review Board in all aspects of the focus groups to protect the privacy of residents and to help ensure that participating in the group caused no harm.

quality assurance. The implementation team also provided technical assistance and troubleshooting for IWISH staff on using PHL.

All 40 IWISH properties used PHL. According to a report produced by the implementation team in April 2020, covering the period March 2019 through March 2020, IWISH staff entered data into 29 of PHL's 30 tabs on average, meaning that they used nearly all aspects of the system.

Throughout the course of the demonstration, the implementation team produced quarterly management of information technology (MIT) reports that documented key IWISH implementation outcomes, such as enrollment and participation in the health and wellness assessments, person-centered interviews, and Individual Healthy Aging Plans. The study team used the MIT reports to track IWISH implementation outcomes over time. The implementation team also provided us extracts of raw PHL data in April 2019, March 2020, and September 2020. We used the raw data from the March 2020 extract to produce the analysis of staff visits in chapter 3.

In consultation with HUD, we determined that the primary analyses of PHL data for this Second Interim Report would focus on data collected between March 2018 (the start of enrollment) and March 19, 2020, excluding data reported to PHL after that.[26] The reason for cutting off the analysis of PHL data at that time was that IWISH fundamentally changed with the onset of the COVID-19 pandemic. Data entry into PHL was less reliable after March 2020, as some staff worked from home for a period of weeks or months and were not able to access the system, and the nature of the work of the IWISH staff changed substantially, as described in appendix A. We and HUD determined that analyzing the PHL data through March 2020 would provide a more representative picture of IWISH "business as usual"—before COVID-19.

Qualitative Data Analysis

We used the qualitative software NVivo to analyze the interview data collected through the study. NVivo allows the user to code the content of transcripts and analyze for common themes. First, the study's interview team created short summaries throughout the data collection process—immediately following each telephone interview, site visit, and focus group, which helped the team identify early themes and patterns for later analysis. The study's analysis team then coded each interview transcript using a coding structure based on IWISH program model components, study research questions, and other themes identified during the data collection process. Examples of themes include health and wellness assessments, working with healthcare providers and facilities, and recommendations. We reviewed results within each theme and also queried the data to identify program successes, challenges encountered, areas for improvement, and perceived program benefits.

Throughout coding, we held regular check-in meetings to discuss emergent themes and data quality. The Project Director and Project Manager reviewed all the coding and analyzed inter-coder reliability, providing additional training to coders as needed.

Rating System Comparing IWISH to Services in the Active Control Properties

We developed a rating system to compare services at the IWISH properties to services at the active control group properties. We based the main categories of the rating system on the IWISH model's core components. We developed the rating measures in consultation with the study's expert panel and based the rating system on available data. For the IWISH properties, we analyzed interview responses and IWISH program data reported in PHL. For the active control properties, we relied solely on responses from the telephone survey conducted with staff in 2018 and interviews in 2019 and 2020.

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[26] The cutoff date was March 19, 2020, exactly 2 years after IWISH staff began enrolling residents of the 40 treatment properties into the IWISH program.

For the ratings based solely on interview data, we sorted and analyzed relevant interview responses by individual property. Exhibit B-5 shows the data sources for each category of the ratings.

Exhibit B-5. Data Sources for Fidelity Ratings by Category

Category	IWISH	Active Control
Onsite services staffing	Implementation Reports, Interviews	Interviews
Resident engagement in services	PHL	Interviews
One-on-one assessments and goal setting	PHL	Interviews
Evidence-based programming based on resident needs	Program Reports, Interviews	Program Reports, Interviews
Healthcare partnerships	Interviews	Interviews
Standardized transitional care coordination	Interviews	Interviews
Medication self-management assistance	Interviews	Interviews

Supplemental Data

The study team analyzed PHL data to learn whether any differences existed in frequency of meetings based on race and ethnicity, age, gender, marital status, and primary language. The findings from that analysis are presented in section 3.3. Complete results from the analysis are reported in exhibit B-6.

Exhibit B-6. Average Number of Visits per Month Enrolled in IWISH Among Residents with One or More Visits, by Resident Characteristics

Variable	N	Mean	Median	25th Percentile	75th Percentile
Number of months enrolled in IWISH	3,278	17.70	19.23	14.33	22.97
Number of visits while enrolled in IWISH	3,278	16	9	4	20
Number of visits per month enrolled in IWISH	3,278	0.96	0.55	0.25	1.21
By race/ethnicity *					
American Indian/Alaska Native	21	1.41	0.51	0.22	1.20
Asian	339	0.52	0.25	0.16	0.55
Black	757	0.77	0.45	0.26	0.89
Hispanic	431	1.41	1.09	0.51	1.92
Hawaiian/Pacific Islander	9	0.77	0.43	0.27	0.75
Other	77	0.87	0.58	0.41	1.31
Unknown	601	0.77	0.38	0.18	0.85
White	1,043	1.18	0.75	0.38	1.51
All Non-White **	2,235	0.86	0.47	0.23	1.04
By marital status *					
Married	441	0.70	0.44	0.22	0.85
Divorced	703	1.13	0.70	0.39	1.43
Widowed	677	1.13	0.72	0.33	1.44
Never married, separated, single, or other	755	0.97	0.52	0.24	1.25
Unknown	702	0.79	0.39	0.19	0.86
By age category *					
< 60	74	0.60	0.30	0.18	0.74
60–64	106	1.10	0.57	0.28	1.16
65–74	1,213	0.94	0.54	0.26	1.21
75–84	1,245	0.92	0.55	0.26	1.17
85 and older	604	1.14	0.63	0.25	1.50
By gender					

Female	2,258	0.97	0.55	0.26	1.22
Male	995	0.95	0.54	0.24	1.19
By spoken language **					
English	2,044	1.06	0.61	0.32	1.29
Non-English	1,006	0.84	0.46	0.21	1.11

IWISH = Integrated Wellness in Supportive Housing. One month = 30 consecutive days.
* = Statistically significant difference in means across all subcategories based on a one-way ANOVA test, *Prob(F)* ≤ 0.0001. The number of visits per month was logged to normalize the variable before the one-way ANOVA test. We did not test for the statistical significance of differences in means between any two subcategories.
** = Statistically significant difference in means between the two subcategories based on a *t*-test, $p < 0.0001$. The number of visits per month was logged to normalize the variable before the *t*-test; results were similar without logging the dependent variable.
Notes: *N* = 3,278 unique residents with at least one visit with a Resident Wellness Director or Wellness Nurse on the same day or after they were enrolled in IWISH. There were 92 residents enrolled in IWISH but excluded because they had no visits on record. Residents missing information on individual characteristics were excluded from relevant subanalysis. There were 36 residents missing information on age, 25 missing information on gender, and 228 missing information on spoken language.
Sources: PHL data extract dated May 22, 2020; analysis of records through March 31, 2020

References

Kandilov, Amy, Vincent Keyes, Noëlle Siegfried, Kevin Smith, Patrick Edwards, Jenna Brophy, Aubrey Collins, and Martijn Van Hasselt. 2019. *Support and Services at Home (SASH) Evaluation: SASH Evaluation Findings, 2010–2016*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Levine, Cheryl A., and Ashaki Robinson Johns. 2008. *Multifamily Property Managers' Satisfaction with Service Coordination.* Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

Turnham, Jennifer, Ian Breunig, Elizabeth Giardino, Gabrielle Katz, and Thyria Alvarez. 2021. *Supporting Aging in Place Through IWISH: First Interim Report from the Supportive Services Demonstration.* Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

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