ShareCare of Leelanau, Inc.

Evaluation Report

February 2015

SCHOOL OF SOCIAL WORK
UNIVERSITY OF MICHIGAN

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Purpose of the Report

In 1993, ShareCare, a unique, non-profit 501(c)(3) corporation, was founded by a group of retirees who wanted to overcome the problems that so often force seniors to leave their homes prematurely. They created this membership organization to offer Leelanau County residents comprehensive and affordable supportive services.

ShareCare offers access to services delivered by health care professionals, experienced caregivers, trusted local independent contractors and a caring network of volunteers based in local communities. ShareCare promotes the independence and well-being of its members by providing convenient access to services and programs that help them remain in their own homes—living as independently and safely for as long as possible.

In 2014, the University of Michigan School of Social Work collaborated with ShareCare of Leelanau, Inc. to conduct a descriptive outcome evaluation of the ShareCare program. Evaluation stakeholders included ShareCare board members, staff, volunteers, ShareCare members, Presbyterian Villages of Michigan, Community Connections of Michigan, Luella Hannan Foundation, and the University of Michigan School of Social Work.

This report provides ShareCare stakeholders with findings from this descriptive outcome evaluation.

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Executive Summary

In the summer of 2014, ShareCare engaged in an external independent evaluation to learn what difference the organization makes in the lives of its members. This report presents the results from a randomized survey of ShareCare members. The University of Michigan School of Social Work guided the evaluation research process. Rachael Wiener, MSW, a recent graduate student, served as the lead field-based evaluator through a summer residency in Lake Leelanau, Michigan, the location of ShareCare's office..

ShareCare stakeholders such as board members and staff contributed substantial time to the guidance, development and delivery of this final report.

Before the collection of self-reported impacts from members, and to answer the broader question, "How do members feel about ShareCare?", a ShareCare Satisfaction Survey was mailed to members. In that study, 75 percent of respondents indicated that ShareCare played a role in their lives. The majority reported feeling satisfied and fulfilled by their ShareCare experiences.

To document member impact, a randomized survey was designed to capture service access, health quality of life, social connectedness and self-efficacy of ShareCare members. These life domains were selected by stakeholders where ShareCare's services were likely to have the largest impact on these areas. The survey process involved interviewing 100 of the 395 ShareCare members, stratified into groups based on length of membership.

Based on research that identified several factors that might also influence impact and outcomes, this study analyzed gender, age, length of membership, household composition, and type of housing as control variables. Self-rated health is of interest as a stand-alone impact measure, but it may also influence perceptions of impact. Thus, self-rated health was reported separately as an impact concept, and then used as a control measure in other aspects of the analysis. ,

<u>Sample Characteristics</u>

- Length of membership results indicated that 46 percent of ShareCare members held their memberships for five years or less. Twenty-two percent were members for 16 to 20 years. These figures mirrored the length of membership for the full membership.
- Almost three-quarters, 73 percent of the respondents, were female. The largest group of respondents was between 70 and 79 years of age. Thirty percent lived alone. Almost all respondents (98 percent) lived in single-family homes.
- Self-Reported Health: A large majority (91%) reported their health as very good or good.

What Were the Impacts?

- Among the four domains, the two that generated the highest level of response were access to services and health quality of life. Members were generally positive about the impact of ShareCare on their happiness and quality of health. Residents in poorer health answered more access questions, perhaps indicating greater familiarity resulting from greater need for services.
- For the self-efficacy domain, Sharecare was strongly endorsed as helping people stay in their homes.
- For social connectedness, a majority of members indicated they know more people as a result of ShareCare and feel more connected because of the program.

Some important differences noted among the demographic categories can serve as the basis for selectively targeting programs to the types of individuals who were less involved or not as likely to answer the questions.

Women were more likely than men to credit ShareCare for increasing their use of community resources and keeping relatives informed (access). Women were somewhat more likely than men to describe ShareCare as contributing to their overall health (health quality of life) and to their ability to leave home more than they used to (self-efficacy).

The youngest and oldest respondents were similar in their response patterns and often differed from the mid-age category (70 to 79). The youngest and oldest described ShareCare as positively impacting their quality of life (health quality of life) and keeping relatives informed (access).

The 70 to 79 year age group volunteered more than the other age groups and was somewhat more likely to participate in activities (social connectedness).

The respondents who lived alone were more likely than others to credit ShareCare as positively impacting their quality of life (health quality of life). They were also more positive than others about their ability to take care of themselves (self-efficacy) and about keeping relatives informed (access).

Open-ended questions allowed respondents to give a wider range of responses and clarify their perceptions. Twenty-three percent said they joined ShareCare because of an element of social connectedness, but that is not why they remained members.

Nine percent of respondents indicated they joined ShareCare because of the services and resources provided, but one-third described access and utilization of services as the most valuable aspect of their membership. ShareCare was described as offering a sense of security in case they might need services.

Utilization of Findings

This report provides the perspective of a representative sample of individual residents concerning the impact ShareCare had on their lives in four specific areas. The next step for utilizing these findings might be a data interpretation session to provide the stakeholders with an opportunity to discuss the importance of various findings. For example, some stakeholders might view expanding

the member knowledge about the services and increasing volunteering as primary goals. Others might focus on the more positive perceptions of women compared to men.

These results indicate that ShareCare is more important to those who were older and more physically vulnerable. Leadership may want to consider ways of branding its services to increase the engagement of younger members.

Establishing a management information system that can track usage and link evaluation responses of impact to those data would enhance understanding of impact over time and may be an appropriate next step as well. Planning and policy development committees or task forces can broaden the discussion about what next steps should be taken with these study findings.

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Introduction

In 1993, ShareCare, a unique, non-profit 501(c)(3) corporation, was founded by a group of retirees who wanted to overcome the problems that so often force seniors to leave their homes prematurely. They created a member-organization to offer Leelanau County residents comprehensive, affordable support services.

ShareCare promotes the independence and wellbeing of its members by providing convenient access to services and programs that maintain and improve their quality of life and help them remain in their homes – living as independently and safely for as long as possible. Share Care offers services provided directly by ShareCare staff and member-volunteers. It also provides information about and referrals to health care professionals, professional caregivers, and trusted local independent contractors.

ShareCare recently celebrated 20 years in operation serving seniors in Leelanau County, Michigan. With this accomplishment came this question: what difference has ShareCare made in the lives of its members? In other words, what has worked? What could be improved? What is the ShareCare story?

Several individuals representing a variety of groups worked to gather historical, administrative, and new research data to answer these questions. Stakeholders in this project include: ShareCare Board members, staff, volunteers, ShareCare members, Presbyterian Villages of Michigan, Community Connections of Michigan, Luella Hannan Foundation, and the University of Michigan School of Social Work.

In a preliminary planning step in June 2013, 134 out of ShareCare's 245 households completed a ShareCare survey of their use of and satisfaction with ShareCare services (55-percent response rate). This survey found that 75 percent of the households felt "fairly well informed" about ShareCare services. The most utilized services of these households in the past year were access to free medical equipment (31 percent) and in-home care need assessment (25 percent). One-fifth indicated they had "no contact at all" with ShareCare services or staff. Three-quarters of those who had used services "agreed" or "strongly agreed" that their needs had been met, and another 13 percent were "neutral."

The present report provides a brief overview of the service survey results and the services ShareCare provides as a context for the descriptive outcome study conducted by the University of Michigan. The main body of the report describes and interprets the quantitative and qualitative data gathered from a randomized survey that focused on capturing the impact of ShareCare services.

The research methods utilized to obtain a sample of ShareCare residents are explained. Findings from the survey are presented along with discussion of implications of the findings.

Available upon request, is a separate report containing a summary appendix to the present study. That report includes material that served as background for the development of the survey and assisted in its interpretation. It also contains information on the history of the organization and issues it has dealt with over the years and as sources of explanation and contextualization of the findings.

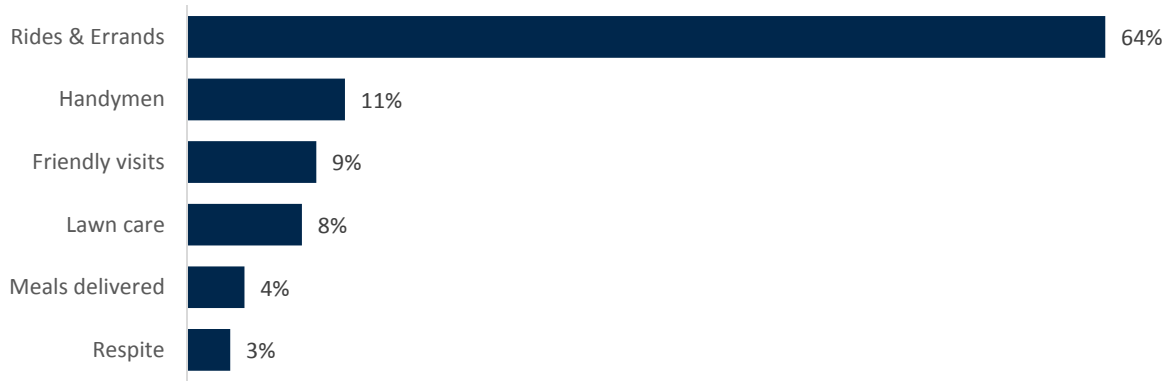
What is ShareCare? Services and Programs

Volunteers, two staff members, and board members are responsible for delivering ShareCare's services and organizing member programs. The staff members include the Care Coordinator, who is a Registered Nurse (RN) and the Volunteer Coordinator/Office Manager.

ShareCare, founded on the principle of volunteerism, encourages members to contribute to ShareCare as a volunteer as well as being a recipient of services. The concept of "Neighbors Helping Neighbors" has been a core value of the organization since its founding and is something for which it is known in the larger community.

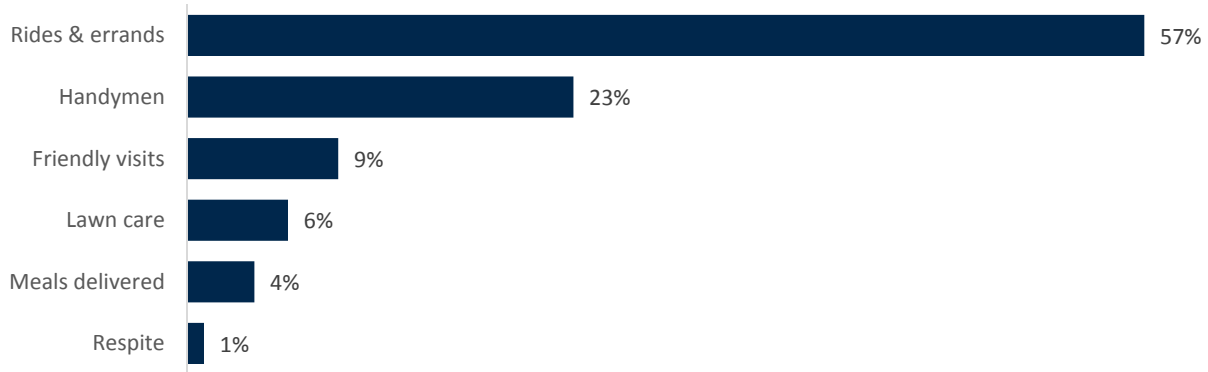
The most used services provided by volunteers in 2013 were transportation and running errands for members (64 percent in 2013). Handyman, friendly visits, and lawn care ranged from 11 to 8 percent. Less frequent were the services provided when a member is particularly needy, such as the provision of home-delivered meals and respite for a caregiver (Figure 1).

Figure 1. Frequency of services provided by volunteers (2013).



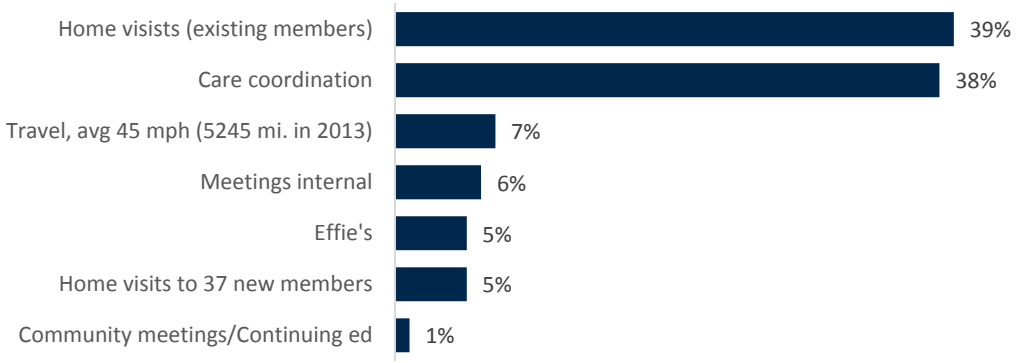
In terms of actual hours of help provided rather than type of help provided, the category of transportation and errands still dominated, but handyman services accounted for 23 percent of the total time spent by volunteers (Figure 2).

Figure 2. Percentage of time spent on services provided by volunteers (2013).



The Care Coordinator has the primary responsibility for assessing the needs of members, coordinating the services that are provided by ShareCare and others, and monitoring the health status of members, especially the most vulnerable, through home visits and by phone. All new members are visited in their homes, at which time basic health information is collected and ShareCare services and volunteer opportunities are explained. Home visits, including travel time, account for about a half of the time of the Care Coordinator. Additionally, 39 percent of the Care Coordinator's time is spent on more complicated cases, working with a member and his or her family to develop a plan of care and, in many cases, helping to coordinate the various services to be provided. This work is frequently done in cooperation with the Volunteer Coordinator/Office Manager. Currently, the Care Coordinator is also providing nursing services to residents at an assisted living residence (Effie's), all of whom are ShareCare members. The activities of the Care Coordinator are outlined in Figure 3.

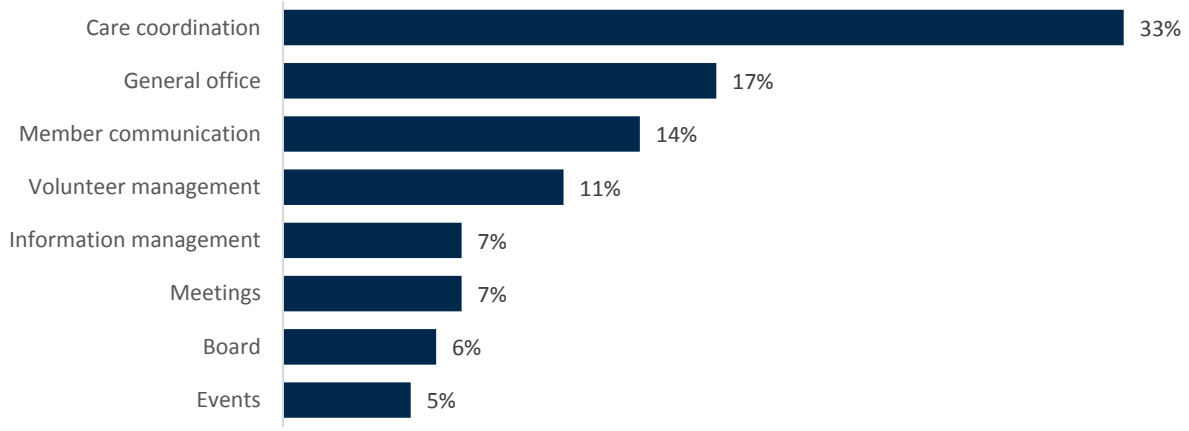
Figure 3. Percentage of time spent by Care Coordinator (2013).



The recruitment and deployment of volunteer service providers is the responsibility of the Volunteer Coordinator/Office Manager, working in close cooperation with the Care Coordinator and volunteer leaders in the different areas of the county served by ShareCare. The Volunteer Coordinator/Office Manager also spends about a third of her time in care coordination.

The Volunteer Coordinator/Office manager also handles phone calls for general assistance, information, referrals to local resources, and/or reassurance, including making sure that the phone is covered during all business hours. In addition, the Volunteer Coordinator/Office Manager is responsible for general communication with members, including the production of a bi-monthly newsletter than contains stories about pertinent resources, events, and other topics of interest to members. Furthermore, the Volunteer Coordinator/Office Manager provides general office support for the organization. The breakdown of the Volunteer Coordinator/Office Manager's time is outlined in Figure 4.

Figure 4. Volunteer Coordinator/Office Manager percentage of time on responsibilities (2013).



Although ShareCare's two staff members have different responsibilities, in practice they operate as a team, often covering for each other, particularly when a difficult situation develops or a member is in need of immediate help. At these times, volunteers often step forward to help as well.

The ShareCare Board plays an important role in the provision of services. Most Board members are also volunteer service providers in addition to their Board responsibilities. The Board sets policy and the Board chair is the Chief Executive Officer. The Board raises all the funds necessary annually for operations, over and above the member dues, which cover approximately 40 percent of ShareCare's annual budget. The Board designs and staffs special educational and social events, and oversees and staffs a regional network of people that helps maintain contact with members and assist with volunteer recruitment. The Board monitors the quality of the program, intervenes and supports staff when a member-related issue needs resolution, and makes changes in the overall program as needed.

What is the Impact?

Methodology

The purposes of this report and the survey of ShareCare members are intended to answer the question: What is the impact of ShareCare on the lives of its members? A randomized survey of members that included both quantitative (forced-choice items) and qualitative (open-ended) questions was conducted in June 2014. A random sampling technique selected 225 names from ShareCare's 395 members. ShareCare staff identified 30 names where mental and physical health limitations would preclude participation, resulting in a final list of 195. These individuals were then stratified into groupings based on their length of membership in ShareCare. Within each group, names were randomly selected for contact until the requisite numbers selected for that group had been interviewed. The length of membership was categorized as 5 years or less, 6 to 10 years, 11 to 15 years, and 16 to 20 years. Phone calls were made over a 2-week period. The final sample (n=100) reflected the same proportional length of membership as was true for the entire membership of ShareCare.

The questionnaire administered to 100 members was focused on different domains of services and quality of life. Stakeholders and leaders from the organization worked closely with the research staff to identify domains of interest, such as health and wellbeing, access to services, independence and self-efficacy, and relationships or connectedness to others. Together, these domains reflect aspects of quality of life. Background research, such as the satisfaction survey completed earlier in the summer, also helped guide the decision of what domains to pursue in the questionnaire.

Impact variables and questions that measure different aspects of the areas of interest were selected from the research literature, and scale development and independent measures for analysis were guided by peer-reviewed studies. Because impact and outcomes related to service utilization and health and wellbeing are known to be associated with many factors, the authors selected the following variables as independent measures or controls: gender, age, length of membership, household composition, and type of housing. Self-rated health is both an impact and outcome variable and will be discussed first after describing the sample.

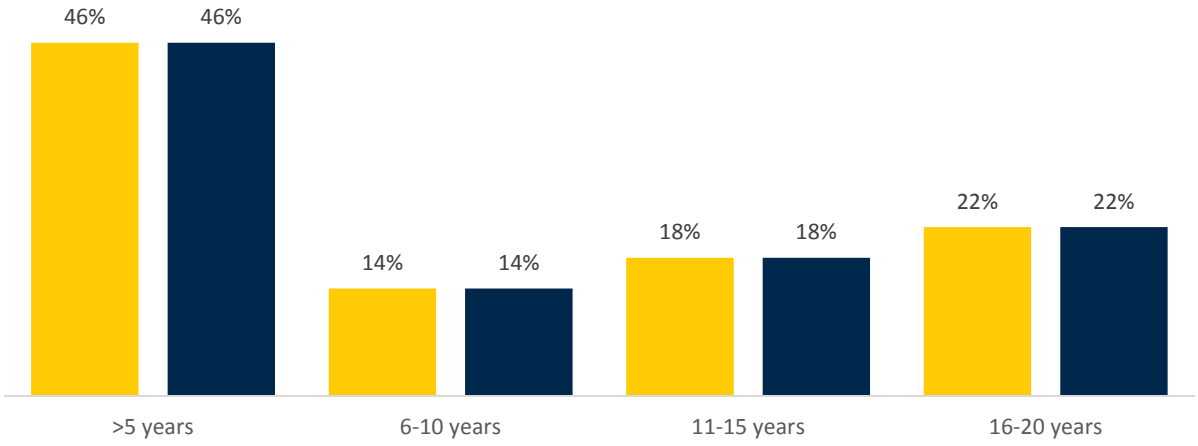
Impact variables were grouped into service access, health, quality of life, social connectedness, and self-efficacy, with multiple queries included in each domain. A cumulative index was calculated for each of the four areas. These groupings were then tested using classification analysis to confirm their validity as an index. The alpha scores ranged from .76 to .79, indicating that the single questions that were grouped into each index were correctly grouped. However, large percentages of selective nonresponses within each grouping resulted in index totals that reflected the perceptions of only a small number of respondents. For example, in the service access grouping, only 13 individuals answered all the questions. The questions were worded to assure that any changes or impacts reported were actually associated with ShareCare's services. An assumption was made that a NA (not applicable) meant that the individual did not link any changes identified in a particular query with his/her membership in ShareCare. The decision was made to present the individual questions organized by index definition so that the NA response could be understood. Patterns of

nonresponse and a summative index of numbers of questions answered within the index were then reported.

Sample Stratification

The sample of 100 ShareCare members reflected the proportions of membership based on how many years they had been a member (Figure 5).

Figure 5. Length of membership comparison between organization (n=395) and sample (n=100).

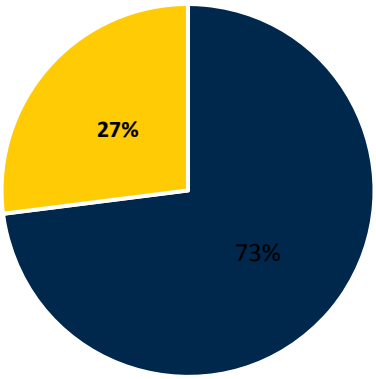


Sample Characteristics

Gender

The majority of participants who completed interviews identified as female (Figure 6); 73 female participants (73 percent) were interviewed and 27 male (27 percent).

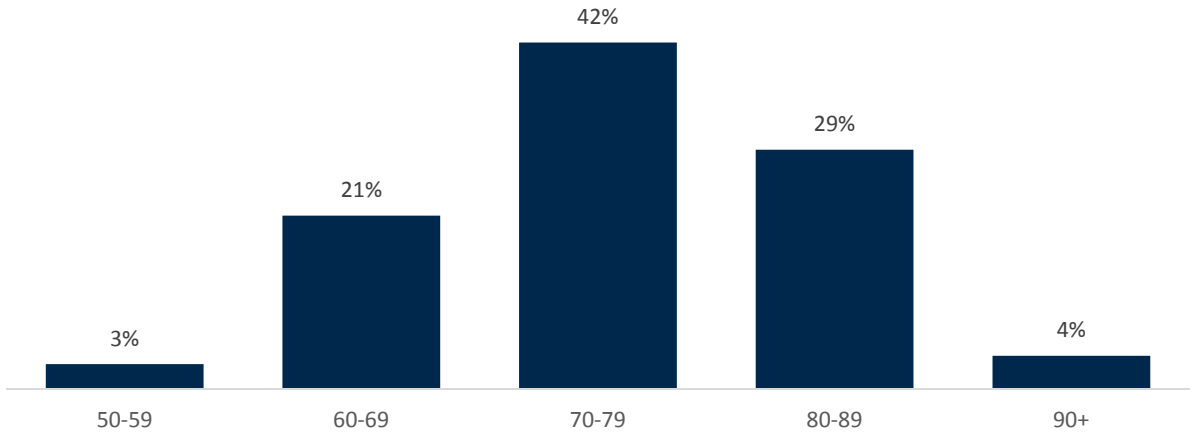
Figure 6. Percentage of male and female participants (n=100).



Age

The majority of participants (42 percent) who completed interviews were between 70 and 79 years of age, and 29 percent of participants were between 80 and 89 years of age (Figure 7). Because the percentages of individuals in the 50-59 and 90-100 age groups were small, they were combined with other age groups so that the later analyses in the study reported the independent variable of age as 69 or younger, 70-79, and 80 or older.

Figure 7. Age of participants in sample (n=99).

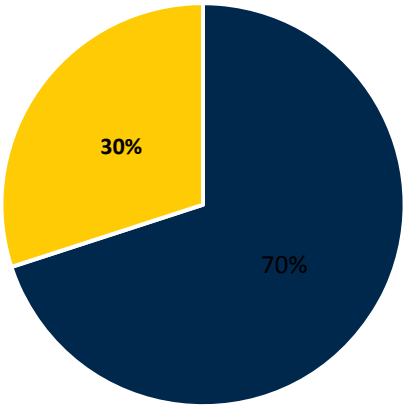


In this and all subsequent graphics, the number who actually answered the question is included in the graphic title. In some cases, a respondent may have refused to respond to a particular question and thus the number does not equal 100.

Household Composition

A majority of participants (70 percent) lived with others, while 30 percent lived alone (Figure 8).

Figure 8. The majority of participants lived with others compared to those who lived alone (n=100).



Household Type

Because almost all (97 percent) of the participants lived in single-family homes, this variable was dropped as an independent measure in further analyses (Figure 9).

Figure 9. Household type of sample (n=99).

Self-Reported Health

A majority of participants reported their health as "Very Good" or "Good" (91 percent). The remaining 8 percent reported "Fair" or "Poor" health status (Figure 10). For analysis, "Fair" and "Poor" were collapsed into one category due to small numbers.

Figure 10. Participants' self-reported health status (n=99).

Member Responses by Domain

Four indices reflecting the four domains were developed for the survey questions to members. The four indices and the questions that make up that measure include:

Service Access Index: As a ShareCare member…

- I have more access to useful information about community resources than I used to
- I use community resources more than I used to
- I am more likely to get the medical care that I need, when I need it
- I am more likely to know how to get assistance of any kind when I need it
- I have had an easier time transitioning home after hospitalization or injury than I used to

Healthy Quality of Life Index: As a ShareCare member…

- ShareCare contributes to my overall health
- ShareCare contributes to my overall happiness
- My quality of life is better than it used to be

Self-Efficacy Index: As a ShareCare member…

- I have an easier time taking care of myself than I used to
- I have an easier time taking care of my home than I used to
- My relatives are more informed about my needs and health than they used to be
- I am more likely to be able to stay in my own home as I get older because of ShareCare

Connectedness Index: As a ShareCare member…

- I know more people than I used to
- I leave my home more than I used to
- I participate in activities and events more than I used to
- I volunteer more than I used to
- I feel more connected with other people than I used to

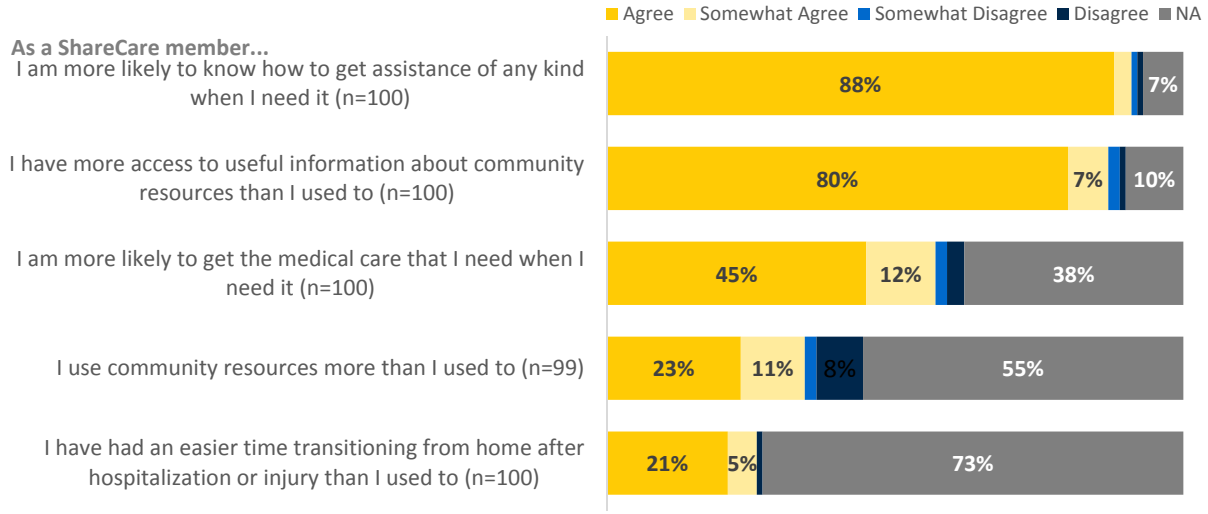
The following figures (Figures 11-14) display the frequencies of responses for each question within the index, including when a member responded "NA" (not applicable). The frequencies that include the "NA" responses are presented first to provide a perspective on the number of respondents who did not perceive ShareCare impacted them on that particular variable. For those who did associate ShareCare with these issues, the overall reaction was substantially positive, particularly in the cases of getting assistance and information.

Service Access

The question that addresses issues about transitioning from hospital to home would be expected to have a large number of "NA" responses, since most respondents had not been hospitalized (Figure 11).

The average number of questions answered for this domain was 3.15. Respondents in the age category of 70-79 years averaged a higher number of responses and the less than 70 years group the lowest number of responses. These differences were statistically significant ($p<.02$). Health status also significantly impacted the number of questions answered. Individuals with "fair" or "poor" health answered a higher number of questions (3.7) when compared to those in "very good" health (2.8, $p<.02$). Length of membership impacted the number of questions answered with the most recent members answering fewer questions (2.8) and the longer term members ranging from 3.3-3.6 questions ($p<.02$). An additional query looked at the individuals who were able to respond to at least one of these questions versus those who gave no response to any. Thirteen percent were able to relate ShareCare to each of the queries, and two percent did not relate ShareCare to any of the access issues.

Figure 11. Service access index question frequencies.[1]



[1]For categories below 5 percent, the numerical value is not labeled

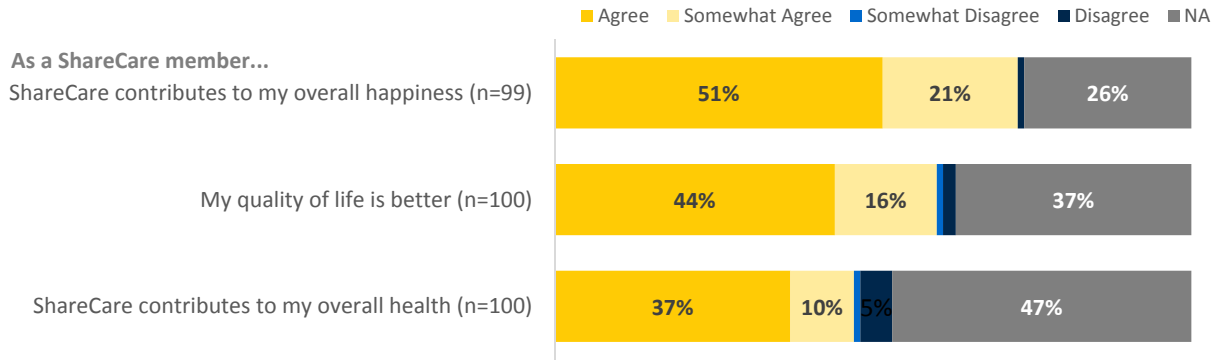
When analyzing responses of those individuals who did not answer the individual questions that comprise the index, gender was the only independent measure that significantly impacted any of the service access queries. Women were more likely than men to rate "I use community resources more than I used to" ($p<.05$). Women also reported ShareCare helped them have an easier time transitioning home after hospitalization than men. This score approached significance, but fell below the $p=.05$ level.

Health Quality of Life

For the health quality of life index, almost half the respondents answered all three questions. The average score for answered questions on the health quality of life scale was 1.8. Average number of questions answered increased significantly as health status decreased ($p<.04$) and older respondents were more likely than younger respondents to answer more questions ($p<.02$). Respondents who had been ShareCare members for 11-16 years answered more questions than other members. ($p<.004$). Gender and living arrangements had no impact on this pattern.

A large majority of those who were able to evaluate ShareCare's impact "agreed" or "somewhat agreed" that ShareCare contributed to their overall happiness. Two-thirds of respondents described ShareCare as positively impacting their quality of life. Almost half (47 percent) credit ShareCare with making their lives healthier. The same percentage did not respond to the healthier lives query (Figure 12).

Figure 12. Health Quality of Life index question frequencies.[2]



[2] For categories below 5 percent, the numerical value is not labeled

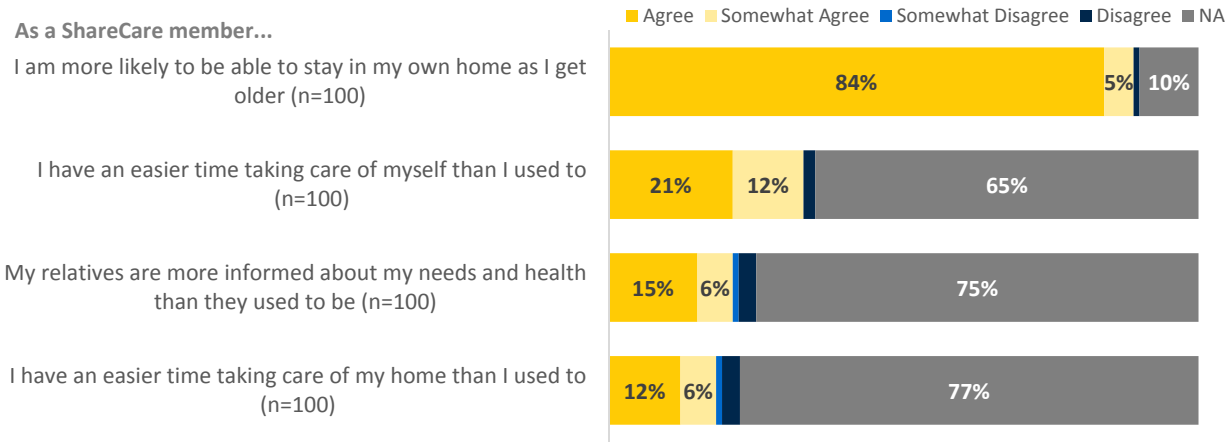
For those who did respond to the questions, the youngest and oldest groups were more positive about ShareCare than were those in the 70-79 age group ($p<.05$). Those individuals who lived alone were also more positive about ShareCare than those who lived with others ($p<.05$). Women were somewhat more positive than men about the statement, "ShareCare contributes to my overall health," ($p<.10$), and youngest and oldest members rated ShareCare higher in contributing to their overall happiness than were the 70 to 79 year old group ($p<.10$).

Self-Efficacy

On the self-efficacy domain, respondents answered an average of 1.8 questions out of a possible four. Older respondents were more likely to answer a higher number of questions (2.3) than were younger respondents (1.3), as were respondents whose health status was in the "fair" or "poor" range, 2.5 ($p<.001$). Length of membership also impacted the number of questions answered with longest-term members providing the highest number of responses, 2.3. Individuals who lived alone also answered a higher number of questions than those who lived with others, 2.2 ($p<.005$). Gender did not impact the number of responses.

On the individual queries, the more positive responses centered on ShareCare's role in helping members stay in their own homes as they aged. Of those who responded to the next three queries, when there was a perception that ShareCare had impacted them, their evaluation was positive, but from two-thirds to three-quarters of the respondents did not associate ShareCare with these issues. Only 10 respondents answered all of the questions associated with this domain (Figure 13).

Figure 13. Self-Efficacy index question frequencies.[3]



[3] For categories below 5 percent, the numerical value is not labeled

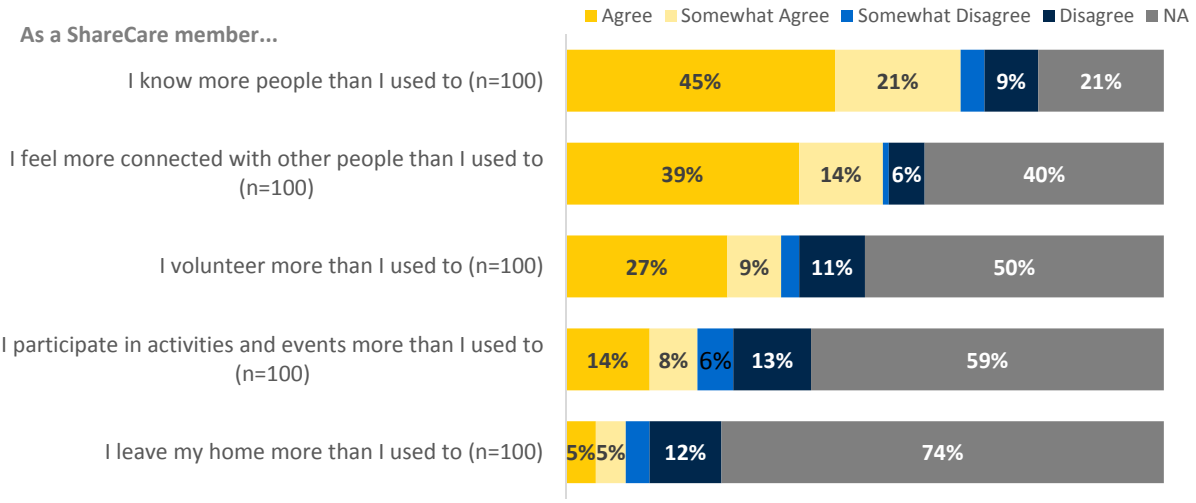
For those answering the individual questions in this domain, women were more likely than men to believe their relatives were better informed about their health than they used to be ($p<.05$) and the most recent and longest-term members were more positive on that statement than were those who were in the middle categories of length of tenure with ShareCare ($p<.05$). Several other differences approached significance as well. Longest term members were more likely than shorter term members to indicate they had an easier time taking care of themselves than they use to ($p<.10$), as did members who lived alone versus those who lived with others ($p<.07$). Those who lived alone also "agreed" that their relatives are better informed than they used to be ($p<.08$).

Social Connectedness

Respondents answered an average of 2.6 questions out of a possible five. Respondents with the best health status answered the fewest questions ($p<.0001$). This variable was the only one among the independent predictors that resulted in a statistically significant difference. Neither gender, nor age, nor length of membership, nor living alone resulted in any identifiable patterns.

Sixteen individuals answered all of the social connectedness queries, but 14 answered none of them. Non-response was not associated with any of the independent measures. Two-thirds of the respondents "agreed" or "somewhat agreed" that they know more people than they used to because of ShareCare and more than half reported feeling more connected than they used to because of ShareCare (Figure 14).

Figure 14. Connectedness index question frequencies.[4]



[4] For categories below 5 percent, the numerical value is not labeled

The oldest respondents credited ShareCare with leaving their home more than they used to ($p<.05$), and the 70-79 year old respondents indicated they volunteer more now because of ShareCare than did the younger respondents ($p<.05$). Women were somewhat more likely than men to indicate they leave their homes more than they used to ($p<.10$), and the 70-79 year old group indicated they participated in more events than they used to ($p<.10$).

The ShareCare Experience: Qualitative Responses

The interview experience provided an opportunity to capture responses to forced-choice question. In addition, each survey allowed the respondent to answer an open-ended set of queries that allowed more discussion and elaboration on their responses. These responses were reviewed and grouped into categories or themes. Respondents were allowed to provide more than one response to each question. In the table below, the number of respondents is indicated as "M" and the number of responses they made as "R." Percentages were calculated based on the number of "R." The categories of responses are presented below for the reasons why members joined ShareCare.

Why did you originally become a member of ShareCare? (M=98, R=219)	
Great idea and organization for self	28%
Security, reassurance, help if needed	*19%*
Social connectedness	23%
Know/knew people involved	*15%*
Alone/far from relatives	*6%*
General	*2%*
Altruism	15%
Volunteerism	11%
Services and resources	9%
Aging in place	9%
Health and wellbeing	6%

Members most often indicated that the reason they became a ShareCare member was because it was a great organization and idea for them (28 percent); this response included the feeling of security and reassurance of knowing someone to call for help if needed. Twenty-three percent also attributed his or her membership to previously knowing someone involved in the organization.

The most frequently mentioned response to why people continue their ShareCare membership reflected their original reason for joining – that it was a great idea and organization and offered security and reassurance if ever in need of help (32 percent). The second most indicated response (19 percent) was a sense of altruism and the feeling that the organization was not only a good idea for themselves, but others in the community as well. Whereas many members joined because of social connectedness (23 percent), only 9 percent indicated that as a reason they continued their membership. The categories of responses are presented below (next page) for the reasons why members continue to stay involved with ShareCare.

Why do you continue to be a ShareCare member? (M=99, R=202)	
Great idea and organization for self	32%
Security, reassurance, help if needed	*24%*
General	*8%*
Altruism	19%
Services and resources	14%
Volunteerism	12%
Social connectedness	9%
Health and wellbeing	8%
Aging in place	6%

When asked why people join, nine percent indicated the access to services and resources was the reason for joining. When asked why people continue to be members, the access to service response increased to 14 percent. When asked what has been the most valuable or helpful part of their ShareCare membership, services and resources was the most cited response (33 percent). Still very important, with 18 percent, was the sense of security and reassurance. The categories of responses are presented below for what members have found to be the most valuable or helpful.

What has been the most valuable or helpful to you? (M=100, R=242)	
Services and resources	33%
Equipment	*10%*
Connection with staff	*8%*
Driver of the day	*2%*
Referrals to doctors, medical facilitates	*2%*
Referrals to outside contractors	*1%*
Keeping relatives informed	*>1%*
General/other	*10%*
Great idea and organization for self	19%
Security, reassurance, help if needed	*18%*
General	*>1%*
Health and wellbeing	13%
Volunteerism	13%
Social connectedness	7%
Haven't used ShareCare	8%
But…	*4%*
So I have nothing to contribute	*3%*
I have not seen a value	*>1%*
Altruism	4%
Aging in place	2%

The categories of responses are presented below for how ShareCare could improve. The most frequent response indicated that ShareCare is fulfilling their needs (28 percent). Many mentioned an area related to the administrative aspects, such as general administrative support (9 percent), more financial resources (5 percent), an improved co-captain system (4 percent), and improved communication to current members (3 percent).

How could ShareCare improve? (M=99, R=159)	
Nothing, ShareCare is great	28%
Administrative	21%
General	*9%*
Financial	*5%*
Co-Captain system	*4%*
Communication to current members	*3%*
No opinion, haven't used ShareCare, don't know	16%
Membership composition and recruitment	10%
Services and resources	10%
New service	*7%*
Improve a current service	*3%*
Volunteering	7%
More opportunities	*4%*
Training, preparedness, organization	*3%*
Social connectedness (activities/opportunities)	6%
Want	*4%*
Do not want	*3%*
Other	2%

The categories of responses are presented below if respondents had any challenging or negative experiences with ShareCare. A majority of respondents expressed no challenges or negative experiences as a ShareCare member (65 percent). Ten percent expressed a challenge with volunteering, caregiving, or serving on a committee. Five percent spoke of feeling guilty for not giving back to the organization.

Have you had any challenging or negative experiences with ShareCare? (M=99, R=113)	
None	65%
No…But…	16%
Challenges with volunteering or caregiving	*6%*
Challenges on a committee or the Board	*4%*
Negative experiences with social events	*3%*
Challenges with communication	*2%*
Challenges asking for help	*1%*
Yes	15%
Feelings of guilt for not giving back	*5%*
Negative experiences with services	*4%*
Challenges with co-captain system	*2%*
Challenges maintaining membership financially	*2%*
Challenges with membership composition	*1%*
Challenges with social events	*1%*
Personal, not related to ShareCare	4%

Summary and Conclusions

The randomized survey of members focused on four domains: access, health quality of life, self-efficacy, and social connectedness. The two domains that generated the highest level of responses were access to services and health quality of life. Members were generally positive about the impact of ShareCare on their happiness and quality of health. Respondents in poorer health also answered more of the access questions, perhaps indicating greater familiarity with it due to need for and use of services. For the self-efficacy domain, ShareCare was strongly endorsed as helping people stay in their homes. For social connectedness, a majority indicated they knew more people as a result of ShareCare, and more than half felt more connected because of the program. Some important differences among the demographic categories were noted in each of the domains. These differences are important as they can serve as the basis for selectively targeting programs to the types of individuals who are less involved or not as likely to be able to answer the questions.

- Of the members who indicated that ShareCare played a role in their lives, the majority of them are positively impacted by their membership.

- Individuals age 70-79 were more likely to answer questions about access than were other age groups, as were members with "fair" or "poor" health. These are individuals who may have

had more opportunity to interact with the ShareCare program. Respondents who joined recently answered fewer access questions, perhaps indicating they had not yet had a need for the services. Older and less healthy individuals were more likely to answer the health index questions, possibly indicating their increasing need for health and wellbeing activities as their age increases and/or their health declines. Older and less healthy individuals and those that lived alone responded to more of the self-efficacy index questions. Members with the highest health status scores were least likely to answer the social connectedness index questions, perhaps indicating less need for ShareCare to assist in these areas of their lives. The ability to answer the question reflects only that the respondent has interacted with ShareCare in some way but it does not provide information concerning actual impact.

Demographic Differences on Individual Queries

- Women were more likely than men to credit ShareCare for increasing their use of community resources and keeping relatives informed. They were also somewhat more likely than men to describe ShareCare as contributing to their overall health and to their ability to leave home more than they used to. Women viewed the post-hospital transition experience more positively than men.
- Youngest and oldest respondents were more similar in their responses and often differed from the mid-age category (70-79 years) in their perceptions. The youngest and oldest described ShareCare as positively impacting their quality of life and keeping their relatives informed. The 70-79 year group volunteered more than the other age groups and was somewhat more likely to participate in activities.
- Those individuals who lived alone were more likely than others to credit ShareCare as positively impacting their quality of life. They were also somewhat more positive than others about their ability to take care of themselves and about keeping relatives informed.

Members Joined and Remain Members for Different Reasons

Social Connectedness is important to some.

Qualitative data from the 100 member interviews: twenty-three percent of respondents said they joined because of an element of social connectedness; only 9 percent indicated they are still members today because of social connectedness, and 7 percent say it is the most valuable part of their ShareCare experience.

Oftentimes the reason a member joins and participates with an organization changes, especially if those motivations are being met by the organization.

The importance of particular services changes over time.

Only 9 percent of respondents indicated that they joined ShareCare because of the services and resources they provided. Fourteen percent indicated services and resources as a reason they were still members today; one-third of the members went on to say that the most valuable aspect of their membership with ShareCare was related to services and resources they provided.

Members joined under the premise that they would not need services themselves, and then found that the services they did need became the most valuable aspect of their membership. This pattern was supported through both the qualitative and quantitative responses of members.

The belief that ShareCare is a great organization and offers a sense of security leads many to join and remain members.

Consistently, either the first or second most indicated response for why a member joined, stayed, or what is most valuable to members is the belief that ShareCare is a great organization for them. It offered a sense of security and reassurance that if and when they might need anything, ShareCare would be there for them.

The concept of being "insurance" for the future is used often in recruiting members. This "branding" of what ShareCare can offer to members, especially in the younger age brackets, is a meaningful consideration.

Limitations of the Study

Although this study was designed to use both quantitative and qualitative data methods of data gathering, there are limitations. The study is retrospective. A better method for measuring impact is to track the same individuals over time to get a more accurate report of actual service utilization and how it changed their lives. Remembering service usage, especially when some members have been with ShareCare for up to 20 years, means that memory errors are introduced.

The survey responses were designed with an option for a nonresponse on each individual question. The authors' assumption was that the individual chose the "NA" option because they did not link that particular concept with their ShareCare membership. Other reasons may have existed for not answering a particular query.

The authors also have no way of identifying how many services were/are used and the quantity of time devoted to those services. As stakeholders consider what next steps to take, considering an ongoing data collection strategy, that may include a management information system that can track usage and link evaluation responses of impact to those data, might be considered.

Potential Next Steps for Consideration by Stakeholders

The potential value of any evaluative study is how it is integrated into the decision-making activities of an organization. This report has provided the perspective of a representative sample of individual members supported with additional information about how the organization operates and their perceptions of ShareCare's impact on their lives. The next step for utilizing these findings might be a values session that provides the stakeholders an opportunity to weigh in on the importance of various findings. For example, some shareholders might believe that improving the administrative time allocation is one of the most important areas of future focus, while others reading the report might see expanding the knowledge of the members about services and increasing levels of volunteerism as primary goals. Others may focus on the trend for women to be more positive about ShareCare's impact than men. The current study would support the idea that ShareCare is more important to the older and/or sicker residents for many of the services. Leadership may want to consider ways of branding its services so that younger members are more likely to be involved as well. It is the role of the evaluators to identify the trends but not to rank order them in importance, as that decision should always draw from the local participants.

The most appropriate next steps would involve planning and policy development committees or task forces that could broaden the discussion about what steps should be taken next. The changes that are to be made will draw more support and enthusiasm when they are introduced from a bottom-up perspective rather than top-down. This document has identified common areas of concern, as well as strengths and weaknesses, through both quantitative and qualitative methods. Ranking those concerns and implementing appropriate service and organizational changes is the role of the organization and its leaders and members.