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Seniors Count Follow-Up Study

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*Seniors Count Follow-Up Study*¹



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November 2003

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Cover Photo of Gerontology undergraduate and certificate students conducting telephone interviews in their classroom phonebank.

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ACKNOWLEDGMENTS

The City of Boston, through the leadership of Commissioner Joyce Williams, undertook an ambitious endeavor when it demonstrated its commitment to elders in 1999 by launching *Seniors Count*. The idea of outreaching door-to-door to all community-residing elders to check on their well-being and to inform them of the City's programs and services designed to address their needs may have seemed overwhelming to most who might question where the resources would be drawn to implement such an initiative. This Commissioner, however, has not faltered from her resolve—the resources have largely come from the over 500 volunteers who have shared her vision as well as from the City of Boston's Mayor Thomas M. Menino, who has supported her in fulfilling the Elderly Commission's mission to serve Boston elders.

The Gerontology Institute and the Undergraduate and Manning Certificate in Gerontology programs at the College of Public and Community Service, University of Massachusetts Boston, were pleased to partner with the Elderly Commission to conduct a follow-up study of this ambitious outreach effort. In the broadest sense, this study attempts to illustrate the extent to which *Seniors Count* has fulfilled its original goals of identifying and addressing the needs of Boston's community-residing elders.

There were many individuals who contributed to the design and implementation of this research project. The study was implemented within the framework of an applied research in aging class that conducts an annual action-research project, a required part of the Gerontology undergraduate and certificate programs at the University of Massachusetts Boston (UMB). The Spring 2003 Action-Research project was directed by Nina M. Silverstein, Ph.D., with research and teaching assistance from doctoral candidate May H. Jawad, M.S., and doctoral student Heather L. Connors.

An Advisory Board was recruited to assist with the formulation and review of the questionnaire as well as provide insight into the interpretation of preliminary findings. The individuals who served on the Advisory Board were: Joyce Williams, Commissioner on Affairs of the Elderly; Guillermo Gonzalez, Deputy Commissioner, Boston Commission on Affairs of the Elderly; Robert Ormsby, Deputy Commissioner, Boston Commission on Affairs of the Elderly; Brian S. Souza, M.S., Director, Boston Partnership for Older Adults; Franklin Ollivierre, Massachusetts Association of Older Americans and co-chair of *Seniors Count Phase I*; Diane Lopes-Flaherty, former Commissioner, Boston Commission on Affairs of the Elderly and co-chair of *Seniors Count Phase I*; Frank Caro, Ph.D., Director, Gerontology Institute, UMB; Suzanne Leveille, Ph.D., Hebrew Rehabilitation Center for the Aged; Anita Nasra, Kit Clark Senior Services; Geraldine Wyse, RN, member of the *Seniors Count Training Team*; and Ralph Browne.

Advisory Board member Commissioner Joyce Williams was especially helpful in presenting some historical background and some of her experiences with *Seniors Count* to the class during a February 2003 lecture. Milton and Arlene Wolk, Gerontology Program alumni and trainers at the Center for Survey Research at UMB, provided the class with helpful training on telephone interviewing in April 2003. In addition, experiences shared by *Seniors Count* volunteers Velda Lashley, Audrey Downey,

Beverly Roye, Mary MacKillop, Connie Mohammed, Michael McColgan, and Lee Grant, who served on two panels and spoke to the class in February 2003, were also helpful in providing insights into the outreach effort.

The data set of information collected at Phase I of *Seniors Count* was obtained with the help of Erik Anderson and Robert Ormsby from the Boston Commission on Affairs of the Elderly. Manning Certificate Program alumni: Jeanne Bragg, Ann Carver, Janet Cote, Carol Courage, Natalie Fultz, Nancy Goldin, Louise Gleason, Judith Gorton, Ada Hayes, Ruth Leabman, Jane Linn, Kay Maguire, Marian Masterson, Marjorie Murphy, Anne O'Malley, Sr. Jeanne Perrault, Renee Summers, and Jane Toomey, and Gerontology Institute volunteer Jack Betterman, volunteered their time to assist with telephone interviewing during data-collection in April 2003.

Diane Pyle, Manning Certificate Program Administrator, and Mary St. Jean, Gerontology Administrative Assistant, provided continued support throughout the project's duration. Robert Geary, Gerontology Institute, edited the final manuscript.

The following students, as members of the Spring 2003 Action-Research class, are acknowledged for their contributions to this study:

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EXECUTIVE SUMMARY

Seniors Count is an ongoing elder-outreach initiative by the City of Boston. The program's purpose is to "identify and reach out to those members of the city's elderly population who live in private housing arrangements and help provide them with the information and services they [may] need" (Boston Commission on Affairs of the Elderly, 2002). Since the program's inception in 1999, it has reached over 5,500 community-dwelling elders in Boston (Boston Commission on Affairs of the Elderly, 2002).

This report shares the findings of a follow-up assessment of the first phase of *Seniors Count*. Insights into *Seniors Count* participants' satisfaction with the program, how well participants felt their needs had been addressed, and whether new needs had arisen since their 1999 in-person household interview are presented. In addition, respondents shared information about their health status, their neighborhoods, their voting behavior, and their perceptions of Boston as an "elder-friendly" city.

Of the 2,533 seniors, who were interviewed in 1999 during *Seniors Count Phase I*, 1,610 seniors were provided at least one specific type of referral information to a program or service. A random sample of 850 *Seniors Count Phase I* participants who received at least one such type of referral information was chosen for the follow-up study. Data were collected through supervised telephone interviews conducted at the Gerontology Institute during April 2003 by 35 undergraduate and certificate students enrolled in an Elder Action-Research course at the University of Massachusetts Boston. The response rate was 44%. The sample ranged in age from 65 to 95 years with the mean age of 77 years. Almost half (49%) had lived in Boston for 71 or more years.

In 1999, 81% of respondents (n = 596) reported that they took at least one prescription medication. In this follow-up 2003 survey, 90% of respondents reported taking at least one prescription medication while the average was four prescriptions per elder. Most respondents (94%) had visited a doctor for a regular check-up within the last year; however, only slightly more than half (52%) of the sample had been to a dentist within the last year. Respondents who reported wearing dentures in 1999 (n = 227) were less likely to have visited a dentist within the last year than those who did not wear dentures (p<.001) with only 39% of persons in that population reporting having visited the dentist.

RESULTS

Most Frequent Types of Referral Information Shared

Respondents had received an average of three referrals each in 1999. The five most frequent types of referral information provided to the sample were: prescription drug benefits, city tax exemptions, smoke detectors, grab bars, and fuel assistance. Over a third, 34%, had called either the Elderly Commission or the Mayor's 24-Hour Hotline.

Elder Commission Cable TV & Radio

The Commission on Affairs of the Elderly produces a cable television program as well as a radio program to share information with Boston seniors. More than three-quarters (76%) of the sample reported having cable television, and 36% of those with cable reported that they watch the Commission's television program. In contrast, only 5% of the sample reported listening to the Commission's radio program.

Transportation

For the most part, the elders surveyed appeared to be managing with the transportation options available to them. Most (91%) respondents reported that they were able to get most places they needed to go. Driving was the most frequently used form of transportation, with 62% of respondents reporting that they had a valid driver's license. Simply having a license did not guarantee driving, however. Seventeen percent of respondents with a valid driver's license reported that they had *not* driven a car within the last six months ($p < .001$). The next most frequently used form of transportation was the Massachusetts Bay Transit Authority (MBTA), with 44% of respondents reporting having used the MBTA within the last month. Familiarity with the MBTA Senior Discount Program was high among respondents, with 70% of respondents reporting being familiar with the MBTA Senior Discount Program. Familiarity with the Senior Discount Program was positively related to use of the MBTA. Respondents who were familiar with the MBTA Senior Discount Program were more likely to have used the MBTA in the last month than those who were not familiar with the Discount Program ($p < .001$).

Voting

Nearly all (96%) respondents in this sample were registered to vote, and 90% of those registered to vote had voted in a government election within the last year. Only 3% of those who had voted within the past year reported not having voted in-person.

"Elder-Friendly"

When asked to rate Boston as an elder-friendly city, 50% of respondents reported that they consider Boston to be "very" elder-friendly, with 3% of respondents considering Boston "not at all elder-friendly." The majority of respondents in the sample reported that they felt safe in their neighborhoods. Three-quarters of those surveyed reported feeling "very safe" in their neighborhoods, with less than 1% saying they felt "not at all safe."

CONCLUSIONS

Overall, *Seniors Count Phase I* achieved its initial goal of personally reaching many in the city's elderly population. Most respondents in the sample remembered the original Seniors Count visit, many reported having used the information they were given, and many had taken advantage of programs for which they were eligible. This sample appeared aware of services and reported using resources to attempt to access services.

Recommendations to *Seniors Count*

A number of useful recommendations emerged from this study that should be considered for future phases of *Seniors Count* and by the City of Boston as it responds to the challenges of an aging population. Although the findings are limited by their lack of easy generalization, trends such as high percentages of elders reporting difficulty using streets or sidewalks in some Boston neighborhoods might prove useful for city planners as they seek to make Boston more accessible for all its residents. Finally, this study illustrates the usefulness of conducting needs assessments for community-dwelling elders. Information gathered from needs assessment surveys may help to improve service providers' ability to tailor programs and services to those most able to benefit from them. Following are some specific recommendations that emerged from this follow-up study:

Regarding the *Seniors Count* initiative and contact with the Elder Commission and the Mayor's Office:

- Provide a written, large-print list of referral recommendations given to elders during the initial *Seniors Count* visit.
- Build in follow-up protocols and procedures for assessing how well *Seniors Count* is meeting its goals.
- The Commission's cable television program had been watched by over one-third of respondents, in contrast to the radio show, which reached only about 5% of the sample. The Commission might consider redirecting resources to promote further the cable show so that more seniors who have cable television become aware of and take advantage of the programs.
- Many of the respondents who reported not being satisfied after calling the Elderly Commission's telephone line or the Mayor's 24-Hour hotline attributed their dissatisfaction to a lack of response. It is important that hotlines respond to requests in a timely manner and seek to direct inappropriate calls to resources better suited to the callers' needs.

Regarding Health Issues:

- Most of the seniors in this sample (90%) reported that they were supposed to take at least one prescription medication. Managing the cost of prescription medications is a concern for many elders. Some felt that they were able to manage the cost of their medications with the help of programs such as Prescription Advantage. The importance of programs such as Prescription Advantage for seniors must be emphasized and supported.
- Although most of the sample had visited a doctor within the last year, dental visits were more infrequent, especially among seniors who reported wearing dentures. A public educational campaign emphasizing the importance of dental hygiene for all persons, even those with dentures, might be considered.

Regarding Neighborhood Accessibility:

- Over 20% of the sample reported difficulty crossing streets and using sidewalks in their neighborhoods. Repairs should be made to streets and sidewalks to improve their safety and accessibility. Streetlights and crosswalks should be assessed to determine whether longer time-delays or more frequent crosswalks would make Boston's streets more accessible for its older persons.

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INTRODUCTION

Seniors Count is an ongoing outreach initiative under the direction of Boston Mayor Thomas M. Menino with the leadership and support of Joyce Williams, Boston's Commissioner on Affairs of the Elderly. The program's purpose is to "identify and reach out to those members of the city's elderly population who live in private housing arrangements and help provide them with the information and services they [may] need" (Boston Commission on Affairs of the Elderly, 2002). Since the program's inception in 1999, it has reached over 5,500 community-dwelling elders in the City of Boston (Boston Commission on Affairs of the Elderly, 2002).

The purpose of this study was to conduct a follow-up assessment of the first phase of *Seniors Count*. This follow-up study provides insights into *Seniors Count* participants' satisfaction with the program, how well participants felt their needs had been addressed, and whether new needs had arisen since their 1999 in-person household interviews. In addition, respondents were asked about health status, neighborhoods, safety, voting behavior, and their perception of Boston as an "elder-friendly" city. The current report provides information and data collected from the *Seniors Count Phase I Follow-Up Study* and will share information about elders' experiences with *Seniors Count*, as well as descriptive information about these other areas of interest.

BACKGROUND

The initial development and success of a community service program requires the careful assessment of the changing and/or growing needs of the program's intended population. As such, needs assessment of the elderly requires knowledge about the psychosocial and emotional needs that can develop through a changing environment, including the aging process (Lewis, 1997). Needs assessments can be conducted through various data collection techniques such as personal observation, one-on-one interviewing, and/or survey instrumentation. Prior to designing the *Seniors Count Follow-Up Study*, existing literature was reviewed in order to build on the experience of studies of similar populations where in-person methodologies were utilized. The following is a brief review of the literature, as well as of local community efforts that have worked to identify and address the various needs of community-residing elderly.

In an effort to investigate the housing and social support needs within the context of the elder's current environment, a study by Lewis (1997) investigated the needs of 128 independently living men and women in an apartment complex in a large Northeastern metropolitan area. The complex provides center services aimed at addressing various housing and social support needs of its elderly residents. More specifically, the study's goals were aimed at 1.) gaining an understanding of the social support needs and perception of needs for the resident; and 2.) evaluating the resident's knowledge and use of available services within the apartment complex and center. Personal interviews were used, and descriptive data were generated that shed some light on the various housing and social support needs of the elderly residents. Findings indicated that the apartment complex and center provided a large range of adequate services as perceived by its residents, and that residents were generally aware of the existing services offered by the

complex and center. However, the author noted that given the homogeneity in perceived use and awareness of services, the diversity existing within a particular group when program modifications are planned should be given attention (Lewis, 1997). The author further argued the need to maintain and enhance independence in any program that provides services to the elderly. Thus, while specific to housing needs, Lewis' study emphasized the importance of understanding diversity and independence among elderly that utilize various community program services.

In another study, Calsyn and colleagues (1998) implemented current theory to design a needs assessment looking at the services provided to seniors by local Area Agencies on Aging (AAA). More specifically, Andersen and Newman's behavioral model (1973) was used to look at 1.) perceived service use, 2.) agency awareness and service knowledge, and 3.) service utilization. According to this model, level of service need, awareness, and utilization are functions of predisposing factors (e.g., race, age), enabling factors (e.g., social resources, income), and need factors (e.g., health status, functional impairment). Utilizing telephone interviews with a representative sample of seniors, the authors found that predisposing and enabling variables significantly predicted perceived service need. For example, African-Americans, those with more service barriers, and those with more potential helpers reported more service needs than their counterparts. In terms of agency awareness, while none of the predisposing variable predicted awareness, more socially active persons (i.e., enabling factors) were significantly more aware of agencies than their counterparts. Finally, Caucasians (i.e., predisposing), those in poorer health (i.e., need), and those with greater agency awareness were significantly more likely to utilize services. Given the strengths of this study in predicting the service needs of community-residing seniors, it is limited by the lack of panel data to assess changes in AAA service need, awareness, and use across time. The authors note the importance of longitudinal data so that respondents' baseline status can be established and comparisons can be made over time. Nevertheless, this study does provide a better understanding of the use of needs assessment when looking to improve and/or modify existing service programs targeted to the elderly.

In addition to the research discussed above, needs assessments can also be conducted in-process during the initial implementation of a specific service program or community coalition. For example, the Boston Partnership for Older Adults (BPOA, 2003), was developed with funding from the Robert Wood Johnson Foundation to "facilitate and improve upon the work of existing networks and service providers to develop a consumer-focused and culturally competent, long-term care system for vulnerable older adults" residing within the Boston area (BPOA, 2003). With the use of several data sources, BPOA has identified a number of issues required to strengthen existing community programs and services for Boston's seniors. These issues range from mental health to diversity and cultural competence. Needs assessments of these issues are fundamental to the current and future well-being of Boston's aging population because some older adults may have difficulty meeting their specific needs due to either the inadequate capacity of programs to meet these demands or the inadequate knowledge of services provided (BPOA, 2003). The BPOA report is especially helpful in providing a context for understanding the findings of this current study.

METHODOLOGY

Seniors Count Phase I was conducted by trained volunteers who went door-to-door throughout Boston's 15 neighborhoods¹ to interview seniors in their homes. Present for each interview were two volunteers – one acting as an observer and the other responsible for directing the dialogue with the senior (Boston Commission on Affairs of the Elderly, 2002). The *Seniors Count Phase I* interview consisted of questions related to the senior's health, including physical limitations and nutrition, social interaction, eligibility for services and programs throughout the city, and community involvement.

Since the program's inception in 1999, *Seniors Count* has contacted over 5,500 community-dwelling elders in Boston (Boston Commission on Affairs of the Elderly, 2002). At the time of the original *Seniors Count* visit, many participants were provided with referral information about programs or services intended to meet needs expressed during the interview. Of the 2,533 who were interviewed during *Seniors Count Phase I*, 1,610 seniors were provided at least one specific type of referral information to a program or service. These data were collected from a random sample of 850 *Seniors Count Phase I* participants who received at least one such piece of referral information at the time of the initial *Seniors Count* visit.

An action-research model was used to conduct this project. This model brings the university faculty and students together with community leaders or agency representatives to address an issue of public concern (Bass & Silverstein, 1996; Silverstein, Moorhead, & Murtha, 2002). The community partner for this project was the City of Boston's Commission on Affairs of the Elderly. An Advisory Board, composed of representatives from the Boston Commission on Affairs of the Elderly, the Gerontology Institute at the University of Massachusetts Boston, and interested community members, then reviewed and commented on the questionnaire, and later on the preliminary findings, resulting in the survey's final report.

The primary source of data collection was phone interviews conducted over three weekends in April 2003 by 35 students enrolled in the Elder Action-Research course. The research project was approved for the protection of human subjects by the Institutional Review Board of the University of Massachusetts Boston.

Gerontology students contributed to the design of the telephone survey using the original *Seniors Count* outreach interview, class readings, and questions they developed after hearing speakers who had participated as volunteer interviewers in *Seniors Count*. The interview schedule included both structured close-ended questions and opportunities for more qualitative open-ended responses.

¹ Alston-Brighton, Back Bay/West End, Charlestown, East Boston, Hyde Park, Jamaica Plain, Mattapan, North Dorchester, Roslindale, Roxbury, South Boston, South Dorchester, West Roxbury, North End, South End

The Boston Commission on Affairs of the Elderly sent letters to the sample (n = 850) in March 2003 describing the study and seeking cooperation (see Appendix A). Individuals who wished not to be contacted were given a telephone number to call to be removed from the master list.

Interviews ranged in time from 9 to 57 minutes with a mean length of 24.5 minutes. When calculating the response rate, the cases in which the subject was deceased, the phone was disconnected, or in which the person was no longer living in the community were dropped. When a phone number was determined to be incorrect or disconnected, efforts were made to find the correct number or to determine through a website search if the elder was now deceased. The response rate is therefore calculated out of 610 cases, making it 44% (271 completed interviews). Table 1 illustrates reasons for non-respondents.

Table 1. Reasons for Non-Responses (n = 579)

Declined/Refused ¹	33%
Wrong Number/Disconnected	23%
Deceased	17%
Dementia/Sickness	11%
Multiple Attempts ²	9%
Language Barrier	7%
No Longer In Community	1%

The analysis begins by seeing if there were differences on selected variables between follow-up respondents (elders participating in *Seniors Count* in 1999 and *Seniors Count Follow-Up Study* in 2003) and follow-up non-respondents (elders participating in *Seniors Count* in 1999 but who could not be reached in 2003). Table 2 shows differences in means between the sample reached and those who did not respond on selected questions asked in 1999. There were no significant differences in means between respondents and non-respondents in home ownership or in whether respondents lived alone in 1999. Similarly, differences were not found between groups in whether respondents took prescription medications, were satisfied with their health insurance, had health limitations affecting their ability to climb stairs, or had fallen recently. Therefore, on these dimensions, the elders who were reached were very similar to those whom we were unable to reach in the sample.

¹ The Declined/Refused category also included some cases in which a proxy refused for the respondent and cases in which the respondent reported being “too busy to take a survey.”

² The Multiple Attempts category consists of cases in which, despite multiple phone calls, the respondent could not be reached.

Table 2. Difference in Means Between Respondents in Follow-Up Study and Non-Respondents in Follow-Up Study

	Follow-Up Respondents (N = 240) ⁴	Follow-Up Non-Respondents (N = 490)	Statistically Significant Difference (t)
	mean		
Age in 1999 ¹	72.974	75.833	5.819 ***
Total # of referrals per person ¹	3.09	2.57	-3.119 *
Time 1: Does Health Limit Climbing Stairs	0.349	0.329	0.532
Time 1: Does Health Limit House Cleaning	0.296	0.263	0.951 *
Time 1: Does Health Limit Grocery Shopping	0.292	0.250	1.204 **
Time 1: Does Health Limit Cooking	0.243	0.188	1.739 ***
Time 1: Does Health Limit Socializing with Family	0.251	0.150	3.334 ***
Time 1: Fallen Recently	0.135	0.129	0.208
Time 1: Satisfied with Health Insurance	0.851	0.829	0.749
Time 1: Take Rx Drugs	0.806	0.813	-0.206
Time 1: Wear Dentures	0.633	0.592	1.063 *
Time 1: Live alone	0.333	0.321	0.32
Time 1: Own Home	0.700	0.675	0.681
Time 1: Rent Home	0.271	0.304	-0.912
Time 1: Self-Rated Health (reverse coded) ²	2.463	2.636	-2.72 *
Time 1: Health Compared to Last Year (reverse coded) ³	1.816	1.949	-2.861 *

See Appendix B for variable coding.

¹ Non-Respondents (N = 569), Respondents (N = 271)

² Non-Respondents (N = 484), Respondents (N = 236)

³ Non-Respondents (N = 485), Respondents (N = 237)

⁴ Time I Data were not available for all 271 Time II Respondents.

* p <.05

** p <.01

***p <.001

However, significant differences were found in several areas. Respondents who participated in both waves were significantly younger and had received more referrals than those who participated in the 1999 wave only. Respondents who participated in both waves were also significantly more likely than those who were only contacted in 1999 to report health problems that limited their ability to house clean, grocery shop, cook, or socialize with family. Finally, respondents who participated in both waves were significantly more likely to wear dentures and reported their health as worse than those who participated only in the 1999 wave of *Seniors Count*. Thus, there were some significant differences between the respondents and non-respondents in this follow-up study, and caution should be exercised in generalizing findings to the larger sample or to all elders contacted by *Seniors Count*.

The resulting sample age ranged from 65 to 95 years with the mean age of 77 years. Twenty-four percent had less than a high school degree, and 14% had a bachelor's degree or higher. The number of years respondents had lived in Boston ranged from 7 to

90 years with a mean of 62 years ($SD = 20$). Table 3 shows descriptive statistics for the sample.

The follow-up questionnaire covered areas including: referral information for programs and services given by *Seniors Count* (Appendices C & D); recalling the original *Seniors Count* visit; health status; neighborhoods; safety; voting behavior; and elder friendliness. Some examples of referral information given to seniors include information about prescription drug benefits, home repairs, fire safety, and tax exemptions. (See Appendix E for a full list of referral programs and services.)

The reader is advised to remember that sample participants include only those elders who had previously been interviewed by *Seniors Count* and who had been given information about at least one referral at the time of the 1999 visit.

Table 3. Sample Descriptives¹

Gender (n = 258)	
Male	31%
Female	69%
Age (n = 271)	
Mean = 77	
SD = 6.167	
65-69	7%
70-74	32%
75-79	25%
80-84	21%
85-90	13%
90 plus	3%
Race (n = 250)	
White	75%
Black or Caribbean Islander	20%
Employment Status (n = 259)	
Employed	8%
Educational Status (n = 258)	
Less Than High School	24%
High School	48%
Associates/Technical	14%
Bachelor	8%
Graduate	6%
Household Income (n = 204)	
Less than \$11,000	21%
\$11,001 to \$20,000	31%
\$20,001 to \$31,000	21%
\$31,001 to \$41,000	12%
\$41,001 or over	14%
Years Lived in Boston (n = 259)	
0-20	4%
21-30	7%
31-40	7%
41-50	12%
51-60	9%
61-70	12%
71-80	32%
81 or more	17%

¹ Respondents were informed at the beginning of the survey that they had the right to refuse to answer any question. Because some respondents chose not to answer all questions, the number of respondents for each question varies.

RESULTS

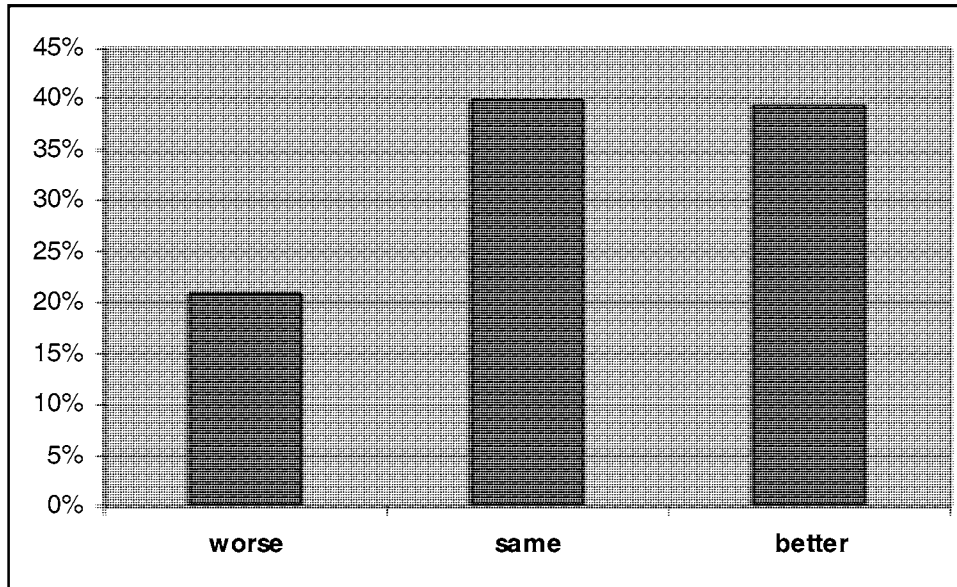
The following sections report results of data collected from the *Seniors Count Phase I Follow-Up Study*. Comparisons are first made between these data and data obtained from the 1999 *Seniors Count* interviews. Findings of respondents' experiences with *Seniors Count* are then presented, including respondents' recall of the information obtained during the *Seniors Count* visit and the referral information they were given. Findings regarding perceptions of the Elderly Commission's radio and television programs, as well as respondents' experiences calling the Elderly Commission and Mayor's 24-Hour Hotline are then presented. Next, information regarding respondents' health status, use of prescription medications, transportation use, and voting behavior is offered. Finally, data are presented on respondents' perceptions of Boston as an elder-friendly city, and the safety of Boston neighborhoods.

Comparisons Between Time I and Time II

It is useful to make comparisons where possible between the data collected by *Seniors Count* in 1999 and the data collected in this follow-up study (2003). For example, there was some change in household composition between 1999 and 2003 with 13% (n = 20) of those who lived with another person at Time I reporting living alone at Time II (p<.001). Changes in home ownership were also detected, with 10% (n = 15) of those who owned their own home at Time I no longer owning their home at Time II (p<.001).

Data regarding respondents' health status can also be compared between waves. Of the 18 persons who reported their health as "poor" at Time I, 33% rated their health as still poor in 2003, with the remaining 67% reporting that their health was fair or better in 2003 (p<.001). Of the 115 respondents reporting that their health was "good" in 1999, 42% reported their health as still "good" at the second interview. Twenty-three percent of those whose health was "good" in 1999 reported their health was worse ("fair" or "poor") in 2003, and the remaining 36% reported their health as better ("very good" or "excellent") at the second interview (p<.001). Figure 1 summarizes respondents' health changes between waves.

Figure 1. Respondents' Changes in Health Between Waves (n = 226)



Recalling the *Seniors Count* Visit

At the time of the initial visit, volunteers left a plastic bag of information for the senior. Because several years have passed since that initial visit, one might wonder how many respondents would still remember receiving the bag and what information had been in the bag. Over half (59%) of the sample did, in fact, recall the bag of information, and many had since used information from the bag.

Respondents recalled information including:

- The Elderly Commission's telephone number
- Emergency telephone numbers
- Transportation information
- Information on government benefits
- Healthcare information

Almost a quarter (23%) of the sample had shared the bag of information with others. Respondents who had shared the information with others were significantly younger than respondents who had not shared the information ($p < .05$). Of those who had shared the bag of information with others:

- 55% had shared information from the bag with a family member.
- 24% had shared information from the bag with a friend.
- 24% had shared information from the bag with a neighbor.

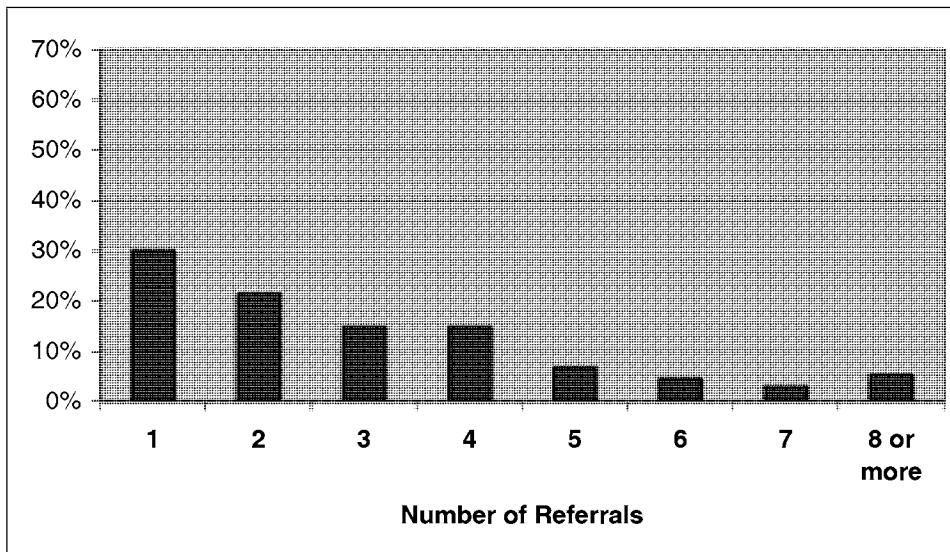
Referral Information

Seniors Count volunteers were trained in how to identify over 80 areas of need among the seniors whom they visited. (See Appendix D for a list of all possible referrals given by *Seniors Count*.) The intended protocol was that at the time of the initial *Seniors Count* visit, elders were supposed to be given information regarding available services for which they might be eligible. Except in cases in which an emergency situation was identified, *Seniors Count* volunteers were instructed to provide referral information to the senior, and the senior then needed to use that information to access the appropriate service on his or her own. In discussions with advisory members and *Seniors Count* interviewers, the research team learned that this protocol was not uniformly followed. Thus, the following findings regarding the referrals are likely to present only a partial picture of the status of referral information. The five most frequent types of referral information provided to the sample were:

- Prescription Drug Benefits¹
- City Tax Exemptions
- Smoke Detectors
- Grab Bars
- Fuel Assistance

Respondents in this sample were given between one and fifteen specific types of referral information, with a mean of 3 (SD = 2.36). Figure 2 illustrates the number of referrals per respondent.

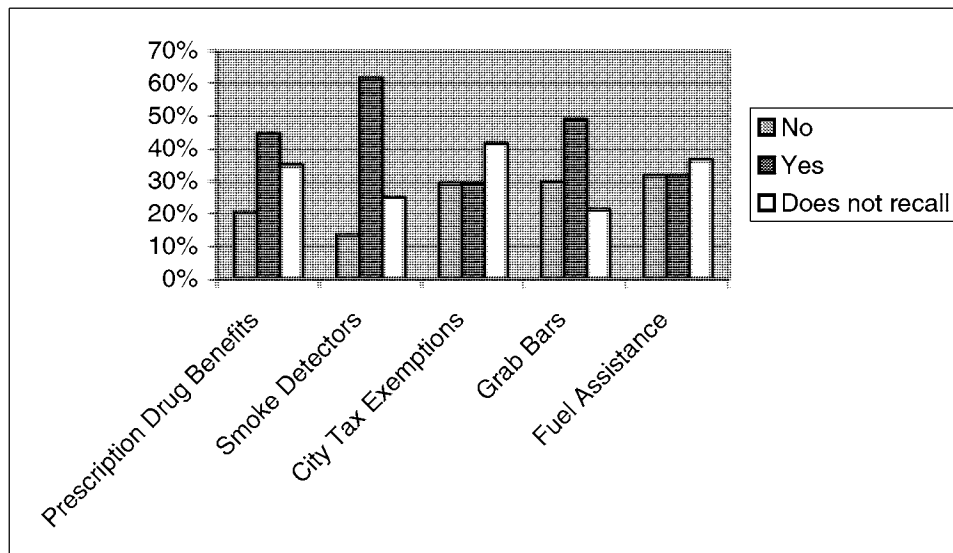
Figure 2. Number of Referrals per Respondent (n = 271)



¹Prescription Drug Benefits – Referral Code 30; City Tax Exemptions – Referral Code 23; Smoke Detectors – Referral Code 2; Grab Bars – Referral Code 39; Fuel Assistance – Referral Code 26. See Appendix E for list of all Referral Codes.

Referral information from *Seniors Count Phase I* was available to the research team so that at the time of this follow-up study it was possible to know exactly which referrals each respondent had been given. A separate face sheet for each member of the sample was prepared that included the individual's specific referral information. This information was useful because it allowed interviewers to ask respondents specific questions regarding each individual referral. Respondents were asked questions on their opinion of the usefulness of the referral, their satisfaction with the referral, whether the referral had been resolved, and whether they had family or friends available to help with any unmet need that may still exist in regards to that referral. Figure 3 illustrates the most frequent types of referral information provided and summarizes responses to the question of whether the referral issues had been resolved.

Figure 3. Was the Referral Issue Resolved?



Prescription Drug Benefits (n = 83)

Smoke Detectors (n = 52)

City Tax Exemptions (n = 48)

Grab Bars (n = 47)

Fuel Assistance (n = 41)

Information regarding prescription drug benefits was the most common referral made to respondents in the sample. Of those who received that referral, over 40% reported that the referral issue had since been resolved. The second most common referral was made for smoke detectors. Over 60% of respondents who received that referral reported that it had been resolved. Fewer than 15% reported the referral had not been resolved. About 30% of respondents who had been given a referral for city tax exemptions reported that the referral had been resolved; 30% reported it had not, and 40% did not recall the referral. About half of those who were given a referral for grab bars reported that the referral had been resolved. Close to a third of respondents reported the referral had not been resolved. About a third of respondents who had been given a referral for fuel assistance reported that the referral had been resolved; a third reported it had not, and the final third of respondents did not recall the referral.

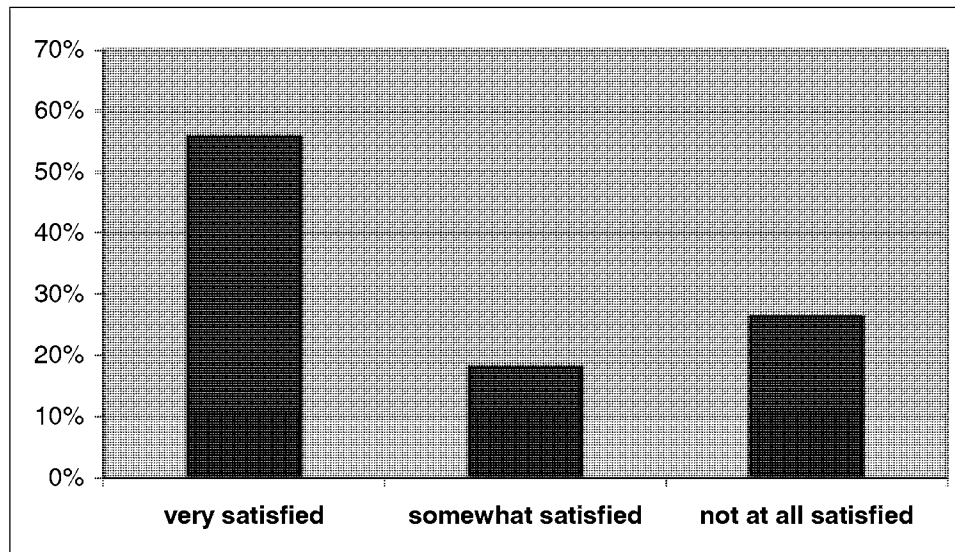
As can be seen in the preceding chart, in each referral category, many respondents were unable to recall whether the issues that prompted the referrals had been resolved. It may be hypothesized that, in some cases, respondents were unaware that a referral had been made in a certain area. For instance, during the *Seniors Count* interview, an interviewer might have noticed that the senior was in need of grab bars for his or her bathroom, but may not have explicitly said, “I am going to make a referral for grab bars to be installed in your home.” If suggestions and recommendations were not explicitly stated, some respondents might not have been aware of referrals, and the level of respondents reporting that they did not recall the specific referral may have been higher.

Contact with the Elderly Commission

During the *Seniors Count* visit, elders were given the Elderly Commission’s telephone number (617 635-4486)¹ and were told to call when they needed information or assistance. Almost a quarter (23%) of respondents reported having called the Elderly Commission since the time of the *Seniors Count* visit. Respondents remembered calling for information on services they had learned about during their visit, such as the Prescription Advantage Program and fuel assistance programs. Others were looking for information on transportation, help with snow plowing, program eligibility, or to inquire about home repair services such as grab bar installation.

Respondents were then asked about their satisfaction with calling the Elderly Commission. Figure 4 shows respondents’ levels of satisfaction with calling the Elderly Commission.

Figure 4. Satisfaction with Calling the Elderly Commission (n = 60)



Respondents who reported being “somewhat satisfied” or “not at all satisfied” with their experience of calling the Elderly Commission were asked to explain why they

¹ The Elderly Commission’s telephone number has since changed to (617) 635-4366

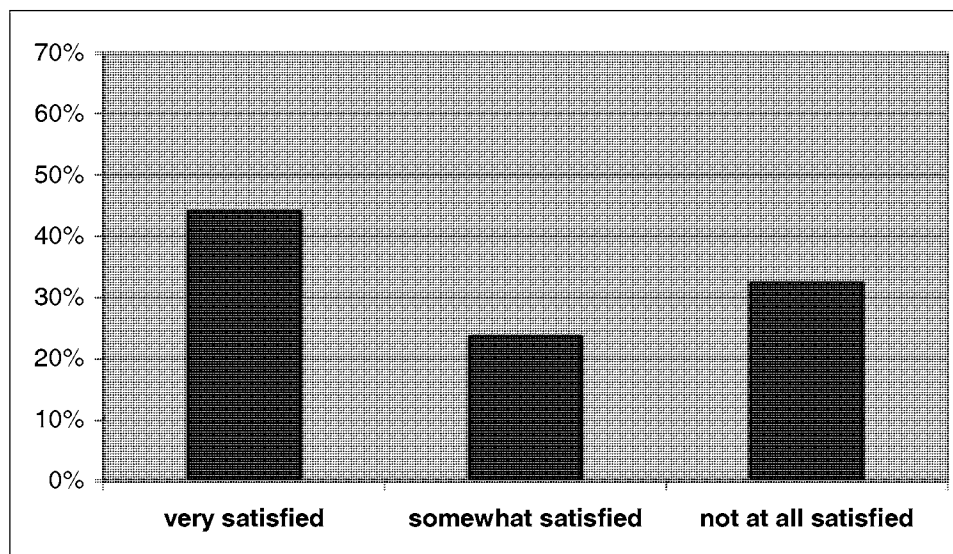
were not satisfied. The most common responses related to the length of time it took to get a response to their question or the inability to have the request resolved.

The Commission on Affairs of the Elderly produces two cable television programs as well as a radio program to share information with Boston seniors. More than three-quarters (76%) of the sample reported having cable television, and 36% of those with cable reported that they watch the Commission's television program. In contrast, only 5% of the sample reported listening to the Commission's radio program.

Contacting the Mayor's 24-Hour Hotline

During the *Seniors Count* visit, elders were also given information about the Mayor's 24-Hour Hotline (617 635-4500) and were encouraged to call the number for information or assistance. Thirteen percent of those surveyed reported having called the Mayor's 24-Hour Hotline. Respondents had called the Hotline because of fears about safety, to report streets or sidewalks in disrepair, for general information, and about services they were interested in receiving. Figure 5 displays respondents' levels of satisfaction with calling the Mayor's 24-Hour Hotline.

Figure 5. Satisfaction with Calling the Mayor's 24-Hour Hotline (n = 34)

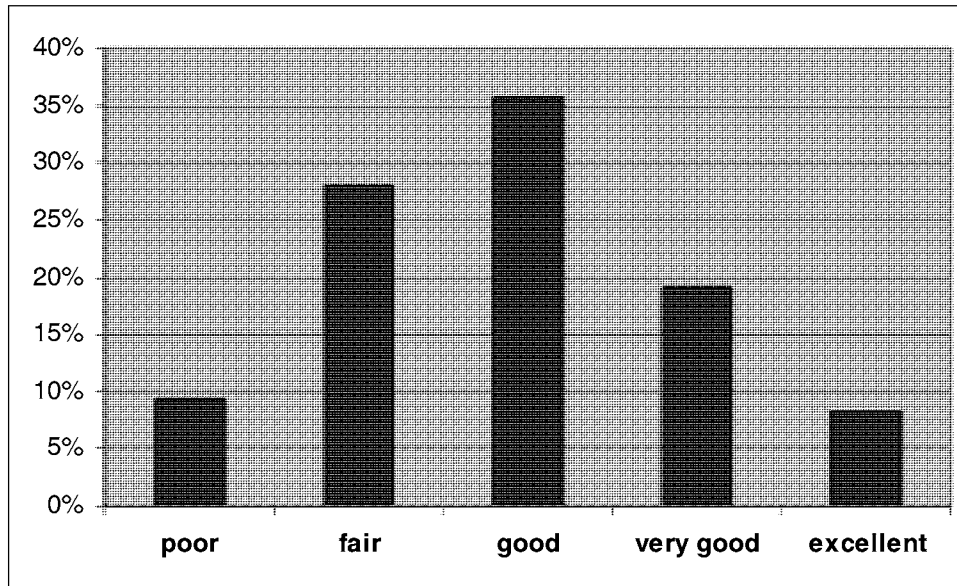


Respondents who reported being "somewhat" or "not at all" satisfied with their experience of calling the Mayor's 24-Hour Hotline were asked to explain why they were not satisfied. Their responses were similar to those of persons who were not satisfied after calling the Elderly Commission, with respondents reporting that information was not helpful or that they did not receive a timely response.

Health

Respondents were asked to rate their health from excellent to poor. Almost two-thirds (63%) of respondents rated their health as good or better. Figure 6 shows the self-rated health of respondents in the sample.

Figure 6. Self-Rated Current Health (n = 258)



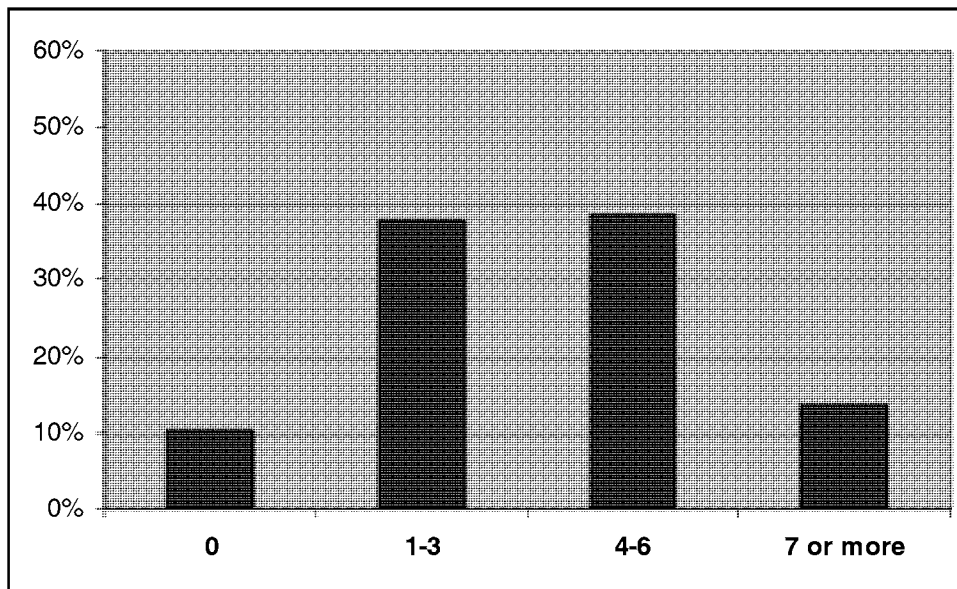
Most respondents (94%) had visited a doctor for a regular check-up within the last year; however, only slightly more than half (52%) of the sample had been to a dentist within the last year. Respondents who reported wearing dentures in 1999 ($n = 227$) were less likely to have visited a dentist within the last year than those who did not wear dentures ($p < .001$), with only 39% of persons in that population reporting having visited the dentist.

Anecdotally, some interviewers involved in this project reported that many of the seniors with whom they spoke seemed unaware that persons who wore dentures had reason to continue to be seen by a dentist. When asked if they had seen a dentist within the last year, some seniors responded, “No, I have dentures.” The misconception that individuals who wear dentures are no longer in need of attention from a dentist is likely to have contributed to this relatively low percentage of respondents reporting that they had visited the dentist within the last year.

Prescription Medications

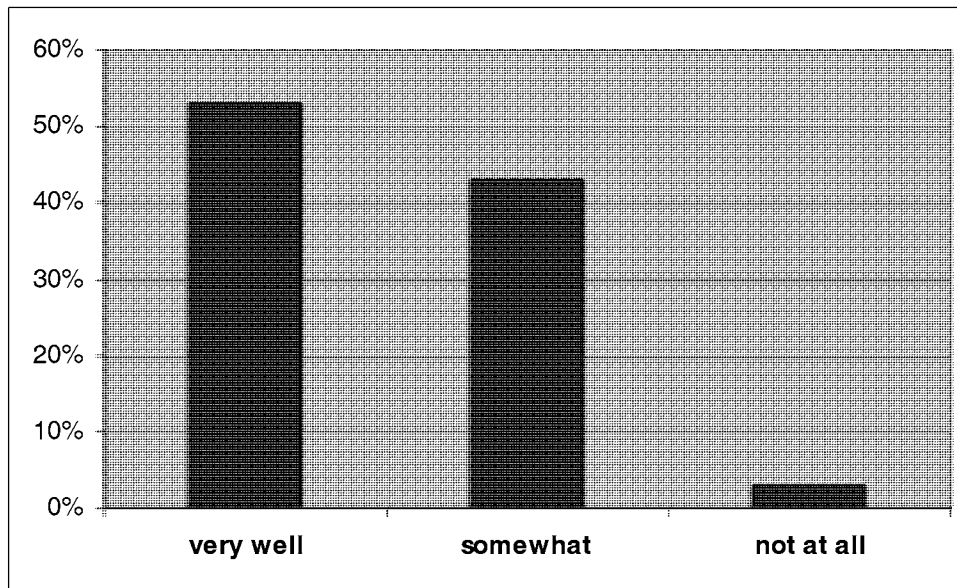
When *Seniors Count* was first conducted in 1999, 81% of respondents (n = 596) reported that they took at least one prescription medication. In this follow-up survey, 90% of respondents reported taking at least one prescription medication. Respondents were asked about the number of prescription medications they were supposed to take, how well they were able to manage the cost of prescription medications, and whether they had ever postponed or not taken a prescription medication due to financial concerns. Respondents in this sample reported taking between zero and seventeen prescription medications with a mean of 3.95 (SD=2.85). The number of medications taken by the sample is slightly lower than the four to five prescription medications cited by the Merck Manual as the average for community-dwelling elders (Beers & Berkow, 1999; p. 2600). Figure 7 shows categories of prescription medications taken by respondents in this sample.

Figure 7. Number of Prescription Medications (n = 255)



Respondents who reported that they were supposed to take at least one prescription medication were then asked how well they were able to manage the cost of their prescription medications. Figure 8 shows how well respondents reported managing the cost of their prescription medications.

Figure 8. “How Well Do You Manage the Cost of Your Prescription Medications?”
(n = 234)



Respondents who reported being able to manage their prescription medications somewhat or not at all were asked to explain. Some respondents said:

I have no choice but to purchase them because I need them.

It's tough on a fixed income. Our insurance caps our prescription coverage. My wife is also taking medications. Our co-pay is expensive.

It's so expensive – my daughters have to help.

Social Security is my only income so I have to withdraw money from the bank at times to pay for them.

Money is tight; my wife's Social Security goes to Alzheimer's unit...things have gone up...my disposable income is next to nil.

Sometimes I take money to pay for my medicine out of my food budget.

I worry about having enough money for my prescriptions.

Some respondents mentioned the Prescription Advantage program as a way in which they were able to manage the cost of prescription medications. Prescription Advantage is an insurance program administered by the Commonwealth of Massachusetts Executive Office of Elder Affairs that offers prescription drug coverage to residents age 65 and older who meet certain eligibility requirements (EOEA, 2003). Payments of premiums, deductibles and co-payments are based on members' gross annual household incomes (EOEA, 2003). Although the program has been funded through fiscal year 2004, at the time the survey was administered, the program's future

was uncertain. The effect that the loss of the Prescription Advantage program would have on some respondents can be seen in the following comments:

I can manage because I have Prescription Advantage.

Who knows for the future; I'm fine with Prescription Advantage as it is.

Twelve percent of respondents who take at least one prescription medication reported having postponed or not filled a prescription due to financial concerns. Respondents who reported managing their prescription medications somewhat or not at all were more likely to report having delayed or not filled a prescription due to financial concerns ($p < .001$). Those who reported having postponed filling a prescription were asked to explain. Some respondents said:

Yes, one pill costs \$4.00 per day.

I've postponed it for a few days – nothing dramatic – I wouldn't dare.

Sometimes I skip my meds so I can spread the 90-day supply over 120 days. I know I shouldn't do that.

Sometimes the prescription is too expensive and I have to wait to buy them.

I was not covered for this prescription at the time. Now it is covered.

Last month my prescription was \$95 so I just took a few pills and paid \$30.

Transportation

For the most part, the elders surveyed appeared to be managing with the transportation options available to them. Most (91%) respondents reported that they were able to get most places they needed to go.

Driving was the most frequently used form of transportation, with 62% of respondents reporting that they had a valid driver's license. Simply having a license did not guarantee driving, however. Eighty-three percent of respondents with a license reported that they had driven a car within the last six months ($p < .001$).

The next most frequently used form of transportation was the Massachusetts Bay Transit Authority (MBTA), with 44% of respondents reporting having used the MBTA within the last month. Familiarity with the MBTA Senior Discount Program was high among respondents, with 70% of respondents reporting being familiar with the MBTA Senior Discount Program. Familiarity with the Senior Discount Program was positively related to use of the MBTA. Respondents who were familiar with the MBTA Senior Discount Program were more likely to have used the MBTA in the last month than those who were not familiar with the Discount Program ($p < .001$).

Respondents used other forms of transportation less frequently. Among other forms of transportation:

- 19% of respondents had used a taxi in the last month.
- 8% of respondents had used the MBTA Ride in the last month.
- 7% of respondents had used the Senior Shuttle in the last month.

Cross tabulations suggested that those who were driving were more likely to have used multiple forms of transportation than those who were not driving. Although further analysis failed to prove these results to be statistically significant, it is suspected that with a larger sample size this relationship is more likely to have been statistically significant.

Voting Behavior

The large majority of the sample reported voting. Nearly all (96%) respondents in this sample were registered to vote, and 90% of those registered to vote had voted in a government election within the last year. Only 3% of those who had voted within the past year reported not having voted in-person.

Only 10% of the sample reported having trouble getting to the polling place. Respondents in poorer health were more likely to report having trouble getting to the polling place than those in good health ($p < .001$).

“Elder-Friendly”

As the Boston population continues to age, the Boston Commission on Affairs of the Elderly was especially interested in learning the extent to which Boston elders consider the city “elder-friendly.” The term “elder-friendly” may pertain to the services the city offers, the way the city and younger people treat older residents, or the extent to which the physical structure of the city is accommodating to older people. The sample was invited to describe what the term “elder-friendly” meant to them. Some respondents defined elder-friendly as:

Helping seniors with their problems.

Services are available for elders.

Being able to get around easily.

The things the city does for older people.

When asked to rate Boston as an elder-friendly city, 50% of respondents reported that they consider Boston to be “very” elder-friendly, with 3% of respondents considering Boston “not at all elder-friendly.” Persons with better self-rated health were more likely to consider Boston “very” elder friendly than were people reporting poorer self-rated

health ($p < .05$) ($n = 240$). Persons who had voted in a government election within the past year were also more likely to rate Boston “very” elder-friendly than those who had not voted within the past year ($p < .01$) ($n = 239$).

When asked what made Boston an elder-friendly city, some respondents said:

Elders are taken care of.

They treat people good. They have good facilities and programs.

When I go to the elderly center people are helpful and younger people talk to me.

People here are friendly to the elderly.

The quality and quantity of services for the elderly is good.

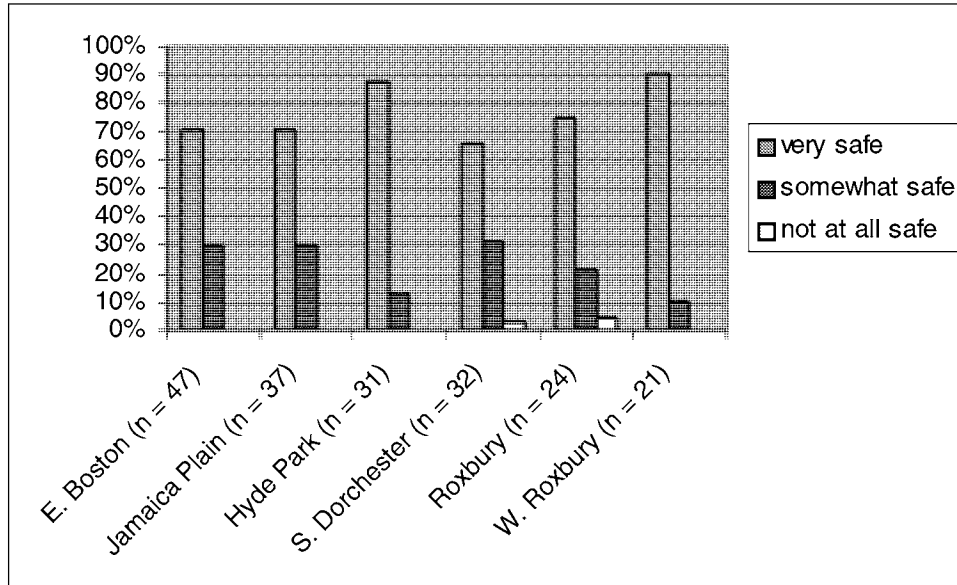
The City of Boston does more than most for the elderly.

There were significant positive relationships among respondents’ assessments of Boston as an elder-friendly city and respondents’ ratings of neighborhood safety ($p < .05$) ($n = 240$), and neighborhood friendliness ($p < .01$) ($n = 237$).

Neighborhoods and Safety

The majority of respondents in the sample reported that they felt safe in their neighborhoods. Three-quarters of those surveyed reported feeling “very safe” in their neighborhoods, with less than 1% saying they felt “not at all safe.” Figure 9 shows the levels of safety reported by respondents in six Boston neighborhoods. Although these associations did not prove statistically significant, significance may have been achieved with a larger sample size.

Figure 9. “How Safe Do You Feel in Your Neighborhood?”



Respondents who reported that their neighborhoods were “somewhat” or “not at all” safe were asked to explain. Some respondents said:

No neighborhood is safe nowadays.

I'm uncomfortable with the noise – I'm looking for a senior place.

Kids sometimes play rough.

I don't go out at night.

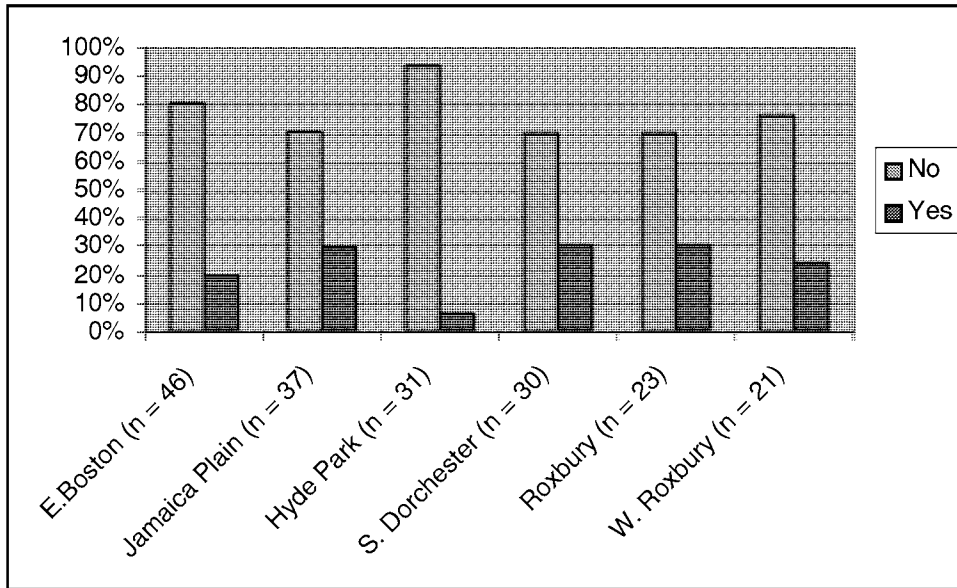
It's not safe at night – there have been muggings in the neighborhood.

When I was younger I had no fear. Now it's different, especially because I'm by myself.

Almost a quarter (24%) of respondents reported having difficulty getting around the sidewalks in their neighborhoods, and almost 21% of the sample had trouble crossing the streets in their neighborhoods. Figures 10 and 11 display how well respondents in six Boston neighborhoods reported getting around the sidewalks and crossing the streets in their neighborhoods. Although these findings are not statistically significant, they may show trends regarding which neighborhoods are more or less accessible.

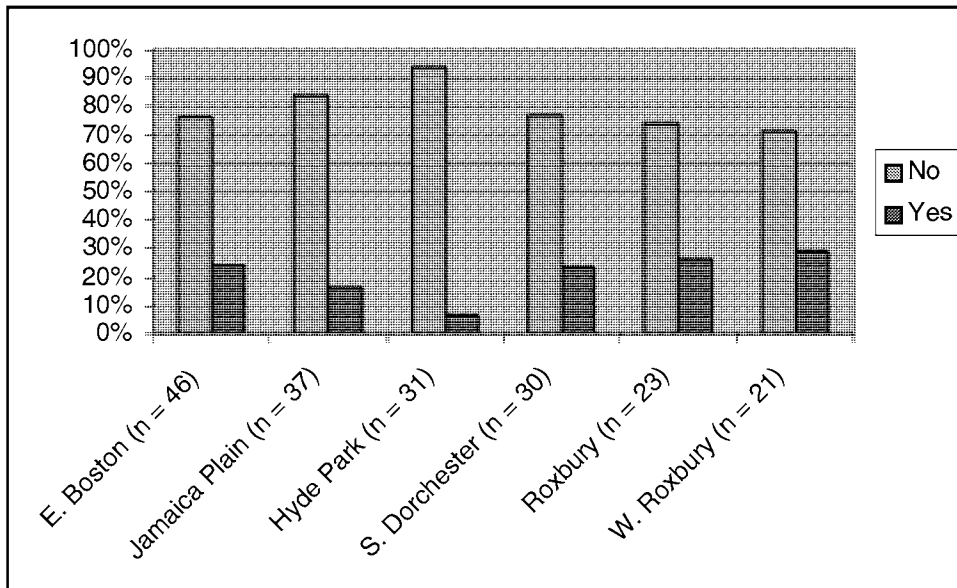
Because of concerns that respondents who reported difficulty crossing streets or using sidewalks were having difficulty due to mobility problems, cross tabulations were conducted with self-reported health status. No significant relationships were found between poor health and reporting difficulty with either streets or sidewalks in one's neighborhood.

Figure 10. “Do You Have Difficulty Getting Around the Sidewalks in Your Neighborhood?”



The large majority of respondents in Hyde Park reported having no trouble getting around the sidewalks in their neighborhood, while almost 30% of respondents in South Dorchester, Roxbury, and Jamaica Plain reported difficulty.

Figure 11. “Do You Have Difficulty Crossing the Streets in Your Neighborhood?”



Over 90% of respondents in Hyde Park reported having no trouble crossing the streets in their neighborhoods. West Roxbury had the highest percentage of residents reporting difficulty crossing the streets.

Although these findings were based on small samples and were not statistically significant, Figures 9 – 11 show neighborhood trends in general feelings of safety, as well as neighborhood accessibility. Residents of Hyde Park, for instance, tended to feel safe and reported relative ease in crossing streets and using sidewalks. In South Dorchester, on the other hand, more than 30% of residents reporting that they felt somewhat or not at all safe, and close to 30% of respondents from that neighborhood reported difficulty with its streets and sidewalks. It may be useful for the City of Boston to look into improving accessibility in some neighborhoods based on responses from some of the seniors in this survey.

CONCLUSIONS

Overall, *Seniors Count Phase I* achieved its initial goal of personally reaching many in the city's elderly population. Most respondents in the sample remembered the original *Seniors Count* visit, many reported having used the information they were given, and many had taken advantage of programs for which they were eligible. Although many respondents reported that referrals received from *Seniors Count* had been resolved, there were also respondents in each referral group who failed to recall whether referrals had been resolved, indicating that perhaps the process of following through on the referral information provided had not been adequately explained to them during the *Seniors Count* visit.

Recall bias may have factored into some aspects of our findings. Because of the several years between the original *Seniors Count* visit and this follow-up study, some respondents could not be reached. Non-response due to death and telephones that had since been disconnected accounted for at least 40% of respondents who could not be reached at follow-up. Some significant differences were found between respondents and non-respondents in the survey, including the number of referrals and some aspects of respondents' health. Had follow-up been conducted within four to six weeks of the original *Seniors Count* visit, it is likely that the non-response rate would have been lower and follow-up findings may have been generalizable to the larger sample. Recall bias is also likely to have affected responses on referral questions. The lag time since the original *Seniors Count* visit and this follow-up survey is likely to have contributed to the number of respondents unable to recall whether a referral had been resolved.

Even with the limitations described, this study advances the literature on follow-up needs assessments of community-residing elders. As noted in the literature review, Lewis' (1997) study of service awareness and use among 128 independently living seniors in an apartment complex in the Northeast found a generally high level of service awareness among residents. Similarly, this sample appeared aware of services and reported using resources to attempt to access services. The fact that 70% of the sample knew about the Massachusetts Bay Transit Authority's (MBTA) Senior Discount Program may be an example of this sample's service awareness. In addition, many seniors in this sample were aware of and reported using resources available through the city for information or assistance. Over a third of the sample reported having watched the Elderly Commission's cable television programs, and 34% had called either the Elderly Commission or the Mayor's 24-Hour Hotline.

Calsyn and colleagues (1998) noted that a limitation of their study was that it lacked longitudinal data. The *Seniors Count Follow-Up Study* benefits from the data obtained from *Seniors Count Phase I*. The ability to track respondents' living situations and health statuses between waves allows the reader to understand changes experienced over time. In addition, the ability to track identified areas of need over time makes it possible to determine the degree of success *Seniors Count* has achieved in meeting the needs of the Boston seniors it seeks to serve.

The Boston Partnership for Older Adults' (2003) publication highlights strengths and areas of need in the identification and delivery of services for seniors in Boston. One goal identified as a "Next Step" in the BPOA's report is to collect data necessary to "evaluate current services and programs to ensure they are meeting defined needs and are doing so efficiently and effectively" (BPOA, 2003). The *Seniors Count Follow-Up Study* adds to the wide-range of information presented in that publication by providing follow-up data on the original *Seniors Count* program, as well as additional information on issues such as health, transportation, and seniors' perceptions of the safety and friendliness of their city and neighborhoods.

The Seniors Count Phase I Follow-Up Study provides additional information about a sample of community-dwelling seniors residing in the City of Boston. In addition to providing follow-up data regarding *Seniors Count Phase I*, this study may be useful in its identification of some issues of unmet need for Boston seniors. Although its findings are limited by their lack of generalizability, trends such as high percentages of elders reporting difficulty using streets or sidewalks in some Boston neighborhoods might prove useful for city planners as they seek to make Boston more accessible for all its residents. Finally, this study illustrates the usefulness of conducting needs assessments for community-dwelling elders. Information gathered from needs assessment surveys may help to improve service providers' ability to tailor programs and services to those most able to benefit from them.

Replicating *Seniors Count*

Communities interested in replicating the *Seniors Count* program should, at the onset of the program design, consider building into the project telephone or mail follow-up, data analysis, and information dissemination. Following up with participants four to six weeks after the original visit allows the program to determine whether participants are making progress in obtaining information on referral recommendations and reinforces to participants the information provided at the initial visit, thus improving the odds of participants taking advantage of available programs and services. In addition, follow-up allows the program directors to collect data that will be beneficial in determining how well the program is meeting its own goals.

Data entry and data analysis must also be built into program plans. Resources, including personnel and technology, need to be available for these purposes. Analysis of the data will allow program coordinators to monitor how well the needs of the population are being met, observe as new needs are arising, and assess the program's success at meeting its goals.

Finally, reports should be prepared and findings should be disseminated. When program coordinators report ongoing findings, they may help service providers and local officials better understand the population they serve. Dissemination of findings may alert providers to unmet needs so that specific neighborhoods or populations can be targeted and services to those populations can be improved. Building follow-up, data analysis, and information dissemination into a community needs assessment and outreach program is likely to improve the program's ability to assess whether it is achieving its intended goals and whether the needs of its participants are being understood and addressed.

RECOMMENDATIONS TO *SENIORS COUNT*

A number of useful recommendations emerged from this study that should be considered for future phases of *Seniors Count* and by the City of Boston as it responds to the challenges of an aging population.

Regarding *Seniors Count*:

- At the time of the initial visit, *Seniors Count* should provide a written, large-print list of referral information to the senior so that the senior is aware of what referrals are recommended. The list might also include instructions on what follow-up should be done, relevant contact names and telephone numbers, and an expected timeline to ensure that identified needs are met. Moreover, interviewer training sessions should emphasize the importance of following this protocol.
- Follow-up studies should be built into the *Seniors Count* program to assess how well the program is meeting its goals and meeting the needs of the seniors whom it is serving. Following up with the seniors on a timely basis (four to six weeks) may improve seniors' compliance with referral recommendations and may reinforce some of the information shared during the initial visit.
- Ongoing data entry and analysis can greatly enhance the success of the outreach project. The ability to compare data between waves will help *Seniors Count* evaluate its success in reaching its goals.
- Analysis of data by neighborhood will help *Seniors Count* understand the different needs of seniors in distinct areas of Boston. Analyzing neighborhood data between waves will help *Seniors Count* observe how needs are resolved and understand new needs as they arise.

Regarding Access to the Elderly Commission and Mayor's Office:

- The Commission's cable television programs had been watched by over one-third of respondents, in contrast to the radio show, which reached only about 5% of the sample. The Commission might consider redirecting resources to promote further the cable shows so that more seniors who have cable television become aware of and take advantage of the programs. In addition, videotapes of the cable shows can be shared with neighborhood libraries and Councils on Aging/senior centers.
- Many of the respondents who reported not being satisfied after calling the Elderly Commission's telephone line or the Mayor's 24-Hour hotline attributed their dissatisfaction to a lack of response. It is important that hotlines respond to requests in a timely manner and seek to direct inappropriate calls to resources better suited to the callers' needs.

Regarding Health Issues:

- Most of the seniors in this sample (90%) reported that they were supposed to take at least one prescription medication. Managing the cost of prescription medications is a concern for many elders. Some felt that they were able to manage the cost of their medications with the help of programs such as Prescription Advantage. The importance of programs such as Prescription Advantage for seniors must be emphasized and supported.
- Although most of the sample had visited a doctor within the last year, dental visits were more infrequent, especially among seniors who reported wearing dentures. A public educational campaign emphasizing the importance of dental hygiene for all persons, even those with dentures, might be considered (see, for example, Mertz & O'Neil, 2002).

Regarding Transportation and Neighborhood Accessibility:

- While a relatively small percentage of elders reported that they were unable to get to most places they need to go, for those elders, transportation was indeed a major concern. This finding, along with the fact that less than 10% of the sample had used either the MBTA Ride or the Senior Shuttle, indicates that some transportation options in Boston may be underutilized.
- Over 20% of the sample reported difficulty crossing streets and using sidewalks in their neighborhoods. Repairs should be made to streets and sidewalks to improve their safety and accessibility. Streetlights and crosswalks should be assessed to determine whether longer time-delays or more frequent crosswalks would make Boston's streets more accessible for its older persons.
- This report should be shared with appropriate city departments who may have jurisdiction to address appropriate recommendations.

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Appendix A

Commission on Affairs of the Elderly

THOMAS M. MENINO
Mayor

JOYCE WILLIAMS
Commissioner

March 27, 2003

Dear *Seniors Count* Participant:

Since 1999, more than 5,500 households in Boston have opened their doors to *Seniors Count* volunteers. Currently, the Commission on Affairs of the Elderly is asking researchers at the University of Massachusetts Boston Gerontology Institute to do a follow-up study to identify how well the seniors' needs were met through the *Seniors Count* program efforts. Because you were one of the many households we visited through *Seniors Count*, we are interested in knowing:

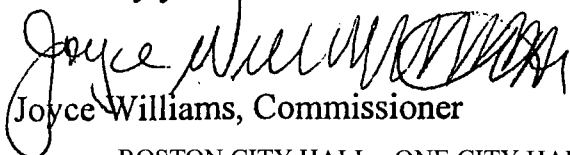
- Your satisfaction with the *Seniors Count* experience;
- Your assessment of the service recommendations received from the *Seniors Count* program;
- Your recommendations for making Boston a more elder-friendly city.

Your experiences and recommendations are very important to us. We hope that you will be willing to speak with a Gerontology student when calls are made. **WE WILL BE CONDUCTING OUR PHONE INTERVIEWS DURING DAYTIME HOURS ON FRIDAY, SATURDAY AND SUNDAY THROUGHOUT THE MONTH OF APRIL (except Easter/Passover weekend). YOUR PARTICIPATION IS COMPLETELY VOLUNTARY.** The interview should take about 20 minutes. All information that you provide will be kept strictly confidential. You may skip over any question that you prefer not to answer. Your responses will in no way impact services you are now receiving. UMass Gerontology will only share overall information with the Elderly Commission, who will NOT be given any information that may be linked to you personally.

If you are unable to participate or would like your name removed from the list of Boston residents to be contacted, please leave a message for ~~Joyce Williams~~, Research Assistant, at: ~~(617) 635-4366~~ or e-mail at: ~~joyce.williams@cityofboston.com~~.

We look forward to your participation in this study.

Sincerely yours,


Joyce Williams, Commissioner

BOSTON CITY HALL • ONE CITY HALL PLAZA • BOSTON • MASSACHUSETTS • 02201
617-635-4366 • Voice TDD 617-635-4599 • FAX 617-635-3213

Appendix B. Coding of Variables in Table 2

Age in 1999	range: 60 - 98 years
Total # of referrals per person	range: 1 - 15 referrals
Time 1: Does Health Limit Climbing Stairs	1 = yes; 0 = no
Time 1: Does Health Limit House Cleaning	1 = yes; 0 = no
Time 1: Does Health Limit Grocery Shopping	1 = yes; 0 = no
Time 1: Does Health Limit Cooking	1 = yes; 0 = no
Time 1: Does Health Limit Socializing with Family	1 = yes; 0 = no
Time 1: Fallen Recently	1 = yes; 0 = no
Time 1: Satisfied with Health Insurance	1 = yes; 0 = no
Time 1: Take Rx Drugs	1 = yes; 0 = no
Time 1: Wear Dentures	1 = yes; 0 = no
Time 1: Live alone	1 = yes; 0 = no
Time 1: Own Home	1 = yes; 0 = no
Time 1: Rent Home	1 = yes; 0 = no
Time 1: Self-Rated Health (reverse coded)	1 = poor; 2 = fair; 3 = good; 4 = excellent
Time 1: Health Compared to Last Year (reverse coded)	1 = worse; 2 = same; 3 = better

**INTERVIEWER LOG SHEET
GERONTOLOGY INSTITUTE
SENIORS COUNT PHASE I FOLLOW-UP
SPRING 2003**

ID # 488
 ██████████
 ██████ Maverick St 1
 Boston MA, 02128
 (617) 567-██████
 DOB: 11/21/1908
 female

Start Time: _____
 End Time: _____
 Total # minutes: _____

Total number of referrals made **6**

Reason for Referral 1	2: City Tax Exemptions: Elderly
Reason for Referral 2	23: Fire Safety: Smoke Detectors Are Missing
Reason for Referral 3	26: Government Benefits: Fuel Assistance
Reason for Referral 4	38: Utilities problems: Utility Payments
Reason for Referral 5	43: Home Repair: General
Reason for Referral 6	73: Transportation Problems: Other
Reason for Referral 7	
Reason for Referral 8	
Reason for Referral 9	
Reason for Referral 10	
Reason for Referral 11	
Reason for Referral 12	
Reason for Referral 13	
Reason for Referral 14	
Reason for Referral 15	

<input type="checkbox"/> Survey Complete	<input type="checkbox"/> Survey NOT Complete
<input type="checkbox"/> Survey Partially Completed	<u>REASON:</u>
	<input type="checkbox"/> Wrong Number
	<input type="checkbox"/> Declined/Refused
	<input type="checkbox"/> Answering Machine
	<input type="checkbox"/> Other

Date	Time	Status (e.g. no answer, not available, left message, etc.)	Comments

Seniors Count Follow-up Survey
University of Massachusetts Boston, Gerontology
College of Public and Community Services

I want to start by asking you about the visit you received from *Seniors Count* a few years ago. I understand that some recommendations were given to you at that time. [INTERVIEWER NOW STATE ALL SPECIFIC REFERRALS MADE FROM INTERVIEWER LOG SHEET.]

R1. Thinking about the time when you were given information about _____ (REFERRAL), how useful did you feel that information was to you?

- Very useful
- Somewhat useful
- Not at all useful

- DOES NOT RECALL

R2. How satisfied were you with the information?

- Very satisfied
- Somewhat satisfied
- Not at all satisfied

- DOES NOT RECALL

R3. Has this concern since been resolved?

- NO →
- YES

- DOES NOT RECALL

Do you currently have family members or friends that could help you with this concern?

- NO
- YES

[INTERVIEWER, USE SEPARATE SHEET FOR EACH REFERRAL MADE THEN RETURN TO SURVEY QUESTION A1.]

Appendix E. Seniors Count Referral Codes

Referral Code	Problem Group	Problem Description
1	City Tax Exemptions	Deferment
2	City Tax Exemptions	Elderly
3	City Tax Exemptions	other/ general
4	City Tax Exemptions	survivor
5	City Tax Exemptions	veterans
6	Cultural	language
7	Cultural	other
8	Dental Problems	dental problems
9	Elder Abuse	caregiver neglect
10	Elder Abuse	emotional
11	Elder Abuse	financial exploitation
12	Elder Abuse	physical
13	Elder Abuse	sexual abuse
14	Elder At Risk	addiction
15	Elder At Risk	dementia
16	Elder At Risk	loss of housing
17	Elder At Risk	medical
18	Elder At Risk	other
19	Elder At Risk	psychological
20	Fire Safety	batteries
21	Fire Safety	bed ridden
22	Fire Safety	hazard
23	Fire Safety	smoke detectors are missing
24	Fire Safety	other
25	Government Benefits	food stamps
26	Government Benefits	fuel assistance
27	Government Benefits	Medicaid/MassHealth
28	Government Benefits	Medicare
29	Government Benefits	other/ SHINE
30	Government Benefits	pharmacy
31	Government Benefits	SSI
32	Government Benefits	veterans
33	Home Care	home health
34	Home Care	home maker
35	Home Care	money management
36	Home Care	nutrition Needs meal delivered
37	Home Care	respite
38	Utilities problems	utility payments
39	Home Repair	grab bars
40	Home Repair	gutters
41	Home Repair	hand rail
42	Home Repair	locks
43	Home Repair	general

Referral Code	Problem Group	Problem Description
44	Home Repair	painting
45	Home Repair	ramps
46	Home Repair	roof
47	Home Repair	steps
48	Home Repair	weatherizing
49	Home Repair	other
50	Housing	code violation
51	Housing	eviction
52	Housing	tenant law
53	Housing	vacant rentals
54	Intergenerational	intergenerational
55	Legal	legal
56	Neighborhood Issues	crime
57	Neighborhood Issues	lighting
58	Neighborhood Issues	other
59	Neighborhood Issues	parking
60	Neighborhood Issues	sewer
61	Neighborhood Issues	sidewalks
62	Neighborhood Issues	signs
63	Neighborhood Issues	snow removal
64	Neighborhood Issues	speeding
65	Neighborhood Issues	streets
66	Neighborhood Issues	trees
67	Medical	Medical general
68	Physical Disabilities	hearing
69	Physical Disabilities	mobility / escort
70	Physical Disabilities	other
71	Physical Disabilities	vision
72	Transportation Problems	medical
73	Transportation Problems	other
74	Transportation Problems	shopping
75	Work / Volunteers	work opportunities
76	Social Isolation	loneliness
77	Housing	information/other
78	Work / Volunteers	volunteer opportunities
79	Work / Volunteers	work opportunities
80	Neighborhood Issues	trash
81	Home Care	system for emergency response
82	Neighborhood Issues	cross walks -- paint
83	Fire Safety	evacuation
84	Health Maintenance	memory assistance