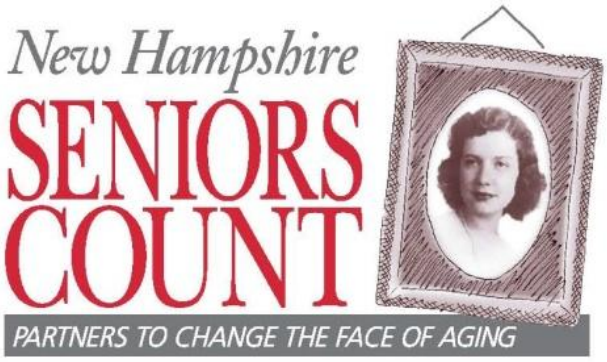
Seniors Count Community Connections
Administration on Aging "Community Innovations for Aging in Place"
Evaluation Report



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CENTER ON AGING AND
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Executive Summary

Funding from the US Administration on Aging "Community Innovations for Aging in Place" grant was awarded to *Seniors Count* in October of 2009 and supported the creation of *Seniors Count* Community Connections. The new initiative built on the foundational work of *Seniors Count* and aimed to improve care for frail seniors in the Greater Manchester, NH area and to promote systems change by improving coordination and facilitating communication among three traditional silos of care: medical services; social- and community-based services; and informal, family caregivers. Data collected between September 1, 2010 and August 31, 2012 show that a positive impact was made in several target areas.

Key findings include the following:

I. Improvements in the lives of frail seniors

A. Connectivity to and coordination among needed community services and supports was increased.
B. High levels of complex needs were reduced.
C. A person-centered approach ensured seniors' priorities were addressed and they were connected to the kind of help they most wanted.

II. Advancement of systems change

A. Coordination of care among medical and community/social providers improved.
B. Partners committed to sustain the work of the initiative.

Future directions

Triumphs and challenges encountered in the course of this pilot and the establishment of partnerships have advanced *Seniors Count* in its creation of a replicable model and have informed future directions for the continuation of its work on behalf of frail seniors in the community. Recommendations for future efforts have been informed by this initiative and include the following:

- Continue to educate regarding the *Seniors Count* philosophy of coordination among the three traditional silos of care and a person-centered approach to working with frail seniors;
- Promote the role of the *Seniors Count* Community Liaison as an essential position in the coordination of care among medical providers, community/social services, and caregivers;
- Support and facilitate the engagement of informal, family caregivers.

I. Background

In October 2009, *Seniors Count* received a 3-year grant from the US Administration on Aging (AoA). The "Community Innovations for Aging in Place" funding awards were intended to support innovative models aiming to advance the ability of older adults to live and age in their home communities.

Since its inception in 2001, *Seniors Count* has engaged the community to fundamentally alter the systems that deliver assistance and information to frail seniors and their caregivers. The *Seniors Count* philosophy of bridging gaps in resources and increasing coordination among services has changed the way the community thinks about and relates to frail seniors, helping to ensure that frail seniors are able to age independently, with dignity, in their own homes.

The 2009 AoA grant funding enabled the launch of *Seniors Count* Community Connections, an initiative that established a replicable, person-centered model in which *Seniors Count* partnered with four other organizations to expand the work of *Seniors Count* Community Liaisons. Forming new bridges among social / community services and medical institutions, *Seniors Count* Community Liaisons coordinated their efforts on behalf of frail seniors from within five settings: *Seniors Count*, housed in Manchester at Easter Seals NH; Hillsborough County ServiceLink Aging and Disability Resource Center; Elliot Hospital; Catholic Medical Center; and Dartmouth-Hitchcock Medical Center.

This report describes the evaluation activities and key outcomes of the initiative. The University of New Hampshire Center on Aging and Community Living (CACL) conducted the evaluation of *Seniors Count* Community Connections. CACL supports system change through an interdisciplinary approach to scholarship, advocacy, evaluation, and the development and

dissemination of tools and skills that innovate and improve social models for consumer-driven services and supports.

II. **Evaluation methods**

Consumer pre-screening

When *Seniors Count* realized its vision to establish Community Connections, plans to embed *Seniors Count* Community Liaisons into three medical institutions in Greater Manchester, NH began to take shape. Early efforts to help the new Community Liaisons to identify and connect with the initiative's target population of frail seniors, as well as to educate their referral sources, led project directors to research a screening matrix initially developed in Ann Arbor, Michigan. With permission, *Seniors Count* adapted and pilot tested the matrix until it was deemed an appropriate and consistent "trigger" to indicate that a frail senior's needs rose to a level at which *Seniors Count* Community Liaison intervention would be appropriate. Recognizing that the matrix has yet to undergo thorough psychometric testing, *Seniors Count* opted to use it as a pre-screening tool. (The matrix is presented in Appendix A.)

The matrix allowed Community Liaisons to assess frail seniors on 11 relevant domains: financial resources, housing and home safety, food and nutrition, utilities, health care, legal, mental health and psychosocial, substance abuse, mobility, family relations and social support, and life skills. Within each domain, the frail senior's functioning in that area was rated on a scale from 1 to 5. The lowest, 1, indicated that functioning was seriously disrupted, while the highest score, 5, meant that the senior was independent and/or not requiring support within that domain. Illustrative examples from two of the matrix domains appear in Table 1. Frail

seniors who were assessed at 3 or below in two or more domains were triggered for referral and further evaluation by *Seniors Count* Community Connections.

Table 1. Examples of functioning assessed with pre-screening matrix

	1	…	3	…	5
Utilities	Utilities shut off	…	Sporadic payment of utility bills without oversight	…	Bills are paid regularly
Health care	Significant health concern unmet by health care provision and/or no medical coverage with immediate need	…	Occasional unmet needs; may delay, reduce, or omit needed care; does not follow routine health care	…	Covered by affordable, adequate health insurance including some preventive care

Data collection

In accord with feedback and guidance from *Seniors Count* Community Connections' Project Directors and Work Group, the evaluators created a data collection instrument using the Microsoft Access platform. Special care was taken during the design phase to make a functional and user-friendly interface that would ensure both anonymity of participants and the provision of needed evaluation data. Easter Seals NH hosted a remote access server which held the dedicated database, where it could be accessed by the Community Liaisons in their five locations, as well as at *Seniors Count* and by the offsite evaluators. The database featured easy-to-enter Access data forms requesting information from several areas of frail seniors' lives: demographics, service utilization, types of assistance desired, a brief medical overview including recent emergency department and hospital use, and presence / interaction with informal caregivers. In addition, care plans, progress notes, and the pre-screening matrix were all available in the database and linked together by participants' anonymous user identification.

All older adults who were referred to *Seniors Count* Community Connections were administered the matrix as a pre-screening assessment, as previously described. Then, seniors

who were identified as needing the support of *Seniors Count* Community Liaisons were assessed in the first 30 days following referral to the program to establish their baseline levels on all variables of interest. The seniors were assessed a second time six months later, and in many cases, a third assessment was completed one year after beginning to work with the Community Liaison. What follows in the next two sections of this report is a description of the seniors who were served (demographics) and the changes that were found to occur over time (impact).

To supplement and expand results analyzed from the Access evaluation database, summative focus groups were convened in June, 2012, to reflect on the work of the initiative and discuss lessons learned. Several of the triumphs and challenges associated with *Seniors Count* Community Connections were highlighted during the conversations. Excerpts and findings from the focus groups appear throughout this document, and a more detailed description of the methods and findings can be found in Appendix B.

III. Demographics: Frail seniors with complex needs

During the course of the *Seniors Count* Community Connections initiative, 232 seniors were assessed with the pre-screening matrix. Of those, 63% (n = 146) were determined to have met the initiative's criteria regarding level and type of need and were added to Community Liaisons' active case loads. Information regarding reported gender and age is shown in Figures 1 and 2. Ninety-eight percent reported their race as White. Of the seniors served, 42% were either divorced or single, 35% were widowed, and 23% were married. Additional variables of interest at the time of intake are conveyed in Figure 3.

Figure 1. Frail seniors served, by gender
n = 143

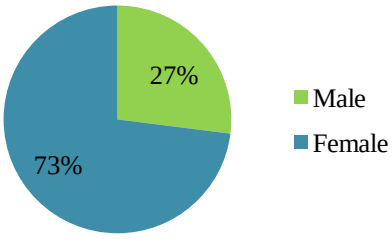


Figure 2. Frail seniors served, by age
n = 138

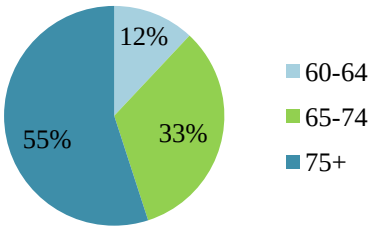
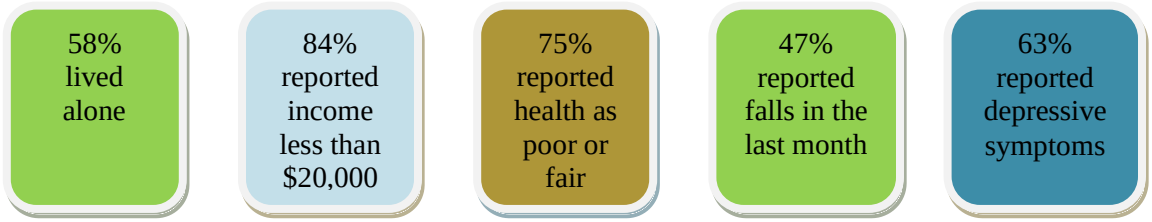


Figure 3. Snapshot of 146 frail seniors served

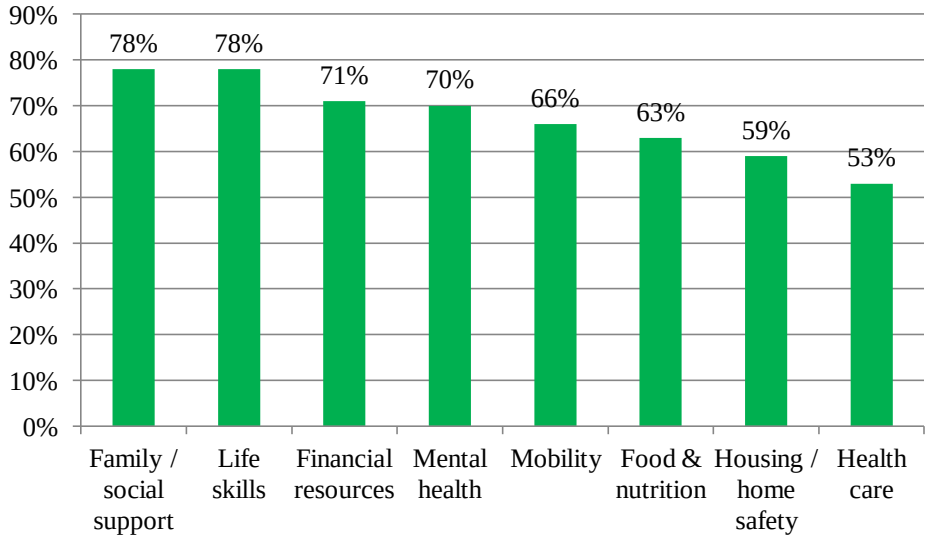


Seniors served by *Seniors Count* Community Connections had a high level of need in multiple domains, as assessed with the pre-screening tool. The domains that are covered by the matrix are detailed in Table 2, and the proportion of frail seniors who exhibited the highest levels of need in 8 of 11 areas is illustrated in Figure 4. The only areas that were not found to be high levels of need among this sample included legal issues, substance abuse, and utilities (see Appendix C, Table C1).

Table 2. Domains assessed by the pre-screening matrix

Domain	Brief description
Family relations / social support	Availability, involvement of informal supports
Financial resources	Sufficiency of income, ability to manage finances
Food & nutrition	Ability to meet basic food needs without assistance
Health care	Access to and compliance with routine health care
Housing & home safety	Safety and security of housing, home environment
Legal	Ability to manage, presence of pending legal issues
Life skills	Independence with activities of daily living
Mental health / psychosocial	Symptoms or issues that may affect functioning
Mobility	Availability of transportation to meet basic needs
Substance abuse	Evidence of substance abuse within 6 months
Utilities	Ability to pay bills consistently and on time

Figure 4. Percent of seniors with high level of need at intake (n = 146)



IV. Impact Evaluation

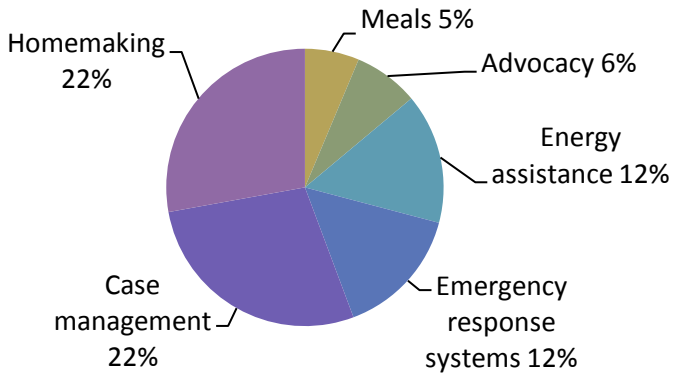
The impact evaluation considers how effective *Seniors Count* Community Connections was at fulfilling its stated goals to improve care for frail seniors in the Manchester, NH area and to promote systems change by improving the coordination of care among medical services and social/community service providers. Success was achieved in both areas, and key accomplishments of the initiative are highlighted below.

Outcome 1: Increased frail seniors' connection to community/ social supports

Frail seniors frequently need help with the basic activities of daily life, and facilitating their ability to receive these kinds of help ensures that they will be able to live independently and remain in the community (or in their community of choice) for a longer period of time as they age and their need for support naturally progresses over time. Following at least six months of intervention by *Seniors Count* Community Liaisons, frail seniors were more likely to

be connected to the services they needed to maintain and enhance living independently in the community. Figure 5 shows that *Seniors Count* Community Liaisons facilitated gains of 5% or more in seniors' utilization of 7 different social / community services. (Also see Appendix C, Table C2.) Of special note is the 22% increase in both homemaking and case management.

Figure 5. Increases in utilization of needed services among frail seniors



Further information about the ways in which *Seniors Count* Community Liaisons were able to connect frail seniors with needed services and supports in the community came from analyzing the care plans that Liaisons had created with each individual. Within the care plans, Community Liaisons named at least 24 community-based organizations and services in the Greater Manchester area to which they were able to facilitate frail seniors' connections. Some examples include the ServiceLink Aging and Disability Resource Center, local food banks, Caring Companions, assistive technology, emergency response, Friendly Visitors, Meals on Wheels, Manchester Mental Health, visiting nurses, and many others.

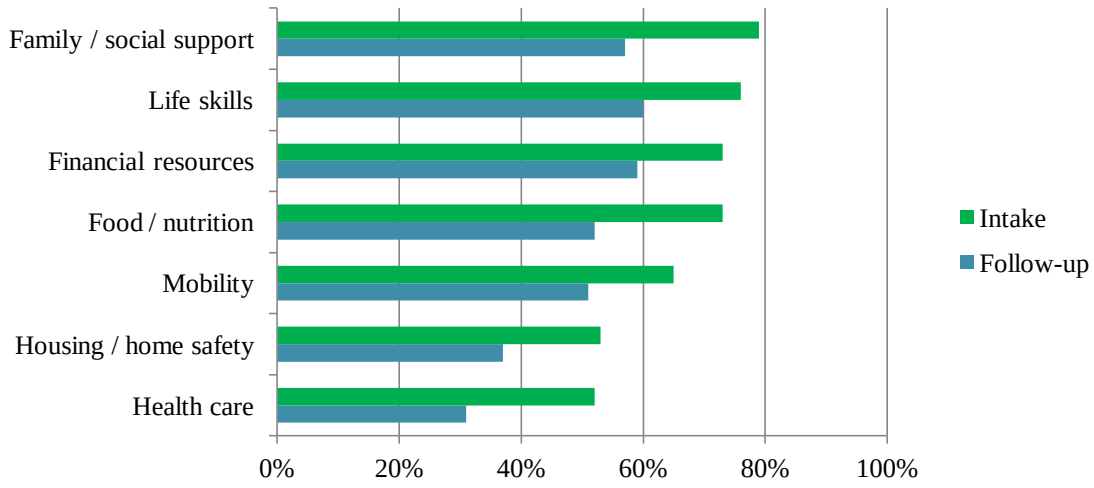
Outcome 2: Reduced level of need in 8 domains relevant to frail seniors

As described in the evaluation methods section of this report, a pre-screening matrix was developed to assist *Seniors Count* Community Liaisons to identify which seniors exhibited a

very high level of unmet needs and therefore fit the target population for the initiative. In addition to serving its purpose as a pre-screening tool, the matrix provided an opportunity for the evaluation to measure how the needs of these frail seniors changed over time as a result of *Seniors Count* Community Connections. The matrix allowed for assessment of seniors in 11 domains at intake and every 6 months thereafter.

Of the 62 seniors who were assessed more than once using the matrix, considerable improvement was evident. Figure 6 shows that, as a group, frail seniors served by *Seniors Count* Community Connections were stabilized in multiple domains. For example, 79% of the sample showed a high level of need at intake in the area of family and social support. At follow-up, this percentage was reduced to 57%, indicating that 22% had moved from high need to stability in this domain. At the individual level, statistically significant improvement was seen in 5 domains: financial resources, housing and home safety, food and nutrition, health care, and family relationships / social support.

Figure 6. Decreases in percentage of seniors with highest level of need in each domain



The care plan template used for the initiative was developed by the evaluators, with input from the Community Liaisons, and was based on the same domains assessed by the matrix. Throughout the course of *Seniors Count* Community Connections, more than 250 care plans were initiated. Analysis of the care plans demonstrates that Community Liaisons targeted their efforts on behalf of frail seniors in the areas of greatest need. To this end, care plans were most frequently associated with the following domains: financial resources (17% of all care plans), life skills (15%), health care (13%), housing and home safety (12%), mental health / psychosocial (12%), family / social support (10%), and mobility (10%). It is notable that even though some of the domains lend themselves to intervention and change more readily than others (for example, it may be easier to help a frail senior with an application for food stamps than to resolve ongoing mental health issues), Community Liaisons did not concentrate on just one or two that would be easiest to influence. Instead, they tended to apply their efforts across a broad range of domains.

Outcome 3: Person-centered planning ensured frail seniors got assistance they desired

Seniors Count Community Connections embraced a person-centered approach to working with frail seniors. Community Liaisons were trained at hire, and were supported through ongoing supervision, regarding the person-centered philosophy and strategies to implement it. Whereas some models of case management prescribe interventions based on providers' perspectives, opinions, and prioritization of what individuals need, person-centered approaches involve starting from the perspective of the individual. Consider an example.

Comments from summative focus group participants appear in green boxes.

Typically when a case manager enters the home of an older adult and observes indications of hoarding or disarray that pose a clear threat to the individual's safety and mobility, that worker might reasonably prioritize the hoarding issue as among the first issues to address. While such action might make sense from an objective standpoint, it risks increasing stress and /or alienating the older adult, which could lead to a refusal of any intervention. The traditional model can lead to providers feeling frustrated with frail seniors' seeming inability to manage and meet their own needs.

Seniors Count Community Liaisons also observe and note relevant issues; however, in contrast, their first action is to ask the older adult what s/he would like, what his/her goals are, and what types of assistance s/he perceives as most useful to his/her well-being at the present time. By doing so, the Community Liaison builds trust and rapport with the senior while also empowering the person to maintain choice and independence. *Seniors Count* calls this "meeting the client where they are," and the senior and the Community Liaison may then move forward together.

Seniors Count Community Liaisons "really talk with patients" and have "more flexibility to meet clients where they are."

Frail seniors who worked with *Seniors Count* Community Liaisons were asked to indicate the activities of daily living (ADLs) and instrumental activities of daily living (IADLs) with which they desired assistance. Table 3 shows the ADLs and IADLs with which seniors most often indicated they would like to receive help. Those activities for which the requests for help substantially increased between initial assessment and follow-up included housework, meal preparation, shopping, and transportation.

Table 3. Percent of sample requesting assistance with ADLs / IADLs

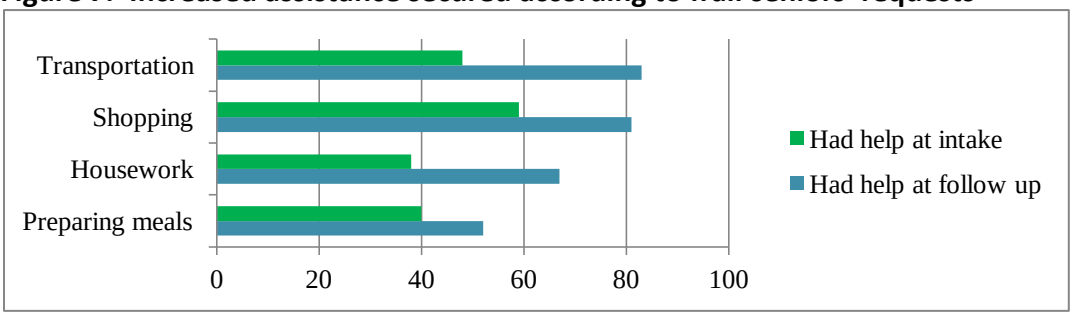
	Intake	Follow up	Increase
Preparing meals	45%	54%	9%
Housework	47%	74%	27%
Shopping	74%	86%	12%
Transportation	57%	85%	28%

While the data do not provide a reason for the increase in perceived need for assistance, two possible explanations logically present themselves. First, the nature of the frail seniors this initiative served (those with complex needs and, initially, minimal supports) may reasonably be expected to decline over time and to need more assistance. Second, as the Community Liaisons were able to develop more meaningful rapport and trust with the seniors, the latter may have become more comfortable sharing a higher level of need than they were originally.

> Frail seniors reported a statistically significant increase in satisfaction with life following intervention by *Seniors Count* Community Liaisons.

Despite sometimes considerable increases in the number of requests for assistance between intake and follow-up, *Seniors Count* Community Liaisons were frequently able to connect frail seniors with assistance in exactly the areas they most desired. Examples of particular note are provided in Figure 7. Frail seniors who asked for and received necessary transportation increased from 48% at intake to 83% at follow-up. Similarly, assistance with housework was available to 38% of those who desired it at intake and 67% at follow-up; help with shopping for those who requested it was provided to 57% at intake and 85% at follow up. (See Appendix C, Table C3. for more detail.)

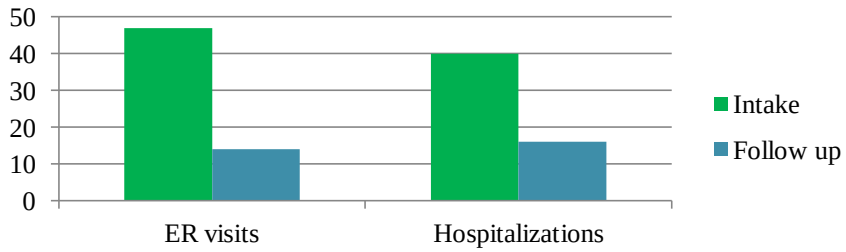
Figure 7. Increased assistance secured according to frail seniors' requests



Outcome 4: Reduced emergency department visits and hospitalizations

Seniors Count Community Liaisons reported data regarding hospitalizations and emergency department visits made by the frail seniors with whom they worked. Community Liaisons from the medical facilities were able to access this information from their respective Electronic Medical Records (EMR), and those from *Seniors Count* relied on seniors' self-report or conversations with primary care physicians. Figure 8 shows the intake and follow-up data regarding hospital use for the 58 seniors who provided data at least twice. Among these individuals at the time of initial assessment, nearly half (47%) had visited the emergency department at least once in the previous 30 days, and 40% had been hospitalized. At follow-up, significant reductions in the number of emergency visits (t_{51} = 4.23, p < .001) and reductions in hospitalizations were found; ER visits in the 30 days prior to reassessment were reported by 14% of the individuals, and 16% reported hospitalizations.

Figure 8. Percent reporting visits to ER / hospital in previous 30 days



One of the aims of *Seniors Count* Community Connections was to reduce inappropriate use of hospital services by harnessing or enhancing supports that would help keep frail seniors safe and healthy in the community. Frail seniors who are unsure where else to turn have sometimes reported visiting the emergency department when they have a need that they can't meet on their own. The presence of a *Seniors Count* Community Liaison in their lives ensured that seniors did have somewhere to turn when they required assistance or did not know what to do. While many factors likely contributed to the reduction in hospital utilization of the reported sample, it is reasonable to suggest that *Seniors Count* Community Connections was among them.

Outcome 5: Advanced systems change by improving coordination of care

Seniors Count Community Connections set out to facilitate and enhance collaboration and communication among three often disparate areas that contribute to frail seniors' care: medical providers, community / social services, and informal caregivers. The initiative's partnership with Elliot Hospital, Dartmouth-Hitchcock Medical Center, Catholic Medical Center, and Hillsboro County ServiceLink Aging and Disability Resource Center and the embedding of four *Seniors Count* Community Liaisons within those sites served as an important vehicle for achieving better coordination of care. Summative focus groups convened with partners and stakeholders revealed that all parties saw beneficial advances in collaboration and felt that channels of communication had expanded. Specific participant comments appear in green boxes throughout the next sections.

"I've seen a lot of good communication that has prevented a lot of tragedies out there."

Partners and stakeholders appreciated *Seniors Count* Community Connections for advancing a model that is inclusive of frail seniors and strives to keep them safe and healthy in the community. Partners from the medical facilities noted that prior to having a Community Liaison, hospital discharge situations with frail seniors could be very frustrating because hospital-based staff could "see what was going to happen [after the patient left their institution] but couldn't help." Community Connections served to fill "that in-between position for transitions."

"Hospital social workers are using [the Community Liaison] as their link to the community."

Some participants agreed that Community Liaisons having access to the Electronic Medical Record was a "huge benefit." "Just being able to find out which medications an individual is taking" allowed the *Seniors Count* Community Liaisons to engage in more troubleshooting than they might otherwise have been able to do without contacting the doctor's office. The EMR and onsite messaging systems for the *Seniors Count* Community Liaisons in the medical facilities was especially helpful in that it permitted fluid and effortless communication directly with doctors and nurses. For Community Liaisons stationed in the community, access to medical information and rapport with primary care providers can be difficult to establish.

The collaboration among medical and social/community service providers was "awareness-building on both sides." Working together was "a benefit" to frail seniors and to the community as a whole.

Outcome 6: Partners committed to sustain the Community Liaison position

Arguably among the most exciting outcomes of *Seniors Count* Community Connections is the decision by two of the three partnering medical facilities to sustain funding of the

Seniors Count Community Connections:

"paving the way for the future of health care"

"a model that is inclusive of patients and how to keep them safe and healthy in the community"

Community Liaison position beyond the grant-funded pilot. This is especially significant in light of recent downsizing at local medical institutions due to major budgetary constraints. The implications of their commitment to continue the efforts of the initiative are multifold. First, it demonstrates that the medical institutions understand the value of the position. Second, greater numbers of frail seniors will be identified and connected with essential services and supports. Third, the fact that a growing number of older adults will be more stable and better able to continue living independently in the community will contribute meaningfully to appropriate utilization of medical care which results in savings to Medicaid and Medicare and the reduction of public health expenditures. Importantly, the commitment to sustainability provides key evidence of systems change.

Seniors Count planned Community Connections to be a vehicle for systems change. Rather than resting on the success of the Community Liaison model as they had defined it within the community, they chose to pursue new partnerships with the medical institutions to increase collaboration across silos of care in the interest, primarily, of frail seniors but also the community at large. Expanding the reach of the Community Liaisons supported hospitals in their consideration of how to help seniors after leaving the hospital and reduced the burden on primary care practices whose clinical staff can afford neither the time nor the flexibility necessary to sufficiently address the range and complexity of frail seniors' needs. That two-thirds of the partnering medical facilities elected to keep funding Community Liaisons is strong evidence of the perceived value added by the position and the model of care.

V. Future directions

Promote a holistic, person-centered approach to address the needs of frail seniors among medical providers, social and community services, and family caregivers.

Triumphs and challenges encountered in the course of this pilot and the establishment of partnerships across medical and community providers have advanced the goal of *Seniors Count* to create a replicable model and improve the care of frail seniors in the Manchester, NH area. Findings from the initiative add important information to the ongoing community, state, and national discussion on care coordination. *Seniors Count* Community Connections expanded the knowledge base for the utilization of a person-centered, holistic approach to addressing the needs of frail seniors in local communities. The evaluation results suggest that when community based providers and medical providers work together to ensure that the unique needs of each frail senior are met, the door between hospital and community care revolves less. This pilot also addressed local systems issues and provided a good foundation upon which the Manchester, NH area community and medical providers may build.

Recommendations for future efforts based on the initiative and evaluation results include the following:

- Continue to educate across the Manchester, NH area regarding the *Seniors Count* philosophy of coordination among the three traditional silos of care and a person-centered approach to working with frail seniors;
- Promote the role of the *Seniors Count* Community Liaison across the Manchester, NH area as an essential position in the coordination of care among medical providers, community/social services, and caregivers;
- Support and facilitate the engagement of informal, family caregivers in the model;
- Educate other communities in NH or nationally on the utility of this care coordination model for the frail senior within an urban area;
- Replicate the model in a non-urban area of NH or another state.

Appendix A:

The pre-screening matrix

DOMAIN	**1**	**2**	**3**	**4**	**5**
1. Financial Resources	No income. Insufficient or no retirement funds. Bills greatly exceed income in multiple areas. Unable to apply for or unaware of state programs.	Inadequate income or inappropriate spending. Bills for basic needs cannot be paid. Outstanding judgments or garnishments.	Meets basic needs with subsidy or assistance. Begins appropriate spending. Needs access to public assistance	Meets basic needs. Manages debt without assistance. Moderate budgeting skills	Income is sufficient
2. Housing and Home Safety	Homeless, in foreclosure, or facing imminent eviction. Home or residence is not safe. Possible APS involvement.	In transitional, temporary or substandard housing. Current rent/mortgage payment unaffordable. Safety issues significant but not life threatening. Substantive oversight needed.	In safe, stable housing. Needs minimal support. Household is safe with support but future uncertain.	Adequate subsidized housing. Needs minimal support. Household is safe with support but future uncertain.	Household is safe, adequate, and affordable.
3. Food and Nutrition	No food or unable to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Meals are missed at least one day per week.	Can meet basic food needs with home delivery, but requires assistance.	Can meet basic food needs without assistance	Can choose to purchase any food household desires
4. Utilities	Utility shut off.	Unable to pay utility bill. Notice of eminent shut off. Utility repair urgent.	Sporadic payment of utility bills without oversight.	Needs minor assistance to budget and pay for utility bills	Bills are paid with regularity.
5. Health Care	Significant health concern unmet by health care provision. No medical coverage with immediate need.	Great difficulty accessing medical care when needed. Intermittent health care needs unmet. Inability to pay for or understand health care financing for specific need.	Occasional unmet needs. May delay, reduce or omit needed care. Does not follow routine healthcare.	Can obtain medical care when needed, but may not follow preventative care or may strain budget.	Covered by affordable, adequate health insurance including some preventative care
6. Legal	Current outstanding tickets, impending lawsuits or warrants of other unresolved legal issues.	Current charges/trial pending. Noncompliance with legal issues impacting housing. Needs representation.	Compliant with plan to resolve other legal issues or has secured representation.	Has successfully completed requirements, no new charges filed or recently resolved other legal issues.	No active legal issues in more than 12 months

7. Mental Health, Psycho-social	Danger to self or others. Recurring suicidal ideation. Experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others. Persistent problems with functioning due to mental health symptoms or dementia.	Mild symptoms may be present but are transient. Only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are acceptable responses to life stressors. Only slight impairments in functioning.	Symptoms are absent or rare. Good functioning in wide range of activities. No more than every day problems or concerns.
8. Substance Abuse	Meets criteria for severe abuse/dependence. Resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, work, emotional or physical problems related to use (disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.
9. Mobility	No access to transportation, public or private. May have care that is inoperable. Unable to obtain accompaniment for life threatening medical appointments.	Transportation is available, but unreliable, unpredictable, unaffordable. Has informal rides, but needs financial help to pay.	Transportation is available and reliable, but limited and/or inconvenient. Needs assistance finding transportation at times.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable.
10. Family Relations and other Social Support	Lack of necessary support from family or friends. Abuse (DV, elder, financial) is present or there is neglect.	Family/friends may be supportive, but lack ability or resources to help. Family members do not relate well with one another. Potential for abuse or neglect.	Some support from family/friends. Family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Adequate support from family or friends. Household members support each other's efforts.	Has viable support network. Communication is consistently open
11. Life Skills	Unable to meet basic needs such as hygiene, food, and activities of daily living.	Can meet a few but not most needs of daily living without assistance.	Can me most but not all daily living needs without assistance.	Able to meet all basic needs of daily living with assistance.	Able to provide beyond basic needs of daily living for self and family.

Appendix B:
Summative Focus Group Results

Methods

In early June, 2012, two focus groups were convened to assist *Seniors Count* Community Connections project directors to assess some of the lessons learned through the work of the Administration on Aging grant. The focus groups were facilitated and analyzed by members of the evaluation team from the UNH Center on Aging and Community Living. First, a focus group comprised of seven individuals representing key partner agencies working with *Seniors Count* Community Connections was convened to share experiences with the project and provide feedback on project effectiveness. Focus group attendees included representatives from one of the three partnering hospitals/medical centers, *Seniors Count*, and other affiliated community-based organizations. On June 5, 2012, a second focus group with six current and former Community Liaisons from *Seniors Count* and from each of the three partnering medical institutions was convened to reflect on the work of the community liaisons and their experience with the project.

Focus group findings provide a measure of whether or how well *Seniors Count* Community Connections succeeded in its attempts to improve connectivity among the community / social arena and the medical providers. *Seniors Count* espouses a philosophy that is determinedly person-centered and fundamentally collaborative. A key goal of this initiative was to promote understanding and to educate the medical community regarding best practices that can help keep frail seniors healthy and viable in the community. The results of the focus groups provide insights into the effectiveness of Seniors Count in reaching this goal and lessons learned for future replication efforts.

Embedding *Seniors Count* Community Liaisons in medical settings

Overall, the partners were supportive of the model that *Seniors Count* envisioned and developed for Community Connections. Community Liaisons were "able to put in place what [seniors] needed as quickly as possible" to keep someone at home. To this end, the "unique" ability of Community Liaisons to drive and make home visits was embraced as a key aspect of their success.

The medical institutions saw great benefit to having the embedded Community Liaison. The Community Liaison's ability to get involved "even before someone leaves the hospital" was viewed as important, allowing them to "get a foot in the door" and "set expectations from the get-go." Connecting with the senior before hospital discharge, Community Liaisons were able to gain capital and trust with the senior. They could have "integrity" and "build a relationship with the client" because they would "follow through" and "do what they said they would do." One participant shared how the Community Liaisons successfully reinforced the medical side of seniors' needs by accompanying them to appointments. She said, "Referrals weren't just made, referrals were DONE!"

Despite positive regard for the overall model and effectiveness of *Seniors Count* Community Connections, both partners and Community Liaisons noted difficulties with supervision being shared between *Seniors Count* and the medical institutions. "Two institutions supervising the same person is hard." Participants felt that due to the nature of the position supervision was really important, style of supervision was key, and "One centralized model of supervision would have helped." Representatives in each of the focus groups expressed challenges in reaching a shared vision and expectation about the community liaison role.

Medical providers note importance of clinical training and supervision

Part of the perceived importance of Community Liaisons' supervision was the idea that clinical input and oversight was an essential aspect of the project's success. However, among the group of participants, there was some disagreement about the type and level of expertise needed for both Community Liaisons and their supervisors. One individual described weekly supervisory meetings with a Community Liaison, in which they went over the "nitty gritty details of cases" and lots of clinical work took place. Others agreed that both the social work perspective and the clinical training were very important. One individual felt that the medical components needed more attention than someone with social work training could provide; she felt this initiative was a "great start" but that a nurse social worker "would have been perfect." She indicated that was the direction her organization would go with the position in the future.

From a different perspective, one individual opined the need to "stretch" the way we look at certain roles. For example, it was said, a community health worker could bring the needed medical competencies to the Community Liaison position, although perhaps without the level of liability coverage. Several others shook their heads. They said that social workers doing jobs such as medication planning was "NOT okay" and not in their scope of service (but they do it because there is no one else). It was also pointed out that frail seniors without a doctor or who are unwilling to present at the hospital need someone who can perform medical assessments in the home. While a social worker was not seen to have this expertise, a Community Liaison could definitely use such capacity because of their ability to maintain contact over time, unlike certain other types of providers who may come in once or twice and then vanish from the scene. Ultimately, it was suggested that these roles comprise gradations

on a continuum of expertise that includes community health workers, social workers, nurses, and more. There was no consensus regarding where on this continuum a Community Liaison ought to fall.

Learning to embrace the person-centered approach

Community Liaisons' work was lauded for its person-centeredness; they were seen to "really talk with patients" about the patients' wishes. It was noted that physicians – or "anyone in the hospital" – can't take the time to do that, and that this was an excellent role for the Liaisons. The Liaisons echoed that, compared to traditional medical social workers, they had "more flexibility to meet clients where they are." One noted that the relationship they could establish with seniors was "more close-knit and personal." Another added that their role was more like family for those who didn't have any family.

The job of the community liaison has been characterized as fulfilling the eldest daughter role. On one hand, some participants took the concept of "eldest daughter to heart." On the other hand was the view, "That's not professional." Many opinions regarding eldest daughter fell somewhere in between the two poles. In one of the focus groups, an individual pointed out that eldest daughter was "not so literal; it's a philosophy" that refers to the fact that the frailest seniors often "don't have anyone who can or will do stuff for them."

One participant admitted that it took time to warm up to the idea. S/he explained that at first, it was "tough" to understand that a high risk senior could best be served by taking the dog to the vet, or that "what they need wasn't going to be taking them to church!" Over the life of Community Connections, however, his/her views expanded. It seemed the participant grew to recognize the importance of those kinds of support to the seniors' self-assessed well-

being and to their subsequent willingness to trust the Community Liaisons and to begin accepting other types of interventions as well.

Flexibility to do the work that is most needed

Community Liaisons appreciated being "less bound than a traditional social worker would have been," and this was echoed in both focus groups regarding the importance of their ability to drive, which was seen as unique in NH. In this light, some of the Community Liaisons felt that instead of counseling around boundaries, they needed guidance to help them navigate the complicated situations of the seniors with whom they worked.

Often, Community Liaisons reported, they were "really involved for a month or two months" in order to help a senior through a point of crisis, to get organized and put services in place, or to assist with a transition. For example, when a senior went to a skilled nursing facility and then was discharged back home, "transitions like that can get lost in the shuffle." A Community Liaison indicated that "often [s/he] gets a call… on the last day of a SNF visit." Another said s/he managed such situations by physically going to the SNF "to show them a face and to make SURE [s/he's] included" in the planning. S/he noted, "it's the leg work."

Successful fulfillment of the Community Liaison role

The supervisors also expressed satisfaction that they "chose the right person for the job." Community Liaisons were described as "awesome… not overwhelmed… not losing sleep" and "knowing how to prioritize… communicate" and be person-centered. One of Liaisons reflected on his/her time with Community Connections saying, "I've loved my job. I got so much out of my clients. They've really showed me what strength is."

Appendix C:
Supplemental Data

Table C1. Change in seniors' level of need following Community Liaison intervention

Assessment Matrix Summary (n = 62)

	Initial		Follow-up	
	High Need	**Low Need**	**High Need**	**Low Need**
Financial Resources	**73%**	27%	**59%**	41%
Housing / Home Safety	**53%**	47%	37%	**63%**
Food / Nutrition	**73%**	27%	**52%**	48%
Utilities	26%	**75%**	18%	**82%**
Health Care	**52%**	48%	31%	**69%**
Legal	5%	**95%**	10%	**90%**
Mental Health / Psychosocial	**69%**	31%	**68%**	32%
Substance Abuse	2%	**98%**	8%	**92%**
Mobility	**65%**	35%	**51%**	49%
Family / Other Social Support	**79%**	21%	**57%**	43%
Life Skills	**76%**	24%	**60%**	40%

Table C2. Change in frail seniors' connectedness to community services

Service	% in place at Initial assessment	% in place at Follow-up	Increase in connectedness to service
Adult Day	2	8	6%
Advocacy	2	20	18%
Assistive Technology	5	14	9%
Case Management	3	22	19%
Community Dining	3	3	0
Energy Assistance	14	25	11%
Food Stamps	17	19	2%
Home Care	24	17	-7%
Home Maintenance	2	2	0
Homemaker	36	54	18%
Meals on Wheels	26	27	1%
Emergency Response	9	27	18%
Prescription Assist.	5	10	5%
Senior Center	2	5	3%
Support Group	0	3	3%
Transportation	14	37	23%

Table C3. Of the sample (n=58), percent of seniors who desired and received help

ADL / IADL		Initial	Follow-up	Change
Bathe / shower	Desires help	38%	36%	-2%
	Receives help	27%	29%	10%
Dress / undress	Desires help	29%	17%	-12%
	Receives help	27%	16%	1%
Eat	Desires help	13%	13%	0
	Receives help	3%	3%	0
Get around the house	Desires help	19%	19%	0
	Receives help	17%	19%	11%
Get in / out of bed	Desires help	12%	12%	0
	Receives help	12%	12%	0
Housework	Desires help	47%	74%	27%
	Receives help	38%	67%	10%
Laundry	Desires help	76%	72%	-4%
	Receives help	57%	62%	11%
Money management	Desires help	71%	45%	-26%
	Receives help	54%	41%	15%
Preparing meals	Desires help	45%	54%	9%
	Receives help	40%	52%	7%
Shopping	Desires help	74%	86%	12%
	Receives help	57%	85%	22%
Taking medications	Desires help	50%	43%	-7%
	Receives help	45%	41%	5%
Transportation	Desires help	57%	85%	28%
	Receives help	48%	83%	13%
Using the phone	Desires help	21%	17%	-4%
	Receives help	21%	17%	0
Using the toilet	Desires help	23%	17%	-6%
	Receives help	21%	17%	9%
Washing / grooming	Desires help	19%	19%	0
	Receives help	12%	17%	26%