2002 - 2003 AGENCY EVALUATIONS

Conducted for

CITY OF COLUMBIA, MISSOURI
OFFICE OF COMMUNITY SERVICES

April 22, 2003

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EXECUTIVE SUMMARY

Summary of Scores and Recommendations

PROGRAM NAME	SCORE ON THE FRAMEWORK FOR CONTINUOUS EVALUATION AND IMPROVEMENT (15 maximum)	SCORE ON THE FRAMEWORK FOR GATHERING AND ANALYZING OUTCOMES (15 maximum)	MAIN THEME ADDRESSED IN THE MISSION STATEMENT	PROGRAM ACTIVITIES ADDRESS THE MISSION	CURRENT PROGRAM OUTCOMES ADEQUATELY REFLECT THE MISSION	SUMMARY OF MAIN RECOMMENDATIONS
Boone County Council on Aging	11	9	promote dignity and self respect	Yes	Yes	Develop outcome objectives based upon currently gathered information.
Cedar Creek Therapeutic Riding Center	HRS rating 5 Self rating 13	HRS rating 5 Self rating 12	promote well being	Yes	No	Develop overall program evaluation based upon individual client reports.
Central Missouri Food Bank Pantry	8	8	alleviate malnutrition	Yes	No	Consider repeating the survey of clients conducted in 1998. Use measures of "food security" to determine client outcomes.
Eldercare Center	10	9	promote well being	Yes	Yes	Develop a mission statement more related to the Eldercare service. Develop outcome objectives based upon currently gathered information. Focus of outcomes evaluation can be on reports of family members.

Summary of Scores and Recommendations (continued)

PROGRAM NAME	SCORE ON THE FRAMEWORK FOR CONTINUOUS EVALUATION AND IMPROVEMENT (15 maximum)	SCORE ON THE FRAMEWORK FOR GATHERING AND ANALYZING OUTCOMES (15 maximum)	MAIN THEME ADDRESSED IN THE MISSION STATEMENT	PROGRAM ACTIVITIES ADDRESS THE MISSION	PROGRAM OUTCOMES ADEQUATELY REFLECT THE MISSION	SUMMARY OF MAIN RECOMMENDATIONS
Meals on Wheels	9	5	alleviate and prevent malnutrition, alleviate and prevent isolation	Yes	Yes	Develop outcome objectives based upon currently gathered information. Recommended exit interview with past clients has already been instituted.
OATS	9	9	promote independence	Yes	No	Add a new question to the existing rider survey to gather client outcomes information.
Seize the Day Volunteers	9	9	alleviate gaps in services	Yes	Yes	Develop outcome objectives based upon currently gathered information. Reword the current objectives to reflect the impact on the client.
Voluntary Action Center	8.5	10	alleviate gaps in services	Yes	No	Reword the currently used instrument to better capture client outcomes. Develop outcome objectives based upon currently gathered information.

Current Status of Evaluation Instruments

Agency	BCCA	CCTRC	CMFBP	ELDER	MOW	OATS	STD	VAC
Currently listing only outputs or process objectives on the Social Services Application	X	X	X	X	X	X		X
Currently listing some outcomes objectives on the Social Services Application							X	
Currently have a client satisfaction measure	X			X	X	X	X	X
Currently ask clients to report on perceived outcomes	X			X	X		X	
Currently follow-up on former clients					X		X	
Currently include a question relating to keeping people out of nursing homes or in the least restrictive environment	X			X	X		X	

BACKGROUND

For the past five years, the City of Columbia has contracted with Horizon Research Services to evaluate city-funded human services agencies. At the start of the first contract period, the Office of Community Services and the Boone County Community Services Advisory Commission had revised the evaluation process to focus more on program services and less on fiscal and management processes. Part of Horizon's role has been to help agencies move toward outcomes-based planning and performance evaluations.

As part of the process of continuous improvement in its planning, allocation, and evaluation procedures, the Office of Community Services and the Boone County Community Services Advisory Commission took further steps to revise the evaluation process. The new process was developed through discussions with Councilman Rex Campbell, the Office of Community Services, the Boone County Community Services Advisory Commission, and Horizon Research Services.

For each year's evaluation, the Office of Community Services plans to choose programs that are generally related to a service delivery system focusing on a specific population being served or a similar set of services being provided (e.g. services for homeless individuals). This will allow the Commission to compare outcomes for similar services each year.

This revised process further increases the emphasis on evaluation of program services and will help the City to judge to what extent agencies are producing measurable positive outcomes for the participants of their programs.

Most of the 2002 – 2003 evaluations relate to agencies serving elderly and disabled populations. The Voluntary Action Center and the Central Missouri Food Bank Pantry were included in the group of agencies evaluated this year even though they serve other populations in addition to the elderly and disabled.

Number of Agencies and Program Services Evaluated

The agency program evaluation process was conducted for nine program services with eight agencies involved in the evaluation process. The Office of Community Services chose these nine programs for evaluation in 2002-2003.

- Boone County Council on Aging (BCCA)
- Cedar Creek Therapeutic Riding Center (CCTRC)
- Central Missouri Food Bank Pantry (CMFBP)
- Eldercare Center (EC)
- Meals on Wheels (MOW)
- OATS
- Seize the Day (STD)
- Voluntary Action Center – Family Information, Referral, and Resource Center (VAC)
- Voluntary Action Center – Essential Transportation (VAC)

DEVELOPMENT OF COMMUNITY INDICATORS

Horizon Research Services (HRS) serves as the external evaluator for City of Columbia and Boone County funded social services agencies. Part of the mandate in the evaluation process is to identify several indicators by which local agencies could track their progress. The agencies to be evaluated in 2002-2003 deal with services for elderly and disabled populations.

Phil Steinhaus from the Office of Community Services and HRS discussed having the service agencies assist in developing a set of standard indicators to measure outcomes for the elderly population in Boone County. Our "Seniors Count" report could be modeled after "Kids Count" or the former Boone County Health Report Card.

To begin the process, the mission statements and main goal statements for each agency evaluated in 2002-2003 were read carefully and broken down into individual elements. These elements were grouped into themes.

The identified themes were used to begin the discussion of the types of community indicators that would be most useful to the agencies being evaluated. Dr. Carol Schultz and Dr. Kathleen Anger from HRS met with the Senior Leadership Network in October, 2002, to begin a "modified Delphi" group process to start generating ideas and finding common outcome objectives for the various services. At a subsequent meeting on January 30, 2003, these concepts and definitions were further discussed as the group endeavored to quantify the outcomes.

This document is a report on the progress made toward identifying indicators of the health and well-being of the elderly and disabled population in Boone County and a suggested group of indicators that can be the beginning for a "Boone County Seniors Count" report.

Themes in Mission Statements and Goal Statements

The mission statements and main goal statements for each agency were read carefully and broken down into individual elements. For example, if a mission statement stated "to promote dignity and respect" this statement was broken down into the two elements, "to promote dignity," and "to promote respect." The second part of most mission statements describes how the agency intends to promote its mission, generally continuing the mission statement, "…by providing." These statements were broken out into their component parts to more easily identify which services could be quantified with outcomes indicators. Another part of this exercise was to examine the different segments of the population each agency states it is serving. Using the first topic as an example, agency #7 (Meals on Wheels) fulfills its mission by providing delivery of a hot, nutritious meal to various populations. It is a lot easier to quantify the population "people recovering from a recent hospitalization" than "people with limited incentive to cook." In the first case, hospital records are easily checked, or this may be part of the information collected from the client upon intake into the program. In the second case, to determine whether a person has limited incentive to cook would require a precise definition and a rating scale that would be applied to the individual to determine if he/she met the definition for "limited incentive to cook."

Mission statements

[Key to agencies: 1=BCCA; 2=OATS; 3=Seize the Day; 4=CMFBP; 5=VAC; 6=EC; 7=MOW; 8=CCTRC]

AGENCY	MISSION	CLIENT GROUP
	Promote well-being	
6	achieve optimal wellness	elderly clients
8	promote well-being	physically challenged persons
8	promote well-being	mentally challenged persons
8	promote well-being	emotionally challenged persons
	Promote dignity and self-respect	
1	promote dignity	elderly clients
1	promote self respect	elderly clients
	Promote independence	
1	promote independence	elderly clients
2	(transportation disadvantaged) can live independently	transportation disadvantaged clients
3	continue to live in the least restrictive environment possible	clients
	Alleviate gaps in services	
3	assure than no individual falls through the cracks of the care system	clients
5	serve as the agency of first and last resort	clients
	Alleviate malnutrition	
4	feed people in need	
7	alleviate malnutrition	clients
7	prevent malnutrition	clients
	Alleviate isolation	
7	alleviate isolation	homebound
7	prevent isolation	homebound
	Other	
1	promote security	elderly clients
6	further the mission of the University in the areas of service, education, research, and extension	elderly clients

Goals and activities

[Key to agencies: 1=BCCA; 2=OATS; 3=Seize the Day; 4=CMFBP; 5=VAC; 6=EC; 7=MOW; 8=CCTRC]

Agency	GOAL OR ACTIVITY	Number of times this is mentioned
	Provide services	**Total 36**
	Provide food and hunger related services	**Sub-total 11**
4	feed people in need	
7	providing delivery of a hot, nutritious meal to people with limited ability to shop	
7	providing delivery of a hot, nutritious meal to people with limited incentive to shop	
7	providing delivery of a hot, nutritious meal to people with limited ability to cook	
7	providing delivery of a hot, nutritious meal to people with limited incentive to cook	
7	providing delivery of a hot, nutritious meal to people recovering from recent hospitalizations	
7	providing delivery of a hot, nutritious meal to people recovering from recent illnesses	
7	assist individuals with problems related to nutrition and health	
7	provide home delivery of nutritious meals	
7	providing delivery of a hot, nutritious meal to homebound people of any age	
7	providing delivery of a hot, nutritious meal to homebound people regardless of their ability to pay	
	Supplement government services	**Sub-total 6**
8	supplement the activities of federal agencies in regard to the rehabilitation of persons with physical disabilities	
8	supplement the activities of federal agencies in regard to the rehabilitation of persons with mental disabilities	
8	supplement the activities of federal agencies in regard to the rehabilitation of persons with emotional disabilities	
8	supplement the activities of state agencies in regard to the rehabilitation of persons with physical disabilities	
8	supplement the activities of state agencies in regard to the rehabilitation of persons with mental disabilities	
8	supplement the activities of state agencies in regard to the rehabilitation of persons with emotional disabilities	
	Provide services – general	**Sub-total 5**
1	provide service to meet unmet needs	
1	provide service when no other community resources are available	
5	provide emergency assistance to families whose needs are not met by social services community	
6	provide rehabilitation services	
8	offer services to all physically-challenged persons regardless of race, creed, sex, or origin	
	Supportive environment	**Sub-total 4**
1	serve as a source of support for seniors who lack natural support mechanisms	
3	provide non-medical support	
6	provide a supportive environment for individuals	
6	provide a supportive environment for families of elderly	
	Other	**Sub-total 3**
8	award graduation certificates to people with disabilities engaged in therapeutic horseback riding	
8	investigate the effects of horseback riding on people with disabilities	
8	set standards for people with disabilities engaged in therapeutic horseback riding	

	Provide services (continued)	
	Quality of life	**Sub-total 2**
7	improve the quality of life of homebound people	
7	promote the quality of life of homebound people	
	Respite	**Sub-total 2**
3	provide respite to family caregivers	
6	provide respite support for families	
	Activities for independence	**Sub-total 2**
2	allow (transportation disadvantaged) to live independently	
6	allow participants to achieve optimal independence	
	Transportation	**Sub-total 1**
2	provide reliable transportation	

Agency		
	Identify and fill gaps in services	**Total 20**
	Identify gaps for clients	**Sub-total 7**
1	identify seniors who lack natural support mechanisms	
1	identifying individual needs	
5	assess client need and provide services if no other appropriate agency	
5	assess client needs for referral to appropriate agency	
6	prepare an individual plan of care	
6	promote each person's right to function at the highest level	
8	conduct periodic examinations for people with disabilities engaged in therapeutic horseback riding	
	Gaps in the service delivery system	**Sub-total 4**
3	fill gaps in the service delivery system with volunteer services	
3	identify gaps in the service delivery system	
5	identify unmet needs in the community	
5	identify emerging community needs	
	Information and referral	**Sub-total 3**
1	provide information so ALL are aware of community resources	
1	providing information for a positive lifelong experience	
5	provide information and referral to the social services community	
	General gaps	**Sub-total 3**
1	provide service to meet unmet needs	
1	provide service when no other community resources are available	
5	work as a catalyst to see that appropriate action is taken to meet gaps in services	
	Match people with existing services	**Sub-total 2**
1	help seniors access available community services	
1	matching individual needs with community resources	
	Gaps in services to families	**Sub-total 1**
5	provide emergency assistance to families whose needs are not met by social services community	

Agency		
	Advocacy	**Total 12**
	Advocate for people at the community level	**Sub-total 8**
1	advocating for seniors at the local level	
1	contribute to the building of community support networks for seniors	
1	ensure that the needs of senior citizens are considered in community planning	
1	primary local community representative for the older citizens	
4	advocate with the public [for the elimination of hunger]	
5	act as a catalyst in identifying and addressing emerging community needs	
5	address emerging community needs	
5	engage people in solving serious social problems	
	General advocacy	**Sub-total 2**
4	advocate with the public for the elimination of hunger	
5	help solve serious social problems	
5	identify serious social problems	
	Advocacy at the state level	**Sub-total 2**
8	coordinate with the activities of state agencies in regard to the rehabilitation of persons with physical disabilities	
8	coordinate with the activities of state agencies in regard to the rehabilitation of persons with mental disabilities	

Agency		
	Education	**Total 10**
	Educate community	**Sub-total 6**
1	provide education for a positive lifelong experience	
4	educate community resources to feed people in need	
4	empower community resources to feed people in need	
5	educate the community as a whole about the various social service programs in our area	
6	provide educational opportunities for participants	
8	educate the community on the benefits of therapeutic riding for people with disabilities	
	Education for families	**Sub-total 2**
6	provide educational opportunities for families	
6	provide educational support for families	
	Education for others	**Sub-total 2**
6	provide educational opportunities for faculty	
6	provide educational opportunities for students	

Agency		
	Cooperation and coordination with other services	**Total 8**
	Among service providers and community resources	**Sub-total 4**
4	partner with community resources [to feed people in need]	
5	coordinate services among providers on the various social service programs in our area	
5	improve the level of awareness among providers on the various social service programs in our area	
5	improve the level of cooperation among providers on the various social service programs in our area	
	Cooperation and coordination with federal level	**Sub-total 3**
8	coordinate with the activities of federal agencies in regard to the rehabilitation of persons with physical disabilities	
8	coordinate with the activities of federal agencies in regard to the rehabilitation of persons with mental disabilities	
8	coordinate with the activities of federal agencies in regard to the rehabilitation of persons with emotional disabilities	
	Cooperation and coordination with state level	**Sub-total 1**
8	coordinate with the activities of state agencies in regard to the rehabilitation of persons with emotional disabilities	

Agency		
	Volunteerism	**Total 6**
	Volunteer development	**Sub-total 4**
1	use volunteers to provide service	
5	engage more people in volunteer service	
5	community-wide volunteer coordination to engage more people in volunteer services	
5	community-wide volunteer coordination to engage people more effectively in volunteer services	
	Cooperation and coordination with volunteers	**Sub-total 2**
1	coordinating volunteer opportunities for older citizens	
5	provide community wide volunteer coordination	

Senior Leadership Network: Success with a Client

Carol Schultz and Kathleen Anger from HRS met with the Senior Leadership Group in October, 2002, to begin a "modified Delphi" group process to start generating ideas and finding common outcome objectives for the various services. The group was asked, "When you are successful with a client, what does that mean?" The ideas generated in October were compiled into three main themes; maintaining independence, support, and quality of life.

At a subsequent meeting on January 30, 2003, these concepts and definitions were further discussed as the group endeavored to quantify the outcomes.

The section below reports on the progress of that process.

Maintains independence

As a result of our services, the client maintains independence in his/her own home.

Definitions of "maintaining independence"

- living independently in their own home
- keeping the elderly in their own home
- functioning in their own home
- keeping a person in his/her own home as long as possible
- keeping a person in residential care – not moving to skilled care facilities

Quality of life

As a result of our services, the quality of life for each client is maintained.

Definition of "quality of life"

- improvement in living conditions
- means something different to each individual
- a senior has someone that loves him/her
- a senior has someone who cares about him/her
- a senior has a reason for getting up in the morning
- improved communication between family members
- helping to resolve problems associated with living in a NH/RCF
- able to enjoy daily leisure activities

Health

As a result of our services, clients are able to maintain good health.

Definition of "good health"

- standard health indicators
    - level of functioning in activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
    - dental/oral health
- maintain good mental health
    - score above a certain score on a standard index of depression

- maintain good nutrition
    - (if not eating well, will become more frail and have longer hospital stays)

Support

As a result of our services clients have support to assist them in maintaining their independence and quality of life.

Definition of "support"

- people feeling connected
- connect people to volunteer opportunities
- function as a surrogate family member
- access to information
- connections to services, resources, information, etc.
- access to services that will support them such as
    - friendly visits
    - transportation
    - yard work
    - home repairs
    - finances
    - marriage relationships

Supporting family caregivers

As a result of our services family caregivers are supported so they can continue performing the duties of a caregiver.

Definition of support for family caregivers

- making family members aware of resources
- guiding family caregivers to the sources of assistance
- helping family members feel more secure
- helping family members have peace of mind
- helping family members feel more comfortable
- making caregivers feel they are doing a good job
- helping family members feel less isolated
- putting a plan in place to stabilize the situation

- family put a plan in place that keeps things stable – whether in the home or in a facility
- reducing the stress of caregiving
- keeping the caregiver functioning (not burning out)
- allowing caregivers to work outside the home

Boone County Seniors Count – Suggested Indicators

Taking the information gathered in the process of analyzing the mission statements and the suggestions of the Senior Executive Network, the HRS evaluators looked at currently available statistics. Statistics collected by the Missouri Department of Health and Senior Services (DHSS) were chosen as a beginning point to collect community indicators for a Boone County's Seniors Count report. The table below lists the suggested indicators that could be tracked from DHSS data.

Boone County

Indicators of the well-being of seniors	Base year numbers
Emergency room admissions	*Base year: 2000*
Emergency room admissions for fracture of upper limb	77
Emergency room admissions for fracture of lower limb	24
Emergency room admissions for fracture of hip	9
In-patient hospitalizations	*Base year: 2000*
In-patient hospitalizations for nutrition problems	177
In-patient hospitalizations for fracture of upper limb	20
In-patient hospitalizations for fracture of lower limb	24
In-patient hospitalizations for fracture of hip	133
Hospital days of care	*Base year: 2000*
Hospital days of care for nutrition problems	40
Hospital days of care for fracture of upper limb	103
Hospital days of care for fracture of lower limb	86
Hospital days of care for fracture of hip	765
Hospital days of care for chronic ulcer of skin	258
Deaths	*Base year: 2000*
Deaths from malnutrition	2
Deaths from falls	3

Elder Abuse	*Base year: 2000*
Reports of incidents of physical neglect	19,799
Substantiated reports of incidents of physical neglect	11,286 reason to believe or findings suspected (8513 unsubstantiated)
Reports of incidents of physical abuse	2,709
Substantiated reports of incidents of physical abuse	1,517 reason to believe or finding suspected (1,192 unsubstantiated)

SELECTED INFORMATION ABOUT PEOPLE 65+ IN BOONE COUNTY

Overview

Boone County

- Total population 135,454
- 8.4% Black/African American
- 1.9% Hispanic
- 13% over 65 years of age
- 15.2% of all households below poverty level in 1999
- 9.6% of females 75+ fall below poverty level in 1999

Columbia

- Total population 84,780
- 10.7% Black/African American
- 2.1% Hispanic
- 9% over 65 years of age
- 19.5% of all households below poverty level in 1999
- 8.1% of females 75+ fall below poverty level in 1999

Age

Adults 65 years and older are approximately 9% of the total population of the City of Columbia. For the state of Missouri the percentage of those 65 and older is somewhat higher, at 13.5%. The fastest growing segments of this age group are those 85 years and over. This group grew from only 812 in 1990 to 1,188 in 2000. Even though Columbia is a college town, the median age changed from 25.6 years to 26.8 from 1990 to 2000. This trend follows the national trend as more baby boomers are living longer and the population in general ages.

Following age expectancies, there are nearly twice a many females over the age of 65 as there are males. The difference is especially prominent with those over the age of 85. In this category there are 287 males and 901 females.

Boone County - Age by Sex Universe: Boone County Total Population				
Age	**Male**		**Female**	
	Number	**%**	**Number**	**%**
Under age 50	52,844	80.7	54,650	78.1
50-54	3,665	5.6	3,750	5.4
55-59	2,357	3.6	2,596	3.7
60-61	800	1.2	932	1.3
62-64	1,056	1.6	1,160	1.7
65-66	590	0.9	757	1.1
67-69	930	1.4	1,034	1.5
70-74	1,084	1.7	1,425	2.0
75-79	1,024	1.6	1,377	2.0
80-84	713	1.1	1,051	1.5
85+	455	0.7	1,204	1.7
Total	**65,518**		**69,936**	

Source: Census 2000

Columbia - Age by Sex Universe: Columbia Total Population				
Age	**Male**		**Female**	
	Number	**%**	**Number**	**%**
Under age 50	33,463	82.7	35,102	79.2
50-54	1,864	4.6	2,101	4.7
55-59	1,314	3.2	1,433	3.2
60-61	473	1.2	501	1.1
62-64	480	1.2	646	1.5
65-66	296	0.7	419	.9
67-69	498	1.2	657	1.5
70-74	644	1.6	864	1.9
75-79	703	1.7	970	2.2
80-84	449	1.1	715	1.6
85+	287	0.7	901	2.0
Total	**40,471**		**44,309**	

Source: Census 2000

Race

Boone County - Population by Race and Hispanic or Latino Origin Universe: Boone County Total Population				
Population	**Total**		**Hispanic or Latino**	
	Number	%	Number	%
White alone	116,335	85.9	1,595	63.5
Black/African American alone	11,351	8.4	93	3.7
American Indian/Alaska Native alone	663	.5	47	1.9
Asian alone	3,865	2.9	0	
Native Hawaiian/Other Pacific Islander alone	34	<.01	0	
Some Other Race alone	719	.5	567	22.6
Two or More Races	2,487	1.8	209	8.3
Total Population	**135,454**		**2,511**	

Source: Census 2000

Columbia - Population by Race and Hispanic or Latino Origin Universe: Columbia Total Population				
Population	**Total**		**Hispanic or Latino**	
	Number	%	Number	%
White alone	69,578	82.1	1,104	61.3
Black/African American alone	9,102	10.7	45	2.5
American Indian/Alaska Native alone	422	.5	17	.9
Asian alone	3,574	4.2	0	
Native Hawaiian/Other Pacific Islander alone	14	<.01	0	
Some Other Race alone	533	.6	442	24.5
Two or More Races	1,557	1.8	194	10.8
Total Population	**84,780**		**1,802**	

Source: Census 2000

Economic Status

Boone County - Poverty Status in 1999 by Age by Household Type Universe: Boone County Population for whom poverty status is determined (*) P91/PCT54. Income Deficit in 1999 for families by family type and unrelated individuals Two universes: Families and unrelated individuals with income in 1999 below the poverty level							
Population with Income in 1999 below Poverty Level Mean							
		- - -All Ages- -					Income
	Total	Number	%	Under 65	65 to 74	75 & Over	Deficit
Total in poverty universe*:	126,458	18,366	14.5	17,718	255	393	$3,881
In Married-Couple Families	75,206	2,603	3.5	2,504	48	51	$1,887
In Other Families:	20,660	5,435	26.3	5,369	26	40	$2,164
Male Householder, No Wife	4,954	1,090	22.0	1,,085	2	3	$1,669
Female Householder, No Husband	15,706	4,345	27.7	4,284	24	37	$2,288
Unrelated Individuals	30,592	10,328	33.8	9,845	181	302	$5,287

*Poverty universe includes all people EXCEPT (1) those in institutions, military group quarters, and college dormitories and (2) unrelated individuals under 15 years old (children who are not related family members).

Source: Census 2000

Boone County - Poverty Status in 1999 of Households by Household Type by Age of Householder Universe: Boone County Households (**)							
Households with Income in 1999 below Poverty Level							
		- - -All Ages- -					
	Total	Number	%	Under 25	25 to 44	45 to 64	65 & Over
Total Households:	53,106	8,049	15.2	3,985	2,439	1,078	547
Family Households	31,665	2,391	7.6	659	1,311	336	85
Married-Couple Family Households	24,662	731	3.0	98	430	150	53
Other Family Households (No Spouse):	7,003	1,660	23.7	561	881	186	32
Male Householder, No Wife	1,678	275	16.4	95	128	50	2
Female Householder, No Husband	5,325	1,385	26.0	466	753	136	30
Nonfamily Households:	21,441	5,658	26.4	3,326	1,128	742	462
Male Householder	10,436	2,789	26.7	1,603	679	404	103
Female Householder	11,005	2,869	26.1	1,723	449	338	359

** Poverty status is NOT determined for households. The counts in this table actually reflect the poverty status of the householder.

Source: Census 2000

Boone County - Poverty Status in 1999 by Sex by Age by Race and Hispanic/Latino [Part 1 of 2 – Income in 1999 Below Poverty Level] Universe: Boone County Population for whom poverty status is determined (*) Population with Income in 1999 below Poverty Level											
	All Races		Race* *							Hispanic * * *	
	Number	%	White Alone	Black or African American Alone	American Indian & Alaska Native Alone	Asian Alone	Native Hawaiian & Other Pacific Islander Alone	Some Other Race Alone	Two or More Races	Hispanic or Latino	White Alone, Not Hispanic or Latino
Males 55 to 64 years	236	5.7%	188	36	0	12	0	0	0	0	188
Males 65 to 74 years	91	3.5%	73	11	0	0	0	0	7	0	73
Males 75 years and over	91	4.4%	75	16	0	0	0	0	0	0	75
Females 55 to 64 years	284	6.1%	230	41	0	6	0	0	7	10	220
Females 65 to 74 years	164	5.2%	98	66	0	0	0	0	0	0	98
Females 75 years or over	302	9.6%	249	46	0	0	0	0	7	6	243

100 Poverty universe includes all people EXCEPT (1) those in institutions, military group quarters, and college dormitories and (2) unrelated individuals under 15 years old (children who are not related family members).

** For Census 2000, persons could report more than one race, but the seven racial categories shown are mutually exclusive and include everyone.

*** Hispanic or Latino is NOT considered a race. People who reported themselves as Hispanic or Latino are also counted in the seven racial categories.

Source: Census 2000

Boone County Poverty Status in 1999 of Families by Family Type by Social Security Income by Supplemental Security Income (SSI) and/or Public Assistance Universe: Boone County Families Families with Income in 1999 below Poverty Level			
	Total	**With Social Security Income in 1999**	**Without Social Security Income in 1999**
Total Families:	31,665	208	2,183
Married-Couple Families:	24,662	77	654
With SSI and/or Public Assistance Income in 1999	658	13	91
Without SSI and/or Public Assistance Income in 1999	24,004	64	563
Other Families:	7,003	131	1,529
Male Householder, No wife Present:	1,678	38	237
With SSI and/or Public Assistance Income in 1999	100	23	30
Without SSI and/or Public Assistance Income in 1999	1,578	15	207
Female Householder, No Husband Present:	5,325	93	1,292
With SSI and/or Public Assistance Income in 1999	782	48	399
Without SSI and/or Public Assistance Income in 1999	4,543	45	893

Source: Census 2000

Columbia - Poverty Status in 1999 by Age by Household Type Universe: Columbia City Population for whom poverty status is determined (*) P91/PCT54. Income Deficit in 1999 for families by family type and unrelated individuals Two universes: Families and unrelated individuals with income in 1999 below the poverty level							
Population with Income in 1999 below Poverty Level Mean							
		All Ages					Income
	Total	Number	%	Under 65	65 to 74	75 & Over	Deficit
Total in poverty universe*:	76,436	14,670	19.2	14,314	138	218	$4,080
In Married-Couple Families	39,718	1,687	432	1,666	7	14	$1,789
In Other Families:	12,717	3,750	29.5	3,704	17	29	$2,359
Male Householder, No Wife	2,799	700	25.0	697	0	3	$1,936
Female Householder, No Husband	9,918	3,050	30.8	3,007	17	26	$2,456
Unrelated Individuals	24,001	9,233	38.5	8,944	114	175	$5,198

*Poverty universe includes all people EXCEPT (1) those in institutions, military group quarters, and college dormitories and (2) unrelated individuals under 15 years old (children who are not related family members).

Source: Census 2000

Columbia - Poverty Status in 1999 of Households by Household Type by Age of Householder Universe: Columbia City Households (**)							
Households with Income in 1999 below Poverty Level							
		All Ages					
	Total	Number	%	Under 25	25 to 44	45 to 64	65 & Over
Total Households:	33,819	6,600	19.5	3,702	1,868	716	314
Family Households	17,579	1,658	9.4	506	902	213	37
Married-Couple Family Households	13,167	476	3.6	90	297	82	7
Other Family Households (No Spouse):	4,412	1,182	26.8	416	605	131	30
Male Householder, No Wife	1,008	190	18.8	80	71	39	0
Female Householder, No Husband	3,404	992	29.1	336	534	92	30
Nonfamily Households:	16,240	4,942	30.4	3,196	966	503	277
Male Householder	7,927	2,467	31.1	1,547	582	272	66
Female Householder	8,313	2,475	29.8	1,649	384	231	211

** Poverty status is NOT determined for households. The counts in this table actually reflect the poverty status of the householder.

Source: Census 2000

Columbia - Poverty Status in 1999 by Sex by Age by Race and Hispanic/Latino [Part 1 of 2 – Income in 1999 Below Poverty Level] Universe: Columbia City Population for whom poverty status is determined (*) Population with Income in 1999 below Poverty Level											
	All Races		Race* *							Hispanic * * *	
	Number	%	White Alone	Black or African American Alone	American Indian & Alaska Native Alone	Asian Alone	Native Hawaiian & Other Pacific Islander Alone	Some Other Race Alone	Two or More Races	Hispanic or Latino	White Alone, Not Hispanic or Latino
Males 55 to 64 ears	173	7.7%	125	36	0	12	0	0	0	0	125
Males 65 to 74 years	42	3.0%	24	11	0	0	0	0	7	0	24
Males 75 years and over	44	3.3%	30	14	0	0	0	0	0	0	30
Females 55 to 64 years	160	6.2%	117	37	0	6	0	0	0	5	112
Females 65 to 74 years	96	5.1%	32	64	0	0	0	0	0	0	32
Females 75 years or over	174	8.1%	121	46	0	0	0	0	7	0	121

100 Poverty universe includes all people EXCEPT (1) those in institutions, military group quarters, and college dormitories and (2) unrelated individuals under 15 years old (children who are not related family members).

** For Census 2000, persons could report more than one race, but the seven racial categories shown are mutually exclusive and include everyone.

*** Hispanic or Latino is NOT considered a race. People who reported themselves as Hispanic or Latino are also counted in the seven racial categories.

Source: Census 2000

Columbia - Poverty Status in 1999 of Families by Family Type by Social Security Income by Supplemental Security Income (SSI) and/or Public Assistance Universe: Columbia City Families Families with Income in 1999 below Poverty Level			
	Total	**With Social Security Income in 1999**	**Without Social Security Income in 1999**
Total Families:	17,579	143	1,515
Married-Couple Families:	13,167	30	446
With SSI and/or Public Assistance Income in 1999	290	11	51
Without SSI and/or Public Assistance Income in 1999	12,877	19	395
Other Families:	4,412	113	1,069
Male Householder, No wife Present:	1,008	30	160
With SSI and/or Public Assistance Income in 1999	73	23	17
Without SSI and/or Public Assistance Income in 1999	935	7	143
Female Householder, No Husband Present:	3,404	83	909
With SSI and/or Public Assistance Income in 1999	563	39	320
Without SSI and/or Public Assistance Income in 1999	2,841	44	589

Source: Census 2000

Living Arrangements

Family and non-family households

Most elderly under age 75 live in family households. Of most concern are those 75 years and older who live alone and those who have some disability. According to the 2000 Census, in Boone County there were 769 men over age 65 and 2,551 women over age 65 living alone. In Columbia there were 498 men over age 65 living alone and 1,768 women over age 65 living alone.

Boone County - Household Type by Age of Households **Universe: Boone County Households**				
Age	**Family**		**Non-family**	
	Number	**% of age group in family**	**Number**	**% of age group in non-family**
15-24	2,033	26	5,801	74
25-34	6,564	58	4,729	42
35-44	8,578	75	2,818	25
45-54	7,123	72	2,792	28
55-64	3,496	65	1,875	35
65-74	2,295	63	1,350	37
75-84	1,294	47	1,473	53
85+	282	22	603	68
Total	**31,665**		**21,441**	

Source: Census 2000

Columbia - Age by Sex **Universe: Columbia Total Population**				
	Family		**Non-family**	
Age	**Number**	**% of age group in family**	**Number**	**% of age group in non-family**
15-24	1,405		5,324	79
25-34	3,857	52	3,607	48
35-44	4,504	70	1,953	30
45-54	3,680	67	1,830	33
55-64	1,810	60	1,184	40
65-74	1,262	59	892	41
75-84	885	47	1,012	53
85+	176	29	438	71
Total	**17,579**		**16,240**	

Source: Census 2000

Boone County - Household Type by Relationship Universe: Boone County Households		
In Households	**All ages**	**65+**
Total in households	**Number**	**Number**
In Households:	126,512	10,753
Family Households:	96,136	7,220
Householder:	31,665	3,871
Male	23,569	3,238
Female	8,096	633
Spouse	24,974	2,731
Parent	551	357
Child	33,783	
Natural-born	31,080	
Adopted	957	
Step	1,746	
Grandchild	978	
Brother or Sister	866	
Other Relatives	945	245
Nonrelatives	2,374	16
Nonfamily Households:	30,376	3,533
Male Householder:	10,436	816
Living Alone	6,972	769
Not Living Alone	3,464	47
Female Householder:	11,005	2,610
Living Alone	8,272	2,551
Not Living Alone	2,733	59
Nonrelatives	8,935	107
In Group Quarters:	8,942	891
Institutionalized	1,066	722
Noninstitutionalized	7,876	169

Source: Census 2000

Columbia - Household Type by Relationship Universe: Columbia Households		
In Households	**All ages**	**65+**
Total in households	**Number**	**Number**
In Households:	76,310	6,715
Family Households:	52,594	4,312
Householder:	17,579	2,323
Male	12,559	1,899
Female	5,020	424
Spouse	13,475	1,669
Parent	306	152
Child	18,019	
Natural-born	16,739	
Adopted	526	
Step	754	
Grandchild	561	
Brother or Sister	648	
Other Relatives	679	152
Nonrelatives	1,327	16
Nonfamily Households:	23,716	2,403
Male Householder:	7,927	521
Living Alone	5,141	498
Not Living Alone	2,786	23
Female Householder:	8,313	1,821
Living Alone	6,021	1,768
Not Living Alone	2,292	53
Nonrelatives	7,476	61
In Group Quarters:	8,470	688
Institutionalized	677	585
Noninstitutionalized	7,793	103

Source: Census 2000

Grandparents responsible for grandchildren

Of growing interest and concern are the numbers of grandparents responsible for grandchildren.

Boone County - Grandparents by Length of Time Responsible for Grandchildren Under 18 Years **Universe: Boone County Population 30 Years and Over in Households**	
Total population 30+ in Households	65,326
Living with own grandchildren under 18 years	1,141
Grandparents responsible for own grandchildren under 18 years	584
Length of time - -	
Less than 6 months	112
6 to 11 months	125
1 to 2 years	105
3 to 4 years	63
5 years or more	179
Grandparents not responsible for own grandchildren under 18 years	557
Not living with own grandchildren under 18 years	64,185

Source: Census 2000

Columbia - Grandparents by Length of Time Responsible for Grandchildren Under 18 Years **Universe: Columbia Population 30 Years and Over in Households**	
Total population 30+ in Households	37,059
Living with own grandchildren under 18 years	607
Grandparents responsible for own grandchildren under 18 years	295
Length of time - -	
Less than 6 months	47
6 to 11 months	42
1 to 2 years	45
3 to 4 years	27
5 years or more	134
Grandparents not responsible for own grandchildren under 18 years	312
Not living with own grandchildren under 18 years	36,452

Source: Census 2000

Institutionalized elderly

Even though the population is aging, according to the census, the nursing home population in Columbia has shrunk from 703 in 1990 to 549 in 2000. This may mean that greater proportions of senior citizens are staying at home and being cared for by family members or other caregivers.

In Columbia there are 913 total beds in long term facilities. This includes one nursing facility with 52 beds, two residential care I facilities with 74 beds, five residential care II facilities with 227 beds,

and 6 skilled nursing facilities with 560 beds. Many seniors choose to stay at home, but need assistance with various activities.

According to information from the National Nursing Home Survey, in 1997 nearly 80% of residents were dependent on help for mobility, nearly 65% were incontinent, and over 45% needed help with eating. This same survey said that almost 36% needed help with mobility, eating and were incontinent.

USA - PERCENTAGE OF NURSING HOME RESIDENTS AGE 65 OR OLDER WHO ARE INCONTINENT AND DEPENDENT IN MOBILITY AND EATING, BY AGE GROUP AND SEX, 1985 AND 1997

	DEPENDENT MOBILITY		INCONTINENT		DEPENDENT EATING		DEPENDENT MOBILITY, EATING, AND INCONTINENT	
	1985	**1997**	**1985**	**1997**	**1985**	**1997**	**1985**	**1997**
TOTAL								
65 OR OLDER	75.7	79.3	55.0	64.9	40.9	45.1	32.5	35.7
65 TO 74	61.2	73.1	42.9	59.2	33.5	42.1	25.7	30.7
75 TO 84	70.5	77.1	55.1	64.3	39.4	44.8	30.6	34.5
85 OR OLDER	83.3	82.6	58.1	66.9	43.9	46.1	35.6	37.8
MEN								
65 OR OLDER	71.2	76.3	54.2	65.0	36.0	42.8	28.0	33.6
65 TO 74	55.8	72.3	38.8	60.1	32.8	42.7	24.1	32.9
75 TO 84	65.7	75.1	54.4	65.9	32.6	43.7	25.5	34.6
85 OR OLDER	79.2	78.3	58.1	65.6	39.2	42.1	30.9	33.0
WOMEN								
65 OR OLDER	77.3	80.2	55.4	64.8	42.4	45.6	33.9	35.9
65 TO 74	64.5	73.7	45.4	58.6	34.0	41.6	26.7	29.2
75 TO 84	72.3	78.0	55.3	63.6	42.0	45.3	32.6	34.4
85 OR OLDER	84.3	83.5	58.1	67.2	45.0	46.9	36.7	38.8

Note: Residents dependent in mobility and eating require the assistance of a person or special equipment. Residents who are incontinent have difficulty in controlling bowels and/or bladder or have an ostomy or indwelling catheter.
Rates for the 65 or older category are age-adjusted using the 1995 National Nursing Home Survey population.
Reference population: These data refer to the population residing in nursing homes. Persons residing in personal care or domiciliary care homes are excluded.
Source: Older Americans 2000; Original Source: National Nursing Home Survey.

Abilities and Disabilities

Missouri statistics

In the state of Missouri, according to the 2000 Statewide Missouri Older Adult Needs Assessment for the Missouri Area Agencies on Aging (unpublished), an estimated 349,023 seniors need some help performing either ADLs (activities of daily living) or IADLs (instrumental activities of daily living). ADLs include eating, bathing, dressing, toileting, getting in/out of bed, and getting around the house. IADLs include light housework, using the telephone, shopping , preparing meals, taking medication and managing money. An estimated 128,538 seniors need help in performing one or more ADLs and an estimated 336,826 seniors need assistance performing one or more IADLs. According the Missouri Needs Assessment, help is most often needed with cleaning and shopping (IADLs) and mobility is the most difficult problem for ADLs. Around 121,970 seniors have trouble walking, getting around the house, and/or getting outdoors. Approximately 43,159 persons in the state of Missouri have difficulty with personal care activities.

National statistics

USA - DISTRIBUTION OF TYPES OF ASSISTANCE AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER WHO RECEIVED HOME CARE FOR A CHRONIC DISABILITY, BY LEVEL OF DISABILITY, 1982, 1989, AND 1994				
	INFORMAL CARE ONLY	**INFORMAL AND FORMAL CARE**	**FORMAL CARE ONLY**	**TOTAL NUMBER (IN THOUSANDS)**
1982				
LEVEL OF DISABILITY				
IADLS ONLY	80.8	12.1	7.1	1,687
1 ADL	74.5	19.8	5.7	1,068
2 ADLS	68.6	25.3	6.1	569
3 ADLS	66.0	29.3	4.7	341
4 ADLS	65.4	32.1	2.6	394
5 ADLS	65.3	33.2	1.5	548
TOTAL	73.6	21.0	5.4	4,607
1989				
LEVEL OF DISABILITY				
IADLS ONLY	77.7	12.6	9.7	1,509
1 ADL	69.0	20.5	10.5	1,153
2 ADLS	61.1	26.9	12.0	734
3 ADLS	58.7	34.8	6.5	519
4 ADLS	53.3	41.2	5.5	479
5 ADLS	54.4	41.6	4.0	399
TOTAL	66.6	24.4	9.0	4,793
1994				
LEVEL OF DISABILITY				
IADLS ONLY	78.3	12.2	9.5	1,488
1 ADL	64.9	24.4	10.7	1,114
2 ADLS	62.8	30.0	7.3	745
3 ADLS	57.4	37.2	5.4	443
4 ADLS	51.1	46.2	2.6	434
5 ADLS	41.4	55.3	3.3	512
TOTAL	64.3	28.0	7.8	4,736

Note: Home care refers to paid or unpaid assistance provided to a person with a chronic disability living in the community.
See "Indicator 18:Disability" for information on the definition of disability.
Reference Population: These data refer to Medicare beneficiaries.
Source: Older Americans 2000; Original Source: National Nursing Home Survey.

USA - PERCENTAGE OF PERSONS AGE 70 OR OLDER WHO REPORTED HAVING SELECTED CHRONIC CONDITIONS, BY SELECTED CHARACTERISTICS, 1984 AND 1995						
	1984	**1995**	**1984**	**1995**	**1984**	**1995**
	TOTAL		**MEN**		**WOMEN**	
ARTHRITIS	55.0	58.1	44.9	49.5	61.1	63.8
DIABETES	9.9	12.0	9.9	12.9	10.0	11.5
CANCER	12.4	19.4	13.8	23.4	11.6	16.7
STROKE	7.8	8.9	8.3	10.4	7.3	7.9
HYPERTENSION	45.6	45.0	36.8	40.5	50.8	48.0
HEART DISEASE	16.4	21.4	18.7	24.7	14.9	19.2
	1984	**1995**	**1984**	**1995**	**1984**	**1995**
	70 TO 74		**75 TO 79**		**80 TO 84**	
ARTHRITIS	55.0	54.4	54.1	58.3	57.3	61.4
DIABETES	10.8	13.4	9.7	12.6	10.8	11.0
CANCER	11.1	18.5	11.9	20.2	15.2	20.2
STROKE	6.0	7.1	7.6	8.7	9.6	10.4
HYPERTENSION	44.8	43.7	45.2	44.9	48.6	47.8
HEART DISEASE	15.6	18.9	15.2	22.0	20.0	23.0
	1984	**1995**				
	85 OR OLDER					
ARTHRITIS	53.3	64.1				
DIABETES	6.5	8.0				
CANCER	13.1	19.0				
STROKE	10.9	13.2				
HYPERTENSION	44.4	45.2				
HEART DISEASE	16.4	25.4				
	1984	**1995**	**1984**	**1995**	**1984**	**1995**
	NON-HISPANIC WHITE		**NON-HISPANIC BLACK**		**HISPANIC**	
ARTHRITIS	54.3	57.9	64.6	67.2	50.6	50.2
DIABETES	8.9	10.9	17.0	20.4	17.4	17.4
CANCER	13.4	21.0	4.6	9.1	6.2	10.5
STROKE	7.5	8.6	10.8	12.2	8.3	9.6
HYPERTENSION	44.3	44.0	59.3	58.7	46.9	42.0
HEART DISEASE	17.1	22.0	11.5	18.5	13.3	17.0

Note: Hispanics may be of any race.
1984 percentages are age-adjusted to the 1995 population.
Reference population: These data refer to the civilian noninstitutional population.
Source: Older Americans 2000; Original Source: Supplement on Aging and Second Supplement on Aging.

USA - PERCENTAGE OF PERSONS AGE 65 OR OLDER WITH MODERATE OR SEVERE MEMORY IMPAIRMENT, BY AGE GROUP AND SEX, 1998						
	MODERATE OR SEVERE MEMORY IMPAIRMENT			SEVERE MEMORY IMPAIRMENT		
	TOTAL	MEN	WOMEN	TOTAL	MEN	WOMEN
65 TO 69	4.4	5.3	3.8	0.9	0.8	0.9
70 TO 74	8.3	10.1	6.9	2.1	2.6	1.8
75 TO 79	13.5	16.2	11.7	5.2	6.4	4.4
80 TO 84	20.1	22.8	18.5	7.6	9.2	6.7
85 OR OLDER	35.8	37.3	35.0	18.3	19.6	17.6

Note: Definition of moderate or severe memory impairment: Four or fewer words recalled (out of 20) on combined immediate and delayed recall tests. Persons are described as having severe memory impairment if two or fewer words are recalled. Respondents who reported "don't know" on either the immediate or delayed recall test (implying that they were unable to recall any words) were assigned a score of zero for that test. Respondents who refused to participate in either test are excluded from the analysis.
Reference population: These data refer to the civilian noninstitutional population.
Source: Older Americans 2000; Original Source: Health and Retirement Study.

Adult Day Services

The staff at the Eldercare Center provided statistics from a recent study of Adult Day Services nation wide. It is estimated that 10,000 Adult Day Service Centers are needed to serve the baby-boom population as it ages. The report predicts that the new generation of aged will expect and desire choice, quality, excitement, diversity, energy, continuance of life experiences, and technology.

To accommodate these desires, programs will need to change to include computer labs, high tech devices, multimedia, in-house restaurants with a choice with meals, holistic therapy, leisure, and cultural activities. The report further reports that centers will have to change from rest time to "power naps."

In the future, centers need to think of these innovations; laundry pick up/drop off, take home meals for families, drive through food, free evening hours for holiday season, collaborations with schools, and all staff bilingual.

Number of centers in USA	Models	Types of centers
3,407 centers	21% medical model	20% dementia specific
2,600 urban	37% social model	79% licensed
800 rural	42% combination	6% accredited

Diagnoses 52% Alzheimer's Disease 41% frail 24% MR/DD 23% physical disability 14% mental illness 9% HIV 7% brain injury	**Profit or non-profit status** Nationwide 78% are not for profit 6% in business for the last 10 years are for profit 44% opened within the last 5 years are for profit	**Free standing or under a parent organization** 70% are under a parent organization 17% Nursing Home 13% Senior Center 10% hospital
Hours of operation 39% open 10 hours or more	**Average enrollment** 42 average enrolled 25 average daily census 38 average capacity	**Utilization rate** 78% have no waiting list 66% average utilization rate
Age range 18-109 72 average **Average length of stay** 2 years	**Ethnicity** 77% Caucasian 26% African American 15% Hispanic 10% Asian	**Length of time in business** 53% have been in business over 10 years 26% have been opened within the last 5 years
Need assistance with ADLs 43% toileting 37% mobility 26% eating	**Living Arrangements** 35% adult child 20% spouse 18% facility	**Average cost** $56/day **Average fees** $42-56 per day
Average revenue 38% 3rd party-Medicaid, AAA, USDA 35% private 14% non operational 13% ancillary	**Funding** 60% Medicaid **Average private pay status** 34% non-profit 40% for profit	**Cost comparison** Day care $400/week Home Care $480/week Assisted Living $500/week Nursing Home $800-1000/week

Source: NASDA

Elder Abuse in the Home and Community

Elder abuse is difficult to quantify. It is believed to be a problem that affects hundreds of thousands of elderly people across the country. An annual report for fiscal year 2000 for the Missouri Department of Social Services Division of Aging entitled *Abuse, Neglect and Exploitation of Seniors and Adults with Disabilities* says that elder abuse is "believed to be largely under-reported because of shame and the shroud of family secrecy. Some experts estimate that as few as 1 out of 14 elder abuse incidents come to the attention of authorities, and reports received by the Aging Hotline represent only a small portion of the problem." That said, the figures must carefully examined. The Missouri report does say that 20% of hotline calls were reports of abuse and neglect in a home or community setting. Reports of abuse and neglect in long-term care facilities comprised nearly 11% of the total number of calls to the hotline. Findings from 8,704 investigations of abuse and neglect in institutional settings found that the majority of the reports were invalid or were unable to be verified. However, 27.8% were valid. The most frequently identified perpetrators of abuse and neglect in long-term facilities were nurse aides (62%). Other residents were the next highest identified perpetrators at 10%.

Physical neglect was indicated in the greatest number of reported incidents according to the Annual Report for Missouri. There were 19,799 reported incidents, however, 43% of these reported incidents were unsubstantiated. Emotional neglect was indicated in the greatest proportion of incidents determined as "reason to believe" and emotional abuse had the highest (25%) percentage of findings that are suspected. Financial exploitation had the highest amount of unsubstantiated claims (62%).

In Missouri the majority of perpetrators of senior abuse are family members of the victims. The typical perpetrator was white, younger than 50 years old, and females were slightly more likely than males to be perpetrators. In fiscal year 2000, the majority of perpetrators were between the ages of 30 and 39. Thirty five percent (34.5%) of the perpetrators were an adult child, 20.8% were some other relative, and 12.9% were a spouse. Only 3.7% of the perpetrators were health care professionals, but 13.7% were considered in-home service providers. Perpetrators were about evenly split between those who live with the victim (48.1%) and those who do not live with the victim (51.9%).

Elder abuse in the home and community

Types of Abuse, Neglect, or Exploitation of Seniors and Adults with Disabilities

Type of A/N/E	Number of Incidents	Reason to Believe	Findings Suspected	Unsubstantiated
Physical Neglect	19,799	38%	19%	43%
Emotional Neglect	5,122	47%	23%	30%
Emotional Abuse	3,196	36%	25%	39%
Physical Abuse	2,709	38%	18%	44%
Financial Neglect	2,317	39%	19%	42%
Financial Exploitation	2,317	16%	22%	62%
Other	556	45%	13%	42%

Source: MDSS, DA, Annual Report FY 2000.

Victim Demographics of Seniors and Adults with Disabilities Reasons to Believe Cases by Source of A/N/E FY2000				
	Self	Circumstances/ Environment	Perpetrator	All Victims
Age				
18-59 Disabled	24.0%	23.3%	22.1%	22.8%
60-84 Elderly	58.4%	58.5%	58.7%	58.6%
85+ Frail Elderly	17.6%	18.2%	19.2%	18.6%
Average Age	69.1	69.5	69.4	69.6
Race				
White	77.1%	80.7%	78.0%	78.9%
African/American	20.4%	16.4%	19.4%	18.2%
Hispanic	0.3%	0.3%	0.3%	0.3%
Asian	0.2%	0.1%	0.2%	0.2%
Native American	0.1%	0.1%	0.2%	0.1%
Other	1.9%	2.4%	1.9%	2.3%
Sex				
Male	38.3%	36.1%	28.4%	35.8%
Female	61.7%	63.9%	71.6%	64.2%
Living Arrangements				
Living Alone	52.7%	48.5%	303%	48.0%
Living with Spouse	13.5%	16.7%	16.9%	15.6%
Living with Relative	23.8%	25.4%	38.2%	25.7%
Other	10.0%	9.4%	14.6%	10.7%

Source: MDSS, DA, Annual Report FY 2000.

Perpetrator Demographics of Reason to Believe Cases			
Age*		**Relationship to Victim**	
Less than 30	20.7%	Adult Child	34.5%
30-39	23.1%	Other Relative	20.8%
40-49	19.6%	Spouse	12.9%
50-59	12.4%	In-Home Service Provider	13.7%
60-69	7.1%	Housemate/Friend/Neighbor	7.2%
70-79	8.2%	Health Care Professional	3.7%
80+	8.9%	Other	7.2%
Average Age	46.0		
Race		**Living With Victim**	
White	68.2%	Yes	48.1%
African American	20.1%	No	51.9%
Hispanic	0.2%		
Asian	0.2%		
Native American	0.1%		
Other	0.1%		
Not Reported	11.1%		
Sex			
Male	44.1%		
Female	53.7%		
Not Reported	2.2%		

* Age is based on the 49% of cases in which age was reported

Source: MDSS, DA, Annual Report FY 2000.

Elder abuse in long-term care facilities

Reports of abuse/neglect in long-term care facilities or regulation violations in Division of Aging licensed facilities comprised nearly 11% of the calls to the Missouri Central Reporting Unit (CRU). The most frequently identified perpetrators of abuse/neglect in long-term care facilities were nurse aides (62%). Other residents were the perpetrators of valid abuse/neglect in 10% of the investigations.

Types of Institutional Abuse/Neglect FY2000				
Type of Abuse	**Number of Allegations**	**Findings**		
		Valid	**Invalid**	**Unable to Verify**
Physical Abuse	1,278	25.8%	43.2%	31.0%
Physical Neglect	37	18.9%	70.3%	10.8%
Emotional Abuse	148	25.0%	48.0%	27.0%
Emotional Neglect	2	0.0%	100.0%	0.0%
Financial Exploitation	5	20.0%	60.0%	20.0%
Financial Neglect	1	0.0%	100.0%	0.0%

Source: MDSS, DA, Annual Report FY 2000.

Hospital Admissions

Emergency Room admissions

Boone County Emergency Room Statistics for Poisoning and Injury Age: 65 and Over – Year 2000		
Diagnosis	**Number**	**%**
Superficial injury – contusion	229	24.86%
Sprains and strains	137	14.88%
Open wounds of extremities	124	13.46%
Open wounds of head, neck, and trunk	109	11.83%
Other injuries and conditions due to external causes	86	9.34%
Fracture of upper limb	77	8.36%
Other fractures	34	3.69%
Complications of surgical procedures or medical care	26	2.82%
Complication of device – implant or graft	25	2.71%
Fracture of lower limb	24	2.61%
Joint disorders and dislocations – trauma-related	11	1.19%
Fracture of neck of femur (hip)	9	0.98%
Poisoning by non-medicinal substances	7	0.76%
Burns	7	0.76%
Skull and face fractures	6	0.65%
Poisoning by other medications and drugs	4	0.43%
Intra-cranial injury	3	0.33%
Poisoning by psychotropic agents	2	0.22%
Crushing injury or internal injury	1	0.11%
Spinal cord injury	0	0.00%
Total Injury/Poisoning at ER	**921**	

Source: Missouri Information for Community Assessment (MICA)

In-patient hospitalizations

Inpatient Hospitalization Statistics Boone County Age: 65 and Over		
Diagnosis	**Total # 2000**	**% of Total Diagnoses**
Heart related	1,223	29.21%
Respiratory related	476	11.37%
Injury related	432	10.32%
Digestive related	426	10.17%
Bone/Connective Tissue	323	7.71%
Other including rehabilitation, etc.	263	6.28%
Cancer	227	5.42%
Urinary Tract	180	4.30%
Nutrition problems	177	4.23%
Mental problems	156	3.73%
Brain/Nervous System	120	2.87%
Infection	78	1.86%
Skin problems	51	1.22%
Blood problems	40	0.96%
Other – unclassified	10	0.24%
Congenital anomalies	5	0.12%
Total for all diagnoses	**4,187**	100.00%
Gender		
Male	**1,670**	**39.9%**
Female	**2,517**	**60.1%**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Heart Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Congestive heart failure – non-hypertensive	243
Coronary atherosclerosis and other heart disease	197
Acute cerebrovascular disease	149
Acute myocardial infarction	138
Cardiac dysrhythmias	124
Nonspecific chest pain	57
Transient cerebral ischemia	55
Peripheral and visceral atherosclerosis	35
Occlusion or stenosis of precerebral arteries	35
Other circulatory disease	32
Phlebitis – thrombophlebitis and thromboembolism	24
Peri—endo—and myocarditis – cardiomyopathy	24
Hypertension with complications and secondary hypertension	19
Aortic – peripheral – and visceral artery aneurysms	18
Pulmonary heart disease	16
Heart valve disorders	14
Conduction disorders	10
Aortic and peripheral arterial embolism or thrombosis	7
Essential hypertension	7
Other and ill-defined cerebrovascular disease	5
Late effects of cerebrovascular disease	5
Other and ill-defined heart disease	3
Other diseases of veins and lymphatics	3
Cardiac arrest and ventricular fibrillation	2
Hemorrhoids	1
Total for Heart	**1,223**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Respiratory Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	195
Chronic obstructive pulmonary disease and bronchiectasis	107
Aspiration pneumonitis – food/vomitus	36
Respiratory failure- insufficiency- arrest (adult)	34
Other lower respiratory disease	33
Influenza	19
Asthma	15
Pleurisy – pneumothorax – pulmonary collapse	15
Acute bronchitis	14
Other upper respiratory infections	7
Other upper respiratory disease	1
Total for Respiratory	**476**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Injury Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Fracture of neck of femur (hip)	113
Complication of device – implant or graft	104
Other fractures	51
Complications of surgical procedures or medical care	36
Fracture of lower limb	24
Intracranial injury	22
Fracture of upper limb	20
Superficial injury – contusion	12
Crushing injury or internal injury	11
Other injuries and conditions due to external causes	11
Sprains and strains	9
Poisoning by other medications and drugs	4
Joint disorders and dislocations – trauma-related	3
Open wounds of head – neck – and trunk	3
Burns	3
Poisoning by psychotropic agents	2
Open wounds of extremities	2
Skull and face fractures	2
Total for Injury Related	**432**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Digestive Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Gastrointestinal hemorrhage	80
Diverticulosis and diverticulitis	57
Intestinal obstruction without hernia	50
Biliary tract disease	42
Other gastrointestinal disorders	32
Esophageal disorders	27
Abdominal hernia	27
Gastritis and duodenitis	21
Pancreatic disorders (not diabetes)	17
Noninfectious gastroenteritis	16
Intestinal infection	15
Gastroduodenal ulcer (except hemorrhage)	11
Other liver diseases	8
Appendicitis and other appendiceal conditions	7
Other disorders of stomach and duodenum	7
Regional enteritis and ulcerative colitis	4
Peritonitis and intestinal abscess	2
Anal and rectal conditions	1
Diseases of mouth- excluding dental	1
Liver disease- alcohol-related	1
Total for Digestive	**426**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Bone/Connective Tissue Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Osteoarthritis	153
Spondylosis – intervertebral disc disorders – other back problems	76
Pathological fracture	40
Other connective tissue disease	14
Other non-traumatic joint disorders	11
Infective arthritis and osteomyelitis (except that caused by tuberculosis or sexually transmitted disease)	7
Rheumatoid arthritis and related disease	7
Other acquired deformities	6
Other bone disease and musculoskeletal deformities	4
Systemic lupus erythematosus and connective tissue disorders	3
Osteoporosis	1
Acquired foot deformities	1
Total for Bone/Connective Tissue	**323**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Other Including Rehabilitation Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Rehabilitation care – fitting of prostheses – and adjustment of devices	168
Syncope and collapse	37
Abdominal pain	15
Gangrene	14
Fever of unknown origin – pyrexia	11
Nausea and vomiting	8
Malaise and fatigue	7
Allergic reactions	1
Medical examination/evaluation	1
Other aftercare	1
Total for Other Including Rehabilitation	**263**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Cancer Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Secondary malignancies	38
Cancer of colon	33
Cancer of bronchus- lung	21
Other and unspecified benign neoplasm	21
Cancer of prostate	18
Cancer of kidney and renal pelvis	12
Non-Hodgkin's lymphoma	10
Cancer of uterus	7
Neoplasms of unspecified nature or uncertain behavior	6
Cancer of ovary	6
Cancer of pancreas	6
Cancer of head and neck	5
Cancer of breast	4
Maintenance chemotherapy- radiotherapy	4
Cancer of liver and intrahepatic bile duct	4
Cancer of bladder	4
Cancer of rectum and anus	3
Leukemias	3
Cancer of bone and connective tissue	3
Cancer of stomach	3
Multiple myeloma	3
Benign neoplasm of uterus	2
Melanomas of skin	2
Cancer of brain and nervous system	2
Cancer of other female genital organs	1
Cancer- other and unspecified primary	1
Cancer of thyroid	1
Malignant neoplasm without specification of site	1
Other non-epithelial cancer of skin	1
Cancer of cervix	1
Cancer of other GI organs- peritoneum	1
Total for Cancer	**227**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Urinary Track Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Urinary tract infections	95
Prolapse of female genital organs	20
Hyperplasia of prostate	15
Acute and unspecified renal failure	14
Other female genital disorders	10
Calculus of urinary tract	7
Other diseases of kidney and ureters	4
163. Genitourinary symptoms and ill-defined conditions	3
Ovarian cyst	2
Inflammatory conditions of male genital organs	2
Endometriosis	2
Nephritis – nephrosis – renal sclerosis	2
Chronic renal failure	1
Inflammatory diseases of female pelvic organs	1
Other male genital disorders	1
Other diseases of bladder and urethra	1
Total for Urinary Tract	**180**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Nutrition Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Fluid and electrolyte disorders	96
Diabetes mellitus with complications	44
Other nutritional- endocrine- and metabolic disorders	11
Other endocrine disorders	9
Nutritional deficiencies	6
Gout and other crystal arthropathies	5
Thyroid disorders	5
Immunity disorders	1
Total for Nutrition	**177**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Mental Problem Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Senility and organic mental disorders	96
Affective disorders	39
Substance-related mental disorders	7
Other mental conditions	4
Other psychoses	4
Anxiety – somatoform – dissociative – and personality disorders	3
Alcohol-related mental disorders	2
Schizophrenia and related disorders	1
Total for Mental Problem	**156**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Brain/Nervous System Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Other nervous system disorders	31
Conditions associated with dizziness or vertigo	29
Epilepsy – convulsions	24
Other hereditary and degenerative nervous system conditions	10
Parkinson's disease	8
Coma – stupor – and brain damage	6
Headache- including migraine	3
Encephalitis (except that caused by tuberculosis or sexually transmitted disease)	2
Inflammation – infection of eye (except that caused by tuberculosis or sexually transmitted disease)	2
Other CNS infection and poliomyelitis	1
Retinal detachments – defects – vascular occlusion – and retinopathy	1
Other ear and sense organ disorders	1
Paralysis	1
Meningitis (except that caused by tuberculosis or sexually transmitted disease)	1
Total for Brain/Nervous System	**120**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Infection Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Septicemia (except in labor)	67
Viral infection	6
Mycoses	4
Hepatitis	1
Bacterial infection- unspecified site	0
Tuberculosis	0
HIV infection	0
Other infections- including parasitic	0
Immunizations and screening for infectious disease	0
Sexually transmitted infections (not HIV or hepatitis)	0
Total for Infection	**78**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Skin Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Skin and subcutaneous tissue infections	38
Chronic ulcer of skin	11
Other inflammatory condition of skin	2
Other skin disorders	0
Total for Skin	**51**

Source: Missouri Information for Community Assessment (MICA)

Breakdown of Blood Related Reasons for Inpatient Hospitalization – Boone County	
Year: 2000	
Age: 65 and Over	
Diagnosis	Number
Deficiency and other anemia	30
Coagulation and hemorrhagic disorders	5
Acute posthemorrhagic anemia	3
Diseases of white blood cells	2
Sickle cell anemia	0
Other hematologic conditions	0
Total for Blood	**40**

Source: Missouri Information for Community Assessment (MICA)

Hospital days of care for selected causes

Hospital Days of Care Statistics for Boone County – 2000		
Age of Patient: 65 and Over		
Diagnosis	**Total Days of Care**	**Percent of total**
Heart and circulation	5,719	27.8
Throat and lung	2,884	14.0
Injury and poisoning	2,537	12.3
Digestive system	2,177	10.6
Bone – connective tissue – muscle	1,456	7.1
Cancer	1,451	7.1
Nutritional – metabolic – immunity	934	4.5
Kidneys – bladder – genitalia	850	4.1
Infection	545	2.7
Brain – spinal cord – eyes – ears	518	2.5
Skin	514	2.5
Symptoms and ill-defined conditions	405	2.0
Mental disorders	285	1.4
Blood and blood forming	193	0.9
Other – unclassified	59	0.3
Congenital anomalies	22	0.1
Pregnancy – childbirth – reproduction	0	0.0
Perinatal conditions	0	0.0
Total for all diagnoses	**20,549**	**100.0**

Source: Missouri Information for Community Assessment (MICA)

Hospital Days of Care Statistics for Boone County-2000		
Age of Patient: 65 and Over		
Diagnosis	**Total Days of Care**	**Percent of total**
Joint disorders and dislocations – trauma-related	8	0.3
Fracture of neck of femur (hip)	765	30.2
Spinal cord injury	0	0
Skull and face fractures	2	0.1
Fracture of upper limb	103	4.1
Fracture of lower limb	86	3.4
Other fractures	333	13.1
Sprains and strains	54	2.1
Intracranial injury	117	4.6
Crushing injury or internal injury	83	3.3
Open wounds of head – neck – and trunk	7	0.3
Open wounds of extremities	5	0.2
Total for injury and poisoning	**2,537**	**100.0**

Source: Missouri Information for Community Assessment (MICA)

Hospital Days of Care Statistics for Boone County-2000		
Age of Patient: 65 and Over		
Diagnosis	**Total Days of Care**	**Percent of total**
Osteoarthritis	592	40.7
Spondylosis – intervertebral disc disorders – other back problems	303	20.8
Pathological fracture	269	18.5
Other connective tissue disease	59	4.1
Other acquired deformities	58	4
Other non-traumatic joint disorders	49	3.4
Rheumatoid arthritis and related disease	41	2.8
Other bone disease and musculoskeletal deformities	34	2.3
Infective arthritis and osteomyelitis (except that caused by tuberculosis or sexually transmitted disease)	33	2.3
Systemic lupus erythematosus and connective tissue disorders	13	0.9
Osteoporosis	4	0.3
Acquired foot deformities	1	0.1
Total for bone, connective tissue, muscle	**1,456**	**100.0**

Source: Missouri Information for Community Assessment (MICA)

Hospital Days of Care Statistics for Boone County-2000		
Age of Patient: 65 and Over		
Diagnosis	**Total Days of Care**	**Percent of total**
Fluid and electrolyte disorders	489	52.4
Diabetes mellitus with complications	293	31.4
Other nutritional- endocrine- and metabolic disorders	50	5.4
Nutritional deficiencies	40	4.3
Other endocrine disorders	32	3.4
Gout and other crystal arthropathies	17	1.8
Thyroid disorders	11	1.2
Immunity disorders	2	0.2
Diabetes mellitus without complication	0	0
Disorders of lipid metabolism	0	0
Cystic fibrosis	0	0
Total for nutritional, metabolic	**934**	**100.0**

Source: Missouri Information for Community Assessment (MICA)

Hospital Days of Care Statistics for Boone County-2000		
Age of Patient: 65 and Over		
Diagnosis	**Total Days of Care**	**Percent of total**
Epilepsy- convulsions	159	30.7
Other nervous system disorders	152	29.3
Conditions associated with dizziness or vertigo	72	13.9
Other hereditary and degenerative nervous system conditions	33	6.4
Parkinson's disease	32	6.2
Coma – stupor – and brain damage	24	4.6
Encephalitis (except that caused by tuberculosis or sexually transmitted disease)	14	2.7
Paralysis	13	2.5
Headache- including migraine	10	1.9
Meningitis (except that caused by tuberculosis or sexually transmitted disease)	4	0.8
Retinal detachments – defects – vascular occlusion- and retinopathy	2	0.4
Inflammation – infection of eye (except that caused by tuberculosis or sexually transmitted disease)	2	0.4
Other ear and sense organ disorders	1	0.2
Total for brain, spinal cord, eyes, ears	**518**	**100.0**

Source: Missouri Information for Community Assessment (MICA)

Hospital Days of Care Statistics for Boone County-2000		
Age of Patient: 65 and Over		
Diagnosis	**Total Days of Care**	**Percent of total**
Chronic ulcer of skin	258	50.2
Skin and subcutaneous tissue infections	243	47.3
Other inflammatory condition of skin	13	2.5
Total for skin	**514**	**100.0**

Source: Missouri Information for Community Assessment (MICA)

Hospital Days of Care Statistics for Boone County 2000		
Age of Patient: 65 and Over		
Diagnosis	**Total Days of Care**	**Percent of total**
Senility and organic mental disorders	198	69.5
Substance-related mental disorders	34	11.9
Other mental conditions	18	6.3
Other psychoses	14	4.9
Anxiety – somatoform – dissociative – and personality disorders	13	4.6
Affective disorders	7	2.5
Alcohol-related mental disorders	1	0.4
Total for mental disorders	**285**	**100.0**

Source: Missouri Information for Community Assessment (MICA)

Causes of Death

There were 603 deaths in Boone County in 2001 of people ages 65 years and older. Of those deaths the largest contributor is heart disease with 169 deaths (28% of the total). The second leading cause of death was various forms of cancer with 135 deaths (22% of the total). There were 47 stroke deaths (nearly 8%) and there were 27 deaths from Alzheimer's disease. There were 11 deaths in Boone County in 2001 attributed to falls.

Death Statistics – All causes				
Age: 65 and over				
Cause of Death	Number of Deaths in '01	% of MO Total Death	Number of Deaths in '01	% of Boone County Total Deaths
Total Accidental Deaths	890	2.14%	18	2.99%
Total for Suicide	128	0.31%	2	0.33%
Alzheimer's disease	1,096	2.64%	27	4.48%
Parkinson's disease	368	0.89%	5	0.83%
Malnutrition	110	0.26%	2	0.33%
Cerebrovascular disease (Stroke)	3,397	8.18%	47	7.79%
Diabetes	1,139	2.74%	17	2.82%
Total for Heart Disease	13,824	33.28%	169	28.03%
Total for Cancer	8,680	20.90%	135	22.39%
All other causes	11,907	28.66%	181	30.02%
Total for all deaths for 65+ in 2001	**41,539**	**100.00%**	**603**	**100.00%**
No deaths reported for 2001 as homicides				

Source: Missouri Information for Community Assessment (MICA)

Breakdown in Number of Deaths from Specific Types of Accidents				
Age: 65 and over for the Year 2001				
Cause of Death	Number of Deaths in '01	% of MO Total Death	Number of Deaths in '01	% of Boone County Total Deaths
Falls	439	1.06%	11	1.82%
Other/unspecified non-transport accidents and their sequelae	223	0.54%	5	0.83%
Motor vehicle accidents	187	0.45%	1	0.17%
Accidental exposure to smoke/fire/flames	30	0.07%	1	0.17%
Accidental drowning and submersion	6	0.01%	0	0.00%
Accidental poisoning and exposure to noxious substances	3	0.01%	0	0.00%
Other land transport accidents	1	0.00%	0	0.00%
Other transport accidents: water/air/space/other/unspecified	1	0.00%	0	0.00%
Accidental discharge of firearms	0	0.00%	0	0.00%
Total for Accidental Deaths	**890**	**2.14%**	**18**	**2.99%**

Source: Missouri Information for Community Assessment (MICA)

2000 Figures for comparison

Death Statistics – All causes		
Age: 65 and over – 2000		
Cause of Death	Number of Deaths in '00	% of Boone County Total Deaths
Total Accidental Deaths	18	2.99%
Total for Suicide	2	0.33%
Alzheimer's disease	27	4.48%
Parkinson's disease	5	0.83%
Malnutrition	2	0.33%
Cerebrovascular disease (Stroke)	47	7.79%
Diabetes	17	2.82%
Total for Heart Disease	169	28.03%
Total for Cancer	135	22.39%
All other causes	181	30.02%
Total for all deaths for 65+ in 2001	**603**	**100.00%**

Source: Missouri Information for Community Assessment (MICA)

Breakdown in Number of Deaths from Specific Types of Accidents – Boone County	
Age: 65 and over - 2000	
Cause of Death	Number
Falls	3
Other/unspecified nontransport accidents and their sequelae	7
Total Accidental Deaths	10

Source: Missouri Information for Community Assessment (MICA)

NATIONAL LEADING CAUSES OF DEATH AMONG PERSONS AGE 65 OR OLDER, BY SEX AND RACE AND HISPANIC ORIGIN, 1997

	WHITE	BLACK	ASIAN AND PACIFIC ISLANDER	AMERICAN INDIAN AND ALASKA NATIVE	HISPANIC
MEN					
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer
3	Stroke	Stroke	Stroke	Diabetes	Stroke
4	COPD	COPD	Pneumonia and Influenza	Stroke	Diabetes
5	Pneumonia and Influenza	Pneumonia and Influenza	COPD	COPD	Pneumonia and Influenza
6	Diabetes	Diabetes	Diabetes	Pneumonia and Influenza	COPD
7	Unintentional Injuries	Nephritis	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries
8	Nephritis	Unintentional Injuries	Nephritis	Chronic Liver Disease and Cirrhosis	Chronic Liver Disease and Cirrhosis
9	Alzheimer's Disease	Septicemia	Hypertension	Nephritis	Nephritis
10	Septicemia	Hypertension	Septicemia	Septicemia	Septicemia
NUMBER OF DEATHS FROM ALL CAUSES	704,603	69,898	10,441	2,485	24,988

NATIONAL LEADING CAUSES OF DEATH AMONG PERSONS AGE 65 OR OLDER, BY SEX AND RACE AND HISPANIC ORIGIN, 1997 (CONTINUED)

	WHITE	BLACK	ASIAN AND PACIFIC ISLANDER	AMERICAN INDIAN AND ALASKA NATIVE	HISPANIC
WOMEN					
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer
3	Stroke	Stroke	Stroke	Diabetes	Stroke
4	COPD	Diabetes	Pneumonia and Influenza	Stroke	Diabetes
5	Pneumonia and Influenza	Pneumonia and Influenza	Diabetes	Pneumonia and Influenza	Pneumonia and Influenza
6	Diabetes	COPD	COPD	COPD	COPD
7	Alzheimer's Disease	Nephritis	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries
8	Unintentional Injuries	Septicemia	Nephritis	Nephritis	Chronic Liver Disease and Cirrhosis
9	Nephritis	Hypertension	Hypertension	Septicemia	Nephritis
10	Atherosclerosis	Unintentional Injuries	Septicemia	Chronic Liver Disease and Cirrhosis	Alzheimer's Disease
NUMBER OF DEATHS FROM ALL CAUSES	844,062	85,445	9,363	2,575	26,383

Note: COPD=Chronic obstructive pulmonary diseases. Hispanics may be of any race.
Reference population: These data refer to the resident population.
Source: Older Americans 2000; Original Source: National Vital Statistics System.

Data Sources

Census 2000 information from Missouri Census Data Center (MCDC) http://mcdc.missouri.edu

MDSS.DA Annual Report, FY2000. Abuse, Neglect, and Exploitation of Seniors and Adults with Disabilities, May 2001.
http://www.dhss.state.mo.us/Senior_Services/EANEannual_report/EANEAnnual_Report.htm

Missouri Information for Community Assessment (MICA)
http://www.dhss.state.mo.us/MICA/nojava.html

National Adult Day Services Association (NASDA), "National statistics in Adult Day Services," Unpublished report from the NADSA furnished by Lois Long, Eldercare Center.

Older Americans 2000: Key Indicators of Well-being:
http://www.agingstats.gov/chartbook2000/default.htm

Links to WWW Resources

http://www.medicare.gov/NHCompare/Home.asp nursing home comparison using quality measures (% compared to MO and USA)

City of Columbia Community Needs Assessment Data links
http://www.gocolumbiamo.com/CommunityServices/Commissions/cna_data_links.html

Information about Medicare enrollees http://cms.hhs.gov/researchers/

Elderly abuse resources http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/Elder_Abuse.asp

Various statistics about senior citizens http://www.aoa.gov/aoa/stats/statpage.html

Names and locations of long term care facilities in Columbia http://www.dhss.state.mo.us/cgi-bin/ltcare.pl

EVALUATION PROCESS

Development of Evaluation Frameworks

In 1998, when Horizon Research Services first submitted a proposal for this evaluation project, a "Sample Evaluation Framework for Outcomes-based Evaluation" was developed. The idea for these frameworks or continuums came from a project Horizon Research Services was conducting for the education community and mainly from a book entitled The School Portfolio by Victoria L. Bernhardt (Eye on Education, Larchmont, NY) published in 1994.

Called "Continuous Improvement Continuums" in the business world, Bernhardt adapted this planning and assessment tool to the world of school improvement. Based on the principles of quality management, the continuums lay out the directions and expectations for growth and continuous improvement. HRS adapted these to the evaluation of agency programs to outline the processes that are crucial to developing effective outcomes-based evaluation systems. The continuums provide a unique and effective framework for describing current processes and for envisioning the best possible scenario. Besides providing a constant guideline for change for the agency or program, the frameworks can also be used to track progress toward the ideal.

The two frameworks developed for these evaluation processes are the "Framework for Gathering and Analyzing Outcomes Information," and the "Framework for Continuous Evaluation and Improvement." Copies of these two frameworks follow this section.

Bernhardt outlines reasons these continuums or frameworks have been successful and useful.

- they focus on what is important in outcomes for clients
- they are simple to use – the goal is to spend time reflecting on progress, implementing the "big picture" and discussing next steps, rather than on conducting cumbersome assessments
- they are indicative of what needs to happen – they make clear the steps that need to be achieved to move forward
- they are set up for self-assessment
- they are challenging but achievable
- they are a working contract, as opposed to a form driven exercise
- they encourage ongoing conversations about the things that are important rather than demanding activities that require conforming to rules and paperwork
- they are comprehensive in scope

These frameworks will give members of the Columbia/Boone County Community Services Commission, as well as Boards and staff of agencies, a chance to reflect on the process and reach a common vision. As the vision and description of the ideal outcomes-based evaluation system is refined, each group can more clearly communicate where they are going and what acceptable and unacceptable evaluation processes look like.

Agencies can use these frameworks as examples to create their own frameworks for different aspects of their programs. The main goal in developing these frameworks is to extend the idea of

continuous quality improvement. Describing the vision and stating the ideal outcomes wished for the people served will help move everyone along the road to an excellent evaluation system.

The frameworks extend from 1 to 5 horizontally, with the rows representing a continuum of expectations related to the approach to the evaluation, implementation of the approach, and the outcomes that result from the implementation.

A rating of "1" is given if the descriptions in the left-most column most accurately describe a program or agency. A rating of "5" is given if the descriptions in the right-most column most accurately describe an agency. This column represents the agency or program that is one step removed from being perfect or "world class quality." The elements between one and five describe how that continuum is hypothesized to evolve in a continuously improving agency. The "5" in each continuum is the target. Vertically, the "approach-implementation-outcome" statements are hypotheses. In other words, the implementation statements describe how the approach might look when implemented, and the outcomes are the "pay-off" for implementing the approach. If the hypotheses are accurate, the outcomes will not be realized until the approach is actually implemented.

FRAMEWORK FOR CONTINUOUS EVALUATION AND IMPROVEMENT

	ONE	TWO	THREE	FOUR	FIVE
APPROACH	Neither goals nor strategies exist for the evaluation and continuous improvement of the agency or elements of the agency's programs.	The approach to continuous improvement and evaluation is problem solving. If there are no problems, or if solutions can be made quickly, there is no need for improvement or analyses. Changes in parts of the system are not coordinated with all other parts.	Some elements of the organization are evaluated for effectiveness. Some elements are improved on the basis of the evaluation findings.	All elements of the agency's operations are evaluated for improvement and to ensure congruence of the elements with respect to the continuum of improvement for all clients.	All aspects of the agency are rigorously evaluated and improved on a continuous basis. Clients, and the maintenance of a comprehensive improvement continuum for clients become the focus of all aspects of the evaluation and improvement process.
IMPLEMENTATION	With no overall plans for evaluation and continuous improvement, individual program managers and administrators change strategies only when something sparks the need to improve. Reactive decisions and activities are a daily mode of operation.	Isolated changes are made in some areas of the organization in response to problem incidents. Changes are not preceded by comprehensive analyses, such as an understanding of the root causes of problems. The effectiveness of the elements of the agency or changes made to the elements, is not known.	Elements of the organization are improved on the basis of comprehensive analyses of root causes of problems, client perceptions, and operational effectiveness of processes.	Continuous improvement analysis of client outcomes and program strategies are rigorously reinforced within each program and across all levels to develop a comprehensive improvement continuum for all clients and to prevent negative client outcomes.	Comprehensive continuous improvement becomes the way of doing business at the agency. Staff continuously improves the appropriateness and effectiveness of program strategies based on client feedback and outcomes. All aspects of the organization are improved to support staff efforts.
OUTCOMES	Individuals struggle with system failure. Finger pointing and blaming others for failure occurs. The effectiveness of strategies is unknown. Mistakes are repeated.	Problems are solved only temporarily and few positive changes result. Additionally, unintended and undesirable consequences often appear in other parts of the system. Many aspects of the agency or program are incongruent, keeping the agency from reaching its vision.	Evidence of effective improvement strategies is observable. Positive changes are made and maintained due to comprehensive analyses and evaluation.	Those delivering service become astute at assessing and in predicting the impact of their strategies on individual clients. Sustainable improvements in clients are evident in all programs, due to continuous improvement.	The agency becomes a congruent and effective learning organization. Only methodology and strategies that produce quality client outcomes are used. A true continuum of improvement results for all clients.

Created by Carol M. Schultz, Ph.D. Schultz, Ph.D., Horizon Research Services, Columbia, MO
Adapted from Victoria L. Bernhardt, The School Portfolio, Eye on Education, Larchmont, NY

FRAMEWORK FOR GATHERING AND ANALYZING OUTCOMES INFORMATION

	ONE	TWO	THREE	FOUR	FIVE
APPROACH	Data or information about client needs are not gathered in any systematic way; there is no way to determine what needs to change at the agency based on data.	There is no systematic process, but some client information is collected and used to problem solve and to establish essential client outcomes.	Agency collects data on client outcomes and conducts client needs assessments. The information is used to drive the strategic quality plan for the agency.	There is systematic reliance on hard data (including data for sub-groups) as a basis for decision making at the client level as well as the agency level. Changes are based on the study of data to meet the needs of clients and staff.	Information is gathered in all areas of client interaction with the agency. Staff engages clients in gathering information on their own outcomes. Accessible to all levels, data are comprehensive in scope, and an accurate reflection of agency quality.
IMPLEMENTATION	No information is gathered with which to make changes. Client dissatisfaction is seen as an irritation, not a need for improvement.	Some data is tracked, such as client recidivism. Individuals are asked for feedback about their experience with the agency.	Agency collects information on clients and former clients, analyzes, and uses it in conjunction with future trends for planning. Identified areas for improvement are tracked over time.	Data are used to improve the effectiveness of service delivery. Client indicators are graphed and utilized for diagnostics. All staff analyzes client evaluations and indicators.	Innovative processes meeting the needs of clients are implemented to the delight of staff, clients, and funding agencies. Root causes are known through analyses. Problems are prevented through the use of data.
OUTCOMES	Only anecdotal and hypothetical information is available about clients behavior and satisfaction. Problems are solved individually with short-term results.	Little data is available. Change is limited to some areas of the agency operation and dependent upon individuals and their efforts.	Information collected about clients' needs and outcomes is shared with staff and is used to plan for change. Information helps staff understand pressing issues, how to analyze information for root causes and how to track for improvement.	An information system is in place. Positive trends begin to appear in individual client as well as community outcomes. There is evidence that understanding and effectively using data collected cause these results.	Clients are delighted with the agency's processes and proud of their own capabilities to assess their own progress. There are good to excellent results for all clients. No client falls through the cracks. Staff use data to predict and prevent potential problems.

Created by Carol M. Schultz, Ph.D. Schultz, Ph.D., Horizon Research Services, Columbia, MO

Adapted from Victoria L. Bernhardt, The School Portfolio, Eye on Education, Larchmont, NY

Individual Program Ratings and Scores From the Frameworks

Framework for continuous evaluation and improvement

Each agency was asked to review the frameworks for continuous evaluation and improvement and to give themselves a score on each framework. The scores reported below are the results of this self-evaluation. (*The scores for Cedar Creek Therapeutic Riding Center are ratings from the HRS. See the CCTRC section for their self ratings and a explanation of the rating.)

Approach to continuous evaluation and improvement

	CCTRC (2)*	CMFBP (3) MOW (3) OATS (3) STD (3) VAC (3)	BCCA (4) EC (4)	
1	2	3	4	5
Neither goal nor strategies exist for the evaluation and continuous improvement of the agency or elements of the agency's programs	The approach to continuous improvement and evaluation is problem solving. If there are no problems, or if solutions can be made quickly, there is no need for improvement or analyses. Changes in parts of the system are not coordinated with all other parts	Some elements of the organization are evaluated for effectiveness. Some elements are improved on the basis of the evaluation findings	All elements of the agency's operations are evaluated for improvement and to ensure congruence of the elements with respect to the continuum of improvement for all clients.	All aspects of the agency are rigorously evaluated and improved on a continuous basis. Clients, and the maintenance of a comprehensive improvement continuum for clients become the focus of all aspects of the evaluation and improvement process

Implementation of continuous evaluation and improvement

CCTRC (1)*	CMFBP (2) VAC (2.5)	EC (3) MOW (3) OATS (3) STD (3)	BCCA (4)	
1	2	3	4	5
With no overall plans for evaluation and continuous improvement, individual program managers and administrators change strategies only when something sparks the need to improve. Reactive decisions and activities are a daily mode of operation.	Isolated changes are made in some areas of the organization in response to problem incidents. Changes are not preceded by comprehensive analyses, such as an understanding of the root causes of problems. The effectiveness of the elements of the agency or changes made to the elements, is not known.	Elements of the organization are improved on the basis of comprehensive analyses of root causes of problems, client perceptions, and operational effectiveness of processes.	Continuous improvement analysis of client outcomes and program strategies are rigorously reinforced within each program and across all levels to develop a comprehensive improvement continuum for all clients and to prevent negative client outcomes	Comprehensive continuous improvement becomes the way of doing business at the agency. Staff continuously improves the appropriateness and effectiveness of program strategies based on client feedback and outcomes. All aspects of the organization are improved to support staff efforts.

Outcomes of continuous evaluation and improvement

	CCTRC (2)*	BCCA (3) CMFBP (3) EC (3) MOW (3) OATS (3) STD (3) VAC (3)		
1	2	3	4	5
Individuals struggle with system failure. Finger pointing and blaming others for failure occurs. The effectiveness of strategies is unknown. Mistakes are repeated.	Problems are solved only temporarily and few positive changes result. Additionally, unintended and undesirable consequences often appear in other parts of the system. Many aspects of the agency or program are incongruent, keeping the agency from reaching its vision.	Evidence of effective improvement strategies is observable. Positive changes are made and maintained due to comprehensive analyses and evaluation.	Those delivering service become astute at assessing and in predicting the impact of their strategies on individual clients. Sustainable improvements in clients are evident in all programs, due to continuous improvement.	The agency becomes a congruent and effective learning organization. Only methodology and strategies that produce quality client outcomes are used. A true continuum of improvement results for all clients.

Framework for gathering and analyzing outcomes information

Approach to gathering and analyzing outcomes information

	CCTRC (2)* CMFBP (2) MOW (2)	BCCA (3) EC (3) OATS (3) STD (3) VAC (3.5)		
1	2	3	4	5
Data or information about client needs is not gathered in any systematic way; there is no way to determine what needs to change at the agency based on data.	There is no systematic process, but some client information is collected and used to problem solve and to establish essential client outcomes.	Agency collects data on client outcomes and conducts client needs assessments. The information is used to drive the strategic quality plan for the agency.	There is systematic reliance on hard data (including data for sub-groups) as a basis for decision making at the client level as well as the agency level. Changes are based on the study of data to meet the needs of clients and staff.	Information is gathered in all areas of client interaction with the agency. Staff engages clients in gathering in-formation on their own outcomes. Accessible to all levels, data is comprehensive in scope, and an accurate reflection of agency quality.

Implementation of gathering and analyzing outcomes information

	CCTRC (2)* MOW (2)	BCCA (3) CMFBP (3) EC (3) OATS (3) STD (3) VAC (3.5)		
1	2	3	4	5
No information is gathered with which to make changes. Client dissatisfaction is seen as an irritation, not a need for improvement.	Some data is tracked, such as client recidivism. Individuals are asked for feedback about their experience with the agency.	Agency collects information on clients and former clients, analyzes, and uses it in conjunction with future trends for planning. Identified areas for improvement are tracked over time.	Data are used to improve the effectiveness of service delivery. Client indicators are graphed and utilized for diagnostics. All staff analyzes client evaluations and indicators.	Innovative processes meeting the needs of clients are implemented to the delight of staff, clients, and funding agencies. Root causes are known through analyses. Problems are pre-vented through the use of data

Outcomes of gathering and analyzing outcomes information

CCTRC (1)* MOW (1)		BCCA (3) CMFBP (3) EC (3) OATS (3) STD (3) VAC (3)		
1	2	3	4	5
Only anecdotal and hypothetical information is available about clients' behavior and satisfaction. Problems are solved individually with short-term results.	Little data is available. Change is limited to some areas of the agency operation and dependent upon individuals and their efforts.	Information collected about clients' needs and outcomes is shared with staff and is used to plan for change. Information helps staff understand pressing issues, how to analyze information for root causes and how to track for improvement.	An information system is in place. Positive trends begin to appear in individual client as well as community outcomes. There is evidence that understanding and effectively using data collected cause these results.	Clients are delighted with the agency's processes and proud of their own capabilities to assess their own progress. There are good to excellent results for all clients. No client falls through the cracks. Staff use data to predict and prevent potential problems.

Review of Materials

At the beginning of the evaluation process, the evaluator conducted a review to determine if the program had written measurable objectives and outcomes. The Social Services Proposals to the City of Columbia, Boone County, and Columbia Area United Way for the years 2003, 2002, and 2001 were the starting points for the review. The agencies were asked to send supporting documents to HRS such as instruments used in internal program evaluation and review processes, instruments from client feedback mechanisms, and instruments from outcomes-based evaluation processes already in use. These documents, reports from all of these measures, as well as reports from external reviewing agencies were reviewed.

The HRS evaluators used their expertise to determine if the program's objectives and outcomes were measurable and appropriate for the programs offered. If the agency had not developed a set of measurable objectives and outcomes for its specific program service, the evaluator developed some suggested outcomes objectives. These were discussed with the appropriate agency personnel during a site visit to the agency. The evaluator used a combination of available program records and data and secondary data to determine the measurable outcomes for the program.

Whenever possible, information from evaluations conducted by external monitoring organizations was utilized in order to reduce redundancy in evaluation practices. For example, if a program is subject to outcomes-based performance evaluations by state or national monitoring and/or accrediting organizations, the HRS evaluator determined the scope and quality of these evaluations and suggested that these findings be reported as outcomes measures in its social services proposals.

Internal agency outcomes-based performance evaluations such as customer satisfaction surveys were reviewed whenever possible and available.

Types of material reviewed

An assessment was made of the current outcomes of the services provided by each agency or program. Depending on the types of data and information available from the agency and from other sources, this assessment looked at one or more of the following types of information.

- Examination of external reviews by licensing and accreditation agencies. The results of these reviews will be compared to the standards and best practices set by the licensing and/or accreditation agencies.
- Examination of agency-provided data on follow-up tracking of client outcomes after clients are no longer in the program. If feasible, this data will be compared with national or state goals, standards, or norms, or it may be compared with data on similar populations that have not participated in the agency's programs or similar programs.
- Examination of agency-provided data on client outcomes while clients are still in the program. This type of data may include measures of clients' knowledge, attitudes, and/or behaviors. If feasible, this data will be compared with goals and objectives set by the agency.
- Examination of agency-provided data on client satisfaction while clients are still in the program. If feasible, this data will be compared with goals and objectives set by the agency.
- Examination of trends in community indicators such as those available from the

Community Needs Assessment, the Health Report Card, *Kids Count*, and other local, state, and national sources. Indicators related to agency services will be examined to see if they are getting better, staying the same, or getting worse.

Consultation with Agency Officials on the Development of Outcomes

HRS evaluators set an appointment with the appropriate agency staff to discuss the preliminary report. During this meeting the scores on the frameworks for continuous improvement and conclusions about outcomes evaluation were discussed.

HRS reviewed and summarized any outcomes-based program evaluations currently being conducted by the agency and made recommendations on the development or refinement of methodologies used by the agency to measure program outcomes. This included recommendations for the refinement and clarification of program objectives and outcome measures.

Status of agency outcomes evaluation processes

The following table shows those agencies that currently report outputs only, those that have a way to measure client satisfaction, and those that gather information related to outcomes.

Agency	BCCA	CCTRC	CMFBP	ELDER	MOW	OATS	STD	VAC
Currently listing only outputs or process objectives on the Social Services Application	X	X	X	X	X	X		X
Currently listing some outcomes objectives on the Social Services Application							X	
Currently have a client satisfaction measure	X			X	X	X	X	X
Currently ask clients to report on perceived outcomes	X			X	X		X	
Currently follow-up on former clients					X		X	
Currently include a question relating to keeping people out of nursing homes or in the least restrictive environment	X			X	X		X	

Program Logic Models

Each agency was asked to develop a Program Logic Model outlining the services provided by the agency. The Logic Model for each agency is at the end of the specific agency materials.

Agencies who created a Program Logic Model

Three agencies created their own Program Logic Model during this evaluation process.

- Boone County Council on Aging
- Cedar Creek Therapeutic Riding Center
- Meals on Wheels
- OATS
- Voluntary Action Center

These drafts were discussed and refined, if needed, during the site visits. The remaining agencies did not create their own model. The model attached was developed by the HRS evaluator after the agency site visit.

For most programs, choosing appropriate program outcomes and indicators is a challenging task. Direct outcomes may be difficult to attribute to the actual service because of so many intervening variables. Each client is different, living in a different situation; each volunteer is different; and each family dynamic may add additional variables.

"Outcomes are usually benefits or changes in participants' knowledge, attitudes, values, skills, behavior, condition, or status. Most often, an outcome represents a change for the better, although the outcome for some programs is that participants get worse more slowly than they would have otherwise." (Plantz, et. al. 1999) In many cases there is not one outcome, but a series of outcomes, with one outcome contributing to another.

To begin to develop outcome measures one must examine the assumptions and theories upon which each program operates. A good place to begin the process of identifying the program theory is to look at what services are being provided. These are the active service elements that program staff and Board believe are responsible for any outcomes the programs may produce. Why do we expect the program to produce good outcomes for participants using the program? Is there any reason to believe that providing these services will make any difference in the lives of the participants served?

BOONE COUNTY COUNCIL ON AGING

Program Mission

The mission of the BCCA is to promote the self-respect, dignity, security, and independence of the older citizens of Boone County by:

1. Identifying and matching individual needs with community resources,
2. Serving as the primary local community representative for the older citizens of Boone County,
3. Coordinating volunteer opportunities for and with older citizens of Boone County,
4. Advocating for seniors at the local level, and
5. Providing information and education for a positive life long experience.

Current Evaluation Plan

BCCA has a system which tracks clients as they come into the program. An intake and needs assessment is conducted to determine which services the client needs to remain independent in his/her own home. BCCA conducts regular client satisfaction surveys to assure that clients are receiving the services they need and are satisfied with those services. One of the questions asked on the client satisfaction survey is "Did this service help you stay in your home?" In addition, since many of BCCA's referrals come from outside agencies, the number of agencies who continue to refer their clients to BCCA measures success. In 2001, a survey of referring agencies was conducted to gather baseline information to compare with subsequent administration of the survey.

Evaluations and reviews from funding sources and accrediting boards

BCCA does not receive state or federal funding for the services being evaluated. BCCA is the administrator of a CDBG home repair program that was reviewed.

Other funding sources	HRS reviewed
Community Development Block Grant – City of Columbia	Review by the Columbia Community Development Coordinator (2/6/2003) noted some documentation deficiencies that are being rectified by BCCA staff.

Follow-up on clients who are no longer in the program

BCCA does not report any follow-up on clients who have left its program.

Outcomes for current clients

BCCA reported several positive outcomes for clients in the 2003 Social Services Proposal.

- 96% of clients served in 2001 who responded to the client satisfaction survey reported the service helped them remain in their own home.

Client population characteristics for 2001 included:

- 106 seniors served by Care Management Program
- 526 seniors accessed the Volunteer and Support Program
  - 81% female
  - 100% of seniors in the Care Management or Volunteer and Support Program were Boone County residents
    - 85% within the City of Columbia
    - 15% out-county
  - 100% of seniors in the Care Management or Volunteer and Support Program were below 150% of poverty
- 459 seniors or their family members were provided comprehensive information services
- 4,165 seniors participated with BCCA in other ways

Types of services given to clients – 2001

Type of service	Number
Transportation	90
Yard maintenance	77
Property tax credit/pharmaceutical credit filing	62
Carrier Alert program	44
Weekly Friendly Visitor	42
Food Pantry delivery	36
Assistance with medical billing questions	31
Home maintenance services	21
Daily telephone reassurance calls	12

Client satisfaction measures

BCCA surveys a group of clients each quarter to assess their satisfaction level and to assess gaps in services. The agencies that refer clients to BCCA were surveyed to address any barriers in the referral process.

- 92% of clients served in 2001 who responded to the client satisfaction survey reported they were very satisfied or satisfied with their volunteer.

- 76% of agencies that referred clients to BCCA in 2001 were very satisfied with the services BCCA provided to the client referred.

Current Objectives

BCCA has identified three main objectives for the funded services.

1. Increase the number of low-income African–American seniors served by 25%.
   - To be accomplished by collaboration with community organizations and churches in the African-American community.

     Impact:

     - increase awareness of BCCA services
     - connect seniors in an under-served population with community resources
2. Increase the number of seniors who access BCCA services by 5%.
   - To be accomplished by increasing awareness of BCCA within the community

     Impact:

     - BCCA will increase the amount of service it provides
     - BCCA will broaden its funding base
3. Ensure the safety and well-being of 20 seniors in the community
   - To be accomplished by repair and modification of seniors' homes using CDBG funds for the Home Repair Program

     Impact:

     - broaden the client base of seniors served
     - help seniors remain safely in their own homes as they age
     - help seniors remain independently in their own home as they age

Recommendations

On-going evaluation

BCCA has a well-developed client tracking system in place that can report numbers of clients and demographic data. BCCA is collecting information on their client surveys that could be used to track outcomes objectives.

Recommended wording for outcomes objectives

It is recommended that BCCA use its current client satisfaction surveys to track outcome measures related to the objectives listed below. The Social Services application could be strengthened by using these, or similar objectives, as the three main objectives each year. Suggested wording is as follows.

- X% of clients who respond to the client satisfaction survey will report the service helped them remain in their own home
- X% of clients who respond to the client satisfaction survey will report they were very satisfied or satisfied with their volunteer
- X% of agencies who referred clients to BCCA will report being very satisfied with the services BCCA provided to the client referred

Program Logic Model

The program logic model developed by BCCA is attached.

Insert BCCA materials here 2 pages

Insert BCCA materials here 2 pages

CEDAR CREEK THERAPEUTIC RIDING CENTER

Program Mission

"The purpose of Cedar Creek Therapeutic Riding Center (CCTRC) is to provide therapy to people with physical, mental, and emotional disabilities using the horse as a therapeutic tool." (2003 Social Services Proposal, p.5)

Individual Program Ratings and Scores From the Frameworks

Each agency was asked to review the frameworks for continuous evaluation and improvement and to give themselves a score on each framework. The scores reported below show the results of this self-evaluation and the rating given by the HRS evaluator (HRS scores marked with *).

Framework for continuous evaluation and improvement

Approach to continuous evaluation and improvement

	CCTRC (2)*		CCTRC Self (4)	
1	2	3	4	5
Neither goal nor strategies exist for the evaluation and continuous improvement of the agency or elements of the agency's programs	The approach to continuous improvement and evaluation is problem solving. If there are no problems, or if solutions can be made quickly, there is no need for improvement or analyses. Changes in parts of the system are not coordinated with all other parts	Some elements of the organization are evaluated for effectiveness. Some elements are improved on the basis of the evaluation findings	All elements of the agency's operations are evaluated for improvement and to ensure congruence of the elements with respect to the continuum of improvement for all clients.	All aspects of the agency are rigorously evaluated and improved on a continuous basis. Clients, and the maintenance of a comprehensive improvement continuum for clients become the focus of all aspects of the evaluation and improvement process

CCTRC staff gave this justification for a score of 4: "Each client at CCTRC is evaluated for progress by an Occupational Therapist or Therapeutic Riding Instructor. CCTRC's operations are rigorously evaluated by its umbrella organization, the North American Riding for the Handicapped. In addition to these evaluations, CCTRC will be the focus of an extensive program evaluation, which will monitor progress and results of clients, client satisfaction, and create more measurable goals."

Implementation of continuous evaluation and improvement

CCTRC (1)*			CCTRC Self (4)	
1	2	3	4	5
With no overall plans for evaluation and continuous improvement, individual program managers and administrators change strategies only when something sparks the need to improve. Reactive decisions and activities are a daily mode of operation.	Isolated changes are made in some areas of the organization in response to problem incidents. Changes are not preceded by comprehensive analyses, such as an understanding of the root causes of problems. The effectiveness of the elements of the agency or changes made to the elements, is not known.	Elements of the organization are improved on the basis of comprehensive analyses of root causes of problems, client perceptions, and operational effectiveness of processes.	Continuous improvement analysis of client outcomes and program strategies are rigorously reinforced within each program and across all levels to develop a comprehensive improvement continuum for all clients and to prevent negative client outcomes	Comprehensive continuous improvement becomes the way of doing business at the agency. Staff continuously improves the appropriateness and effectiveness of program strategies based on client feedback and outcomes. All aspects of the organization are improved to support staff efforts.

CCTRC staff gave this justification for a score of 4: "Each session, progress notes are carefully evaluated to see how each individual client responded to the therapy, and now changes could be made to continue improving therapy for the client. During each session, if needed, changes are made to improve therapy to individuals. Volunteer training and staff in-services occur three times (for Volunteer training) and five plus (staff in-services) per year to talk about our quality of therapy and our consistent commitment to improvement of client outcomes."

Outcomes of continuous evaluation and improvement

	CCTRC (2)*			CCTRC Self (5)
1	2	3	4	5
Individuals struggle with system failure. Finger pointing and blaming others for failure occurs. The effectiveness of strategies is unknown. Mistakes are repeated.	Problems are solved only temporarily and few positive changes result. Additionally, unintended and undesirable consequences often appear in other parts of the system. Many aspects of the agency or program are incongruent, keeping the agency from reaching its vision.	Evidence of effective improvement strategies is observable. Positive changes are made and maintained due to comprehensive analyses and evaluation.	Those delivering service become astute at assessing and in predicting the impact of their strategies on individual clients. Sustainable improvements in clients are evident in all programs, due to continuous improvement.	The agency becomes a congruent and effective learning organization. Only methodology and strategies that produce quality client outcomes are used. A true continuum of improvement results for all clients.

CCTRC staff gave this justification for a score of 5: "At CCTRC, we only use methods that benefit and encourage improvement for each client. We constantly gain innovative ideas and try new things with our clients, keeping the successful practices and discarding unsuccessful ones. We attend several conferences and training workshops each year to facilitate our learning and provide the most innovative and successful equine therapy available."

Framework for gathering and analyzing outcomes information

Approach to gathering and analyzing outcomes information

	CCTRC (2)*		CCTRC Self (4)	
1	2	3	4	5
Data or information about client needs is not gathered in any systematic way; there is no way to determine what needs to change at the agency based on data.	There is no systematic process, but some client information is collected and used to problem solve and to establish essential client outcomes.	Agency collects data on client outcomes and conducts client needs assessments. The information is used to drive the strategic quality plan for the agency.	There is systematic reliance on hard data (including data for sub-groups) as a basis for decision making at the client level as well as the agency level. Changes are based on the study of data to meet the needs of clients and staff.	Information is gathered in all areas of client interaction with the agency. Staff engages clients in gathering in-formation on their own outcomes. Accessible to all levels, data is comprehensive in scope, and an accurate reflection of agency quality.

CCTRC staff gave this justification for a score of 4: "Our OT and instructor progress notes are comprehensive and complete. They provide a detailed look at the program and how our clients improve. They can be used to adjust or change the program where needed. In addition, the program evaluation will provide additional information about how well CCTRC operates and serves its clients."

Implementation of gathering and analyzing outcomes information

	CCTRC (2)*		CCTRC Self (4)	
1	2	3	4	5
No information is gathered with which to make changes. Client dissatisfaction is seen as an irritation, not a need for improvement.	Some data is tracked, such as client recidivism. Individuals are asked for feedback about their experience with the agency.	Agency collects information on clients and former clients, analyzes, and uses it in conjunction with future trends for planning. Identified areas for improvement are tracked over time.	Data are used to improve the effectiveness of service delivery. Client indicators are graphed and utilized for diagnostics. All staff analyzes client evaluations and indicators.	Innovative processes meeting the needs of clients are implemented to the delight of staff, clients, and funding agencies. Root causes are known through analyses. Problems are pre-vented through the use of data

CCTRC staff gave this justification for a score of 4: "All documentation is tallied and compared with original goals. Therapists and instructors analyze client outcomes to indicate if andhow a clients' therapy should be changed."

Outcomes of gathering and analyzing outcomes information

CCTRC (1)*			CCTRC Self (4)	
1	2	3	4	5
Only anecdotal and hypothetical information is available about clients' behavior and satisfaction. Problems are solved individually with short-term results.	Little data is available. Change is limited to some areas of the agency operation and dependent upon individuals and their efforts.	Information collected about clients' needs and outcomes is shared with staff and is used to plan for change. Information helps staff understand pressing issues, how to analyze information for root causes and how to track for improvement.	An information system is in place. Positive trends begin to appear in individual client as well as community outcomes. There is evidence that understanding and effectively using data collected cause these results.	Clients are delighted with the agency's processes and proud of their own capabilities to assess their own progress. There are good to excellent results for all clients. No client falls through the cracks. Staff use data to predict and prevent potential problems.

CCTRC staff gave this justification for a score of 4: "Our database of client progress notes and evaluation forms helps us to track changes and implement ideas to match client needs."

Current Evaluation Plan

In 1998, CCTRC met the requirement for accreditation from the North American Riding for the Handicapped Association (NARHA). They are being reviewed for re-certification in 2003.

Individual outcomes are tracked by assessing the functional status of each client when they come into the program and then again when they leave the program. A medical assessment from a physician is required for participation. A therapeutic evaluation is completed for each client and individual goals set. Progress is documented after each riding session.

CCTRC staff develops a complete plan of care for each individual client. The Functional Status Report, completed at the beginning of the session and at the end of the session, asks the family, caregiver, or client to list three goals they wish to accomplish during the 9-week therapeutic riding session. At the end of the session, the same family member, caregiver, or client is asked to say whether the goals were met during the sessions ("End of session: The above goals were met during this session. Yes, No, or Partially").

On this same Functional Status Report, the family member, caregiver, or client is asked to complete two open-ended questions. The first question asks them to list areas where they saw progress ("I feel that progress was made during this session in the following area:"). The second asks them to list other areas they would like to work on (I would like to see progress in the following areas:")

Documentation is maintained for each client. However, even though the Executive Director and the therapists know each individual client very well, no summary of client outcomes is produced. Each client has a set of outcomes in an individual therapy plan, but there is not an overall evaluation plan for the programs or the agency.

Evaluations and reviews from funding sources and accrediting boards

Other funding sources	HRS review on-site
North American Riding for the Handicapped Association (NARHA)	1998 report is the last available, the 2003 report yet to be done. CCTRC passed the certification review with no deficiencies.
Christopher Reeve Paralysis Foundation	Self-evaluation written – copy was to be sent to HRS but was never received

Follow-up on clients who are no longer in the program

CCTRC does not report any follow-up on clients who have left its program.

Outcomes for current clients

CCTRC makes use of student interns from the Truman School of Public Affairs at MU. The current intern, Sarah Smith, is using CCTRC as her case study that includes a program evaluation. As suggested in the recommendations in this report, she will review individual case files to determine how many of the clients in each session met their goals. This will be summarized into a report showing outcomes for current clients. In July 2003, she plans to survey parents, caretakers, and clients about the impact the program has made on them. She has agreed to make the preliminary report available to the Office of Community Services when it is completed.

Outputs reported by CCTRC

Documentation is maintained for each client, however, this information is not summarized or reported as a whole.

For 2001 CCTRC reported this:

- provided three 9-week sessions with the highest standards of safety
- served more than 300 students during sessions in 2001
- served 180 Boone County residents in 2001
- reported that in 2001, 4 clients took their first steps, thanks to riding therapy
- reported that in 2001, 6 riders said their first words while riding
- provided professional training for development of staff, instructors, and therapists
- secured financial support to increase the number of horses used for therapy, and replace safety equipment for riders
- expanded facility usage to rove services to individuals with disabilities (example: sponsor horse show June 4, 2000)
- provided shelter for shade in five-acre pasture, through the construction of a lean-to

Client satisfaction measures

CCTRC staff distributed a parent/program form in 1992 but it has not been re-done.

State and national indicators which may be applicable

There are no national indicators to which the program can be compared. The evaluator placed a call to the North American Riding for the Handicapped Association headquartered in Denver, Colorado, to see if other therapeutic riding programs were reporting program evaluation strategies. They provided a bibliography of published articles, most of which were about the effects of therapeutic riding on individuals with specific diseases. They could not refer me to a program that was attempting to transform its objectives into outcome objectives. Once outcome objectives are developed for CCTRC, it may well be the first therapeutic riding center nationwide to state outcome objectives.

Current Objectives

CCTRC lists 8 objectives in its 2003 proposal:

- provide three 9-week sessions with the highest standards of safety
- provide professional training for development of staff, instructors, and therapists
- secure financial support to increase the number of horses used for therapy, and replace safety equipment for riders
- develop and continue capital campaign strategy for payment of permanent site for CCTRC
- Expand facility usage to rove services to individuals with disabilities; (CCTRC will host the 2003 seven state regional convention for NARHA)
- Provide services through the Department of Vocational Rehabilitation concerning clients in the Welfare-to-Work program with the Central Workforce Investment Board
- Continue to develop and improve the Drill Team to help accomplished riders continue to enjoy the opportunity to progress to higher levels of equine participation
- Build and develop a memorial site for horses that have worked with CC for volunteers, riders, and families who wish to remember its heroic deeds.

The outcomes are currently stated as process objectives, worthy goals for organizational development.

Recommendations

On-going evaluation plan

It is recommended that aspects of the comprehensive evaluation being conducted by the student intern be made an integral part of the CCTRC evaluation plan.

Suggested wording of outcome #1

- Out of the total clients served each year, 95% will meet one of their individual goals

Data collection for this objective

CCTRC already collects information which could be used to track overall program outcomes. The Functional Status Report, completed at the beginning of the session and at the end of the session, asks the family, caregiver, or client to list three goals they wish to accomplish during the 9-week therapeutic riding session. At the end of the session, the same family member, caregiver, or client is asked to say whether the goals were met during the sessions ("End of session: The above goals were met during this session. Yes, No, or Partially"). From this report, a tally could be made of the responses to this question.

Setting the baseline

A count from 2002 could serve as the baseline from which CCTRC staff and board could set goals. For example, if 80 out of 100 clients marked "yes," the baseline measure could be stated: "80% of the clients served in 2002 reported at the end of the session that the goals were met.

Outcome objective #1 for 2004 proposal

The outcome objective for 2004 could be stated: of the total clients served in 2004, 95% will report that their goals were met

Suggested wording of outcome #2

- out of the total clients served each year, 95% of the family members or caregivers will report that they "felt that progress was made during the session" on one of the three goals set.

Data collection for this objective

On this same Functional Status Report, the family member, caregiver, or client is asked to complete two open-ended questions. The first question asks them to list areas where they saw progress ("I feel that progress was made during this session in the following area:…"). Again, a tally could be made of the responses to this question and a baseline measure calculated. The second question asks them in which areas they would like to see progress which can be used as a way to find out new and on-going program areas to be addressed.

Setting the baseline

The baseline measure could be stated, "80% of the clients served in 2002 reported at the end of the session that progress had been made in at least one area."

Outcome objective #2 for 2004 proposal

The outcome objective for 2004 could be stated: of the total clients served in 2004, 95% of the family members or caregivers will report that they "felt that progress was made during the session"

on one of the three goals set.

Suggested wording outcome #3

- 95% of the volunteers who complete the volunteer satisfaction survey will report that the volunteer experience at CCTRC was "very rewarding."

Data collection for this objective

CCTRC does not currently survey volunteers to assess their satisfaction and to gain their suggestions for improving the program. It is recommended that the student intern, Sarah Smith, modify the instrument she will use in her total program evaluation to create a short survey that can be administered to volunteers at the end of each session.

Setting the baseline

It is expected that most volunteers are satisfied with their experience at CCTRC, so the baseline measure could be stated, 95% of the volunteers surveyed in 2002 reported at the end of the session they were very satisfied with their volunteer experience. However, the percentage used for the baseline can be adjusted to reflect the actual percentage achieved.

Outcome objective #3 for 2004 proposal

The outcome objective for 2004 could be stated: of the total surveyed in 2004, 95% of the volunteers reported they felt the experience was "very rewarding"

Program Logic Model

The CCTRC Center submitted a Program Logic Model after the preliminary report was written. The program model is attached. The logic model, developed by the evaluator, is also attached.

CEDAR CREEK THERAPEUTIC RIDING CENTER

Inputs	Activities	Outputs	Outcomes		
			Initial	Intermediate	Long-term
Board of Directors	3 9-week sessions held	300 participants engage in the program	Evidence of improved balance	Improved balance	Individuals reach their maximum level of self-sufficiency
Certified Instructors	Motion therapy	3 volunteers per rider engaged	Evidence of improved coordination	Improved coordination	Individuals reach their maximum level of mobility
Certified Therapists	Therapeutic riding	180 Boone County Clients	Evidence of improved muscle strength	Improved muscle strength	Individuals able to live in the least restrictive environment
Corporate Support	Mobilization of joints - body is moved in a way to simulate walking	New horses purchased	Evidence of improved muscle tone	Improved muscle tone	Family stress is reduced
Grants and contracts	Instruction in horsemanship skills	Drill team started	Evidence of improved socialization skills	Improved socialization skills	Individuals have high self esteem
	Instruction in stable management	Memorial site developed	Evidence of improved speech production	Improved speech production	Individuals' have stress level reduced
	Opportunities to socialize with others		Evidence of improved concentration	Improved concentration	
	Opportunities to experience human to animal bonding				

INSERT CCTRC LOGIC MODEL HERE

CENTRAL MISSOURI FOOD BANK PANTRY

Program Mission

The mission of the Central Missouri Food Bank is through empowerment, education and partnerships, to bring together community resources to feed people in need.

Current Evaluation Plan

The Central Missouri Food Bank Pantry (CMFBP) is the Boone County component of the Central Missouri Food Bank. CMFBP currently evaluates its operation on the following criteria:

1) number of people served by county and by city
2) number of elderly persons served
3) total number of pounds of food distributed monthly and annually
4) evaluation of these numbers against the census data

CMFBP has a client database system that generates a lot of descriptive information about its clients and the amount of food distributed.

Evaluations and reviews from funding sources and accrediting boards

Other funding sources	HRS review on-site
America's Second Harvest National Food Bank Network – Bi-annual audit	Next review scheduled for April 2003. The 2001 report stated they passed all administrative requirements, there were a few issues with warehouse practices.
USDA – inspects annually	Last review completed 2/02/02. No adverse findings, all food handled according to USDA standards.
Boone County/Columbia Health Department – inspected quarterly	Last review 12/11/02 – 0 deficiencies

Follow-up on clients who are no longer in the program

CMFBP does not report any follow-up on clients who have left its program.

Outcomes for current clients

A region-wide survey was conducted by CMFB in 1998 to identify the characteristics of clients being served. A report describing Boone County clients was included. The survey included some questions related to "food security" that could be used as baseline indicators for client outcomes.

Some examples follow:

Q4. In general, do you have enough food?

28% answered "yes"

Q25. Do you ever go without buying food so that you can pay your other bills?

29% answered "no"

Q26. Do you ever go hungry so that you can feed your children?

29% answered "no"

CMFBP engages in strategic planning, setting goals in several different areas. The Annual Report (Report Card 2002) reports to funders and the public in a visually appealing, easily understandable way. Boone County services reports for 2002 are as follows.

- 15,386 people served
- 19,022 food baskets distributed
- 1,963,839 pounds of food
- started a Kid's Café (summer feeding program for low-income children) in Columbia
- 16,389 hours of service provided by volunteers

Client satisfaction measures

CMFBP does not report any client satisfaction measures.

State and national indicators which may be applicable

America's Second Harvest has conducted nation-wide surveys of hunger in America. The latest report Hunger in America 2001 is available at http://www.hungerinamerica.org Several of the questions used relate to "food security," the demographic and social characteristics of the national sample could be compared to the local client base.

The International Food Policy Research Institute (http://www.ifpri.org) has developed a series of technical papers that address outcome indicators of household food security. Its publication Choosing Outcome Indicators of Household Food Security (http://www.reliefweb.int/training/ti1226/html) points out some of the difficulties and complexities in developing outcomes for food programs. Among the methods they discuss are the "indices of household coping strategies." This method is very similar to the questions about food security mentioned above. Three other methods "individual food intake data," "household caloric acquisition," and "dietary diversity" are also discussed.

The Federal Interagency Forum on Aging Related Statistics published Older Americans 2000: Key Indicators of Well-Being. (http://www.agingstats.gov/chartbook2000/default/htm) While most indicators do not apply to a food distribution program, the "Dietary Quality" indicator (p. 36) may have some relevance. Respondents were asked to self-report their food intake which was then rated on a "Healthy Eating Index."

Current Objectives

CMFBP has three main objectives listed in its Social Services Application:

- increase the number of people served
- increase the amount of food available
- increase services available to clients through increased hours and increased referrals

The outcomes are currently stated as process objectives, giving the number of clients to be provided with food, the number pounds of food, and number of hours open for service.

Recommendations

On-going evaluation plan

CMFBP staff are considering repeating 1998 survey as a way to track changes that have taken place in Boone County. Doing another survey in 2003 would make a valuable contribution as a 5-year follow-up survey. The Board and staff will have to determine the feasibility of this option.

CMFBP could modify its intake procedure to add some questions that would track indicators for outcomes objectives. A specific time could be chosen during which additional questions would be asked at intake or a questionnaire distributed to all clients who come to the Food Pantry on a given day. As an example, the Voluntary Action Center randomly selects one week each quarter during which all clients who come to the agency are asked to complete a survey about the impact VAC has on their lives, their satisfaction with the services, and any needs not being met. CMFBP could develop a survey schedule that fit its needs; one day each month, one week each quarter, one week semi-annually, etc.

Some examples of the types of questions that could be asked are as follows:

Indices of Household Coping Strategies from Choosing Outcome Indicators of Household Food Security (page 11) (http://www.reliefweb.int/training/ti1226/html)

In the last seven days:

1. Has the household consumed less preferred foods? (Circle the best response)

   1. Never 2. Rarely (once) 3. From time to time (2 or 3 times) 4. Often (5 or more times)

2. Have you reduced the quantity of food served to men in this household?

   1. Never 2. Rarely (once) 3. From time to time (2 or 3 times) 4. Often (5 or more times)

3. Have you reduced your own consumption of food?

   1. Never 2. Rarely (once) 3. From time to time (2 or 3 times) 4. Often (5 or more times)

4. Have you reduced the quantity of food served to children in this household in the last seven days?

   1. Never 2. Rarely (once) 3. From time to time (2 or 3 times) 4. Often (5 or more times)

5. Have members of this household skipped meals in the last seven days?

   1. Never 2. Rarely (once) 3. From time to time (2 or 3 times) 4. Often (5 or more times)

6. Have members of this household skipped meals for a whole day?

   1. Never 2. Rarely (once) 3. From time to time (2 or 3 times) 4. Often (5 or more times)

Examples of food security questions from the National Food Survey Hunger in America 2001 (pages 90-109) (http://www.hungerinamerica.org) The question number refers to the question number on the national survey.

31. Have you ever applied for Food Stamps?
32. Are you receiving Food Stamps now?
33. How long have you been receiving Food Stamps?
34. In the past 12 months, have your Food Stamp benefits increased, decreased, or remained the same?
35. How many weeks do your Food Stamps usually last?
36. Did you receive Food Stamps in the past 12 months?
37. Why haven't you applied for the Food Stamp program?
38. Why don't you receive Food Stamps now?
42. The food I/we bought just didn't last, and I/we didn't have money to get more.

    (Often true, sometimes true, never true)
43. I/We couldn't afford to eat balanced meals.

    (Often true, sometimes true, never true)
44. In the last 12 months, did you ever cut the size of your meals or skip meals because there wasn't enough money for food?

    44. a. How often did this happen?
45. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?

    (Often true, sometimes true, never true)
46. In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food?
47. In the last 12 months, did you ever not eat for a whole day because there wasn't enough money for food?
48. Is there at least one child under 18 in household?
49. My child is not eating enough because I/we just couldn't afford enough food.

    (Often true, sometimes true, never true)
50. In the last 12 months, did your child ever skip meals because there wasn't enough money for food?
51. In the last 12 months, was your child ever hungry but you just couldn't afford more food?

52. In the past 12 months, have you or anyone in your household ever had to choose between: paying for food and paying for medicine or medical care; paying for food and paying for utilities or heating fuel; paying for food and paying for rent or mortgage?
53. Please rate how satisfied you are with the food that you and others in your household receive here.
54. When you come here, how often are you treated with respect by the staff who distributes food?
55. If this agency weren't here to help you with food, what would you do?
56. How many different food pantries gave you food in the past month?
57. How many different soup kitchens gave you meals in the past month?

Some of the questions on the national survey could be adapted for customer satisfaction questions. Answers to the questions relating to paying for food vs. other necessities are combined in the national survey as indicators of food security. Questions about Food Stamps are included as an example of some questions asked to formulate a description of other resources Food Pantry clients may access. In a discussion with the Evaluation Committee of the Community Services Commission, one member suggested that removing barriers to participation in Food Stamps might relieve the pressure on the local food pantry program. Gathering information about why clients are not on food stamps would aid in this effort.

Suggested wording of outcome objectives

CMFBP could strengthen its Social Services application by presenting some outcomes objectives for the clients served. A periodic survey of clients could yield information about the impact the service is having on them. Some suggested objectives are listed.

- As a result of services provided by CMFBP
  - increasing numbers of clients will become "food secure"
    - 35% of clients surveyed will report "yes" in general, they have enough food (baseline in 1998 - 28%)
    - 35% of clients surveyed will report "no" they do not go without buying food so they can pay other bills (baseline in 1998 - 29%)
    - 35% of clients surveyed will report "no" they do not go hungry so they can feed their children (baseline in 1998 - 29%)

Program Logic Model

The CMFBP did not submit a Program Logic Model. The evaluator developed a draft Logic Model that follows this section.

CENTRAL MISSOURI FOOD BANK PANTRY

Inputs	Activities	Outputs	Outcomes: Initial	Outcomes: Intermediate	Outcomes: Long-term
Board of Directors and staff	Distribution of food	Number of people served by county and city Number of elderly persons served	X% of those completing survey cards report in general they have enough food	Clients are able to supplement their income (purchase other necessary items with the money they would otherwise have to use to buy food).	Individuals become/remain productive citizens.
Donated food	Community volunteer services opportunities	Number of pounds of food distributed monthly and annually	X% of those completing survey cards report they do not go hungry so they can feed their children	Children are adequately nourished	Children remain healthy and develop according to accepted norms.
Volunteers	Volunteer fund raising activities	Number of activities held Number of volunteer hours	X% of those completing survey cards report CMFBP has made a significant difference in their lives		Family stress is reduced
Funding sources	Upgrading agency capacity to use and store food	Estimated wholesale value of food Economic impact to the community based on the value of the food	X% of those completing the survey cards report they do not have to go without buying food so they can pay other bills.		Indicators measured show Boone County households who are clients of CMFBP are food secure.

ELDERCARE CENTER

Program Mission

> "The Eldercare Center will further the mission of the University in areas of service, education, research, and extension. The primary emphasis will be on a balance between service and education with an additional focus on research and extension components. The program will serve adults who have experienced physical, cognitive, and/or emotional change and need a supportive environment. An effort will be made to serve participants' families as well as the participants." (2003 Social Services Proposal, p.5)

Current Evaluation Plan

Eldercare meets the requirement for licensure from the Missouri Department of Health and Senior Services that has approved all aspects of the program.

Eldercare staff develops a complete plan of care for each individual participant. Individual outcomes are tracked by assessing the medical and functional status of each participant when they come into the program, and assessments are repeated on a monthly basis. A medical assessment from a physician is required for participation. The physical therapist, the occupational therapist, or the speech and language therapist completes a therapeutic evaluation, if needed, and in cooperation with the participant and family members, goals are set for the individual. Progress is documented monthly. A communication notebook is used on a daily basis to inform staff of care issues that need immediate attention.

Family caregivers are asked to complete an evaluation every year. The evaluation asks the family member to rate the functioning ability of the participant in several areas, as well as give their own observations of behavior.

Evaluations and reviews from funding sources and accrediting boards

Other funding sources	HRS review on-site
Missouri Department of Health and Senior Services – licensure inspection every 6 months	The report from the latest DHSS inspection completed 12/10/02 was reviewed. Eldercare was found to be in compliance with Adult Day Care Rules and Regulations.
Veterans Administration	VA accepts the results of the MDHSS inspection. They conduct an on-site visit to verify findings, but do not produce a report. Eldercare continues to be approved as a provider of Adult Day Care for Veterans.

Other funding sources (continued)	HRS review on-site
Robert Wood Johnson Foundation – Partners in Caregiving Technical Assistance Award (In-kind only)	In-kind consultation provided and recommendations given by staff from an Adult Day Program in Winston-Salem, North Carolina. The recommendations are being taken under consideration.

Follow-up on clients who are no longer in the program

Most participants who leave the Eldercare program either go to a long-term care setting or pass away. Eldercare records the client's reason for discharge from the program at the time of discharge, but in most cases does not have any contact with family members afterwards.

Outcomes for current clients

A student intern, Stephanie Scantlen, completed a comprehensive evaluation of Eldercare as a class project in 2002. She reported on the results from the annual Family Caregiver Evaluation.

Characteristics of participants

Characteristics of participants	% of total	% of sub-group
Alzheimer's disease or other form of dementia	82.0%	
Goals listed by caregiver upon initial assessment	58.8%	
Socialization		80.0%
Exercise		20.0%
Reason for admittance listed by caregiver in initial assessment	88.2%	
Socialization		80.0%
Respite		53.3%

Family caregiver rating of ability

The Family Caregiver Evaluation asks the family member to rate their loved one's ability to function. [Note: Since most participants in Eldercare are eligible for nursing home placement, they are not expected to increase their ability to function much.]

	Increased	Decreased	Did not change
During the past year has the participant's ability to function independently…	50.0%	50.0%	0.0%

Qualitative statements from caregivers completing the evaluation:

> "The decrease in functioning is the result of her illness and the center has probably tempered this decline by reinforcing her strengths."

Family caregiver rating of difference in behavior

	Yes	No
After a day at the Center, do you see any differences in behavior as opposed to a day not attended?	50.0%	50.0%

Qualitative statements from caregivers completing the evaluation:

> "Mother is more restless in the evenings and on weekends. I think the center activities provide her with necessary interactions and stimulation so that she has had a more satisfying day and has exercised herself both physically and intellectually and is more relaxed."

> "He's excited after a day at the center. Is he more animated there? He seems to have made friends. He loves speech therapy which has helped him so much."

> "Mother tends to talk about new things, not repeating something that has already been discussed. She is also fatigued, but I see that as a positive, as her stamina is nil and the center is challenging that."

> "She is not nearly as confused after a day at the center as she is on days when she stays at home and doesn't have as much activity."

Where would your family member be if not at Eldercare?

	With caregiver	Home alone	Care facility
Where would the family member be if not attending day care?	44.4%	27.8%	50.0%

What are you able to do because of Eldercare?

Question 7 (open-ended): What are you able to do now, that you were not able to do before your family member began attending day care?

Qualitative statements from caregivers completing the evaluation:

> "I have a schedule that I can predict. While at the center, I have a peace of mind that mother is safer, stimulated. I can focus on other responsibilities, not thinking about what I could be doing for mom."
>
> "Run errands, respite, lead a more normal life. Mom's adjustment to the center has been such a blessing!"
>
> "I have a feeling of peace knowing that she is okay. I can go shopping and not feel guilty."

Client satisfaction measures

Eldercare staff distributes the Family Caregiver Evaluation every October. The student intern compiled a report on some of the questions.

The client and caregiver satisfaction measures and the scores reported are as follows:

Please rate the Eldercare Center in the following areas:	Excellent	Good	Fair
Number and type of staff	11.1%	88.9%	0.0%
Caring and professionalism of staff	100.0%	0.0%	0.0%
Daily fee	50.0%	33.3%	16.7%
Overall rating	77.8%	22.2%	0.0%

	Yes	No
Does the participant look forward to coming to the Center?	94.4%	5.6%

Qualitative statements from caregivers completing the evaluation:

> "Mom says that she is so lucky that there are places like the center that people her age can come to." "She enjoys sharing what she has done all of her life, gets discouraged when she can't share memories."
>
> "He loves the staff and the discussion topics."

Question 12 (open-ended): Other comments:

> "This program gives mom a place to be 3 days a week and a purpose. I'm impressed with the greeters at the door in the morning. It makes participants feel like you are waiting for them and that you are glad to see them."
>
> "A wonderful, invaluable program that has made it possible for my mother to continue to participate in the world, even as her illness has progressed and her function has declined. Saved my life."

State and national indicators which may be applicable

The Federal Interagency Forum on Aging Related Statistics published Older Americans 2000: Key Indicators of Well-Being. (http://www.agingstats.gov/chartbook2000/default/htm) While some of the indicators relating to social contacts may apply to Eldercare services, there were no indicators that mentioned adult day services. However, on page 52, in a section on "Data Needs," there is a heading,

> "Distinguishing between different types of long-term care facilities and the transitions that occur between them"

Adult day services are not mentioned in the paragraph which points out the lack of information about this service as well as the ones mentioned.

> "Current surveys and censuses that include information on the entire older population rarely distinguish between these types of 'institutional' residences. As a result, there is a lack of information on the characteristics of older persons in different residential care settings and their service use and health care needs…there is little information on the costs, duration, and transitions into and between different long-term care settings.

The Eldercare Center could add to the information available about "transitions into and between different long-term care settings" by tracking discharges from its program and average length of stay. Eldercare has information about the cost of its program as compared to nursing home care, so this cost savings could also be reported as a dollar amount savings to individuals and taxpayers.

Current Objectives

Eldercare has three main objectives listed in its 2003 Social Services Application:

- establish time line for expansion project, including steps for fund raising efforts
- identify sources for funding through foundations and grants
- determine options for transportation to meet current and future needs for Eldercare participants

The outcomes are currently stated as process objectives, worthy goals for organizational development.

Recommendations

On-going evaluation plan

The Eldercare Center has a well-developed on-going evaluation plan. It is recommended that it begin to report these results in the Social Services Applications. By re-stating its objectives and reporting data already gathered, the outcomes could be stated strongly.

Suggested wording of outcome #1

- A long-term outcome for Eldercare is to maintain individuals in their own home for as long as possible. The immediate outcome is that X% of caregivers who complete the Family Caregiver Evaluation will report their family member would be in a care facility if not attending Eldercare.

Data collection for this objective

Eldercare already collects information which could be used to track overall program outcomes. The Family Caregiver Evaluation, completed annually, asks the family caregiver to mark one of 4 choices in answer to the question "Where would your family member be if not attending day care?" (Choices of answers: with a caregiver, home alone, care facility, other.) A tally of the responses to this question can serve as an indicator of the progress toward the outcome of keeping the elderly maintained in the least restrictive environment as long as possible.

Setting the baseline

A report from 2002 could serve as the baseline from which Eldercare Center staff and board could set goals for this objective. The evaluation completed in 2002 reported that 50% of caregivers that completed the Family Caregiver Evaluation reported their family member would be in a care facility if not attending Eldercare.

Suggested wording of outcome #2

- A long-term outcome for Eldercare is that **caregivers** remain productive citizens of the community and that caregivers are able to care for a family member at home to the extent of their ability. The intermediate outcome is that family caregiver stress is reduced. The immediate outcome is that
    - 1) X% of **caregivers** who complete the Family Caregiver Evaluation will report they were able to enjoy free time activities

and/or

    - 2) X% of caregivers who complete the Family Caregiver Evaluation and who work, will report they were able to continue employment

Data collection for this objective

On the Family Caregiver Evaluation, the family caregiver is asked to complete an open-ended question, "What are you able to do now, that you were not able to do before your family members began attending daycare?" This question could be modified to include a checklist of activities most commonly mentioned, so that the top three items could be counted. The Eldercare staff listed some

of the activities that caregivers might report: shopping, seeing a movie, cleaning house, enjoying quiet time alone, reading. The checklist could include "able to continue employment," which could then be reported for a separate objective.

Setting the baseline

A qualitative analysis of the responses reported in 2002 could serve as the baseline from which Eldercare Center staff and board could set goals for this objective.

Suggested wording outcome #3

- A long-term objective for Eldercare is to allow elderly individuals to enjoy a high quality of life. An intermediate objective is that family caregivers report that the participant is happier and more content. The immediate objective is the X% of caregivers report an increase in morale of their family member.

Data collection for this objective

On the Family Caregiver Evaluation, the family caregiver is asked to report on a group of indicators. "Since attending Adult Day Health Care, has the participant's functioning in the following areas changed?" (Those completing the evaluation can mark increase, decrease, or same.) One of the items listed is "Morale (positive feelings about life)."

Setting the baseline

The report from 2002 could serve as the baseline from which Eldercare Center staff and board could set goals for this objective. The evaluation completed in 2002 reported 50% of respondents marked "yes" to this question.

Program Logic Model

The Eldercare Center did not submit a Program Logic Model. Program Logic Model. Some of the elements of a beginning model were discussed at the on-site visit. Eldercare staff has been discussing this and thinking about the components that would go into their model. The logic model on the next page, developed by the evaluator, can be used as a starting point.

ELDERCARE CENTER

Inputs	Activities	Outputs	Outcomes: Initial	Outcomes: Intermediate	Outcomes: Long-term
Director	Respite and education for caregivers	# participants engage in the program daily	X% of caregivers report the family member would be in a care facility (Q6)	Individuals are maintained in their home as long as possible.	Individuals are maintained in their home as long as possible.
Nursing Coordinator	Nursing assessment	# participants engage in the program annually	X% of caregivers report an increase in morale of their family member (Q2j)	Caregivers report that individuals are happier and more content	Individuals enjoy a high quality of life
Activities Coordinator	Structured therapeutic activities	Impacts # family members of participants	X% of caregivers report they were able to enjoy 3 activities (Q7)	Family caregiver stress is reduced	Caregivers remain productive citizens of the community
Student interns in PT, OT, TR, SW, nursing, audiology	Nutritious meals	# students gain practical experience with elderly individuals	X% of caregivers who work reported they were able to continue employment (Q7 or a modification)		Caregivers are able to care for a family member at home to the extent of their ability
Grants, contracts, and foundation support	Exercise and sensory stimulation	Caregivers able to enjoy # days of respite			
Volunteers	Safe, secure environment	# family members continued employment			
Family members	Opportunities to socialize with others				
University resources					

MEALS ON WHEELS

Program Mission

The mission of the Meals on Wheels is to assist individuals with problems related to nutrition and health, by providing delivery of a hot nutritious meal to

- homebound people of any age,
- people with limited ability or incentive to shop or cook,
- and people recovering from recent hospitalizations or illness

regardless of their ability to pay.

Current Evaluation Plan

Meals on Wheels has a system which tracks clients as they come into the program. An intake and a brief nutritional needs assessment is conducted to determine whether a special diet is needed. Meals on Wheels conducts a client satisfaction survey every other year to assure that clients are receiving the services they need and are satisfied with those services. One of the questions on the client satisfaction survey asks clients to give an indication of what the service has meant to them. They can check all choices that apply to the statement, "Meals on Wheels has allowed (1) me to stay in my home rather than go to a nursing home (2) the daily life of my children to be easier (3) the daily life of my spouse to be easier."

The Meals on Wheels Board had been discussing ways to implement a system to follow up on clients who leave the program and implemented such a system of follow-up in 2003. The exit interview will be administered to a client soon after he/she discontinues the program.

A survey of the volunteer meal drivers is conducted every other year. This is to track any needed improvements in the program and respond to the needs of the volunteers.

In 2001, a survey of referring agencies was conducted to assess awareness of Meals on Wheels referral and payment processes and to improve these systems if needed. This survey will be administered every other year to track changes in these scores.

Evaluations and reviews from funding sources and accrediting boards

Meals on Wheels operates on client fees and private donations, so is not subject to outside reviews.

Follow-up on clients who are no longer in the program

Meals on Wheels conducted a follow-up survey with clients in March 2003.

Four clients who left the Meals on Wheels Program in 2002 completed surveys.

How long were meals delivered?	Number who responded
1 - 6 months	1
Nearly a year	2
1 – 5 years	1

What is the reason for discontinuing the meals?

- all 4 circled "moved"
- all 4 reported they were now in a long-term care facility

	Number who marked "Yes"
Do you feel the meals provided better nutrition than you had previous to receiving the meals?	2
Have you had a hospitalization during the time you were receiving the meals?	2

Did Meals on Wheels had an impact on your life?	Number who responded (could mark as many as applied)
allowed you to stay in your home longer	3
allowed you more independence	4
gave relief to your family or spouse	3
gave you information on other community resources	3

Outcomes for current clients

Meals on Wheels reported several positive outcomes for clients in the April 2002 newsletter. Recipients who answered the client survey reported the following

- 59% reported Meals on Wheels allowed them to stay in their homes rather than moving to a nursing home
- more than half reported that Meals on Wheels has improved their intake of nutritious foods
- 38% reported Meals on Wheels makes the daily life of recipients' children easier

- 17% reported Meals on Wheels makes the daily life of recipients' spouses easier

The client survey for 2003 was administered in March 2003. The results were available as this report was being developed and are reported here.

- 53% reported Meals on Wheels allowed them to stay in their homes rather than moving to a nursing home
- 78% reported that Meals on Wheels has improved their intake of nutritious foods
- 30% reported Meals on Wheels makes the daily life of recipients' children easier
- 14% reported Meals on Wheels makes the daily life of recipients' spouses easier
- 3% reported Meals on Wheels made life easier for the client
- 73% do not feel they have any other choices for meals if they do not receive Meals on Wheels

Description of current clients

- 26% pay full cost
- 20% pay nothing

The client survey for 2003 was administered in March 2003. The results were available as this report was being developed and are reported here.

- 32% reported being on a special diet
- 47% report not being able to do their own grocery shopping
- 53% report they re-heat meals in the microwave or stove oven

Client satisfaction measures

Meals on Wheels surveys a group of clients every year to assess their satisfaction level and to assess gaps in services. The survey asks clients to rate the quality of the food served, the portion size, the time delivered, the price, the temperature of the food, items that clients disliked from the current menu, the items they would like to see added to the menus, if it is meeting their dietary needs, their assessment of their volunteer, their rating of the frozen weekend meal, and their general rating of the services provided.

Results from the March 2002 survey are as follows:

- 12% feel the quality of the food is excellent
- 75% feel the quality of the food is good
- more than half feel the variety is about right
- more than half rate the overall service as very good

The client survey for 2003 was administered in March 2003. The results were available as this report was being developed and are reported here.

- 22% feel the quality of the food is excellent

- 71% feel the quality of the food is good
- 56% rate the overall service as excellent
- 44% rate the overall service as very good
- 93% rate the volunteers who deliver the meal as "friendly and helpful"
- 83% rate the serving sizes received as "just enough"
- 10% rate the serving sizes received as "not enough"
- 7% rate the serving sizes received as "more than enough"

Volunteer satisfaction measures

One hundred three volunteers completed a survey in March 2002 with the following results.

- more than 80% rated their volunteer experiences as very good
- 20% reported their volunteer experiences as good
- 93% reported their expectations as a volunteer were met to a great extent
- 93% reported the attitude of the staff towards volunteers is excellent
- 97% reported they felt very appreciated by the staff
- 100% reported they felt needed

What do you find most enjoyable about volunteering with Meals on Wheels?

- 85% the feeling of helping others
- 71% the appreciation of the recipients
- 63% being with staff and other volunteers

Current Objectives

Meals on Wheels has identified three main objectives for the funded services.

- Increase volunteer support
- Increase client numbers
- Increase customer satisfaction with menu variety

Recommendations

On-going evaluation plan

Meals on Wheels has a good start on gathering information to track progress on outcome objectives.

If feasible, Meals on Wheels should do an exit interview with all clients who leave the program. This could assist in the continuous improvement of the program and track the number of clients who either die or go into long-term care facilities. The average length of time a client receives Meals

on Wheels prior to their admission to a nursing home would be an interesting measure supporting the goal of delaying institutionalization. Questions that could be asked on an exit interview could include: "Did this make an impact on you/your loved one?" "What was the reason you/your loved one discontinued the program?" "Who is completing this form?"

An added use for the follow-up would be to provide information to volunteers who may want to continue to visit the person. Wording on the card could include, "People will ask about ___. If you don't mind sharing the information about where ___ is now, we can let people know." Another use for the follow-up would be to ask family members for a donation to Meals on Wheels.

In 2001, a survey of referring agencies was conducted to assess awareness of Meals on Wheels referral and payment processes and to improve these systems if needed. It would also be useful to track the source of referrals to show the numbers of clients referred from each source. It could then be shown that the network of providers in the community depends greatly on Meals on Wheels as a vital and needed service.

Suggested wording of objectives

Meals on Wheels could strengthen its Social Services application by listing outcomes objectives using information already being gathered. The wording for new objectives is as follows.

- X% of clients served who respond to the client satisfaction survey will report the meals received keeps them out of nursing homes
- X% of clients served who respond to the client satisfaction survey will report the meals received improved their nutrition
- X% of clients served who respond to the client satisfaction survey will report that the meals received makes the daily life of family members easier

Program Logic Model

The Program Logic Model developed by Meals on Wheels is attached.

Attach MOW materials here 1 page

OATS

Program Mission

The mission of OATS, Inc. is to provide reliable transportation for transportation-disadvantaged Missourians so they can live independently in their own communities.

Current Evaluation Plan

OATS currently tracks each one-way trip, classifying it by the purpose of the trip. An overall report and a county specific report are prepared annually.

A "New Rider Questionnaire" is distributed by the driver to each new rider. These cards are tallied on a quarterly basis and used to gauge customer satisfaction and any new needs that arise.

A "Rider Comment and Suggestion Form" is published in the OATS quarterly newspaper (*The Wheel*).

Internal monthly reports look at the effectiveness of particular programs and contracts through

- units per operating hour
- miles per operating hour
- operating hours per bus
- miles per bus
- miles per unit

OATS engages in an on-going strategic planning process, looking at various issues, assigning staff to address the goal, and setting a time line for completion. The issues addressed relate to funding and financial matters, operations, and county support committees. This serves as an evaluation of the process and implementation of the services.

Evaluations and reviews from funding sources and accrediting boards

Other funding sources	Results of the review
T Brown and Associates – MTM vendor assessment, May 29, 2001	All aspects passed, no areas of concern, no recommendations for improvement
CMAAA, April 25, 2002	Boone County passed all aspects.

Follow-up on clients who are no longer in the program

OATS does not report any follow-up on clients who have left its program.

Outcomes for current clients

OATS does not currently report on outcomes for clients, but it does collect ridership information from which some assumptions can be made. "OATS has no means to track specific 'program outcomes.' However, basic 'conclusions' can be made. By providing transportation to the elderly and disabled they are able to maintain their health, resulting in a reduction in the mortality rate. Meeting transportation requests for medical, nutrition, essential shopping and business needs influences the number of clients who may be forced into institutionalized care (2000 census indicates a 17.0% decline in the nursing home population in Boone County). Having accessible transportation empowers the client to remain independent, which results in feelings of usefulness and value, all, which helps reduce bouts of depression and doubts of self-worth." (FY 2003 Social Service Proposal, p. 14)

BOONE COUNTY **Ridership Information (July 1, 2001 to June 30, 2002)**		
TRIP PURPOSE	ONE WAY TRIPS	% OF ALL TRIPS
Medical	25,805	54.9%
Employment	6,807	14.5%
Essential shopping	4,597	9.8%
Nutrition	3,861	8.2%
En Route Stops	3,730	7.9%
Business	1,634	3.5%
Recreation	301	0.6%
Education	229	0.5%
Total	**46,964**	**100.0%**
TRIP CLASS	ONE WAY TRIPS	% OF ALL TRIPS
In-Town (Urban Columbia)	34,843	74.2%
In-Town (Rural)	823	1.8%
Within Boone County	5,469	11.6%
Adjoining County	1,084	2.3%
Beyond Adjoining County	1,015	2.2%
En Route Stops	3,730	7.9%
Total	**46,964**	**100.0%**

Client satisfaction measures

The "New Rider Questionnaire" is a survey card given to first time riders. The report compiled from the cards collected during the first quarter of 2003 from the total OATS program was

provided.

- 100% report the drivers and volunteers as helpful, friendly, and courteous
- 61 out of 64 (95%) report they would schedule another trip with OATS
- 100% report the bus was clean and comfortable

State and national indicators that may be applicable

The Federal Interagency Forum on Aging Related Statistics published Older Americans 2000: Key Indicators of Well-Being. (http://www.agingstats.gov/chartbook2000/default/htm) While some of the indicators relating to social contacts may apply to OATS services, there were no other indicators that mentioned transportation services. However, on page 52, in a section on "Data Needs," there is a very important statement.

> "While much is known about the safety issues of crash involvement and fatality rates of older people, more information is needed on the effects of transportation on the quality of life. The ability to move freely from place to place, while often taken for granted, is as crucial to the well being of older people as it is to the rest of the population. For example, access to quality health care is effectively removed if an older person cannot get from his or her home to a medical facility. More data are needed on the **number of trips older people take and the types of transportation they use**. This critical information will aid policymakers in planning for the transportation needs of older Americans."

Current Objectives

OATS lists three main objectives in its Social Services Proposal:

- meet the request for transportation by the residents of Columbia and Boone County
- fleet replacement – maintaining a safe and reliable fleet of vehicles
- reduction in service denials

The outcomes are currently stated as process objectives, giving the number of clients to be provided transportation, the number of vehicles replaced, and the service denials as a percentage of the total trips.

Recommendations

On-going evaluation plan

The mission of OATS is to allow people to live independently in their own communities. By re-stating the objectives and with just a little modification in the type of data already gathered, outcomes objectives could be developed. The following suggestions can be discussed to determine what best fits the goals of the agency and seem most feasible.

It is recommended that the existing New Rider Questionnaire card be modified into a general Rider Questionnaire. If there are compelling reasons to keep the New Rider Questionnaire, it is recommended that an additional Rider Survey card be developed.

To modify the existing New Rider Questionnaire to a customer impact and satisfaction survey, a

question #7 could be added in the space where the "additional comments" are now, asking for a self-reported assessment of the impact the service is having on the individual. This card could then be distributed to all riders at specific intervals. An example of the added question is;

Please tell us the main benefits you get from riding on the OATS bus (mark all that apply):

- ❑ made it possible for me to stay in my own home
- ❑ made it possible for me to maintain good health
- ❑ made it possible for me to get good meals
- ❑ made it possible for me to maintain contact with my friends
- ❑ made it possible for me to continue working
- ❑ made it possible for me to volunteer

If a Rider Survey card is developed, it could be in the same format as the New Rider Questionnaire but distributed to all riders at regular intervals. More questions related to customer satisfaction and the impact of the service could be asked on a card specifically developed for this purpose. A specific time could be chosen during which the driver would distribute the cards to all riders. As an example, the Voluntary Action Center randomly selects one week each quarter during which all clients who come to the agency are asked to complete a survey about the impact VAC has on their lives, their satisfaction with the services, and any needs not being met. OATS could develop a survey schedule that fits its needs; one day each month, one week each quarter, one week semi-annually, etc.

Suggested wording of outcome #1

- A long-term outcome for OATS is that as a result of services provided by OATS, clients are able to live independently in their own homes and community. The immediate outcome is
    - X% of those completing survey cards reported that OATS trips allowed them to remain in their own homes.

Suggested wording of outcome #2

- A long-term outcome for OATS is that as a result of services provided by OATS, clients are able to maintain their health. The immediate outcome is
    - X% of those completing survey cards reported that OATS trips assisted them in maintaining good health.

Suggested wording of outcome #3

The third outcomes objective could relate to a customer satisfaction goal. Using the questions on the current New Rider Questionnaire as an example;

- X% of those completing survey cards marked "yes" to at least 3 of the 4 questions (questions 3 through 6) on the New Rider Survey (indications of satisfaction with the friendliness and attitude of the scheduler and the driver, and the cleanliness and comfort of the bus).

Program Logic Model

OATS submitted a Program Logic Model that was discussed at the on-site visit. It is attached. The evaluator developed an alternate Logic Model that follows this section.

Insert OATS material here 1 page

OATS

Inputs	Activities	Outputs	Outcomes: Initial	Outcomes: Intermediate	Outcomes: Long-term
Board of Directors	Provide medical trips	Number of medical trips provided	X% of those completing survey cards report OATS trips allow them to remain in their own homes	Client maintains control over their ability to live independently in their own homes and community	Individuals able to live in the least restrictive environment
County volunteers	Provide trips for necessary shopping	Number of necessary shopping trips provided	X% of those completing survey cards report OATS trips assisted them in maintaining good health.	Isolation of elderly and disabled is reduced	Rates of depression reduced
Licensed drivers	Provide trips for nutrition	Number of nutrition trips provided	X% of those completing survey cards report OATS has made a significant difference in their lives		Reduction in nursing home placements
Funding sources	Provide trips for socialization	Number of socialization trips provided	X% of those completing New Rider Cards report the driver displayed a friendly attitude and offered assistance		
Grants and contracts	Volunteer fund raising activities	Number of activities held			

SEIZE THE DAY VOLUNTEERS

Program Mission

> "Seize the Day Volunteers provide non-medical support to any person in the Columbia, Missouri, area suffering from a chronic, life-threatening, terminal illness, or disability, regardless of age, disease, or financial situation." (2003 Social Services Proposal, p.5)

Current Evaluation Plan

A questionnaire is sent to clients to assess their satisfaction with their assigned volunteer and to determine if there are additional needs. This questionnaire also has a section that asks clients to determine how these volunteer services add to their quality of life. A questionnaire is sent to volunteers to assess their satisfaction with their volunteer experience. In addition to the questionnaires, telephone calls are placed to clients and volunteers throughout the year to discern any immediate issues.

Evaluations and reviews from funding sources and accrediting boards

Seize the Day is funded solely from donations, so is not subject to any outside evaluation or monitoring.

Follow-up on clients who are no longer in the program

In May, 2002, a self-reporting evaluation was sent to 23 current and former clients of Seize the Day. The report did not say how many of the respondents were former clients. The results from this survey are reported below.

Outcomes for current clients

In May 2002, a self-reporting evaluation was sent to 23 current and former clients of Seize the Day. Fifteen responded. Respondents were asked to report how Seize the Day Volunteers had affected their life.

- 80% reported Seize the Day provided them with greater independence
- 60% reported Seize the Day improved the quality of their life
- 47% reported Seize the Day made it possible for them to remain in their homes
- 47% reported their volunteer prevented them from feeling isolated

Seize the Day reports serving 28 clients in 2001 with the following characteristics.

- 66% women
- 34 % men
- 30% under age 55
- 5% minority

- 5% Boone County residents outside of Columbia

Client satisfaction measures

Seize the Day staff distributes a survey to clients and volunteers to gauge their satisfaction with the services and the volunteer experience.

In May 2002, a self-reporting evaluation was sent to 23 current and former clients of Seize the Day. Fifteen responded.

- 100% rated their assigned volunteer as excellent or very good
- 100% rated their volunteers reliable
- 100% stated they would recommend Seize the Day Volunteers to others
- 93% rated the care given by their volunteer as excellent or very good
- 75% rated the amount of time given by their volunteer as excellent or good

Volunteer satisfaction measures

In May 2002, a self-reporting evaluation was sent to 30 current and former volunteers of Seize the Day. Eleven responded.

- 100% would recommend volunteering for Seize the Day to others
- 73% reported their volunteer assignment was excellent or very good
- 72% rated the overall experience with Seize the Day as excellent or very good

State and national indicators which may be applicable

Since Seize the Day is a fairly unique organization, no state or national indicators applicable to their services could be found.

Current Objectives

Seize the Day has three main objectives:

- provide volunteer services to 80 clients in Columbia that will be evaluated for its benefit in meeting client needs, enabling them to live more independently, and providing support to care-givers
- recruit and train 30 new volunteers, providing them with enriching volunteer experiences and training as reported through volunteer evaluations
- develop and conduct volunteer training and in-service training programs that are complete, informative, and helpful as reported through evaluations of activities. Offer new training courses to area communities of faith to develop a larger volunteer base.

The outcomes as currently stated are more like process objectives, listing numbers of clients and volunteers. The last part of each objective has the potential to become an outcome measure as will be recommended below.

Recommendations

On-going evaluation plan

Seize the Day should continue to administer the client and volunteer satisfaction survey each year. As the number of former clients increases, a separate analysis of scores for former clients could be reported each year as follow-up on former clients.

Suggested outcomes objectives

Seize the Day is currently collecting information that could be used in the formulation of outcomes objectives related to clients. It is recommended that the Board and staff choose some of the following objectives for the Social Services Application.

- X% of clients will report Seize the Day made it possible for them to remain in their homes
- X% of clients will report that Seize the Day provided them with greater independence
- X% of clients will report Seize the Day improved the quality of their life

Some outcomes objectives could also be listed for the volunteers.

- X% rated the overall experience with Seize the Day as excellent or very good

Program Logic Model

Seize the Day did not submit a Program Logic Model. A beginning model developed by the evaluator follows this section.

SEIZE THE DAY

Inputs	Activities	Outputs	Outcomes: Initial	Outcomes: Intermediate	Outcomes: Long-term
Director	Individual assessment of client needs	# of volunteer hours provided	X% of clients report the services made it possible to remain in their own homes	Individuals are maintained in their home as long as possible.	Individuals are maintained in their home as long as possible.
Volunteers	Assignment of appropriate volunteer	# of volunteers	X% of clients report the service provided them with greater independence	Individuals are allowed to continue their employment	Individuals enjoy a high quality of life
Funding sources	Training of volunteers	# of clients served	X% of clients report the service improved their quality of life	Family caregiver stress is reduced	Caregivers remain productive citizens of the community
Family members	Provision of needed services	Impacts # family members of clients	X% of volunteers rated the overall experience with Seize the Day as excellent or very good		Caregivers are able to care for a family member at home to the extent of their ability
		Caregivers able to enjoy # days of respite			

VOLUNTARY ACTION CENTER

Program Mission

The VAC Mission is three-fold:

To serve as the agency of first and last resort:

- by providing information and referral to the social services community
- by providing emergency assistance when local programs are unable to meet critical needs

To provide community-wide volunteer coordination:

- engaging more people in volunteer service
- to help solve serious social problems

To act as a catalyst:

- in identifying
- and addressing

….emerging community needs

City and County funding is provided for two services: the family information, referral, and resource center and essential transportation.

Current Evaluation Plan

VAC has a very good system to track client contacts. VAC is able to track families as well as individuals and the type of service provided. The number of clients served and the number of different services rendered measure success. Once per quarter, clients accessing services during a selected week are asked to complete a questionnaire to gauge satisfaction with VAC's services and to identify gaps in services.

Evaluations and reviews from funding sources and accrediting boards

Other funding sources	HRS reviewed
Points of Light Foundation	Last review 8/22/01. The Board conducted an extensive self-evaluation rating VAC on national standards. VAC meets the standards for governance, management, funding, planning and evaluation, connecting people with opportunities to serve, building capacity for effective local volunteering, promoting volunteering, and participating in strategic initiatives.

Other funding sources	HRS reviewed
Alliance of Information and Referral Systems	A spring 2003 social work class was to take on the project of conducting an external evaluation of VAC according to the standards set by the Alliance of Information and Referral Systems. This did not work out, so the VAC Evaluation Committee is looking for other ways to conduct this evaluation.

Follow-up on clients who are no longer in the program

VAC does not report any follow-up on clients who have left its program.

Outcomes for current clients

VAC staff states that they do not have outcome information on current clients. As stated in the 2003 Social Services Proposal (p.10), "Because we provide emergency services, not case management, we do not have outcome information on individual clients except for those who come back to our office and provide that feedback."

VAC has reported service numbers for 2002 as shown in the tables that follow.

Family Information, Referral, and Resource Center

Summary of Client Contacts	2002 Total	2002 Percentage
Total contacts	**27,202**	
I&R		74.3%
Volunteerism		23.5%
Other		2.2%
Phone contacts	**20,224**	
I&R		78.5%
Volunteerism		15.6%
Other		6.0%
Walk-in contacts	**17,277**	
I&R		72.0%
Volunteerism		28.0%
Other		0.0%
Number of households served	**5,825**	
Persons in households served	**15,442**	
Unduplicated households served	**3,194**	
Unduplicated persons in households	**7,937**	

Client Needs	2002 Total	2002 Percentage
Food	6,560	28.6%
Transportation	5,030	21.9%
Holiday	3,777	16.5%
Miscellaneous	2,121	9.3%
Medical	1,059	4.6%
Clothing	999	4.4%
School supplies	840	3.7%
Other	2,543	11.0%
Total client needs	**22,929**	100.0%

VAC Christmas Basket Program 2002 Summary	Number of Families and Persons Assisted
Families signed up in October (3,382 people)	1,130
Additional families were assisted (138 people)	26
Front Door Teenagers were helped at KMART	24
Boys and Girls Club children were given toys	80
West Boulevard Families (23 people) were assisted at KMART	5
Children were assisted through Operation Sleighride	100
Children were assisted through Big Brothers/Big Sisters	150
Children at Alpha School were given gifts	10
Total Families (3,907 people –1,451 adults 2,456 children)	**1,166**
41 Churches (197 groups) sponsored	495
221 Businesses, University and College Departments, Faculty, and Student Groups, University, Boone and Regional Hospital Groups, Public School Groups, Service Clubs, Social Services Agencies, and Scout groups sponsored	364
124 Individuals and Families sponsored	159

Essential Transportation Program

Essential Transportation	2002 Total
Total trips	**4,375**
Total persons	**514**
Different households	**480**

Characteristics of clients (based on households)	2002 Total	2002 Percentage
Residency		
Inside city limits of Columbia	433	90.2%
Outside city limits – in Boone County	46	9.6%
Other Missouri County	1	0.2%
Gender		
Male	294	61.3%
Female	160	33.3%
Couple/family	26	5.4%
Employment status		
Employed full time	138	28.8%
Employed part time	70	14.6%
Unemployed	272	56.7%
Other characteristics		
Below poverty level	**479**	**99.8%**
Single parent household	**82**	**17.1%**
Homeless	**64**	**13.3%**

Reason for trip (based on total trips)	4,375	
Job	2,161	49.4%
Shelter	1,402	32.0%
Medical services	511	11.7%
Food	100	2.3%
Other	78	1.8%
School	75	1.7%
Bus station	48	1.1%

Client satisfaction measures

VAC surveys a group of clients each quarter to assess their satisfaction level and to assess gaps in services.

The results from the survey administered for the 4th Quarter 2002 are reported here.

Characteristics of respondents

Gender	Number reporting	% of 4th Quarter Clients
Male	13	23%
Female	44	77%

Approximately how many times during the year do you use services provided by VAC?

Times during the year	Number reporting	% of 4th Quarter Clients
1-5	39	71%
6-10	10	18%
11-20	6	11%
21 or more	0	0%

Please identify the type of assistance you have received from VAC this year.

Type of assistance	Number reporting	% of 4th Quarter Clients
Food	35	30%
Employment	2	18%
Utilities	21	15%
Prescription	8	13%
Transportation	17	11%
Medical/dental treatment	4	7%
Other	13	3%
Housing	2	2%
Clothing	15	2%

Has VAC helped you with your needs/request for assistance?

Answer	Number reporting	% of 4th Quarter Clients
Yes	49	86%
No	2	4%
Sometimes	6	11%

If you received assistance from VAC, how would you describe the services?

Rating	Number reporting	% of 4thQuarter Clients
Excellent	31	55%
Satisfactory	18	32%
Good	7	13%
Poor	0	0%

Do you feel that you were treated fairly by staff at VAC?

Answer	Number reporting	% of 4thQuarter Clients
Yes	56	98%
No	0	0%
No response	1	2%

State and national indicators that may be applicable

VAC has or is in the process of conducting self-evaluations based upon standards set by the Points of Light Foundation and the Alliance of Information and Referral Services. These standards related to administrative and reporting structures and provide no guidance for setting indicators or outcome measures.

Current Objectives

VAC has identified three main objectives for each of the funded services.

The Family Information, Referral, and Resource network at VAC has three main objectives:

- provide "extended I & R" services to ___ households. Extended I & R is defined as persons having more than one need, or a need that requires multiple referrals
- provide in-house I & R to ___ households and telephone I & R to ____ persons
- improve collaboration between service providers and work to decrease fragmentation of services by cooperating with __ agencies, by receiving ___ referrals and making ____ referrals to ___ other agencies.

The Essential Transportation Program at VAC has three main objectives:

- VAC will provide ___ units of bus transportation and __ units of car repair
- allocation of transportation services will be based upon a priority set as follows: employment (50% of total), medical appointments, education/training, accessing social service agencies, and shelter
- staff will attend the monthly transportation committee meetings, visit a minimum of __ agencies that work with similar clientele and collaborate with these agencies to increase the accessibility of transportation for all persons.

The outcomes are currently stated as process objectives, giving the number of services to be provided or the number of clients to be served.

Recommendations

On-going evaluation plan

VAC has many of the systems in place to track clients needs and services. They should continue all the present reporting systems.

Change the VAC Service Evaluation form

With a slight change to the existing VAC Service Evaluation form, VAC could collect some information on a quarterly basis that could be reported as outcome measures.

Use a 10 point scale on scaled questions

It is recommended that VAC change several of the questions from the "yes-no" format to a scale of 0 to 10. Using a scale of 0-10 would provide a mean score for each question (the higher the mean score, the higher the satisfaction level) that could be tracked annually. Also, a scale is more sensitive to the actual opinion of the client than a yes-no choice.

Questions 6 currently asks, "Has VAC helped you with your needs/request for assistance?" The choices for responses are "yes," "no," or "sometimes." This could be changed to a scaled question such as,

"On a scale of 0 to 10, with 0 being not at all helpful, 5 being helpful, and 10 being

extremely helpful, rate VAC on how helpful VAC is/has been with your requests for assistance."

Question 8 could also be changed to a scale. Question 8 asks, "If you received assistance from VAC, how would you describe the services?"

> "On a scale of 0 to 10, with 0 being very poor, 5 being satisfactory, and 10 being excellent, rate how you would describe the service provided by VAC."

Question 9 could also be changed to a scale. Question 9 asks, "Do you feel that you were treated fairly by staff at VAC?"

> "On a scale of 0 to 10, with 0 being not at all fairly, 5 being fair, and 10 being extremely fair, rate VAC on how fairly you feel you were treated by the staff."

Add an open-ended question

It is recommended that an open-ended question be added to the VAC Service Evaluation asking how the services impacted their life. The results from this question could then be used as a measure for one of the outcomes objectives. For example:

> "The services I received from VAC helped me in this way (please list) _____"

After a few years of collecting this information, a checklist of the most frequently mentioned results could follow the question. For example:

> "As a result of the help I received from VAC, (check all that apply)
>
> I was able to keep my job
>
> I bought needed prescription medicine
>
> My family was able to stay together
>
> I was able to stay in my own home

Outcome measures for the Family Information, Referral, and Resource Center program

Suggested wording for outcome objective #1

Objective 1: (Using current wording of the question) X% of clients completing the survey report "yes, VAC helped them with their needs/request for assistance."

Objective 1: (Using the scale) X% of the clients completing the survey will rate VAC at 7.0 or higher on a scale 0 to 10, with 0 being not at all helpful, 5 being helpful, and 10 being extremely helpful.

Data collection for objective #1

Answers to question 6 in its current or the suggested revised form could collect information for measurement of outcomes objectives.

Suggested wording for outcome objective #2

Objective 2: (Using current wording of the question) X% of clients completing the survey report VAC services as excellent.

Objective 2: (Using the scale) X% of the clients completing the survey will rate VAC at 7.0 or higher on a scale 0 to 10, with 0 being very poor, 5 being satisfactory, and 10 being excellent.

Data collection for objective #2

Answers to question 8 in its current or the suggested revised form could collect information for measurement of outcomes objectives.

Suggested wording for outcome objective #3

The recommended new open-ended question could provide information for an outcomes objective related to the impact of the services on the client.

Objective 3: X% of clients completing the survey will report that services from VAC allowed them to keep their family together.

Recommended outcomes for the Essential Transportation program

Using the same VAC Service Evaluation, all clients who reported receiving the Essential Transportation service could be subjected to a sub-group analysis. Their scores could be used to set baselines and to track outcomes for this sub-group of clients.

Objectives 1 and 2 would be the same as listed for the Family Information, Referral, and Resource Service. For Objective 3, responses relating to being able to keep a job would provide a logical indicator of the outcome for the client.

Program Logic Model

VAC presented Program Logic Models for several of its programs. They are attached to this report.

Insert VAC materials here 7 pages