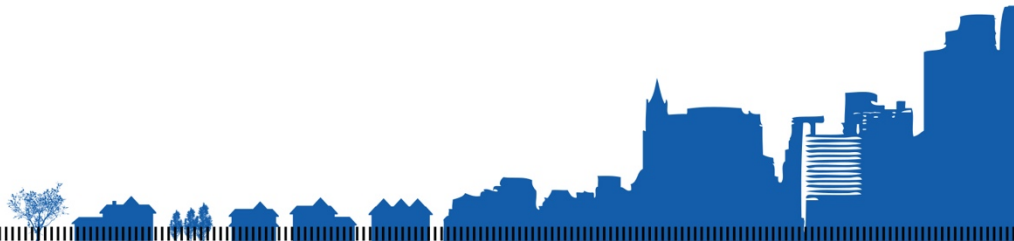# United States Department of Housing and Urban Development

and

Japan
Ministry of Land, Infrastructure, Transport and Tourism
Urban Renaissance Agency

Aging in Place:
U.S. Case Studies

Preface

Since February 2017, the U.S. Department of Housing and Urban Development's (HUD) Office of Policy Development and Research (HUD-PD&R) and the Japan Ministry of Land, Infrastructure, Transport and Tourism's (MLIT) Policy Research Institute (MLIT-PRI), along with the Housing Bureau and Urban Renaissance Agency of Japan (UR), have held numerous joint research meetings focused on Aging in Place (AIP). The first two meetings were held in Washington, D.C. at HUD headquarters in February and June 2017. The third meeting was held at MLIT's headquarters in Tokyo in December 2017. Delegations visited New York City, Baltimore, and Washington, D.C. in January 2018. A forum was held in San Francisco in October 2018 and in Los Angeles in June 2019. HUD researchers visited MLIT in September 2018. The most recent forum was held in Tokyo in February 2020.

At the June 2017 meeting in Washington, D.C., Secretary Ben Carson of HUD; Minister ISHII Keiichi of MLIT; Maren Kasper, Executive Vice President of Ginnie Mae; and NAKAJIMA Masahiro, President of UR, signed a Memorandum of Cooperation (hereinafter referred to as the "MOC"). The MOC focuses on AIP among elderly citizens in both countries. In Japan, 28 percent of the population is age 65 or older with birthrates at an all-time low (7.5 per 1,000 of population in 2017). In the U.S., 14 percent of the population is age 65 or older, and by 2030 the number is expected to increase to 19 percent. Each day in the United States, 10,000 citizens turn 65 years old. As in Japan, the United States is also experiencing record low birthrates (11.8 per 1,000 of population in 2017), marking the lowest birthrate in 30 years. The aging of the population presents both countries with a significant demographic shift and AIP housing challenges.

In the United States and Japan, older adults prefer to age in place, remaining in their current homes or communities. In the United States, Naturally Occurring Retirement Communities (hereinafter referred to as the "NORCs") and Villages are models of actively providing supportive services for the elderly with organized networks of volunteer, corporate, and governmental stakeholders. In Japan, mixed communities with a focus on promoting multi-generational resident communities are models of efficient service delivery to the elderly. As such, the MOC's initial focus on AIP and related housing and urban planning policies is an area of joint research that will benefit both countries.

To date, HUD-PD&R and MLIT-PRI have implemented joint projects that fully capture the spirit of the MOC. These activities described below represent a high level of engagement and evaluation exchanges between the MOC partner organizations.

A. Research exchanges at HUD headquarters where HUD-PD&R and PRI-MLIT identified a common research topic and began a process of focused exchanges of research and evaluation on AIP.

B. HUD-PD&R and MLIT-PRI provided briefings on the housing conditions facing the elderly in their respective countries, especially those in subsidized housing. These briefings

covered current policies regarding housing for the elderly as well as descriptions of supportive services delivery models in both countries.

C. Site visits of AIP supported housing and community development projects were conducted in the United States and Japan. HUD-PD&R and MLIT-PRI research and policy staff participated in site visit exchanges where supportive housing models were being implemented across a variety of housing and community contexts. These site visits, along with presentations by program staff with an understanding of the social, historical, and political context within which these AIP housing models were developed, provided both research teams with useful information for assessing their respective housing policy for elderly residents who desire to age in place.

As the United States and Japan continue to engage in an exchange of research and policy activities focusing on AIP in their respective countries, each partner has outlined a set of activities that are desired for the upcoming year.

<u>For HUD-PD&R:</u>
HUD-PD&R would like to learn more about housing and community development strategies MLIT and/or its affiliates (including UR) are undertaking to support AIP.

    i.   HUD-PD&R would like to receive additional information on community development models implemented in Japan to foster AIP. For example, what are MLIT's community planning considerations for AIP? Are there different considerations for very low-income elderly compared with low- to moderate-income elderly?

    ii.   HUD-PD&R would welcome information on the ease of access to services as well as the impact of more efficient services delivery on elderly residents in the UR's "Mixed Community" developments that promote multi-generational resident communities in suburban rental developments and often include healthcare facilities, health and wellness centers, and easy access to high-quality grocery stores.

    iii.   HUD-PD&R would benefit from information on strategies to promote multi-generational communities. For example, what are the core components of national and local housing policy that promote multi-generational community development? What approach(es) were taken to garner local support? How was financing handled? That is, what role did both national and local government play in financing these types of community development projects?

    iv.   HUD-PD&R is interested in any developments on the Seven Eleven Japan local shopping support demonstration approach to supporting the delivery of healthy foods to seniors.

<u>For MLIT and UR:</u>

MLIT and UR would like to learn more about ongoing AIP research projects underway by HUD and/or its affiliates.

i. MLIT-PRI would like to receive background information about the U.S.'s NORCs and Village models of supportive services for older citizens, as well as the benefits of these models on the health and well-being of their members, including any research that has been published in peer-reviewed journals. Additionally, it would be worthwhile to acquire information about NORCs/Village formation, demographics of participants/residents, typical social supportive services provided, and membership fees. Finally, MLIT-PRI would appreciate any information about how NORCs/Villages are financed, common sustainability models, and forms of support from volunteer, corporate, and governmental stakeholders.

ii. MLIT-PRI would welcome updates on the status of PD&R's Integrated Wellness in Supportive Housing (IWISH) demonstration. Ideally, MLIT-PRI would like to receive information on the subsidy mechanism, cost sharing, hiring and training process, and initial implementation experience.

iii. UR would like to learn more about initiatives in which private sectors (such as private enterprises, paid/non-paid volunteers, non-profit organizations) collaborate with public sectors (such as local governments and housing authorities) or neighborhoods to promote sustainable AIP by focusing on measures such as mutual aid and multi-generational interaction or any others, if applicable. UR would benefit from information on various concrete examples including the background of the initiatives, ideas/practices to sustain the initiatives, and outcomes (both positive and negative) of the examples.

iv. The Housing Bureau would welcome information on the status of HUD-PD&R's recently awarded accessibility design grants.

A huge debt of gratitude is owed to Secretary Ben Carson (HUD), former Minister ISHII Keiichi and current Minister AKABA Kazuyoshi (MLIT), former Ambassador SASAE, and current Ambassador SUGIYAMA for their leadership and support for the ongoing research and policy exchange focusing on a topic of important social significance—the promotion of housing and community development efforts to support aging-in-place among elderly residents. Without their leadership and support, the activities performed under this MOC would not have happened with the level of collegial and thoughtful exchanges that have been experienced. This partnership has facilitated a knowledge exchange that transcends cultures and supports AIP in both the United States and Japan.

We hope you find the following set of case studies informative. Again, we express our gratitude to our senior leadership, as well as collaborators within HUD-PD&R, MLIT, and UR.

We look forward to the ongoing joint research and policy exchanges among HUD, MLIT, and UR.

October 2020

Mr. Seth Appleton
Assistant Secretary
Policy Development and Research (PD&R)
U.S. Department of Housing and Urban Development (HUD)

Mr. SUMIMOTO Yasushi
President Policy Research Institute (PRI)
Ministry of Land, Infrastructure, Transport and Tourism (MLIT)

Case Study One
Accessible Housing and Technology Research
and Demonstration Grant Program

The current housing stock in the United States may not meet the needs of a growing and aging population. The majority of graying baby boomers desire to live in their homes and remain connected to important neighborhood social networks and cultural pastimes where they have a sense of belonging, companionship, and familial ties. This country, however, faces a challenge with providing housing that is suitable for those with physical impairments. It is often the case that homes may not be adaptable for persons with certain types of disabilities. As such, elderly persons may find it difficult to perform routine daily activities such as showering and cooking. In fact, according to the Centers for Disease Control (CDC), one in four U.S. adults, or about 61 million Americans, have a disability that impairs their ability to perform daily activities. The most common of these disabilities is difficulty walking or climbing stairs.

Immobility affects one in seven adults. For low-income families, or those with limited resources to move or make modifications to their existing homes, the challenge becomes that much greater. The following illustration provides the percentage of adults with functional disability types.[1]

Percentage of Adults by Type of Functional Disabilities
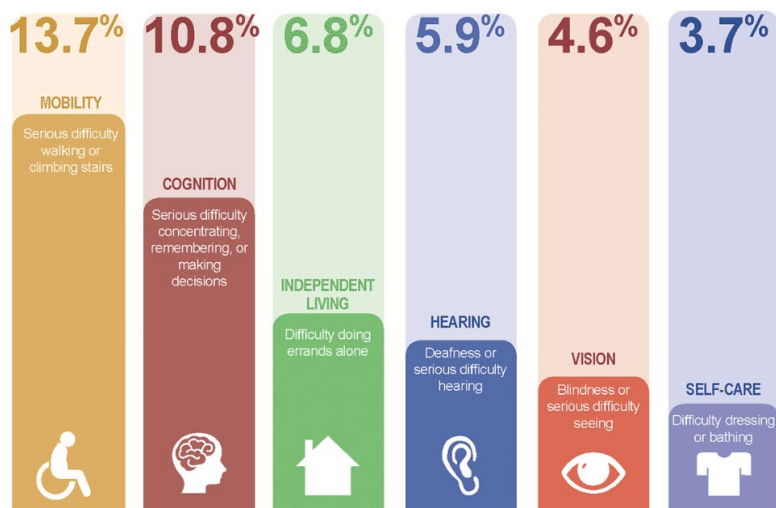
As more attention is focused on improving housing for seniors and those with disabilities, researchers are generating more evidence to demonstrate that the need for accessible housing has become urgent. These communities are voicing their concerns to policymakers as well. For

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[1] https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html, (May 8, 2019).

example, in 2011, the *American Housing Survey* (AHS) included a module on accessibility that asked about the presence of 22 accessibility features in housing units and whether those features were used. The researchers found that one-third of housing is potentially modifiable, but only 0.15 percent is wheelchair accessible. The following exhibit provides a summary of the level of accessibility and prevalence.[2]

Accessibility and Prevalence

Accessibility level	Prevalence
Level 1: Potentially Modifiable. The home has some essential structure features for accessibility, but would not be accessible without further modifications. This includes stepless entry from the exterior, bathroom and bedroom on the entry level or presence of elevator in the unit.	33.3% of all housing units 44.2% of housing units with a resident wheelchair user
Level 2: Livable for individuals with moderate mobility difficulties. A person with moderate mobility difficulties can live in the home. This includes all the elements in level 1 plus no steps between rooms or rails/grab bars along all steps and an accessible bathroom with grab bars.	3.8% of all housing units 12.4% of housing units with a resident wheelchair user
Level 3: Wheelchair accessible. The home has a minimum level of accessibility so that a wheelchair user can live in the home and prepare his or her own meals. This includes all the elements in levels 1 and 2, but removes the possibility of any steps between rooms, even if grab bars are present, and adds door handles and sink handles/levers	0.15% of all housing units 0.73% of housing units with a resident wheelchair user

The U.S. Department of Housing and Urban Development (HUD) established the Accessible Housing and Technology Research and Demonstration Grant Program in 2015 to address the housing needs of people wishing to age in place and for persons with disabilities. Through this program, HUD's Office of Policy Development and Research (PD&R) issued research grants to study innovative practices in the design and construction of affordable, accessible, and aesthetically pleasing housing. Three grants were awarded in Fiscal Year 2017 to explore accessible design strategies for people living with various kinds of disabilities. The objective of these grants is for researchers to develop prototypical housing models that incorporate aesthetically pleasing design solutions that promote accessibility without sacrificing affordability.

Now in the interim phase of the research, the analysts are currently exploring technological adaptations that can be made to existing housing that accommodates persons with various types of disabilities. The researchers are testing how well advancements in housing technologies respond to the needs of this population. The analysis is limited to the design and

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[2] Bo'sher, Luke, Sewin Chan, Ingrid Gould Ellen, Brian Karfunkel and Hsi-Ling Liao. 2015. *Accessibility of America's Housing Stock: Analysis of the 2011 American Housing Survey (AHS)*, Multi-Disciplinary Research Team Report. Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research. https://www.huduser.gov/portal/publications/mdrt/accessibility-america-housingStock.html.

retrofitting of non-detached single-family homes, semi-detached townhomes, and structures with four or fewer residential units. The ultimate goal is to demonstrate how low-cost physical configurations and technological adaptations can be implemented in existing homes so that residents can remain in their homes for as long as possible. The modified housing should comply with accessible design standards, including the Uniform Federal Accessibility Standards or the 2010 Americans with Disabilities Act (ADA) Standards for Accessible Design.[3] The total value of the Accessible Housing and Technology Research and Demonstration Grant Program was $2 million. The awards were given to Auburn University,[4] the Home Innovation Research Labs,[5] and University of Florida, Gainesville.[6]

Each grantee was required to: (1) conduct a review of the relevant literature, (2) convene an interdisciplinary advisory team (IAT) that represents a diversity of skills and expertise in housing design, (3) hold focus groups with users and caregivers, and (4) deliver a cost-benefit analysis of multiple approaches and designs which would make possible comparison of different approaches and methods. Each of the grants will use the information provided by its IAT and focus groups to develop affordable, aesthetically acceptable solutions for the common issues identified in the proceedings.

Brief descriptions of each grant follow:
Auburn University: Accessible and Affordable Design for Semi-Detached Housing. Auburn's Department of Architecture is partnering with the university's Center for Disability Research and Policy Studies to offer an interdisciplinary team of architects, designers, construction professionals, smart home technologists, people with disabilities, and disability research and policy specialists. Their goal is to create new and adapted home designs, tested by people with certain disabilities. The research team is developing incentive-based policy recommendations and preparing tools and strategies for educating the public and the design/construction sector. The goal of this effort is to move beyond "study and design" to real change in home design and construction practices.

Home Innovation Research Labs: Research, Prototype Testing, and Evaluation of Accessible Design Retrofits for Semi-Detached and Non-Detached Houses. Home Innovation Research Lab (Home Innovations) researchers are in the process of developing up to eight research-based prototype building configurations, rooms, or room features to be constructed in the lab, and design documents. If necessary, typical non-accessible configurations will be built first, followed by partial demolition and modification with the pre-determined accessibility solution being tested. The least-cost practicable approach will be used, such as a flexible, full-scale modeling system that uses moveable walls and non-working proxies for plumbing fixtures and accessory items for modification and repeated re-use. The process will be documented (notes, photos, video) for analysis of design results, costs and benefits, evaluation, training, and dissemination of results.

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[3] https://www.access-board.gov/guidelines-and-standards/buildings-and-sites/about-the-aba-standards/ufas
[4] http://ocm.auburn.edu/newsroom/news_articles/2017/11/architecture,-design-and-construction-interdisciplinary-team-awarded-largest-hud-grant-in-auburn-university-history.php
[5] https://www.homeinnovation.com/hudaccessibilityretrofit/
[6] http://www.shimberg.ufl.edu/

University of Florida: Project Re-Envision at UF. The University of Florida's Shimberg Center for Affordable Housing will develop a series of repurposed interior layouts and fixtures of prototypical small-scale attached housing (SSAH) for different occupant types to test for accessibility, aesthetics, and affordability using multiple assessment tools. Researchers will identify prototypical dwelling plans from a systematically gathered inventory of older housing stock of public and market-rate SSAHs. Key problematic and efficacious spaces and fixtures (S/F) will be identified, informed by a literature review, Housing Enabler (HE), expert focus groups, spatial modeling, and human behavior monitoring. Following this research phase, digitized 3-D models with enhanced realization will be developed from several designs of repurposed S/Fs, targeted to different occupant types. These designs will be tested using multiple methods, procedures, and end-users with various types of disabilities. Affordability analyses will be conducted on the most successful repurposed layouts and fixtures. Mock-ups of different formats (for example, podcasts and brochures) of results and solutions will be presented to multiple peer groups for feedback on appeal and utility as an end-user communication tool.

All three research teams have completed their literature review and focus groups. Their findings will be used to develop the designs for accessible features. A few key findings are:

- Several possible deficiencies faced by the resident in their existing home, such as deferred maintenance, repairs, and improvement to safety, can be mitigated by testing and incorporating accessible design features specific to their needs.

- Home modifications are implemented for a variety of reasons, but primarily for safety concerns—to reduce the anxiety of and decrease the rate of injury and falls. Modifications need not resemble conventional institutional settings that are often not physically appealing. The researchers will present prototypes that are affordable, accessible, and aesthetically pleasing.

- Some external facing modifications can cause safety concerns for the residents. For example, installing a ramp in the front of the home is a public announcement of their disability.

- It is important that occupational therapists, nurses, designers, and other important stakeholders and providers consult with homeowners prior to any home modification.

- Homeowners should be involved throughout the home modification process and understand how the adaptations will help to improve their lives.

During the focus group event, participants identified challenges and potential solutions to make their homes more livable. Some common issues are listed in exhibit 1.

Exhibit 1. Challenges and Potential Solutions

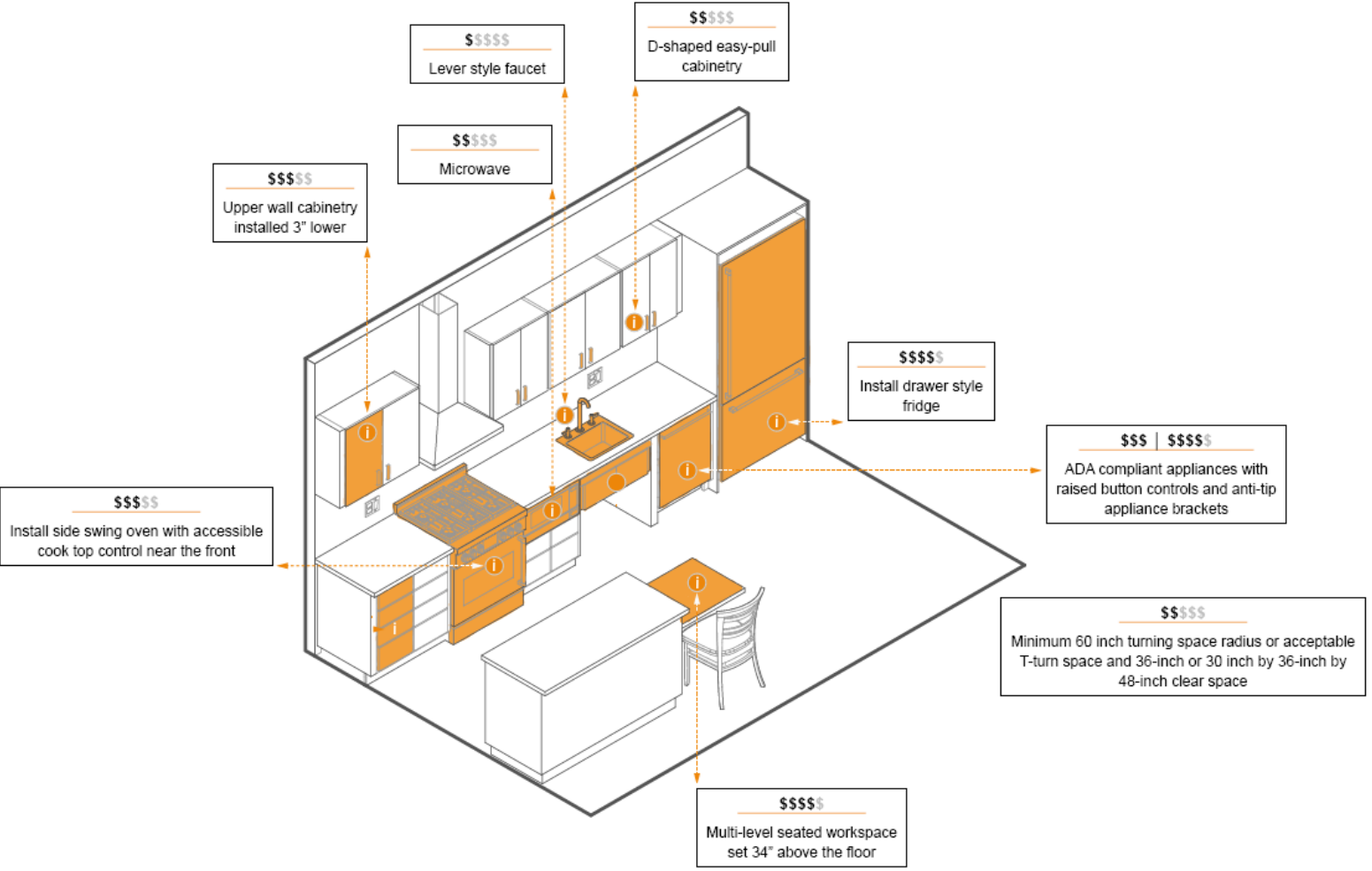| Challenges	Solutions
Climbing stairs	• Handrails on both sides of the stairwell • Contrast between steps to make the steps more visible
Carrying heavy items	• One level that accommodates activities for daily living (ADL)
Turning knobs	• Replace with levers
Seeing objects	• Brighter and better lighting
Hearing	• Lighting cues when someone rings the doorbell
Individuals may not use proper adaptive equipment, so these individuals use the walls or bureaus as needed support	• Better education
General Home Navigation	• Wider halls allowing for the wheelchairs to turn as needed • Marking thresholds with colored tape to limit tripping risk

Problems + Solutions for Bed to Bathroom Transition	
Slick/hard to maneuver flooring	• Using rubber mats • Non-slip rugs or floor covers
Problems + Solutions for Kitchen	
Inaccessible Kitchen	• Better lighting • Removing lower kitchen cabinet doors and replacing with curtains • Converting dining room into makeshift kitchen • Modify food packing • Hooks for hanging cups and pans for easy access • Transparent plastic storage drawers on wheels
Problems + Solutions for Bathrooms	
Getting in and out of tub	• Grab bars (more than one) • Install walk-in/roll-in showers with no lip or raised edge • Ledge for easy access to toiletries • Install a secure bench (the shower bench should allow for wheelchair-bound residents to easily transfer to and from the chair) • Add a hand handle shower (the shower bench should allow for wheelchair-bound residents to easily transfer to and from the chair)
Getting on and off the toilet	• Grab bars, preferably on both sides • Sinks with open bases to allow for wheelchairs to roll underneath • Easy storage, accessible from all heights

Exhibit 1 represents a small sample of challenges elderly people and people with disabilities must deal with as they complete their daily activities. Generally, most homes must provide:

- Sufficient clearance through doorways and hallways to ensure general safety and accommodate mobility devices.
- Safety when using stairs.
- Independent and safe bathing and use of the toilet.
- Independent and safe transfers into and out of bed.
- Safety and full facility in the kitchen.
- Safe access in and out of the residence.

In June 2019, the three research grantees will travel to HUD headquarters to deliver an interim presentation of these and other study findings. The final reports will expand on the preliminary and interim findings and deliver to HUD policy recommendations that will inform the Department on accessible design for persons with disabilities. The grantees are expected to deliver these final reports in September 2020.

Fully Accessible Kitchen

$$$$
D-shaped easy-pull cabinetry

$$$$$
Lever style faucet

$$$$$
Microwave

$$$$$
Upper wall cabinetry installed 3" lower

$$$$$
Install drawer style fridge

$$$ | $$$$$
ADA compliant appliances with raised button controls and anti-tip appliance brackets

$$$$$
Install side swing oven with accessible cook top control near the front

$$$$$
Minimum 60 inch turning space radius or acceptable T-turn space and 36-inch or 30 inch by 36-inch by 48-inch clear space

$$$$$
Multi-level seated workspace set 34" above the floor

Case Study Two
U.S. Department of Housing and Urban Development
Supportive Services Demonstration and Evaluation

Abstract

The HUD Supportive Services Demonstration (SSD), also referred to as Integrated Wellness in Supportive Housing (IWISH), leverages HUD's properties as a platform for the coordination and delivery of services to better address the interdependent health and supportive service needs of its older residents. The IWISH model funds a full-time Resident Wellness Director (RWD) (that is, enhanced service coordinator) and part-time Wellness Nurse (WN) to work in HUD-assisted housing developments that either predominantly or exclusively serve residents aged 62 or over. The RWD and WN are implementing a formal strategy for coordinating services and liaising with providers to help meet residents' needs, including the use of standardized assessments, individual and community healthy aging plans, partnerships with providers, and bringing in evidence-based programming. The 3-year demonstration (October 2017–September 2020) is being implemented in HUD-assisted multifamily properties in California, Illinois, Maryland, Massachusetts, Michigan, New Jersey, and South Carolina. HUD has designed a cluster-randomized controlled trial to evaluate the model: eligible HUD-assisted properties that applied for the demonstration were randomly assigned to one of three groups: a "treatment group" that received grant funding to hire a RWD and WN and implement the IWISH model (40 properties); an "active control" group that will participate in the evaluation and continue business-as-usual (40 properties); and a "passive control" group that received neither grant funding nor is actively participating in the evaluation, but for which administrative data will be used (44 properties). A process study will assess fidelity to the IWISH model, successes and challenges to implementation, and answer questions related to resident health, well-being, and housing. The impact evaluation will use HUD administrative data linked with Medicare and state Medicaid claims data to assess the impact of IWISH on healthcare utilization.

Background

HUD currently assists over 1.6 million low-income senior households age 62 or older through its housing programs. These housing programs use a variety of mechanisms to provide subsidized rental housing for the elderly, including public housing, tenant- and project-based vouchers, and privately-owned multifamily housing. HUD's Office of Multifamily Housing (Multifamily) Section 202 Supportive Housing for the Elderly Program is one of the main vehicles for subsidizing multifamily housing for low-income senior adults and to date has developed over 400,000 units for low-income seniors, and the Congress has also appropriated an additional $161 million in fiscal years 2017, 2018, and 2019 for new construction of additional units. Multifamily also subsidizes elderly designated and elderly restricted properties through its Section 221(d)(3), Section 236, and Section 8 project-based rental assistance programs.

Many Section 202 and other elderly-restricted Multifamily properties also connect residents with supportive services, particularly through the on-site resident service coordinators. Service

coordinators are typically funded via the operating budget, rental subsidies, or HUD's Office of Multifamily Housing Service Coordinator Grant Program, which provides grants for the employment of service coordinators in HUD-assisted multifamily housing for the elderly and persons with disabilities. The role of service coordinators varies widely among properties, but HUD-funded service coordinators typically work onsite at each property to provide information and refer residents to supportive services available in the community—such as transportation and meal services—to facilitate continued independent living.

The health-service needs of HUD-assisted seniors are primarily supported by Medicare and Medicaid insurance programs; an estimated 70 percent of HUD-assisted seniors are covered by both Medicare and Medicaid (often referred to as "dual-eligible beneficiaries" or "duals"). For dual-eligible beneficiaries, Medicare is the primary payer of primary and specialty care, inpatient and outpatient acute care, and post-acute skilled-level care. Medicaid may provide support to cover Medicare premiums and other services, such as long-term services and supports. Historically there has been poor coordination and alignment between the provision of housing, social, and health services; the two have operated as separate, distinct sectors to address what have been considered non-overlapping needs. The intent of the Supportive Services Demonstration is to better integrate assisted housing with health and social services, such that assisted housing properties can be used as a platform for improved health and housing outcomes.

Previous Research

To better understand the health of HUD-assisted older adults, and explore the potential to better align and coordinate social and health services, HUD conducted three research initiatives that have direct bearing on the demonstration: In 2010, HUD and the Department of Health and Human Services (HHS) contracted The Lewin Group to develop design options for a demonstration of coordinated housing and long-term services and supports for low-income seniors. Following an extensive scan of best practices, the report recommended a model comprising an on-site enhanced service coordinator and nurse team that helps residents address their social and health needs. In this model, the service coordinator assumes a proactive role to conduct assessments, develop and monitor individual healthy aging plans, and encourage resident engagement in programs and activities. The on-site nurse works in conjunction with the enhanced service coordinator and performs health and function assessments, answers health-related questions, provides one-on-one and group health education, liaises with healthcare providers, and monitors transitions home following an emergency department or hospital visit. The model was also designed such that it can build directly upon the existing service coordinator program already present in many HUD-assisted properties. Many of the recommendations are included in the current demonstration.

As part of the same contract, HUD and HHS engaged The Lewin Group to pilot an administrative data match that linked HUD administrative and Centers for Medicare and Medicaid Services (CMS) Medicare and Medicaid claims data. The goals of this study were to explore the feasibility of linking HUD and CMS administrative data, determine the extent to which these linked data could track health and housing outcomes, and assess whether this approach could support

future research. The study found that HUD-assisted dual beneficiaries had more chronic conditions, greater healthcare utilization, and higher healthcare costs than similar unassisted beneficiaries residing in the community.[7] Importantly, this pilot linkage has provided the basis for the data collection and analysis portion of the impact evaluation of the Supportive Services Demonstration.

The third key piece of research is the evaluation of the Support and Services at Home (SASH) program. SASH is designed to connect older adults living in affordable senior housing properties in Vermont with community-based healthcare and supportive services to promote greater care coordination, improve health status, and slow the growth of healthcare expenditures. Each SASH panel consists of up to 100 participants served by a full-time SASH coordinator and a quarter-time wellness nurse, typically using HUD-assisted or other nonprofit affordable housing properties as the locus for coordination. Under contract from HHS and HUD, RTI International and the LeadingAge have been evaluating the SASH program to examine program implementation and assess health outcomes and service utilization of SASH participants. Many of the promising practices from the SASH model have been incorporated into the Supportive Services Demonstration model design.

Implementation
The Fiscal Year (FY) 2014 Consolidated Appropriations Act provided authority for HUD to test housing with services models that have the potential to allow elderly persons to successfully age in place. In January 2016, HUD announced the availability of a funding opportunity (Notice of Funding Availability or NOFA) under the *Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing*, which aims to promote aging in place and improve housing stability, well-being, health outcomes, and reduce unnecessary or avoidable healthcare utilization associated with high healthcare costs. It made available approximately $15 million in 3-year grants to owners of multifamily properties to implement the demonstration.

Eligible applicants were owners of elderly designated or restricted multifamily properties with at least 50 assisted housing units occupied by eligible tenants (households consisting of one or more persons of whom one is at least 62 years of age or older); up to 10 percent of the units could be occupied by a person with a disability under the age of 62. Properties with and without current resident service coordinators could apply. Eligible HUD-assisted housing types included housing assisted under Section 202 of the Housing Act of 1959, housing with project-based Section 8 assistance (including USDA Section 515 rural housing projects), housing insured under Section 221(d)(3), and housing assisted under Section 236 of the National Housing Act. Awardees consisted of properties in seven states: California, Illinois, Massachusetts, Maryland, Michigan, New Jersey, and South Carolina.

HUD contracted The Lewin Group—with the support of subcontractors LeadingAge and the WellHome Network—to refine the demonstration model and fully implement the Supportive

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[7] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. 2014. "Picture of Housing and Health: Medicare and Medicaid Use Among Older Adults in HUD-Assisted Housing," Washington, DC: HHS. http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.pdf.

Services Demonstration. The team developed the model known as Integrated Wellness in Supportive Housing, or IWISH. The IWISH model relies upon a housing-based Resident Wellness Director (RWD) and a part-time Wellness Nurse (WN) who implement a formal strategy for coordinating services to help meet residents' needs. The RWD engages with all residents (who decide to participate) in a proactive, comprehensive, and ongoing manner and works closely with the WN to implement the six components of the IWISH model:

1. Formal partnerships with appropriate local health and social service providers;

2. Formal resident engagement and roll out strategy to maximize resident recruitment and retention;

3. Standardized assessment with all participants after program enrollment and periodically throughout demonstration;

4. Individual health aging plan (IHAP) for each participant and community health aging plan (CHAP) for each property to guide service and program planning;

5. Centralized, web-based platform where properties can enter assessment and tracking information for report generation, tracking sentinel events, and service planning and coordination; and

6. Implementation of appropriate evidence-based wellness and health education.

Implementation officially began in October 2017, and the demonstration will run through September 2020. The location of the 40 properties implementing the IWISH model can be found in exhibit 1.

Exhibit 1. Location of Properties Implementing the IWISH Model
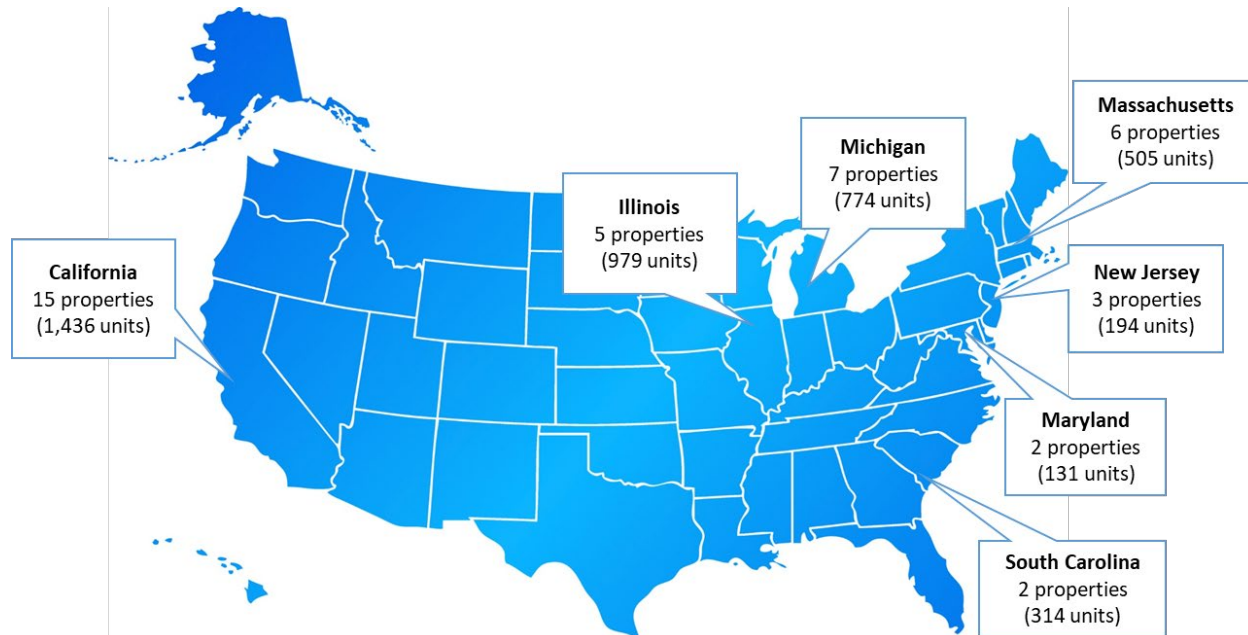
Location map created by Abt Associates, Inc.

In November 2017, the implementation team hosted a two-day, in-person training for all the RWDs and WNs on staff at the time. The initial training, focused on staff roles and responsibilities, the IWISH model, and working with residents. To date, the implementation team has hosted over 30 webinars on a wide variety of topics to help train and support staff, including strategies for relationship building and supporting behavior change, teamwork, privacy, assessing resident and community needs, trauma informed care, working with serious mental health challenges, and conflict resolution. The implementation team also has regular check-ins with sites and provides technical assistance and support on an ongoing basis.

Evaluation

In an effort to fully evaluate the IWISH model and demonstration, HUD is also funding an independent evaluation conducted by Abt Associates, with the major goal of producing reliable, credible, quantitative evidence for Congress and stakeholders about the impact of IWISH on healthcare utilization and transitions to nursing home care. Eligible HUD-assisted properties that applied for the demonstration were randomly assigned to one of three groups: a "treatment group" that received grant funding to hire an RWD and a WN and implement the IWISH model (40 properties); an "active control" group that did not receive grant funding but received a stipend to participate in the evaluation (40 properties); and a "passive control" group that received neither grant funding nor a stipend (44 properties). The random assignment enables an evaluation that quantifies the impact of the IWISH model by comparing outcomes at the 40 treatment group properties to outcomes at the 84 properties in the active and passive control groups.

The evaluation consists of a process study and impact evaluation. The process study will assess fidelity to the IWISH model, successes and challenges to implementation, and answer important questions related to resident health, well-being, and housing. The impact evaluation will use HUD administrative data linked with Medicare and state Medicaid claims data to quantitatively assess the impact of IWISH on healthcare utilization by comparing those participating in IWISH and those in the control groups. The impact evaluation is focused on four main questions:

1. What is the impact of IWISH on utilization of Medicare and Medicaid covered unplanned hospitalizations and other acute care?
2. What is the impact of IWISH on utilization of Medicare and Medicaid covered primary care and other non-acute healthcare services?
3. What is the impact of IWISH on housing exits and resident tenure?
4. What is the impact of IWISH on transitions to long-term institutional care?

The interim report is expected in the fall of 2019 and the final, comprehensive report is expected in the spring of 2022.

Case Study Three
Naturally Occurring
Retirement Community and Villages

Naturally Occurring Retirement Community (NORC) and Villages are neighborhood/community supportive services program models that promote independent living arrangements among elderly populations. *NORCs* form "naturally" as residents in a neighborhood, an apartment/condominium building, or cluster of apartment/condominium buildings in close proximity age and account for a sizeable share of the population within the defined geography. NORCs are typically run by non-profit organizations that establish relationships with community healthcare providers and social service organizations to facilitate healthy independent living among elderly residents. Services are typically delivered onsite with social events and programming occurring both onsite and offsite. Villages are typically membership organizations for elderly residents whereby supportive services and social events are arranged and coordinated for Village members. Village membership is available to elderly residents irrespective of their place of residence. Based on the needs of Village members, Village staff members coordinate a range of services provided by trusted vendors (for example, home repairs, landscaping, wellness groups, exercise classes, meal preparation, social and cultural excursions) and ensures that members are satisfied with the quality of these services. Village staff are often paid and rely heavily on support from local volunteer organizations.

As residents within a community begin to age, it is inevitable that Villages in communities with high concentrations of elderly residents might become Village NORCs—blending the two models to support independent living and combat social isolation among the elderly. Whether these services are provided by NORCs, Villages, or Village NORCs, the primary objective remains the same—supporting healthy aging in the community.

In the section below, I describe the Hamilton-Madison House NORC Supportive Services Program and the Hotel Oakland Village. Because Hamilton-Madison House SSP is an example of a "classic NORC" or "vertical NORC" (apartment building or set of apartment buildings within a development) and the Hotel Oakland Village was established within a large multifamily property (converted hotel), the reader will notice similarities in the location where services are delivered but differences in the range of services offered between the two. It is worth noting that NORCs and Villages are uniquely tailored to the needs of their residents. So, it is possible to observe a NORC and Village with a similar set of services and activities for its residents/members.

Naturally Occurring Retirement Community

The Hamilton-Madison House NORC Supportive Services Program (HMH NORC SSP) is in the Lower Eastside of Manhattan and is near the Alfred E. Smith NORC and the Knickerbocker Village NORC. The HMH NORC SSP services 3,500 apartments with more than 8,000 residents (majority seniors). The HMH NORC SSP is mostly publicly funded, receiving three-quarters of its funding from the New York City Department on Aging. The programs offered by HMH NORC SSP are based on a community needs assessment and includes early feedback from residents, health and human services providers, and other community support organizations in the program development phase. This process ensures that services deemed by elderly residents to be necessary for independently living and promotion of social engagement are included in program activities. Additionally, HMH NORC SSP develops relationships with philanthropic organizations, businesses, and other community sponsors to support their NORC programming efforts.

Exterior Elevation of HMH NORC SSP site location.

The New York State Legislature has specific legislation to support NORCs. Specifically, New York state law defines NORC and includes provisions for the delivery of supportive services within a NORC. As defined under Article 2 Title 1 Section 209 (Elder Law), the Hamilton-Madison House NORC SSP is a "classic NORC:"

"an apartment building or housing complex which: (1) was not predominantly built for older adults; (2) does not restrict admissions solely to older adults; (3) (A) at least forty percent of the units have an occupant who is an older adult; and (B) in which at least two hundred fifty of the residents of an apartment building are older adults or five hundred residents of a housing complex are older adults; and (4) a majority of the older adults to be served are low or moderate income, as defined by the United States Department of Housing and Urban Development."

As part of NORC programming, HMH NORC SSP delivers services that promote independent living, improve the quality of life for its residents, and slow the rate of emergency care utilization as well as transition to assisted and nursing care facilities. Residents within HMH NORC SSP access services in the following areas: service coordination and casement management for healthcare assessments and follow-up linkages and preventive interventions, in-home care, counseling, housekeeping/chores, congregate meal, exercise, transportation, shopping, recreational activities, and social excursions. These services are considered supplements to existing onsite and community-based health and well-being efforts—not replacement thereof.

The following table provides basic demographics of the residents serviced by HMH NORC SSP. Although roughly a third of NORC residents are elderly, half of households served by the NORC have at least one elderly household member. And given the age distribution among elderly residents, the NORC has supportive services to address elderly residents' needs as they continue to "age in place."

	Alfred E. Smith NORC	Knickerbocker Village NORC
Year Founded	1953	1934
Total Units	1,931	1,589
Number of Residents	4,316	3,720
% Elderly Residents (age 60+)	33	28
% Households with at least one Elderly Resident	54	51
Age Categories: % age 60 to 69 % age 70 to 79 % age 80 to 89 % age 90 or older	47 36 15 2	43 35 18 4

Note: Twenty percent of NYCHA residents are age 62 or older (similar to nationwide estimates for HUD-assisted residents).

The Village

Hotel Oakland Village
Originally opened in 1912 as a luxury hotel that hosted past United States Presidents, movie stars, and dignitaries from around the globe, Hotel Oakland experienced tough economic times during the 1930's. Shortly thereafter, the hotel was taken over by the military and converted to military hospital (Oakland Area Station Hospital) and later became a VA hospital. Between 1963 and 1978, the hotel laid dormant and averted a series of demolition attempts by the city.
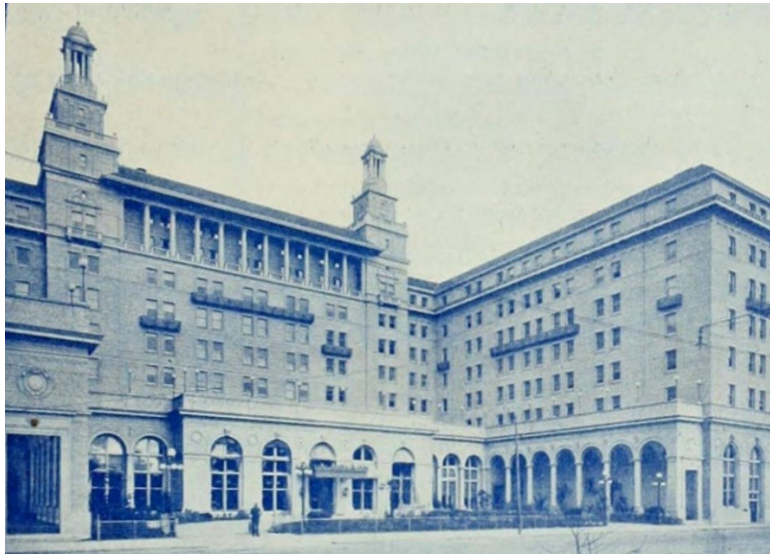
Exterior Elevation of Hotel Oakland – Early 1900's.
Source: LocalWiki.org

In 1979, real estate investor Bill Langelier and his partners purchased the landmark hotel and converted it to affordable senior housing. Their goal was to provide 400 quality affordable units to low-income seniors. After observing limited social engagement amongst residents and understanding the impact of social isolation on the health of seniors, Langelier decided to establish health education groups co-managed by residents with a focus on promoting social engagement around health and wellness topics. In July 2011, he and his team established the Hotel Oakland Village.

Exterior Elevation of Hotel Oakland – 2000's.

Essentially, the Hotel Oakland Village was established to address the impact of social isolation on the health and wellness of the Village's resident. With nearly 400 elderly residents, many whom are "active," Hotel Oakland Village seized the opportunity to develop programming addressing social isolation while also attending to the healthcare needs of its residents. During the early years, Langelier and his management team facilitated the creation of 8 resident co-managed health education groups. As resident participation increased, so did the number of health education groups – from 8 groups in 2011 to 15 groups in 2016. Health education groups promote social engagement among residents who might otherwise be at risk of living an isolated life with little social interaction within their immediate community [or "with limited social interaction with their neighbors"]. These resident co-managed groups provide health-centered social engagements for residents with a focus on informing and building healthy habits that support independent living. [The collection of information delivery and healthy habit building activities is expected to extend residents' ability to live independently while avoiding negative healthcare events.]

Resident Managed Health Group
Hotel Oakland Village's health groups provide residents with access to services that are co-managed by their fellow residents. These health groups promote social engagement within the Village and healthy independent living. By partnering with residents to delivery peer-led health education groups covering medical diagnoses most common to Village residents, residents are engaging their neighbors on healthy independent living practices and lowering the walls of social isolation.

The following table is a selection of health education groups co-managed by Village residents.

Falls Prevention	• Increases awareness of risk of falling and promotes a culture of falls prevention • 15-member Resident Advisory Board
Healthy Eating	• Provides insight on personal nutrition and healthy eating habits • Cooking classes and shared learning
Healthy Minds	• Seminars on cognitive disorders and the conditions they create • Promotion of brain stimulation activities
Neighbor Helping Neighbors	• Neighbors taken on the role of supporting neighbors in their time of need • Two 'Floor Captains' on each floor
Personal Safety	• Covers crime prevention and safety issues • Organized walks and errand groups

Health and Wellness Connection

In February 2016, Hotel Oakland Village began "Village Health and Wellness Connection." As part of Village Health and Wellness Connection, a comprehensive long-term wellness plan is developed for each resident. In partnership with the onsite Wellness Director, residents are connected to onsite services to address elements outlined in the wellness plan. Resident who experience similar health ailment meet regularly to support each other in addressing the health ailment.

With ongoing monitoring of adherence to the wellness plan and support with implementing the plan, Hotel Oakland Village's approached this partnership with a focus on providing supportive services that allow residents to transition from independent living to assisted living to skilled nurse supported living without having to leave the facility. This model is a well-designed housing with supportive services program that is committed to supporting seniors who desire to age in place.

The following groups have been established with 100 percent of residents participating in at least one group.

Heart Problems	Stomach Problems	Arthritic Problems
Three High (high blood pressure, high cholesterol, and high sugar)	Emotional Well-Being	Music Therapy
Chore Provider		

Hong Fook

In addition to onsite services provided to residents, Hotel Oakland Village offers two Hong Fook community-based adult services centers (CBAS) that support health living among the broader

community's elderly and disabled adult populations at risk of institutional care. CBAS centers are funded by Medi-Cal. CBAS centers provide nursing care, chronic disease management, dietitian and rehabilitative services, social services, and stimulating cognitive and recreational activities. These services are offered onsite to community residents and are also made available to Hotel Oakland Village residents through a referral from the Village's Wellness Director. For Village residents, the wellness plan is the focus of engagement. The additional CBAS services expand the types of service providers available to Village residents to include speech therapist, occupational therapist, physical therapist, dietician and nutritionist, social workers, and activities coordinator.

Case Study Four
Volunteerism in the United States:
Case Study for the US-Japan Aging in Place Research Project

Volunteering in the United States has become a classic tradition. Many Americans start volunteering at an early age and continue this practice throughout their lives. Numerous venues to participate in voluntary projects are available, including education, youth clubs, and religious-affiliated groups.

Example of Religious Groups and Volunteering
Religious congregations offer a variety of opportunities for volunteers of all ages. Some of these tasks include ushering in members as they join the service, helping with administrative tasks, cleaning the church, or doing yard maintenance. Children learn the value in serving others as they volunteer their time and energy helping maintain the church building and assisting elderly church members.

Example of Youth Club
The Boy Scouts of America and the Girl Scouts of the United States of America are very large organizations within the United States that offer a wide variety of volunteer opportunities. There are 2.4 million youth participants and nearly 1 million adult volunteers participating in the Boys Scouts. In addition, there are 1.7 million youth members and 750,000 adult volunteers in the Girl Scouts. These Scout programs are educational, after-school programs that teach children a variety of skills through the merit badge program. Once a Scout accomplishes a task, he/she is awarded a badge that is sewn on a sash, which the child proudly wears to their scouting meetings. These merit badges include badges for community service.

The highest status for a Boy Scout is the rank of Eagle Scout, which is usually not attained until high school. This scouting milestone requires an additional 21 merit badges including several that are focused on community services such as Citizenship in the Community, Citizenship in the Nation, Emergency Preparedness, Lifesaving, and Environmental Science or Sustainability. The Eagle Scout candidate must choose a community project that shows their engagement in the greater community, focused on volunteerism.

Examples of Education Institutions
College admissions are highly competitive in the United States, especially at the top tier universities and colleges. High school students know that community service and volunteerism can give them the edge over other similarly qualified students. Colleges are looking for young people who are committed to not only attaining a high level of education through superior grades but also to their community and to making the world a better place.

Parents also encourage their teenage children to pursue international volunteer projects. There are numerous web sites solely devoted to helping parents and students find an international volunteer project. Through those projects, students not only have an opportunity to learn a new culture and travel abroad, but they will also receive a sense of accomplishment and purpose.

Many high schools across the United States make performing community service a requirement for graduation. Some schools require as many as 40 hours of volunteer time to complete their degree. Many grade schools will also organize a volunteer day at least once during the academic year. Students perform some sort of volunteer service project on those days, such as cleaning up a park or recreation area, collecting canned goods for a food drive, or perhaps organizing a clothing drive for the needy.

Community service and volunteering have always been a part of the American society, and this sense of community spirit is part of the culture of growing up in the United States.

U.S. Government Involvement in Promoting Volunteerism
The U.S. Government created the Corporation for National and Community Service (CNCS) with the National and Community Service Trust Act of 1993. The agency's mandate is to support the American culture of citizenship, service, and responsibility through the following volunteer programs: AmeriCorps, Learn and Serve America, Senior Corps, and other national service initiatives. CNCS supports volunteerism through grants and is the nation's largest annual grant maker for supporting community service and volunteering. In fiscal year 2019, the agency's budget was $1.08 billion, which included operating costs and also provided for grants to encourage volunteerism.

The Senior Corps program is targeted at those who are 55 and over by matching them with the right volunteer organization. One program, Senior Companions, pairs volunteers with two to four adults who are aging in place in their homes but need volunteers to help with chores and other tasks. This service connects volunteers to the elderly who need a senior companion. Senior Corp programs are available across the country.

The Senior Corps program, however, helps more than just elderly people. Senior Corps' RSVP program was created to help those over 55 find specific service opportunities that may include:

- Organizing neighborhood watch programs.
- Tutoring and mentoring disadvantaged or disabled youth.
- Renovating homes.
- Teaching English to immigrants.
- Assisting victims of natural disasters.

CNCS is able to provide volunteer matching on a national scale through local state offices, however, there are many other volunteer matching services available.

Examples of Nonprofit Organization Promoting Local Volunteerism
HandsOn Bay Area in San Francisco, CA is a nonprofit organization that acts as a broker to connect organizations that need volunteers with people looking for a volunteer opportunity who are not sure how to find a good match. HandsOn Bay Area also works with local companies to plan and organize corporate volunteer days. In 2017, they organized more than 25,000 volunteers, resulting in more than 76,000 hours of service to more than 280 schools, parks, and nonprofits across the Bay Area. The projects included education and literacy, youth development, health and aging, homelessness, and environmental projects.

Example of a Private Nonprofit Working in Collaboration with Volunteers Using Government Funding
Meals on Wheels America is an excellent example of a nationwide nonprofit group that relies on both volunteers and paid employees to provide services for preparing and delivering meals.

In order to qualify for a free meal from Meals on Wheels, the recipient must be housebound and 60 years or older. Recipients must also meet income limitations of no more than $1,218 per month. Meals on Wheels America provides one meal delivery a day, often large enough for a full day of food. Some delivery drivers are paid but many are volunteers, including those who prepare the food and those administering the program. Meals on Wheels America noted that, in 2018, "millions of volunteers enabled 225 million meals to be delivered to 2.4 million seniors."

Meals on Wheels America is funded through a number of income streams, mostly private, but the organization receives 38 percent of their funding through the Older Americans Act. This grant pool is administered by the U.S. Department of Health and Human Services (DHHS). In 2016, DHHS dispersed $590 million to local Meals on Wheels America organizations. The remaining 62 percent of funding is through other sources including private donations and foundation grants. Private foundation, corporate philanthropy, and community foundation funding of aging and senior services is less than 2 percent of total giving for Meals on Wheels. This amount is an incredibly low share of overall philanthropy and demonstrates the need for volunteers. Without volunteers, this organization could not exist.

2018 Volunteering in America Report
CNCS recently released the 2018 Volunteering in America report. Their research found that 77.34 million adults (30.3 percent) volunteered through an organization in 2017. Americans volunteered nearly 6.9 billion hours, worth an estimated $167 billion in economic value, based on the Independent Sector's estimate of the average value of a volunteer hour for 2017. Other key findings from the report (quoted):

- Americans in Utah report the highest rate of volunteering (51 percent), holding the top spot among states, followed by Minnesota (45.1 percent). Oregon (43.2 percent) climbed from the 13th-ranked state to the third; and is joined by Iowa (41.5 percent) and Alaska (40.6 percent), which are both also new to the top five.

- Among cities, Minneapolis-St. Paul (46.3 percent) once again ranks first, with Rochester, NY (45.6 percent), Salt Lake City (45 percent), Milwaukee, WI (44.6 percent), and Portland, OR (44.3 percent) trailing slightly behind.

- Parents volunteer at rates nearly 48 percent higher than non-parents, and working mothers give more time than any other demographic, with a volunteer rate of 46.7 percent.

- Generation X has the highest rate (36.4 percent) of volunteering, whereas Baby Boomers give more hours of service (2.2 billion). Millennials are stepping up to do more in Utah and the District of Columbia.

- Americans most frequently gave their time to religious groups (32 percent), one-fourth volunteered most often with sports or arts groups (25.7 percent), with another nearly 20 percent supporting education or youth service groups.

- One in three volunteers raises funds for nonprofits (36 percent). Additional volunteer activities include food donation and meal preparation (34.2 percent), transportation and labor support (23 percent), tutoring young people (23 percent), serving as a mentor (26.2 percent), and lending professional and management expertise (20.5 percent).

- Nearly 80 percent of volunteers donated to charity, compared with 40 percent of non-volunteers. Overall, one-half of all citizens (52.2 percent) donated to charity this past year.

Conclusion

These numbers are remarkable and show that, without volunteers, far fewer services would be offered to our nation's most needy, including our elderly.

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