Gateway Program Evaluation

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Executive Summary

May, 2019

1. Overview

Gateway is the Berkeley Continuum's peer-based, prevention and early intervention program. Gateway uses home visits to assess, educate, and offer linkages to older adults for social and logistical needs/resources that support wellness and independence. At its' core, it is designed to activate and motivate elders to take charge of their aging experience to make positive and proactive choices in the context of their age and their specific challenges.

The goal is to identify elders age 65 and older (or younger with functional need) who do not qualify for case management services but could benefit from limited support to plan for their coming years – no matter what barriers they face. In addition to benefits at the individual/couple/family level, Gateway is expected to have the long-term effect of reducing medical costs, use of critical/emergency care systems and homelessness.

The program leaves the particant(s) with an agreed upon Action Plan and a colorful resource manual divided by domains that are similar but not identical to the Age Friendly Communities domains. Each section has a listing of local resources, a pocket with informational flyers, brochures, and a space for noting particular information or actions of interest to each individual.

2. Gateway Evaluation Overview and Methods

The start-up goal was to conduct a pilot of the program and evaluate it to support continuous quality improvement and learn about the relatively short-term impact with emphasis on:

1. What works to get invited into people's homes for Gateway visits?
2. How do we define our target population for maximum effectiveness? Who does the program NOT work for?
3. What can we learn about needs, satisfaction and short-term impact?

Staff tracked demographic data on participants and conducted 30-day follow-up phone calls to encourage participants to follow-up on Action Plan items from their visit, and identify any new problems/issues that may have arisen. The internal evaluator conducted 90-day phone calls with a sample of clients. Staff and individuals from 3 key referring agencies were also interviewed.

3. Number Served and Participant Characteristics

The 78 participants served through this pilot of 68 home visits were predominantly ages 65 to 84 with a few 85 or older. Not surprisingly, they are 76% female. An estimated 54% were low or very low income and another 33% "were moderate" income – which puts them in the "donut hole" of often not being able to afford resources to meet their needs but having too much income to qualify for low/no cost services. 76% of participants live in the 5 lowest income zip codes in Berkeley.
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

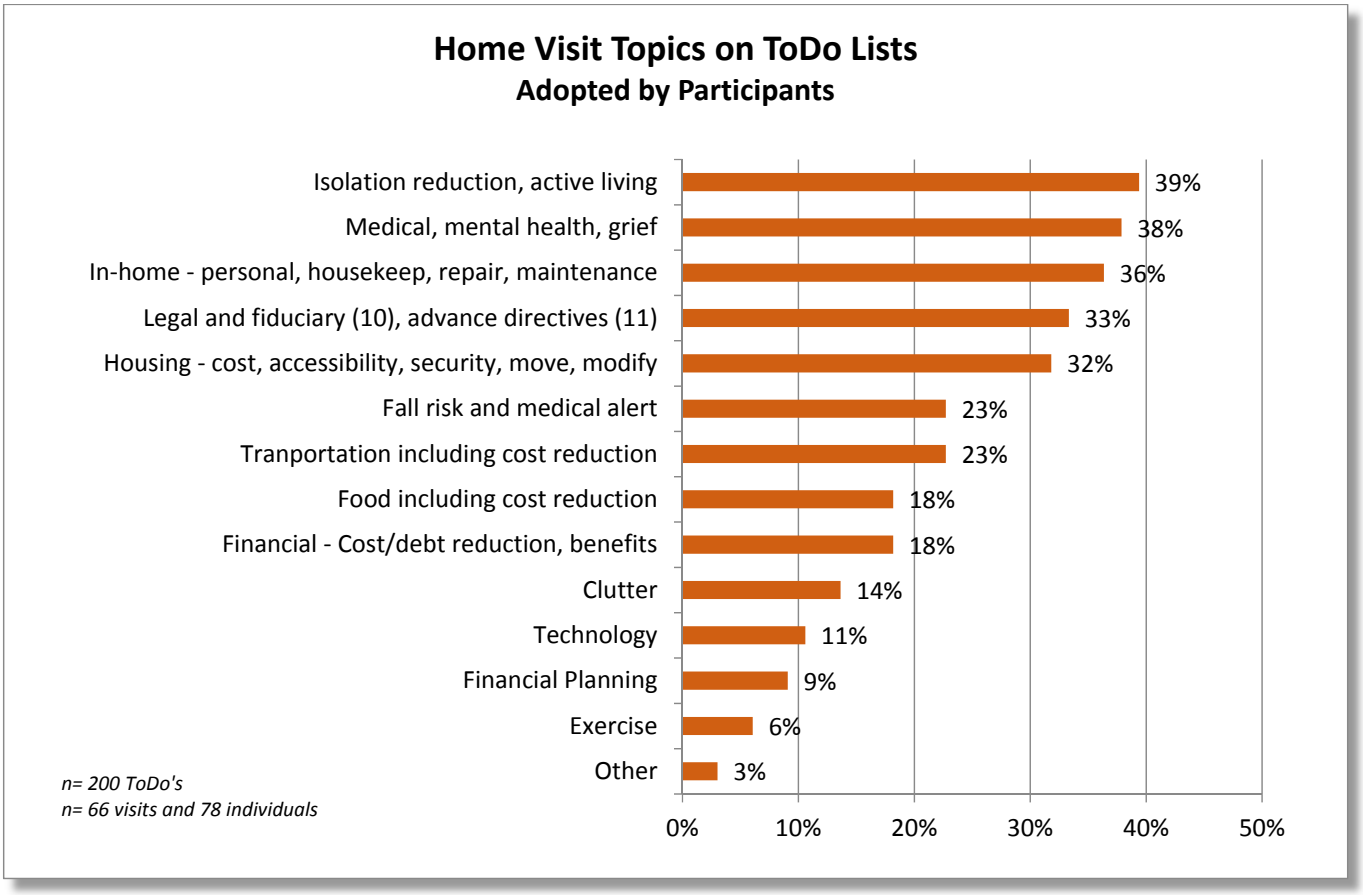
In this group, an estimated 23% were of color including 13% African American, 12% Asian/PI, and 3% Latino. This is near but slightly below the American Community Survey's 2015 estimate of 31% of Berkeley residents being nonwhite (all ages). An African American Planner (the third of three home visitors) was hired in July, 2019 who will focus on outreach in the African American community.

4. Outreach and Referrals

Gateway launched with the expectation that it would gain referrals from other service providers who recognized that an individual or couple needed to begin thinking about their aging process before needs became critical. Initial outreach was with Berkeley senior center staff and Over 60 Clinic doctors, nurses, and social workers. It quickly became evident, however, that direct service providers were too busy to take this on, may not have understood it, or may not have been convinced of its usefulness. Because of this slow initial uptake, the team began testing a variety of outreach methods including tables at health fairs, presentations at senior centers, service organizations, senior housing buildings, faith-based organizations and events in the community. These new activities generated self-referrals which had not been considered at the start. This has resulted in a diverse set of referral sites and sources that continues to grow.

5. Findings

a. Participant-Defined Priorities at Home Visit: Below is a summary of participant Action Plan items.



Other Issues Identified by Planners During Home Visits: There were a number of instances where participants shared challenges but were not ready/willing to do anything about them. Additionally, there were instances where Planners were able to observe challenges that the participant did not recognize. These additional observed challenges identified in chart notes include: Safety, Cognitive Decline, Mental Health, and Overwhelm.

In many instances, when raised by the Planner, the participant was also not interested in addressing the issue(s).

b. 30-Day and 90-Day Calls: Planners call participant households approximately 30 days after their visit for follow-up. In these calls, the Planner uses a "stages of change" approach, asking whether the Participant remembers or has thought about their Action Plan items, whether they have taken any action steps, and if not, how likely they are to act in the future. Realizing early on that the call was serving as a "booster" to the original visit, Planners have spent increasing amounts of time reviewing the Plan, hearing about what worked, didn't work, motivating participants, and exploring any new needs. The Planner also asks whether the Participant (or partner) has experienced any falls, 911 calls, or emergency room visits since the visit. If yes, and the experience was avoidable, more discussion and/or an additional visit followed.

From calls to the 37 who had reached 30 days post-visit we learned that:

- 3 or 8% reported having fallen since their visit; none had called 911 since their visit; 2 or 5% had been to the emergency room (self or partner) whether for a fall or other issue. All of these were explored as to whether they were avoidable and education about alternatives to emergency care was provided;
- 35 of 36 who were reached (97%) could remember one or more item from their Action Plan;
- 81% reported having acted on at least one item on their list
  - Many reported that knowing that the Planner was going to call them in 30 days had helped motivate them to take action
  - Reasons for not acting were fairly evenly divided between a) life events getting in the way (travel, illness, etc.), b) not "ready" to take these actions but happy to have a plan and resources identified, and c) not remembering or being motivated to act.

c. Sample Stories: A series of case stories are included as an Attachment.

d. Satisfaction: Key quotes from participants include:

- "*Great! Mainly you had good questions and good answers to my questions. You had a non-threatening way of communicating things that can be threatening or challenging."*
- *"I feel more motivated. This took some of the fear away."*
- *"I appreciate the opportunity to talk through my situation with you and see things differently."*
- *"This has been very useful, really appreciate the time. I feel good about things I have done so far and I have set up some systems. This has helped me to think more proactively about my home."*
- *"Over the top. Beyond expectations. Highly substantive. Actionable content I can start using immediately and I will have results soon."*

1. **What works to get invited into people's homes for Gateway Visits?**

Gateway has not found a single answer to this question but is steadily increasing its' effectiveness. Having started with provider referrals and migrated to elder self-referral, the volume of requests for visits went up sharply but the self-referral (or friend referral) led to knowing less about each potential participant at first contact. As a result, more phone screening is necessary before home visit appointments to screen out those who are not a good fit for the program.

Gateway will continue to work multiple pathways for referrals and is seeking to conduct more outreach in churches and to local hospital social work departments.

2. **How do we define our target population? Who does the program NOT work for?**

A few findings in this area are clear:

- The program works for people who are **functional enough to set goals and follow through** on steps to meet them. Functionality may be affected by health status, cognitive and mental health status, personality, and circumstances. While Planners do a lot of work to motivate people to follow-through (including 30-day call), it is more difficult to motivate those who are depressed, overwhelmed, or experiencing cognitive decline.
- Those who are already in **case management** don't benefit much from Gateway as the resources offered are too similar. Most already in case management can be screened out before the visit.

  Some participants have urgent or serious needs requiring case management and Gateway cannot meet those needs. So far, we have not identified the need until the visit. In some cases, Gateway has then been able to link individuals to a case manager before they fall into crisis, and that in itself is a positive outcome. Others could benefit from "case management lite" but unless they can afford to pay, few resources are available to them. In these instances, Gateway helps reduce overwhelm, and focuses participants on their most urgent needs.

  Gateway was originally envisioned to allow for "case management lite" for a small proportion of its participants but funding has not yet been secured for that – it would be useful.
- **Age:** There is no single age group that benefits more from Gateway but rather, we have learned that the message and methods must be different for those at different ages or stages. Those who face fewer medical or cognitive challenges (often younger) have greater freedom to think expansively about the next chapter of their lives and have more time to plan for such things as housing or personal supports that may not be needed until later. Their immediate needs are often around finances, social engagement, and getting ahead of medical conditions.

  Those who are older or already experiencing multiple challenges of aging (or disability at a younger age) have fewer options and critical needs may be more immediate. This group doesn't tend to appreciate "visioning" exercises but wants to jump to business on critical needs.

  Gateway is learning to increase its effectiveness by tuning into where each participant is on the aging continuum and refining the visit to match.

3. **What can we learn about wants, needs, satisfaction, and short-term impact?**

a. **Wants and Needs**

As matched by needs assessments, participants' top desire is to age independently, in their own home,

in Berkeley. The shortage of suitable, affordable housing (including assisted living) is a great barrier to this regardless of income level. This requires planning to begin sooner than later but there is great resistance to this.

Additionally, finding and financing personal and household assistance is a high need. Affording and managing transportation, food, and social activities follow closely. Depression, anxiety, grief, and isolation are seen widely at varying degrees of severity. Cluttering is suggestive of greater mental health disorders.

Frailer adults are also challenged by the need to be assertive and persistent in getting the medical care they need (e.g.: going back when they don't feel good on a new medication), having the capability to follow through on steps to improve their current or upcoming situation, and feeling or believing they have any capacity to be in control of their situation - even small ways.

b. Satisfaction: Satisfaction with Gateway is extremely high (near 100%). Follow-through on at least one Action Plan item is very high (86%) with a number of those who have not acted still fully meaning to in the future. Illness, holidays, travel and memory problems are large contributors to "delaying" action.

Participants also report their increased sense of responsibility for managing their lives, and feeling connected to the caring Planner as important gains. The way that the Resource Binder organizes materials and allows note taking and action items to be written into it is an overwhelming success.

c. Outcomes and Impact: Gateway is strong at moving older adults through passivity and overwhelm to motivated to act on a focused list of things that can be done to improve their position – at whatever their stage. Participants report feeling like their Planner provides valuable resources they did not know about, acts as a motivator and partner, and checks back in later to see how it is going.

Planners themselves report that they are also working hard to break denial and to help elders recognize barriers/risks that can be reduced if addressed proactively (e.g.: safety, isolation, homelessness, food insufficiency). Data shows that Planners are making headway in providing materials for advance directives, planning for future housing needs, reducing food insufficiency (especially at the end of the month), lowering utility costs for the lowest income, getting home safety assessments, reducing isolation, and raising awareness about fall hazards.

It is harder to measure economic impact in a program like this but education and emphasis on preventing falls and alternatives to calling 911 and going to emergency rooms is high. Planners conduct additional follow-up with participants when they have established follow-up on a medical need as part of their Action Plan.

d. Strengths and Challenges: Strengths of Gateway include its' client-driven and positive approach, the wide array of resources offered in a customized, clear and concise manner, goal setting, accountability at 30 days, the focus on in-home safety and housing security, and the magic ingredient of a caring personal touch.

Challenges include finding the right outreach and messaging to identify and recruit the right elders; not having the capacity for follow-up visits for those who need a little more support; finding the balance between asking and telling people what they need; the housing shortage/cost; and what to do about cluttering. Additionally, on the funding and policy side, the program faces a challenge to educate/convince planners and funders that prevention/early intervention is not a luxury because of its high potential to reduce system overload and reduce system costs in the long run.