# Assessing the Effectiveness of the Trumbull Advocacy and Protective Network: A Formative Evaluation

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**Assessing the Effectiveness of the Trumbull Advocacy and Protective Network: A Formative Evaluation**

A formative evaluation of the Trumbull Advocacy and Protective Network (TAPN) was conducted in fall 2007 and fall 2008. Seventeen TAPN member agencies participated in this evaluation in phase one, while 19 participated in phase two. From phase one to two, t-tests revealed that mean scale scores for the TAPN Accomplishment Scale had increased significantly over time, with the most significant changes being in indirectly addressing the special needs of older adults, advocating for the efficient and effective allocation of resources, enabling agencies to better serve their clients, and offering a "single focus location" for advocacy. Important current and future activities for TAPN, the benefits of membership, the problems and strengths of the senior network, the need for additional services, the willingness to use consultants and serve on TAPN committees, and suggestions for expanding the network were also examined. Methodological issues, implications for practice, and future research were discussed.

Key Words: Program evaluation, senior services network, advocacy, service coordination, multi-need clients

The number of elderly individuals aged 65 and over in the United States is growing as is the cost and demand for services (Fisher et al., 2009; Gallagher, Truglio-Londrigan, & Levin, 2009; May, 2004; Willging, 2007). The helping professions recognize the responsibility of providing evidence that programs that serve the elderly and others are efficient and effective in their efforts in improving the quality of life of their consumers (Bloom, Fischer, & Orme, 2009; Gibbs, 2003; Hebert, 2008: McNeill, 2006; Rubin & Babbie, 2008; Slivinske & Slivinske, 2005/2006; Royse et al., 2006; Weinbach, 2005). In this regard, program evaluations have examined the need for services, barriers to accessing the system, and the effectiveness of programs that serve the elderly.

Regarding need, research has shown that the elderly have many chronic and acute physical conditions that required medical interventions as well as problems such as social

isolation, suicide, depression, anxiety disorders, and cognitive loss, to name a few (Erlangsen et al., 2006; Herbert et al., 2008; Keller-Cohen et al., 2006; Lavretsky et al., 2003; Lubitz et al., 2001; O'Brien, 2006; Tomaka, Thompson, & Palacios, 2006; Tse, Choi, & Leung, 2008). Barriers to care have been identified such as lack of knowledge of the system; lack of transportation; and lack of informal caring networks such as family, friends, and congregations (Krause & Wulff, 2005; Porter, 2005; Tse, Choi, & Leung, 2008). Other barriers that have been studied include location of services; affordability of services; disenfranchised elders; race; and/or the ability of the formal system to keep pace with the increasing, future demands for high levels of care (Brotman, 2003; Li, 2006; Schoenberg, Coward, & Albrecht, 2001). Finally, there have been a myriad of approaches that have examined program outcomes. These included the effect of case management, the use of volunteers, health promotion, client centered approaches on elder health, the politics of care, the relationship of perceptions held by the elderly to program participation and success, and developing new models of practice (Bullet, 2006; Chapko et al., 2009; Chiang et al., 2008; Dacey & Newcomer, 2005; Holland et al., 2005; Li, 2004; Petrella, Koval, & Peterson, 2003; Schein et al., 2005).

**Setting**

The Trumbull Advocacy and Protective Network (TAPN) is located in Trumbull County in Northeastern Ohio. According to the by-laws of The Trumbull Advocacy and Protective Network, TAPN was organized as a model of practice whose mission is to 1) address the special needs of older adults who are being served by more than one system and whose situation warrants extraordinary interventions; 2) advocate for the efficient and effective allocation of resources to address these needs; and 3) promote the highest

levels of collaboration for the ultimate good of older adults, their families, and the community. In attempting to accomplish its mission TAPN reviewed all existing programs; integrated existing programs so that they led to better results and reinforced each other; developed a countywide service coordination plan; and maintained an accountability system that demonstrated progress on achieving the objectives of the network. Finally, the main activities of TAPN include system-level coordination and integration of program; case-level coordination and integration of services; and training of service providers and cross-training of network members.

The goals of TAPN are to develop and implement a process that annually plans and prioritizes services; fills service gaps where possible; creates new approaches to achieve better results for older adults in need of protective services; and evaluates the impact of the network on the integration, coordination, and delivery of services. Other goals are to maintain an accountability system which monitors progress; to establish a mechanism to ensure ongoing input from a broad representation of older adults and their families who are receiving services within the county system; and to participate in the development and implementation of a countywide, comprehensive, coordinated, multi-disciplinary, integrated interagency system for older adults and their families. TAPN membership potentially includes all public systems with mandates which include high-risk older adults and their families in Trumbull County and agencies which are funded by public systems and/or provide services to high-risk older adults and their families. At the time this study began in 2007, there were twenty seven agencies with fifty eight members affiliated with TAPN.

The purpose of this formative evaluation was to identify the strengths and weaknesses of TAPN with the intent of guiding and directing program change to enhance the effectiveness of the Network (Royse, et. al., 2006). In this regard TAPN accomplishments were assessed, TAPN functions/activities were prioritized, unmet needs of older adults and their families were identified, suggestions for improving network services were made, and the willingness of members to become more active in TAPN was explored. After initial data were gathered, the results were made known to TAPN and the Board of TAPN. Data were gathered again one year later in 2008, to measure program improvement in TAPN and the state of the county senior service system.

## Methodology

### Sample

Seventeen out of 27 agencies affiliated with TAPN participated in the initial phase of this evaluation. The response rate was 63%. The data from the survey were coded in a fashion to protect the confidentiality of those participating. Please note that some agencies had multiple members. In phase two, data were gathered again from 19 out of 29 TAPN affiliated agencies with a response rate of 65.5%.

Of those responding in phase one, the average number of years of TAPN involvement was 2.24, while the median number of over age 60 consumers served by their agencies was 1,157. Also, the median number of clients that were introduced to the clinical committee was 2. Regarding the position/title of members, 10% identified themselves as caseworkers, 20% as program directors, 35% as executive directors, and 35% as other. The multiple and sometimes overlapping systems that were represented included 23.8% legal/courts, 28.6% social service, 9.5% government, 19% housing,

23.8% mental health/substance abuse, 23.8% medical, 23.8% disability services, 14.3% long-term care, and 23.8% other. The primary sources of funding for fiscal year 2006 included 55% of the agencies receiving federal funding, 65% State, 70% local, 57.9% grants and 25% other. Also, regarding fiscal year 2006, 27.8% had budgets under $500,000, 5.6% from $500,000 to under one million dollars, 33.3% from one million to five million dollars, and 33.3% over five million dollars. Regarding meetings, 95.2% believed that the frequency of TAPN meetings were appropriate to the business at hand. Members reported attending an extrapolated average of 3-4 full TAPN meetings, 1-2 executive board meetings, 1-2 clinical committee meetings, 1-2 training committee meetings, and 1-2 TAPN annual cross trainings. Table 1 summarizes the demographic characteristics of the sample.

**Table 1. Demographic Characteristics of the Sample.**

| Variable Name | Mean | s.d. |
|---|---|---|
| Years of TAPN involvement | 2.24 | 1.327 |
| | Median | Minimum/Maximum |
| Number of over age 60 consumers | 1,157 | 0 to 57,205 |
| Number of clients introduced to the clinical committee | 2 | 0 to 5 |

| | Percent |
|---|---|
| Position/title | |
| Caseworker | 10.0% |
| Program Director | 20.0% |
| Executive Director | 35.0% |
| Other | 35.0% |
| Types of systems | |
| Legal/Courts | 23.8% |
| Social Service | 28.6% |
| Government | 9.5% |
| Housing | 19.0% |
| Mental Health/Substance Abuse | 23.8% |
| Medical | 23.8% |
| Disability Services | 23.8% |
| Long-term Care | 14.3% |
| Other | 23.8% |
| Primary Funding Sources in 2006 | |
| Federal | 55.0% |
| State | 65.0% |
| Local | 70.0% |
| Grants | 57.9% |
| Other | 25.0% |
| Agency Budget Fiscal year 2006 | |
| Under $500,000 | 27.8% |
| $500,000-under 1 million | 5.6% |
| $1 Million to 5 Million | 33.3% |
| $ Over 5 million | 33.3% |
| Appropriate Number of TAPN Meetings | |
| Yes | 95.2% |
| No | 4.8% |

| | Extrapolated Average |
|---|---|
| Number of TAPN Meeting/Events Attended | |
| Full TAPN Meetings | 3-4 |
| Executive Board Meetings | 1-2 |
| Clinical Committee Meetings | 1-2 |

| | |
|---|---|
| Training Committee Meetings | 1-2 |
| TAPN Annual Cross Trainings | 1-2 |

n = 17 agencies with 21 members

**Instrumentation**

The TAPN Membership Survey Form (questionnaire) was developed by Youngstown State University by reviewing the by-laws; mission, goals, and objectives; minutes of meetings; and other documents of TAPN. The initial form was reviewed by the Board of TAPN, the director of TAPN, and selected TAPN members. The form was revised to include the suggestions of those mentioned above and was approved by the Board of TAPN in mid-summer, 2007.

The form included items which described those completing the questionnaire, their agencies, and consumers as well as items that were used to assess TAPN accomplishments, prioritize TAPN functions and activities; identify the unmet needs of older adults and their families; make suggestions for improving network services; and assess the willingness of members to become more active in TAPN.

A fourteen item, five-response category Likert scale that measured "TAPN Accomplishments" was included in the questionnaire as well as two related validity questions. Scale items were scored in the following manner: Strongly Disagree = 1, Disagree = 2, Undecided = 3, Agree = 4, Strongly Agree = 5. The theoretical range of scores was 14-70, with high scores representing great accomplishment and low scores little accomplishment. The internal consistency of the scale was assessed in phase one using Cronbach's alpha. The reliability of the scale was found to be excellent ($\alpha = .90$). The face, content, and discriminant validity of the scale also was assessed in phase one. Eighty six percent of those responding to the survey agreed or strongly agreed that the

scale appeared to be measuring TAPN accomplishments, while 85.7% agreed or strongly agreed that the scale items were representative of all important aspects of TAPN accomplishments. Therefore the scale was considered to have both face and content validity. Regarding the discriminant validity of the scale, scale scores in the lower quartile (mean score = 48.67, s.d. = 4.844) were compared to those in the upper quartile (mean score = 64.71, s.d. = 2.983). It was assumed the mean scale scores in each of these contrasted groups (quartiles) would be significantly different. A t-test revealed this to be the case (t= -7.318, d. f. = 11, p = .000). Since these contrasted groups had significantly differently mean scores, the scale was considered to have discriminant validity. A recheck of the reliability and validity of the scale in phase two found the same results.

Regarding setting priorities for current and future TAPN activities/functions, participants were asked to rank order the functions with 1 being the most important and 7 and 9 being the least important respectively for current and future activities/functions. Finally, scale items, the scale, and the other main study variables were screened for missing data, outliers, and normality. All were found to be within acceptable limits. Table 2 displays the TAPN Accomplishment Scale contained within the survey form.

**Table 2. TAPN Accomplishment Scale.**

| Items |
|---|
| 1. TAPN is indirectly addressing the special needs of older adults being served by more than one agency and whose situation warrants extraordinary interventions. |
| 2. TAPN advocates for the efficient and effective allocation of resources to address the special needs of these older adults. |
| 3. TAPN promotes the highest level of collaboration for the ultimate good of older adults, their families and the community. |
| 4. TAPN membership has improved your understanding of other member agencies. |
| 5. TAPN membership has improved your communication with other member agencies. |
| 6. TAPN membership has resulted in better access and referrals to services for your clients. |
| 7. TAPN membership has enabled you to better serve your clients. |
| 8. TAPN membership has reduced the number of gaps in services for older adults. |

9. TAPN membership has improved the cooperative environment of the senior services network.
10. TAPN membership has offered your agency a "single focus location" for senior advocacy in the county.
11. TAPN membership has improved your knowledge of the senior services system.
12. TAPN membership has improved the quality of service provision to older adults in the county.
13. TAPN helps you meet the needs of your most high risk, senior clients.
14. TAPN trainings have helped you to better understand the specific needs of seniors.

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## Design

In collaboration with the Area Agency on Aging 11, TAPN, and Youngstown State University, a survey of current TAPN affiliated agencies was conducted from August through October 2007 (phase one). Questionnaires were distributed during regularly scheduled TAPN meetings and e-mailed to all members. Multiple requests were made to members who did not initially respond. Completed questionnaires were sent to Youngstown State University. After the initial results were reported to TAPN and the Board of TAPN in December 2007, data were again gathered eight months later from August through November 2008 (phase two), following the same procedures described above.

## Results

In phase one the TAPN Accomplishment Scale mean was 56.59. The three items with the highest mean scores were Items 4 (mean = 4.57), 11 (mean = 4.38), and 5 (mean = 4.29). TAPN membership improved their understanding of other member agencies, improved their knowledge of the senior services system, and improved their communication with other member agencies. The three items with the lowest mean scores were Items 8 (mean = 3.55), 10 (mean = 3.57), and 7 (mean = 3.71). Respectfully these were, TAPN membership had reduced the number of gaps in services for older adults, had offered member agencies a "single focus location," and enabled member agencies to better serve their clients.

In phase two, t-tests revealed that the TAPN Accomplishment Scale mean scores increased significantly from phase one (mean = 56.59) to phase two (mean = 60.77, t = -2.100, d.f. = 46, p = .020). The four items that showed the most improvement were Item 7, TAPN membership has enabled you to better serve your clients (t = -2.774, d.f. = 46, p .004); Item 1, TAPN is indirectly addressing the special needs of older adults being served (t = -2.045, d.f. = 46, p = .024); Item 2, TAPN advocates for the efficient and effective allocation of resources (t = -1.896, d.f. = 46, p = .034); and Item 10, TAPN membership has offered your agency a "single focus location" (t = -1.876, d.f. = 46, p = .034). All other items with one exception (Item 4—improving understanding of other agencies) also showed positive improvement. Table 3 summarizes the mean scores, standard deviations, and probabilities for each item and the entire scale in phases one & two.

**Table 3. Mean Scores and Standard Deviations for Items in the TAPN Accomplishment Scale and the Scale in Phases One & Two.**

| Items and Scale | Phase One | | Phase Two | | |
|---|---|---|---|---|---|
| | Mean | s.d. | Mean | s.d. | p |
| 1. TAPN is indirectly addressing the special needs… | 4.19 | .512 | 4.52 | .580 | .024 |
| 2. TAPN advocates for the efficient and effective… | 4.10 | .831 | 4.48 | .580 | .032 |
| 3. TAPN promotes the highest level of collaboration… | 4.19 | .814 | 4.48 | .580 | NS |
| 4. TAPN membership has improved your understanding... | 4.57 | .598 | 4.48 | .580 | NS |
| 5. TAPN membership has improved your communication… | 4.29 | .784 | 4.48 | .580 | NS |
| 6. TAPN membership has resulted in better access… | 3.95 | .865 | 4.31 | .666 | NS |
| 7. TAPN membership has enabled you to better serve... | 3.71 | .845 | 4.30 | .609 | .004 |
| 8. TAPN membership has reduced the number of gaps… | 3.55 | 1.050 | 3.93 | .958 | NS |
| 9. TAPN membership has improved the cooperative… | 4.24 | .700 | 4.52 | .700 | NS |
| 10. TAPN membership has offered your agency a "single… | 3.57 | 1.076 | 4.07 | .781 | .034 |
| 11. TAPN membership has improved your knowledge… | 4.38 | .498 | 4.48 | .700 | NS |
| 12. TAPN membership has improved the quality of… | 3.95 | .740 | 4.30 | .775 | NS |
| 13. TAPN helps you meet the needs of your most high… | 3.95 | .740 | 4.11 | .698 | NS |
| 14. TAPN trainings have helped you to better understand… | 3.95 | .759 | 4.31 | .773 | NS |
| TAPN Accomplishment Scale | 56.59 | 7.252 | 60.77 | 6.433 | .021 |

n = 17 agencies and 21 members in phase one, 19 agencies and 27 members in phase two

During phase one, agencies prioritized current TAPN activities and functions. Agencies revealed that the most important were 1) meetings/networking (mean = 2.29), 2) formal cross trainings (mean = 3.19), and 3) clinical support (mean = 3.29). The least important current priority was providing print material such as a newsletter or membership lists (mean = 5.67). For setting priorities for future TAPN activities and functions, the three most important were found to be 1) developing a clinical support fund for TAPN agencies to use in Wrap Around Case Planning (mean = 3.43), 2) initiating a community-wide gatekeeper program (police, fire, meter readers, bank tellers, etc., mean = 3.90), and 3) developing a research/data collection program for the system (to show gaps, accomplishments, duplication, etc., mean = 3.90). Note that these two future priorities were tied for second place. Besides "other" (mean = 9.29), the least important future priority was developing a TAPN speakers' bureau (mean = 7.14).

In phase two, agencies again prioritized setting priorities for current TAPN activities and functions. Agencies revealed that the three most important in 2008 were 1) meetings/networking (mean = 2.68), 2) clinical support (mean = 2.72), and 3) access to a single contact point to reach the senior service system (mean = 3.08). The least important priority was providing print materials such as a newsletter or membership list (mean = 5.44). For setting priorities for future TAPN functions, the three most important were 1) develop a clinical support fund for TAPN agencies to use in Wrap Around Case Planning (mean = 2.88), 2) initiate a community-wide gatekeeper program (police, fire, meter readers, bank tellers, etc., mean = 3.39), and 3) develop a research/data collection program for the system (to show gaps, accomplishments, duplications, etc. mean = 3.96). The least important future priority besides "other" (mean = 8.43) was to develop a TAPN

speakers' bureau (mean = 7.13). From phases one to two, t-tests revealed that the only two changes that were statistically significant were in current priorities with "formal cross trainings" moving from 2nd to 4th place (t = -2.874, d.f. = 44, p = .006) and in "single contact point" moving from 4th to 3rd place (t = 2.029, d.f. = 44, p = .049). Table 4 summarizes the rank ordering of priorities, mean scores of the rankings, and probabilities in phases one and two for current and future TAPN activities and functions.

**Table 4. Rank Ordering of Current and Future Activities and Functions, Mean Scores, and Probabilities for Phase One and Two.**

| Rank Ordering of Priorities | | | Mean Scores | | p |
|---|---|---|---|---|---|
| Current TAPN Activities/Functions | | | | | |
| Phase One | Phase Two | | Phase One | Phase Two | |
| 1st | 1st | Meetings/networking | 2.29 | 2.68 | NS |
| 2nd | 4th | Formal cross trainings | 3.19 | 4.52 | .006 |
| 3rd | 2nd | Clinical support | 3.29 | 2.72 | NS |
| 4th | 3rd | Access to single contact point… | 4.24 | 3.08 | .049 |
| 5th | 5th | Informal trainings at regularly scheduled meetings | 4.33 | 4.44 | NS |
| 6th | 6th | Quality control mechanism for the system… | 4.52 | 4.68 | NS |
| 7th | 7th | Print materials-newsletter/membership lists, etc. | 5.67 | 5.44 | NS |
| Future TAPN Activities/Functions | | | | | |
| Phase One | Phase Two | | Phase One | Phase Two | |
| 1st | 1st | Develop a clinical support fund for TAPN agencies.. | 3.43 | 2.88 | NS |
| 2nd | 2nd | Initiate a community-wide gatekeeper program… | 3.90 | 3.39 | NS |
| 2nd | 3rd | Develop a research/data collection program… | 3.90 | 3.96 | NS |
| 3rd | 4th | Investigate underutilization of mental health/substance abuse… | 4.10 | 4.04 | NS |
| 4th | 6th | Expand advocacy activities regarding legislative issues | 4.24 | 5.29 | NS |
| 5th | 5th | Increase senior service training opportunities… | 4.29 | 4.45 | NS |
| 6th | 7th | Contract a clinical consultant to focus on… clinical mission… | 6.05 | 6.65 | NS |
| 7th | 8th | Expand TAPN membership… | 6.75 | 7.05 | NS |
| 8th | 9th | Develop a TAPN speakers' bureau | 7.14 | 7.13 | NS |
| 9th | 10th | Other | 9.29 | 8.43 | NS |

n = 17 agencies with 21 members in phase one, 19 agencies with 27 members in phase two

In phase one, agencies were asked to give examples of how TAPN has allowed them to better serve their clients by listing and prioritizing the benefits of TAPN membership and to identify the biggest problems in the county and shortcomings of the senior service system within the county. They were also asked to report the greatest strength of the senior service system. Regarding benefits, forty-nine were listed. The most frequently mentioned benefit was "networking," followed by increased "knowledge of services/information of other agencies." The next benefit was related to "clinical cases." Examples included advocating for clients, funding solutions for problems, and brainstorming. The problem/shortcoming that was mentioned most often was "lack of services" and/or "resources." The next most often mentioned problems were "lack of knowledge of the services available" and "transportation." Other problems identified related to care coordination, medical concerns, isolation issues, housing, and eligibility requirements that are too stringent. The strength that was most often mentioned was the good "cooperation of agencies" followed by "TAPN" itself. The next strengths listed were tied in the frequency of responses. These were "advocacy," the "levy," and "agencies/professionals that care."

In phase two, participants again were asked to give examples of how TAPN allowed them to better serve their clients, the problems/shortcomings in the county, and the strengths of the system. For the benefits of TAPN membership, sixty two examples were provided. The three most frequently mentioned benefits were problem resolution via "networking," increased "knowledge/information" regarding other agencies, and access to "funding" including the clinical fund. In this phase, the problem/shortcoming that was mentioned most often was "funding." This was followed by "medical care/medications,"

and “transportation.” For strengths, the one mentioned most often was “collaboration/networking,” followed by “services provided/agencies,” and “TAPN”. In all categories the rank orderings were relatively stable with the following exceptions. In benefits, the third one changed slightly from issues related to direct service provision to “clinical cases” to providing “funding” for the “clinical cases.” In problems, there was a change in the ones identified to be in second place. The “lack of knowledge of services available” was replaced by “medical care/medications.” Pertaining to the strengths of the senior system the same basic three were mentioned in both phases. The only change being that “TAPN” and “advocacy/the levy/agencies,” exchanged places (second to third and third to second) from phases one to two. There were not enough cases in any category to reliably perform any statistical tests between phases one and two to determine if any of the changes were statistically significant. Table 5 summarizes the most frequently mentioned benefits of TAPN membership, the biggest problems facing seniors in the county including shortcomings of the senior service system, and strengths of the senior service system in phases one and two.

**Table 5. Benefits, Problems/Shortcomings, and Strengths in Phases One and Two.**

| Phase One | | Phase Two | |
|---|---|---|---|
| Benefits of TAPN membership | | | |
| 1st | Networking | 1st | Networking |
| 2nd | Knowledge of services/ information of other agencies | 2nd | Knowledge of services/ information of other agencies |
| 3rd | Clinical cases | 3rd | Access to funding/clinical fund |
| Biggest problems in the county and shortcomings of the senior service system | | | |
| 1st | Lack of services and resources | 1st | Funding for services |
| 2nd | Lack of knowledge of services available | 2nd | Medical care/medications |

| | | |
|---|---|---|
| 3rd | Transportation | 3rd Transportation |

Strengths of the senior service system

| | | |
|---|---|---|
| 1st | Agency cooperation/networking | 1st Collaboration/networking |
| 2nd | TAPN | 2nd Services provided/agencies |
| 3rd | Advocacy/agencies and professionals that care/levy | 3rd TAPN |

n = 17 agencies with 21 members in phase one, 19 agencies with 27 members in phase two

In phase one, 30% of the TAPN members completing the survey said they would use consultants with 45% being uncertain, 73.7% would serve on TAPN committees, and 47.4% would commit to a TAPN speakers' bureau. The types of consultants requested were estate planners, long-term care planners, social workers, rehabilitation teachers, and those familiar with the law, housing, and Medicaid. In phase two, 24% of respondents said they would use consultants, 50% would serve on TAPN committees, and 31.8% would commit to a speakers' bureau. The most frequent type of consultant requested was legal. All the remaining were tied at one request each for social workers, grant writers, instructors for the disabled, interpreters for the deaf, etc. Chi square tests revealed that none of these changes in percents were significant (respectively $X = .209$, d.f. = 2, $p = .901$; $X = 3.766$, d.f. = 2, $p = .152$; $X = 1.706$, d.f. = 2, $p = .426$).

Additionally, in phase one the most frequently reported request for services were related to "knowledge of the system" which included system awareness, advertising, a program outline, and staffing lists. In phase two, the most frequently requested service identified was the need for emergency funds/resources.

Finally, in phase one, respondents provided information regarding the systems that needed to be included or expanded within TAPN. The most frequently mentioned

was “services” which included legal aid, financial, safety, assessment, long-term care, home maintenance, and payeeships/guardianships. Next were police and law enforcement, physicians, and churches, followed by consultants. In phase two, all responses were tied. These included the faith community and churches, health care providers and physicians, nursing homes and assisted living facilities.

## Discussion

During phase one TAPN accomplishments were assessed, current and future priorities were identified, and suggestions to better serve clients were made. Also, strengths and problems of the county and network were noted, ideas for adding additional systems and members were made, and the willingness of members to become more active was studied. The results of phase one were reported to TAPN and its Board in December 2007. TAPN had approximately eight months to attempt to change their program based upon the strengths and weakness that had been identified and to implement the suggestions and recommendations that had been made by member agencies.

It appeared that TAPN from phase one to two had improved its accomplishments in serving agencies and seniors as the TAPN Accomplishment Scale mean scores had increased significantly. Therefore, TAPN overall appeared to be accomplishing virtually all of its important activities/functions as they related to its goals and mission. All individual scale items showed improvement with one exception, Item 4. The individual items that showed the greatest improvement were Items 7, 1, 2, and 10. Therefore TAPN enabled members to better serve their clients, was indirectly addressing the special needs of older adults being served, advocated for the efficient and effective allocation of resources, and had offered member agencies a “single focus location.” It is interesting to

note that two of these individual items, Items 7 & 10, (better serving clients and single focus location) had had the lowest mean scores in phase one. One unintended outcome from phase one to two was that the only item to show a slight decrease in mean scores was Item 4 (improving your understanding of other agencies) which had been the item with the highest mean in phase one. Perhaps since TAPN had improved the members' understanding of other agencies in phase one, TAPN did not pay as much attention to this area as it had in the past. Another explanation could be that the mean of the item over time simply regressed toward the true mean score.

Regarding setting current and future priorities for TAPN activities and functions, the suggestions were relatively stable over time with only two significantly changing rank orderings over the phases. These were in current activities and functions with "formal cross trainings" becoming less important ($2^{nd}$ to $4^{th}$ place) and "access to a single contact point" becoming more important ($4^{th}$ to $3^{rd}$ place). It could have been that over time training becomes less important as member agencies become more familiar with the operating procedures and services provided by each other and the importance of a "single contact point" increased as it appeared to enable the agencies to perform their functions more effectively. It also should be noted that for current activities and functions "meetings/networking" remained the most important in both phases. Meetings/networking are the typical mode of operating for most agencies in accomplishing their tasks and meeting their goals and objectives. At these meetings members may have built interpersonal relationships which enabled them to get to know each other better. These relationships may have been paramount to understanding the best process to follow in better serving their clients. Although the importance of "clinical

support" rose from 3rd to 2nd place when comparing phase two to phase one, the change was not statistically significant. The remaining priorities for current activities and functions remained unchanged. So overall the current priorities for TAPN were stable over time with the two exceptions mentioned above. For future activities and functions the priorities were even more stable with "developing a clinical support fund," "initiating a community-wide gatekeeper program," "developing a research/data program," and "investigating the underutilization of mental health/substance abuse" remaining at the top of the list. The only real change being that "expanding advocacy activities regarding legislative issues" and "increasing senior service training opportunities" shifted their positions from phase one to phase two. The remaining priorities from contracting a "clinical consultant" to "other" stayed in their respective positions.

To summarize the benefits of TAPN membership and the problems/shortcomings and strengths of the senior service system the following may be said. The first two benefits of TAPN membership, "networking" and "knowledge of services and information of other agencies," remained unchanged from phases one to two. The third benefit changed slightly from issues related to "direct service provision to clinical cases" to providing "funding" for the clinical cases. Therefore the benefits of TAPN membership seemed to be stable over time with a slight increase in attention being paid to funding. The biggest problems in the county and the shortcomings/strengths of the senior service system over time also were relatively stable. The first and third which respectively related to "lack of funding/resources for services" and "transportation" remained unchanged, while in phase two the need for "medical care and medications" replaced the "lack of knowledge of services" available which was in second place in

phase one. In phase two it appeared more attention was being paid to health and medical problems of seniors perhaps reflecting a change in the types of presenting problems being experienced by the network at that time. More importantly it also may reflect the fact that TAPN had provided member agencies knowledge of all services that were available in the county and attention could now be paid to other pressing concerns. Pertaining to the strengths of the senior system the same basic three were mentioned in both phases, with the only change being that "TAPN itself" and "advocacy/the levy/agencies," exchanged places (second to third and third to second) from phase one to two. The first strength, "agency cooperation/networking," remained in first place in both phases. Here too stability of the strengths appeared to be the norm. Since there were not enough cases in each category to perform any reliable statistical tests it was unknown if any of the above mentioned changes were statistically significant.

TAPN was given the percent of members from agencies that would be willing to use consultants, who would serve on TAPN committees, and would commit to a TAPN speakers' bureau. Although none of the changes in percents were found to be significantly different there was a slight decrease in all three of the categories mentioned above. The percents decreased slightly over the phases for the willingness to use consultants (30% to 24%) probably reflecting the fact that the members were now better trained in how to deal with seniors and their families with serious problems and were more knowledgeable of the network of services available. The final two categories "serving on TAPN committees" and "committing to a TAPN speakers' bureau" also showed slight decreases in percentages, respectively 73.3% to 50% and 47.4% and 31.8%. These decreases may have reflected the fact that funding for many agencies had

been reduced substantially during phase two and many members had to perform more work at their agencies which would reduce the amount of time that could be spent elsewhere. Also, it could be that committing to a speakers' bureau had repeatedly been identified as a very low future priority. For these reasons, extra effort should be expended asking TAPN members and their respective boards to suggest and/or recruit others who may be able and willing to volunteer at TAPN. It should be noted that the types of consultants mentioned in the two phases included estate planners, long-term care specialists, social workers, rehabilitation specialists, grant writers, lawyers, interpreters for the deaf, Medicaid specialists, housing specialists, and instructors for the disabled which gave TAPN an idea of the type of expertise that is still required to make the system more responsive to the needs of its senior consumers and their families. Perhaps these types of consultants also could be engaged as presenters for the speakers' bureau which would be one method to provide the expertise requested by members.

The most frequently requested service over time changed from the "need for knowledge of services" to the "need for emergency funds/resources." This again reflected the fact as did the change in the problems facing the network that TAPN had provided the member agencies the knowledge needed to function more effectively in providing services to elderly individuals.

Finally, the listing of agencies to be included or expanded within the network in both phases one and two included physicians, long-term care, and the faith community and churches. Attention should be paid to adding or expanding contact with these systems as they were mentioned both at the beginning and at the end of this study.

Overall, this formative evaluation provided evidence that TAPN was in compliance with the substantive standards that were mutually identified and shown on the TAPN Accomplishment Scale (Gibbs, 2003). It also examined the barriers for entry into the system, the need for services, the strengths and weaknesses of the system, and other data that provided information that will be used for improving the network (Bloom, Fischer, & Orme, 2009; Gibbs, 2003; Royse et al., 2006; Tse, Choi, & Leung, 2008).

**Limitations**

One limitation of this study concerned the representativeness of the sample. Although the response rate was satisfactory (63% in phase one and 65.5% in phase two) the results of this survey should be related only to the TAPN network and should not be generalized outside of that system. Another limitation was that regarding the reliability and validity of the instrument used in this survey. Even though the reliability and validity were judged to be adequate for the purposes of this study in both phases one and two, in the future the contrasted groups should be selected in a more independent fashion. Finally, another potential limitation was that some of the problems/shortcomings mentioned in the report may be beyond the ability of the local community to solve and may require Federal and/or State intervention. For these reasons, the results of this evaluation should be interpreted with these cautions in mind.

**Implications for Practice**

First and foremost was that a model was developed for assessing a network of services. TAPN and its Board, the local area on aging, and outside consultants all reviewed the by-laws, mission, goals, and objectives of TAPN. The end result of this review was the development of a questionnaire that measured the accomplishments of

TAPN, prioritized current and future activities and functions, provided information to better serve clients, identified the problems/shortcomings and strengths of the senior network of services, showed the percentage that would use consultants and become more active in the network, identified the need for additional services as well as agencies that should be included or expanded within TAPN. Next, data were gathered and a report of the findings was shared with TAPN, its board, and member agencies. Strategies for improvement were developed and implemented and data were gathered eight months later to determine if progress had been made. The entire process should be repeated in the future.

Specifically, TAPN was given data which detailed in which areas it had excelled and that which now needed some additional attention. It also was provided information that could be used in determining current and future priorities, how its services benefited agencies and elderly individuals in the county, the problems and strengths of the entire senior service system, who needed what type of consultants and would be willing to voluntarily serve on TAPN committees, etc. and which additional services and agencies need to be included in the network. This type of information may be used to demonstrate the effectiveness of TAPN to its funding sources and may be used in its grant writing to obtain additional funding from foundations and local, state, and federal governments.

Finally, the formative evaluation model may be used by other networks to provide evidence to improve the quality of their practice. This model is powerful enough to produce sound results, yet is practical enough to be easily duplicated.

**Future Research**

After TAPN, the Board of TAPN, and its member agencies have again had the opportunity to attempt to address the issues identified in this report, the survey should be repeated, using a larger more representative sample of TAPN members, to see if there were any significant improvements in the service delivery network. Specifically, it would be assumed that the TAPN Accomplishment Scale scores would remain at high levels; that TAPN membership, activities/functions, and services would increase; and that some of the problem areas and shortcomings that were identified would be addressed. It also, would be useful to assess the outcomes of consumers who were brought before the clinical committee to see if any significant improvements could be identified and to obtain input from a broad, representative sample of older adults and their families who live in Trumbull County regarding the effectiveness of TAPN.

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