

Analysis of Satisfaction Survey Results for the R3² Program

Presented to:

Hebrew Senior Life

By

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Introduction

One component of the R3² study focused on participants' overall satisfaction with the program -- in addition to assessing whether participation in the R3² program led to changes in health care utilization, closing care gaps, and improving quality of life. The voluntary nature of the program means that satisfaction among those who enroll (currently, roughly one-third of residents) is critical to ensuring future program sustainability; thus, it is important to understand whether enrollees feel that they are benefitting from their participation, and why. To do so, we distributed a short survey to participants during the second and third quarters of 2020. We also added a set of common questions to the final assessments and distributed a separate survey to non-participants at the R3² sites during the 2nd and 3rd quarters of 2020 to compare the experiences of R3² participants with other residents in the R3² and with residents in control buildings. The final dataset comprised survey responses from 120 R3² participants, survey responses from 73 non-participants, and completed assessments from 243 R3² participants and 97 controls. We present analysis of these data in the section that follows.

Findings

Table 1 below characterizes socio-demographic characteristics of R3² survey respondents.

Table 1: Selected Socio-Demographic Characteristics of Survey Respondents

Socio-demographic Characteristic	Percentage of Respondents (n=244)
Age 81 years old (average)	
<75	30%
75-84	35%
≥85	35%
Gender	
Male	19%
Female	81%
Marital Status	
Married	15%
Unmarried	85%
Functional Status	
Activity of daily living (ADL) Limitations	23%
No ADL Limitations	77%
Instrumental activity of daily living (IADL) Limitations	52%
No IADL Limitations	48%
Cognition – Short Portable Mental Status Questionnaire	
Normal (0-2 errors)	90%
Mild (3-4 errors)	6%
Moderate to Severe (≥5 errors)	4%
Self-Rated Health Status	
Fair or Poor	30%
Good or Excellent	70%

As shown, most respondents are over age 75 years (70%) and no longer married (85%), either because they never married (19%) or were widowed or divorced (66%). While roughly a quarter are limited at least one activity of daily living (ADL), a slight majority (52%) have at least one limitation in an instrumental activity of daily living (IADL). Finally, slightly less than one third rate their health care as fair or poor.

In Table 2 below, we summarize the reasons that respondents gave for participating in the R3² program.

Table 2: Percent Agreeing with Statement about Reasons for Participating in the R3² Program

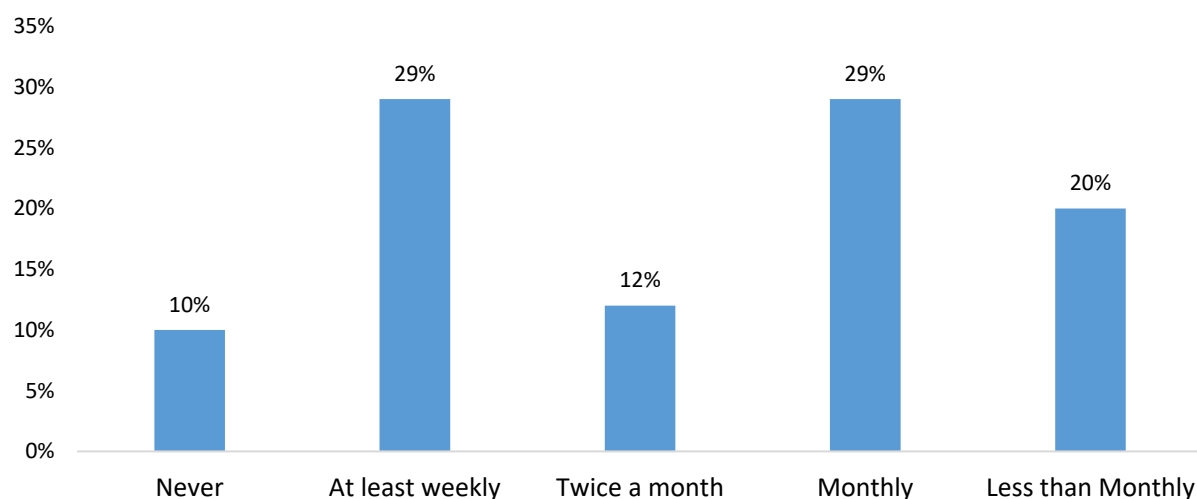
Reason for Joining Program	% Agreeing (n=120)
I wanted help in the future if I needed it	78%
Staff seemed nice	66%
I valued having someone to talk to	59%
The activities were appealing	38%
I wanted help with a specific problem I was facing	25%
Other	23%
I wanted help with finding care	19%
My family is unable to help me/I don't have family	10%
Friend recommended it to me	10%
I wanted help with medications	8%
My doctors are not responsive to me	1%

As shown in Table 2, most people joined the program not to address current needs, but to have help available in the future should need arise. As well, the social aspects of the program -- namely, having someone to talk to -- were cited by about three-in-five participants as an important reason to join the program. The fact that "staff seemed nice" was also viewed as important by a high percentage—two-thirds—of respondents. This is not surprising given that many program participants are unmarried and at higher risk for social isolation. Respondents were also asked which of the reasons cited above was the most important. Slightly less than half (48%) of respondents indicated that the desire to have help available if needed was most important, followed by the desire to have someone to talk to (24%).

Figure 1 below shows the level of contact that people are having with the two R3² staff members serving their buildings -- the wellness nurse and wellness coordinator. Most participants are in contact with R3² staff at least monthly (70%), with the average number of

monthly contacts across the group being 5.9. This high average level of interaction is driven by a relatively small number of residents, who are in contact with R3² staff more than once a week, making the distribution of visits highly skewed. It is important to note that nearly one-in-five respondents did not answer this question. Responses below are based on all of those responding to the question.

Figure 1: Contact with R3² Staff (n=97)



In Tale 3 below, we highlight the benefits that respondents indicate they are receiving by participating in the R3² program.

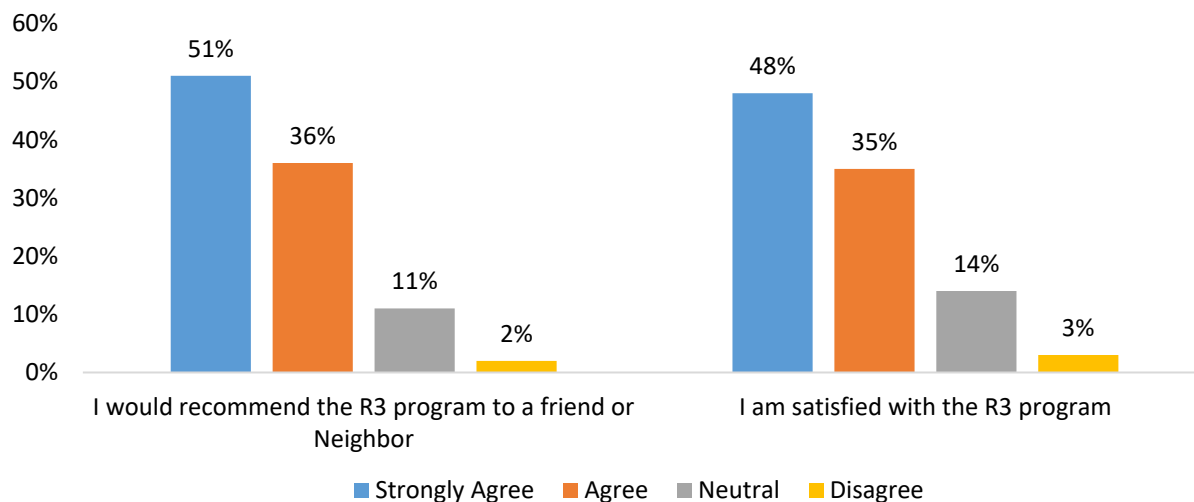
Table 3: Percent Agreeing with Statements about the R3² Program

Statements about the Program (n=120)	Agree	Disagree	Neutral
I know how to contact R3 ² staff when I need them	97%	1%	3%
I trust the R3 ² staff with my personal information	91%	1%	8%
The R3 ² program is a good source of information and support	85%	2%	13%
The R3 ² program makes me feel less alone	68%	4%	28%
The R3 ² program helped me be healthier.	65%	3%	32%

These results show that a high percentage of individuals perceive benefits from R3². Nine-in-ten respondents trust that R3² staff will protect their privacy and virtually all respondents (97%) know how to reach R3² staff should they need them; most (85%) feel that R3² is a good source of information and support. Moreover, roughly two-in-three feel that the program has helped them to be healthier and feel less lonely; very few individuals (<5%) disagree with these two statements. Participants were also asked whether they are satisfied

with the program and whether they would recommend it to a friend – two important measures of program attractiveness and quality as well as commitment to the program. Results are presented in Figure 2.

Figure 2: Measures of Satisfaction with Program (n=114)



As shown, high proportions of respondents are satisfied with the program (83%) and would recommend it to a friend (87%). Very few respondents are unsatisfied or do not feel that the program is worthy of recommending to a friend (just 3% and 2%, respectively).

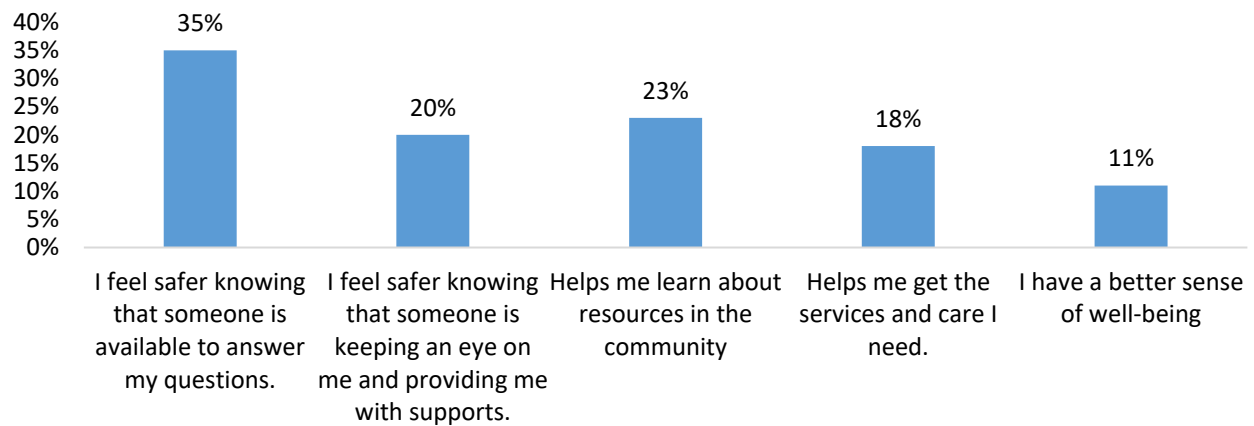
We then asked respondents to provide more specificity regarding what they believe the program is doing for them. This runs the continuum from obtaining more knowledge and education, to engaging in more self-care activities, to reducing the need for unnecessary emergency room visits. Table 4 below highlights these results. Well over half of respondents reported that they feel safer knowing that someone is available to answer their questions (84%), are able to learn about resources in the community (69%), feel safer knowing someone is looking out for them and providing support when needed (57%) and appreciate that there is help to obtain services when needed (50%).

Table 4: Specific Program Benefits Cited by Participants

Benefits Received by the Program Participation	% Citing Reason (n=117)
I feel safer knowing that someone is available to answer my questions.	84%
Helps me learn about resources in the community	69%
I feel safer knowing that someone is keeping an eye on me and providing me with supports.	57%
Helps me get the services and care I need.	50%
Helps me take better care of myself.	48%
I will be able to stay in my apartment longer because of the help I get from the service coordinators	42%
I have a better sense of well-being.	38%
Helps me avoid medical emergencies and going to the emergency room.	31%
Helps me to communicate better with my doctor and other people involved in my medical care.	23%
I am eating better	21%
I feel healthier	19%
Helps me manage my medications.	18%

We then asked respondents which of program benefits listed above were most important. Figure 3 shows the top five most cited benefits. The pattern of responses is similar to that found in Table 4, which showed that the presence of someone who can help if care is needed and who can proactively provide education, resources and connection to the community is highly valued.

Figure 3: Five Most Cited Benefits of Program Participation (n=117)



Multivariate Modeling

We conducted several analyses to determine which socio-demographic characteristics are associated with people who indicated that they were very satisfied with the program as well as those who indicated that they would strongly recommend the program to a friend. Table 5 summarizes these results.

Table 5: Logistic Regression Modeling for Two Dependent Variables

Independent Variables	Dependent Variable: Very Satisfied (n=103)		Dependent Variable: Strongly Recommend to Friend (n=102)	
	B	Exp (B)	B	Exp (B)
Being over age 85	1.43***	4.2	1.2***	3.2
Being Female	1.67***	5.3	.99	2.7
Being Married	-.99	.37	-.97	.38
Rated Health as good or excellent	-.55	.58	-.49	.61
Having an IADL Limitation	.21	1.2	.09	1.1

Note: *** Significant at the .05 level; Exp (B) is the odds ratio that indicates the impact of having a characteristic on the likelihood of either being very satisfied or strongly recommending the program to a friend.

IADL=Instrumental Activities of Daily Living

Table 5 shows that being over age 85 and being female are associated with a greater likelihood of being very satisfied with the program. In fact, individuals age 85 and over are 4.2 times more likely to be very satisfied with the program than are those under age 85. As well, females are 2.7 times more likely to be very satisfied with the program than are males. Self-rated health status, marital status, and the number of IADL limitations are not related to high satisfaction. While we desired to test whether the number of contacts one has is related to being very satisfied, too few individuals chose to respond to this item to be able to analyze this. We also find that the only variable that influences whether or not someone would strongly recommend the program to a friend is being over age 85: people age 85 and over are 3.2 times more likely to strongly recommend the program to a friend than are younger individuals. No other variables were statistically significant.

Common Question Analysis

A number of questions related to people's sense of self-efficacy in managing their own health were added to the final assessments of individuals in the R3² program and residents at the control sites. As well, individuals who lived in a building where the R3² program was operating but chose not to participate in the program were also asked questions related to self-efficacy.

Table 6 below compares key demographic variables for individuals in the R3² program and control sites. This information is not available for individuals who lived in the building but did not participate in the R3² program. What this table shows is that there is a higher percentage of R3² participants who have graduate degrees and more likely to have IADL limitations, this indicating that they are somewhat more impaired than respondents in the control group.

Table 6: Summary Statistics of Socio-Demographic Variables by Group Type

Variables	R3 ² participants (n =244)		Controls (n = 97)	
	M	(SD)	M	(SD)
Demographics				
Age	80.6	8.63	79.9	7.67
Age groups				
Under 65	1.8%		2.1%	
65-74	30.0%		28.4%	
75-84	34.4%		42.1%	
85+	33.9%		27.4%	
Female	78.7%		87.5%	
Marital status				
Married	14.7%		13.4%	
Separated/Divorced	24.4%		32.0%	
Widowed	42.4%		42.3%	
Never married	18.5%		12.4%	
Education				
11 grade or less	8.3%		12.4%	
High school/tech/trade school	27.9%		41.2%**	
Some college	26.7%		28.9%	
Bachelors	14.6%		10.3%	
Graduate school	22.5%**		7.2%	
Health				
Self-rated health ^a	2.73	0.622	2.78	0.746
Number of difficulties in ADLs	0.44	1.283	0.28	1.038
Number of difficulties in IADLs	1.60***	2.009	1.00	1.514
Cognition (SPMSQ Score)	1.08	1.251	0.96	0.798

Notes. N = 341. ^a Rated from 1 (*poor*) to 4 (*excellent*). **p < .05. ***p < .01.

ADL=Activities of Daily Living; IADL=Instrumental Activities of Daily Living; SPMSQ=Short Portable Mental Status Questionnaire

Tables 7a and 7b below summarize the results for two broad questions: (1) Are you confident you know who to go for help with specific-health related issues, and (2) What do you do when you have serious concerns about your health? We compared individuals in the R3² program, those in control sites, and those living in buildings where the R3² program exists but do not participate. Statistically significant differences are indicated by a letter next to the variable, (A) when compared to R3²participants, (B) when compared to residents at the control sites, and (C) when compared to non-participants in the R3² buildings. A letter next to a number

indicates that the value in the column is statistically different from the number in the other letter-identified column.

For example, for the question “feeling confident that you know who to go for help with identifying resources and services in the community” (Table 7a), the letter “C” next to the number in the control column indicates that individuals living in control sites are more likely to feel confident on this dimension than are individuals in R3² buildings who are not participating in the program. By contrast, there is no statistically significant difference in results between the R3² group and the control group with respect to knowing who to go for help with identifying resources and services. For the questions, “feeling confident that you know who to go for help in addressing concerns about paying for health and other health related services, and in managing a chronic health condition”, the “A” and “C” next to the number in the control column indicates that a significantly higher percentage of individuals at the control site felt that they knew who to go to address concerns about paying for health and other health-related services as well as manage a chronic health condition than did respondents in R3² buildings – be they program participants or not.

Table 7a: Health Confidence and Self-Efficacy Results by Group Type

	R3 ² (n=244) (A)	Control (n=97) (B)	In-building (n=73) (C)
Confident that you know who to go for help with:			
Identifying resources and services in the community	79%	98% C	86%
Applying for benefits and services	76%	96%	89%
Addressing concerns about paying for health and other health-related services	69%	96% AC	78%
Answering my questions about my health	81%	97%	89%
Communicating with my doctor or other providers	80%	95%	85%
Understanding what my doctor has told me about my health situation	79%	96%	90%
Learning about ways to better take care of my health	80%	97%	88%
Understanding how and why I should take my medications	80%	98%	88%
Managing a chronic health condition	74%	98%AC	84%
Making sure I have everything I need when I am coming home from a hospital stay	73%	99%	84%

The results are mixed when it comes to what individuals would do if they had a serious concern about their health (Table 7b). On the one hand, individuals in control buildings report that they are more likely than R3² program participants and non-participants in R3² buildings to take medication prescribed by a doctor or other care provider, take over-the-counter medications, and use meditation, visualization, prayer, or other ways of feeling better. Yet,

individuals in control buildings are also nearly two times more likely to call 911 or go to the hospital than are individuals in R3² buildings. They are just as likely to call a doctor, as are R3² members, though more likely to do so than non-participating residents in R3² buildings. Finally, individuals in control buildings are more likely to call a service coordinator or building staff or call a friend, neighbor, or relative than are R3² members or non-participants in R3² buildings.

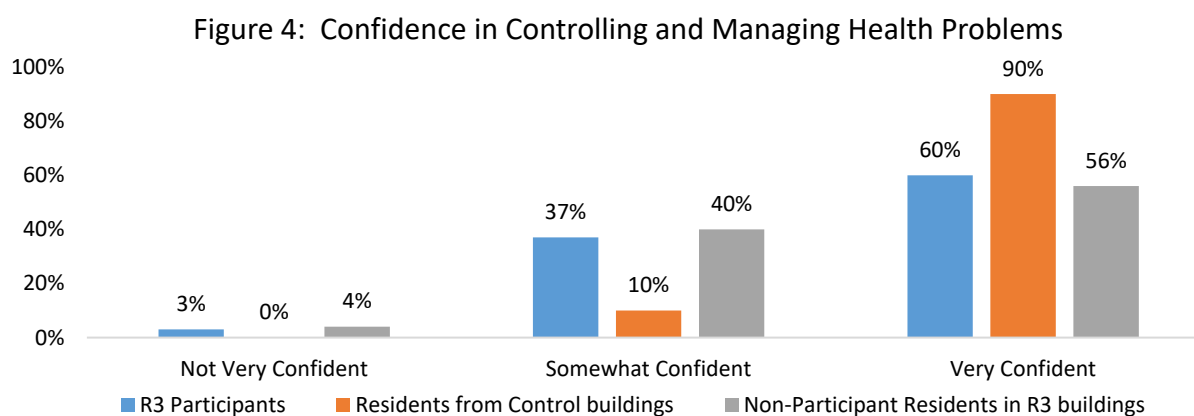
It is difficult to interpret these results and it is likely that these patterns of responses may have a great deal to do with who chose to answer the survey, that is, results are likely affected by selection bias. Put another way, it is quite likely that the individuals responding to the survey in control sites are qualitatively different in relevant, but unmeasurable respects, from individuals in the R3² buildings. In terms of measurable variables, we know that R3² participants are somewhat higher educated and more disabled as evidenced by greater levels of IADL impairment. In addition, our analysis is limited because we do not have pre- and post-measurements on these variables so there is no control to measure whether there have been changes in attitudes after participation in the R3² program or simply over time. For these reasons, the results in this analysis must be viewed with caution.

Table 7b: Health Confidence and Self-Efficacy Results by Group Type

	R3 ² (n=244) (A)	Control (n=97) (B)	In-building (n=73) (C)
What do you do when you have serious concerns about your health?			
Call a doctor or other care provider's office	80%	97% ^C	77%
Take medication prescribed by a doctor or other care provider	52%	93% ^{AC}	47%
Take over-the-counter medication	32%	81% ^{AC}	34%
Call 911 or go to the hospital	54%	96% ^{AC}	49%
Call a friend, neighbor, or relative	56%	95% ^{AC}	64%
Call the service coordinator building staff	34%	68% ^{AC}	29%
Use meditation, visualization, prayer, or other ways of feeling better	30%	65% ^{AC}	25%
Go to urgent care	38%	41%	29%
Wait to feel better	27%	14%	34%

Individuals were also asked how confident they were in controlling and managing their health problems. Figure 4 summarizes results and shows that nine in ten individuals in the control buildings say they are very confident in controlling and managing their health problems compared to R3² participants and non-participants in R3² buildings. Again, this finding must be viewed with caution, as we already know that individuals in the control sites are somewhat

healthier than participants in R3² buildings and the same issues regarding selection mentioned above, apply to this finding.



R3 Participants=244, Control residents=97, In-building residents=73.

Summary

Findings presented here suggest that the R3² program is very popular among participants. The vast majority of enrollees are interacting with R3² staff; they trust them and feel that they provide important information; and, they feel safer, less alone and healthier because of their participation in the program. Moreover, roughly, nine-in ten are satisfied with the program and three in five would recommend it to a friend. Older residents and women are most likely to cite high levels of satisfaction. Fully one-third of program participants believe that the program is helping them avoid medical emergencies necessitating a trip to the emergency room. This is also consistent with the finding that when faced with a serious medical concern, program participants as well as non-participants living in R3² buildings, are far less likely to view calling 911 or going to the emergency room for treatment as a way to address their issue compared to individuals living in control buildings.

The comparative findings related to health confidence and self-efficacy in managing care are difficult to interpret. Our view is that issues related to selection bias and the different health profile of individuals living in control buildings may be driving the pattern of responses. Thus, such results must be viewed with caution. Taken on their own however, findings show that most individuals in R3² buildings feel somewhat or very confident in their ability to handle health issues, and rely less heavily on emergency room visits.