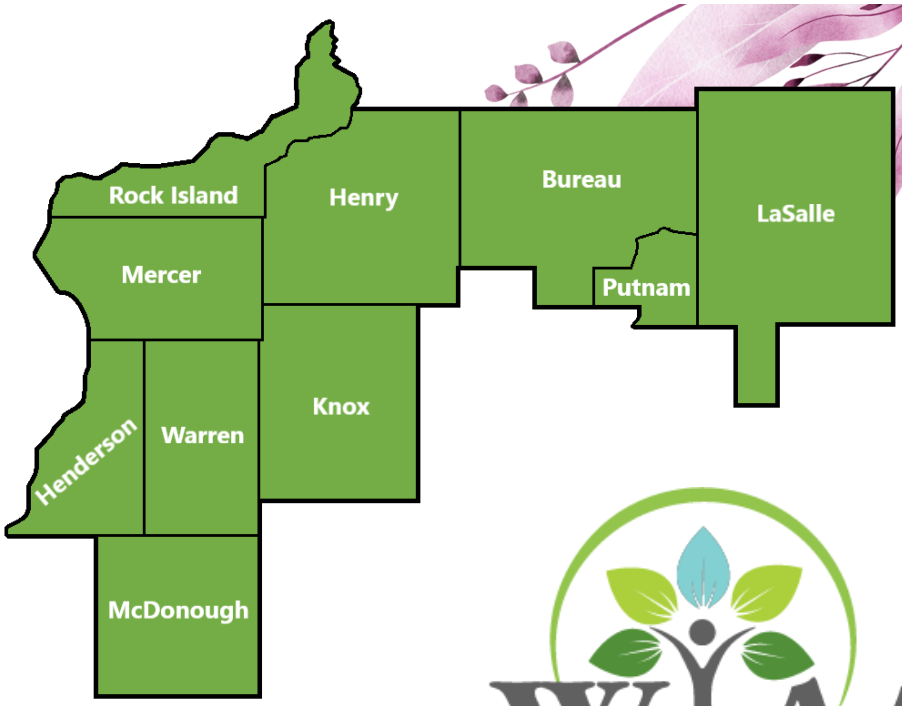


WIAAA

Western Illinois
Area Agency on Aging

Comprehensive Needs Assessment Findings Report

Published April 22, 2024

INTRODUCTION

Western Illinois Area Agency on Aging (WIAAA) is a 501(c)(3) nonprofit that empowers and supports older adults, adults with disabilities, and family caregivers by providing quality services, resources, and opportunities to maintain independence and elevate quality of live. We strive to lead a network of community agencies to provide accessible and coordinated services so that older adults and adults with disabilities may live independent, dignified lives. WIAAA is one of 13 area agencies on aging in the state of Illinois and provides services in these ten counties: Bureau, Henderson, Henry, Knox, LaSalle, McDonough, Mercer, Putnam, Rock Island, and Warren.

BACKGROUND

WIAAA has the primary task of planning and coordinating services and programs to meet the needs of older adults and family caregivers in the ten-county area also known as Planning & Service Area (PSA) 03. This is completed through a Full Area Plan which is a document submitted to the Illinois Department on Aging (IDoA) every three years to receive grants of Older Americans Act funds and General Revenue Funds (GRF). The Area Plan is a formal commitment to IDoA as to how the Area Agency intends to carry out programs and administrative responsibilities and how funds will be used to meet the needs of older adults. To develop the Full Area Plan, WIAAA follows a five-step planning process:

1. Assess Needs of Older Persons
2. Evaluate Existing Service Systems
3. Determine Availability of Resources to Meet Needs and Alternative Approaches Available to Meet Needs
4. Establish Priorities
5. Service Delivery Modification and Refinement

To assess the needs of older adults, WIAAA conducted a comprehensive needs assessment. The methods, analysis, and findings of this research are outlined in the remainder of this report.

METHODOLOGY

The collection and analysis of the data was based on a foundation of sociological research, utilizing both quantitative and qualitative methods. There were two sources from which data was collected: the Needs Assessment Survey and Community Input Meetings. The two will be discussed together in this section, but it is important to note that the former strongly informed the latter.

PLANNING PROCESS

The redesign of the survey and the planning of the Community Input Meetings spanned over four (4) months and took more than 130 hours of staff time. We began by asking ourselves a series of questions. What do we hope to achieve? What do we want to know? How do we want to utilize the gathered information? As we answered these questions and more, we developed three primary goals:

1. Set objectives for the next Area Plan (FY 2025 – FY 2027).
2. Understand the needs of older adults, adults with disabilities, and caregivers in our PSA.
3. Determine how we can better serve older adults, adults with disabilities, and caregivers.

STRUCTURE

Survey

The survey was designed using the online survey platform, Survey Monkey, which allowed us to utilize the piping feature. The piping feature allows respondents to be directed to a specific question(s) based on their response to a previous question. For example, at the end of page one, we asked respondents if they had Medicare. If they responded, "Yes," they were directed to two follow up questions on page two. If they answered, "No," they skipped ahead to page three.

In total the Needs Assessment Survey consisted of 39 questions. There were nine pages of questions. The pages were titled as follows:

Page 1: Tell us about yourself
Page 2: Medicare Questions
Page 3: Questions on Aging
Page 4: Family Caregiver
Page 5: Caregivers
Page 6: Follow Up Questions on Services
Page 7: Current Employment
Page 8: Working in the Aging and/or Disability Field
Page 9: May we follow up?

The first page included nine demographic questions and the previously mentioned question that asked if the respondent had Medicare. Page two asked two follow up questions for those who have Medicare. Page three contained nine questions in relation to aging services and concerns. Five of the questions on page three were matrix questions, which used five-point Likert scales to ask about familiarity of services, agreement statements, and frequency of habits and stressors.

Page four only had one question, "Do you consider yourself to be caregiver?" Above the question we included this statement,

> *We define a family caregiver as someone who provides care for a loved-one. Family is not limited to those you are related to. Care can include anything that you do to assist your loved-one. You do not have to be the primary caregiver to be considered a caregiver.* ***Anything from helping a neighbor with yardwork and groceries to helping your parent with their medications can be considered caregiving.***

If the respondent answered "Yes," they were directed to Page five, which consisted of eight questions about caregiving. If they responded, "No" they were directed to Page six. Page six asked follow up questions about the services respondents indicated they had utilized.

Page seven asked about the respondent's employment and if they worked in the aging and/or disability field. If they answered, "Yes," to working in the field, they were asked two additional questions on Page eight. If they responded, "No," they were directed to Page nine. Page nine allowed respondents to provide their contact information if they were interested in attending one of our Community Input Meetings. Any contact information provided was removed before the data analysis began.

Community Input Meetings

WIAAA conducted eight Community Input Meetings in our ten-county area. Each meeting was a semi-structured group interview. An outline of questions was prepared to provide guidance during the meetings. The semi-structured format allowed us to focus on certain topics while granting the flexibility to ask follow-up questions and omit questions if they were not applicable to the group or if time did not allow. The end goal for these meetings was threefold:

1. Improve the quality and efficiency of service delivery in the planning and service area.
2. Increase access to Older Americans Act services and other older adult programs.
3. Increase the level and type of information disseminated by WIAAA and providers to older adults, family caregivers and the public.

The meetings began with WIAAA's Executive Director welcoming attendees and providing an overview of WIAAA, the structure of the aging network, and an overview of the Older Americans Act. The meetings then shifted into the group interview. Each interview began with an ice-breaker question, then questions about aging, and questions about caregiving. Additional questions were asked relating to Alzheimer's and dementia at some meetings. These additional questions were added after some meetings had already taken place.

EXECUTION

Survey

The survey distribution began on August 22, 2023 and concluded on February 1, 2024. The survey link was distributed to WIAAA service providers along with marketing materials to assist in the collection of surveys.

Community Input Meetings

The eight Community Input Meetings are listed below.

- Mercer County – October 16, 2023 @ Viola Public Library
- Henry County – October 23, 2023 @ Kewanee Public Library
- Bureau & Putnam Counties – October 23, 2023 @Spring Valley Public Library
- Knox County – October 27, 2023 @ Galesburg Public Library
- Warren & Henderson Counties – October 30, 2023 @ Henderson County Public Library
- LaSalle County – November 1, 2023 @ Mendota Area Senior Services
- Rock Island County – November 2, 2023 @ Rock Island Public Library
- McDonough County – November 6, 2023 @ Macomb Public Library

ANALYSIS

SURVEY

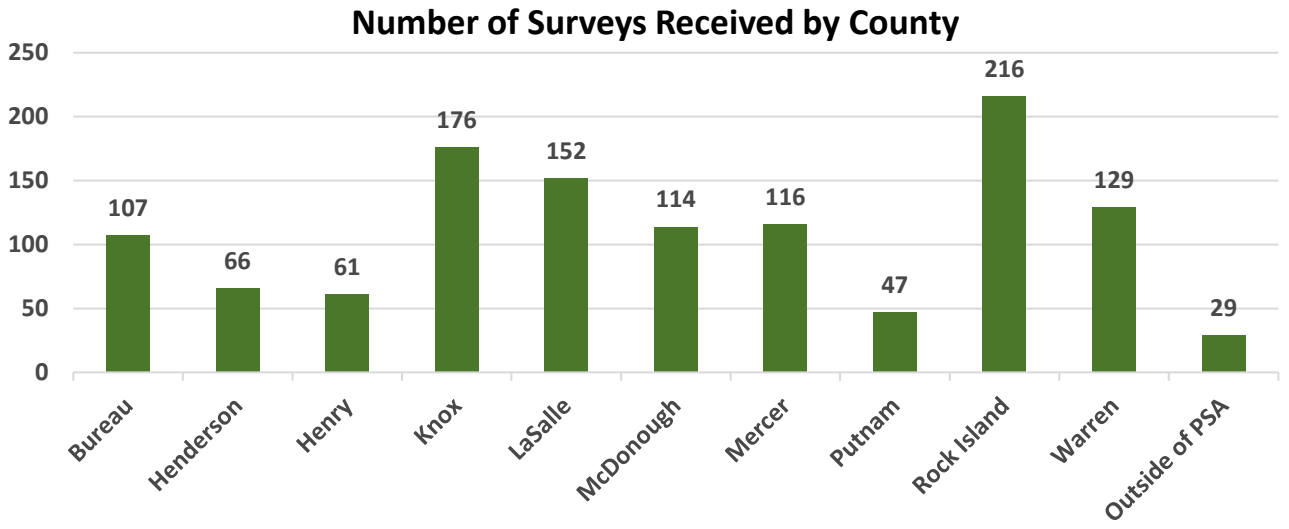
A total of 1,297 surveys had at least one question answered. Ten surveys were removed from the dataset because they answered three or fewer questions. An additional 74 surveys were removed from the dataset because the respondent did not answer questions beyond demographic information. The remaining 1,213 survey responses were utilized in the data analysis.

The dataset was viewed both as a whole and in subgroups. We identified these two subgroups:

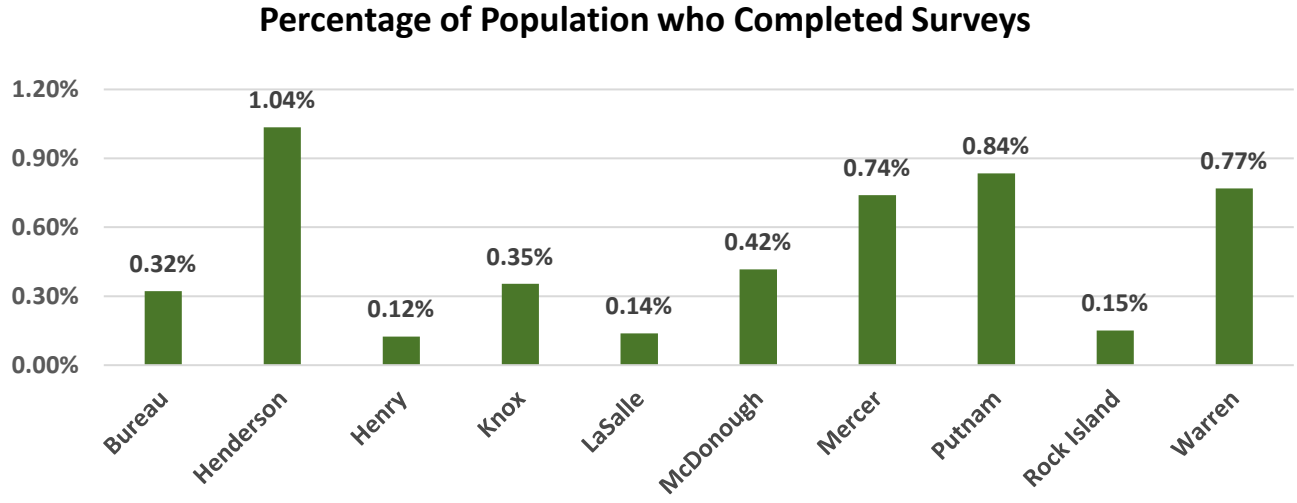
- Older Adults (60+) – 1,030 Respondents
- Self-identified Caregivers – 259 Respondents

Representation

The survey began with nine demographic questions. The first question of the survey asked what county the respondent lived in. Below is a chart showing the number of surveys received from each county.



While the most responses came from Rock Island County, Henderson County was the most represented county based on the number of competed surveys divided by the total population. The chart below shows the percentage of the county population who took the survey.



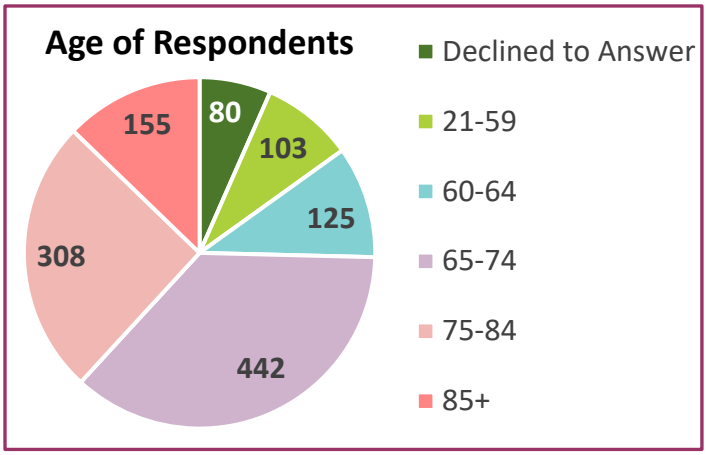
The 2022 Census estimates the total population of PSA 03 will be 457,249 in 2025, with approximately 124,551 people who are 60 and over. Seven of the ten counties in PSA 03 are considered rural, with the other three counties – Rock Island, Henry, and Mercer – categorized by the U.S. Census Bureau as part of the Davenport-Moline-Rock Island Metropolitan Statistical Area. A profile of the older adults who live in our ten-county planning and service area is depicted in the table below:

Profile of Older Adults in PSA 03

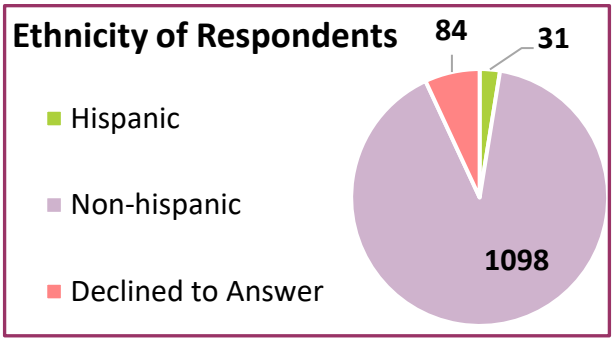
2022 Census Population Estimates for 2025 provided by Illinois Department on Aging

COUNTY	RURAL	TOTAL POPULATION	55+	60+	65+	75+	85+	POVERTY	MINORITY	LIVING ALONE	RURAL
Bureau	Y	33,203	12,249	9,621	7,415	3,291	913	856	574	2,480	9,621
Henderson	Y	6,374	2,760	2,255	1,660	766	272	74	53	545	2,255
Henry	N	49,157	17,348	13,715	10,311	4,407	1,380	1,123	575	3,435	--
Knox	Y	49,751	17,722	14,445	10,844	4,700	1,327	1,646	1,069	4,650	14,445
LaSalle	Y	109,495	37,322	28,710	20,944	8,865	2,706	2,393	1,776	7,305	28,710
McDonough	Y	27,370	8,347	6,708	5,144	2,269	826	572	319	2,225	6,708
Mercer	N	15,692	5,754	4,491	3,381	1,490	417	351	118	1,030	--
Putnam	Y	5,628	2,247	1,890	1,324	533	128	49	75	340	1,890
Rock Island	N	143,819	47,513	38,265	28,436	12,111	3,460	3,488	5,520	10,965	--
Warren	Y	16,760	5,549	4,451	3,258	1,389	483	435	295	1,215	4,451

The age of respondents was not asked outright; rather we asked respondents for their date of birth (MM/DD/YYYY). The question suggested entering "01" for DD to maintain anonymity. Ages were then calculated based on the date in which the respondent filled out the survey. There were 32 respondents who entered the current year as the year they were born. Those responses were added to those who left the question blank. Those two groups were combined into the "Declined to Answer" group.

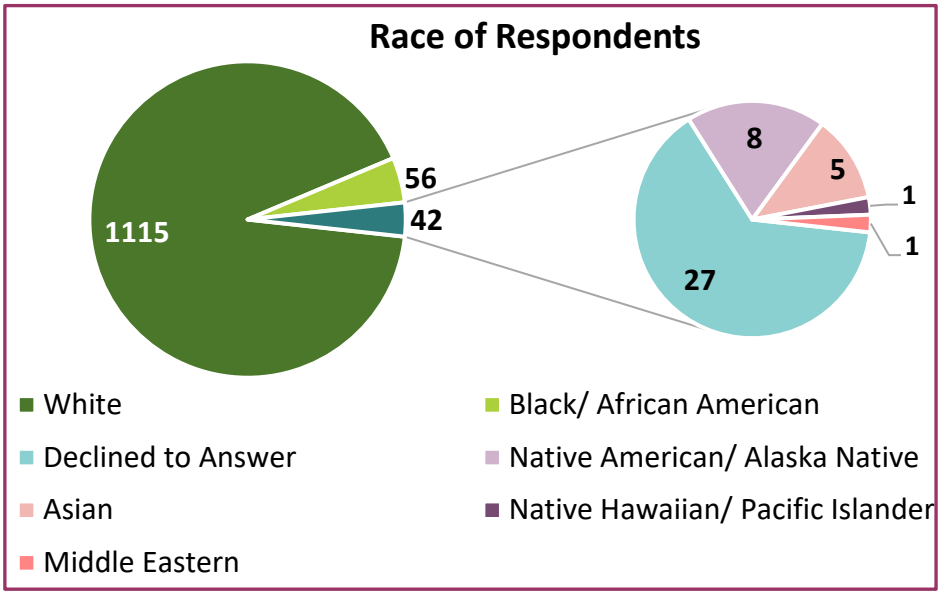


The chart above shows the number of people who fell into each age grouping. It is important to note that the groupings are not equally spaced. This was intentional. The first group listed is the previously mentioned "Declined to Answer" group. The second group (21-59) included anyone who was not considered an older adult. The third group (60-64) included those who are considered older adults but are not eligible for Medicare based on their age. The next two groups (65-74 and 75-84) were evenly spaced by tens. The final group (85+) included the remainder of respondents.

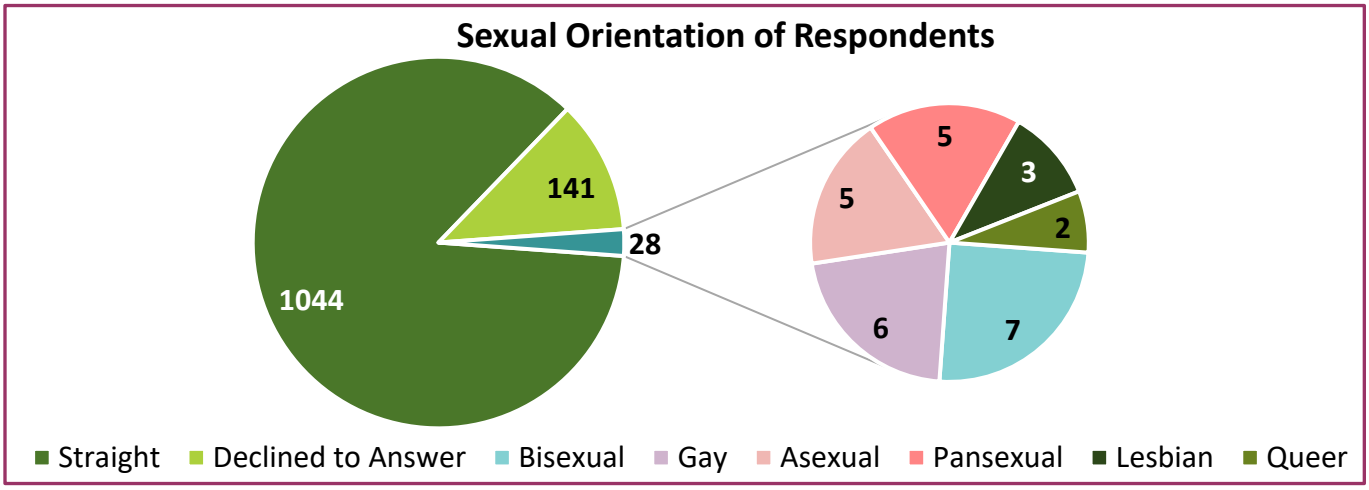


According to the 2020 US Census, just under 80% of the population of PSA 03 was white, and 10% were Hispanic or Latino. The majority of survey respondents were white at 92%. Meanwhile, only 3% of survey

respondents identified as Hispanic or Latino. The lack of diversity in survey responses is something WIAAA was mindful of when analyzing the data. The lack of diversity does not discount the responses we received, but we are aware these results may not be representative of minority communities. The racial and ethnic diversity of survey respondents can be seen in the charts above and to the right.



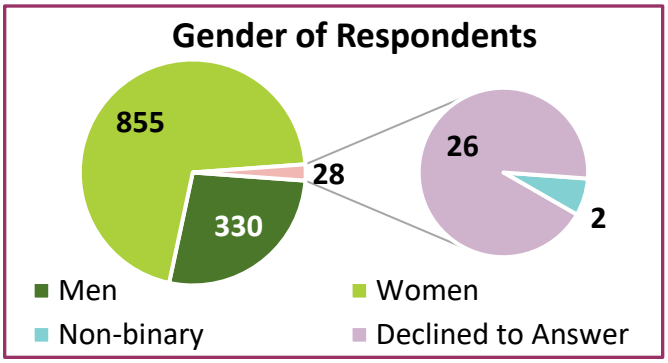
When asked about their sexual orientation, 86% of respondents identified as straight. A chart with the sexual orientation of respondents can be seen below.

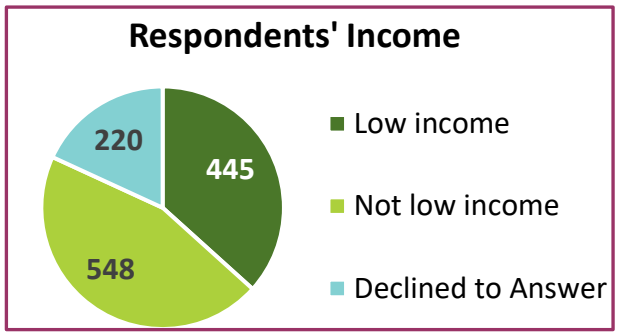


For this question we allowed individuals to self-identify and write-in a response that best aligned with their sexual orientation. Very few people, eight to be exact, chose to write-in a response; however, the responses provided, did not answer the question. For example, someone wrote, “this is a terrible question.” We received feedback from some individuals who were displeased with our questions. We are sharing this information **not** to give weight to those who are offended by such questions, but to highlight the importance of why we collect this information. We acknowledge that it can be uncomfortable to share personal information such as this, and the option of “Prefer not to Answer” was available to respondents; however, it is important to identify and listen to individuals from groups who have been historically marginalized. The response provided from an individual does not change the way we provide services to them. WIAAA aims to provide quality services to all people regardless of race, ethnicity, gender, sexual orientation, or income level. We collect this information to allow ourselves the ability to study trends in the dataset and compare to future datasets. Our data does not

contain enough responses from minority communities to determine if the data trends among minority respondents are representative of that minority group as a whole, so our findings are likely to be more representative of the majority groups of respondents. This does not discount the value of the data we received.

Most survey respondents were women, as can be seen in the chart to the left. It is interesting to note that the two individuals who identified as non-binary were both under 60.





To the right is a chart showing the breakdown of respondents' income level. About 37% of respondents identified as low income, with 18% of respondents declining to answer.

COMMUNITY INPUT MEETINGS

The Community Input Meetings ranged in size from one participant to twenty-one participants. In total 61 people attended the Community Input Meetings. One participant attended two meetings, and one participant attended three meetings.

Table 1

Meeting Code	# of Attendees
A	1
B	4
C	4
D	6
E	7
F	10
G	11
H	21

With more than nine hours of recorded data to review, a thematic coding method was used to analyze the results. While listening to the recordings, we took notes on the responses to each question. We then complied lists of responses, grouping them by question and color coding by meeting. Since the meetings were semi-structured, the questions varied from meeting to meeting, but there were four primary questions asked at each meeting:

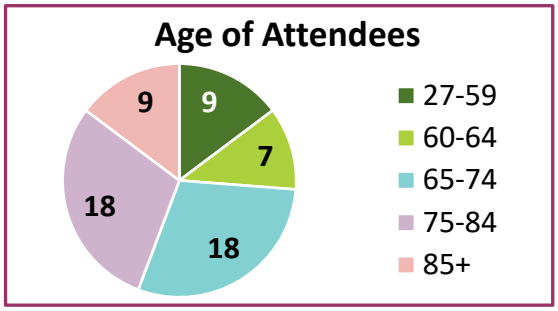
1. What news or information is important to you, and how do you get it?
2. What could help older adults better navigate resources?
3. What concerns do you have in relation to aging and/or caregiving?
4. What services or resources are missing?

Each meeting spent the majority of time discussing the question, "What concerns do you have in relation to aging and/or caregiving?" In the meetings this question was usually split into two questions, one for aging and one for caregiving. For data analysis purposes we combined the two questions. After analyzing the data, we identified 18 themes. Many of the themes overlapped and are interconnected. More details will be discussed in the findings section.

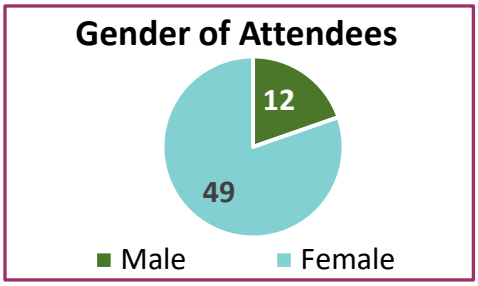
In the findings section each meeting is given a letter label, found in table one. The letter label is used to maintain anonymity while giving context to how many attendees were at each meeting.

Demographics

Demographic information was collected from meeting attendees with an intake form. The intake form collected age, race, ethnicity, gender, and income information.



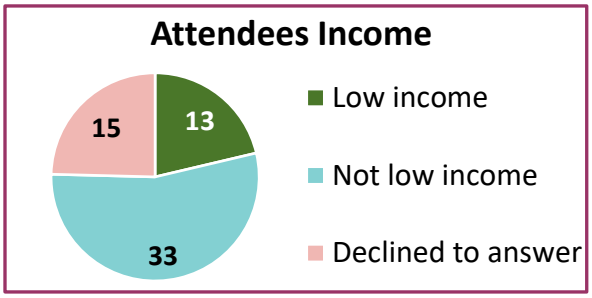
The ages of attendees ranged from 27 years old to 94 years old. Seven of the nine attendees under 60 are from WIAAA funded provider agencies. The other two work with-in the aging and disability field as well. A chart with the age groupings can be seen to the right. As we did with the survey respondents, the groupings are intentionally unevenly spaced. Please see page five for the explanation.



The race and ethnicity of attendees was less diverse than the survey response, with only two people who were Black/ African American and zero people who identified as Hispanic or Latino.

Similar to the results of the survey, the majority of meeting attendees were women. A chart of the gender breakdowns can be seen to the left.

Unsurprisingly, most attendees were not low income. This is unsurprising because we know income can be a barrier both for people to get places and to learn about events. We selected public libraries for most of the meetings in an attempt to eliminate some of those barriers. A chart showing the breakdown of attendees' income levels can be seen to the right.



KEY FINDINGS

After considering the themes identified in meeting data analysis, we analyzed the open-ended responses from our survey. The question, "What other concerns do you have in relation to aging?" resulted in 230 responses. Looking at these responses as well as the overall survey data trends, we identified four key findings:

1. Lack of Awareness of Services
2. General Health Concerns
    a. Falls, balance, and mobility
    b. Social Isolation
3. Need for Transportation
4. Caregiving Concerns

1. AWARENESS OF SERVICES

The number one concern was access to, and awareness of, services. This included concerns about knowing what services are available and finding resources. In our meetings, the phrase, "the people who need the most help don't know how to get it" was often repeated. The lack of awareness of available services was evident in the survey data.

Our survey asked respondents rate their familiarity with twelve services offered in PSA 03. The twelve services were:

- A Matter of Balance (Falls Prevention)
- Adult Protective Services
- Benefit Access Programs
- Congregate Meals
- Home Delivered Meals
- Legal Services
- Senior Health Insurance Program (SHIP)
- Transportation Services
- Information & Assistance
- Long-Term Care Ombudsman
- Reducing Social Isolation
- Senior Center Activities

The familiarity scale was as follows:

- Very Unfamiliar (I have never heard of this service)
- Unfamiliar (I have heard of this service, but I don't know what it is)
- Somewhat Familiar (I know about this service, but I've not used it)
- Familiar (I have used this service)
- Very Familiar (I use this service often)

There were 1,180 respondents who marked familiarity with at least one service. Of those, 1,011 respondents were 60 and over. If familiarity was not indicated by the respondent, it was marked "no response" so long as they responded to at least one service category. Unfamiliar and Very Unfamiliar were combined, as were Familiar and Very Familiar.

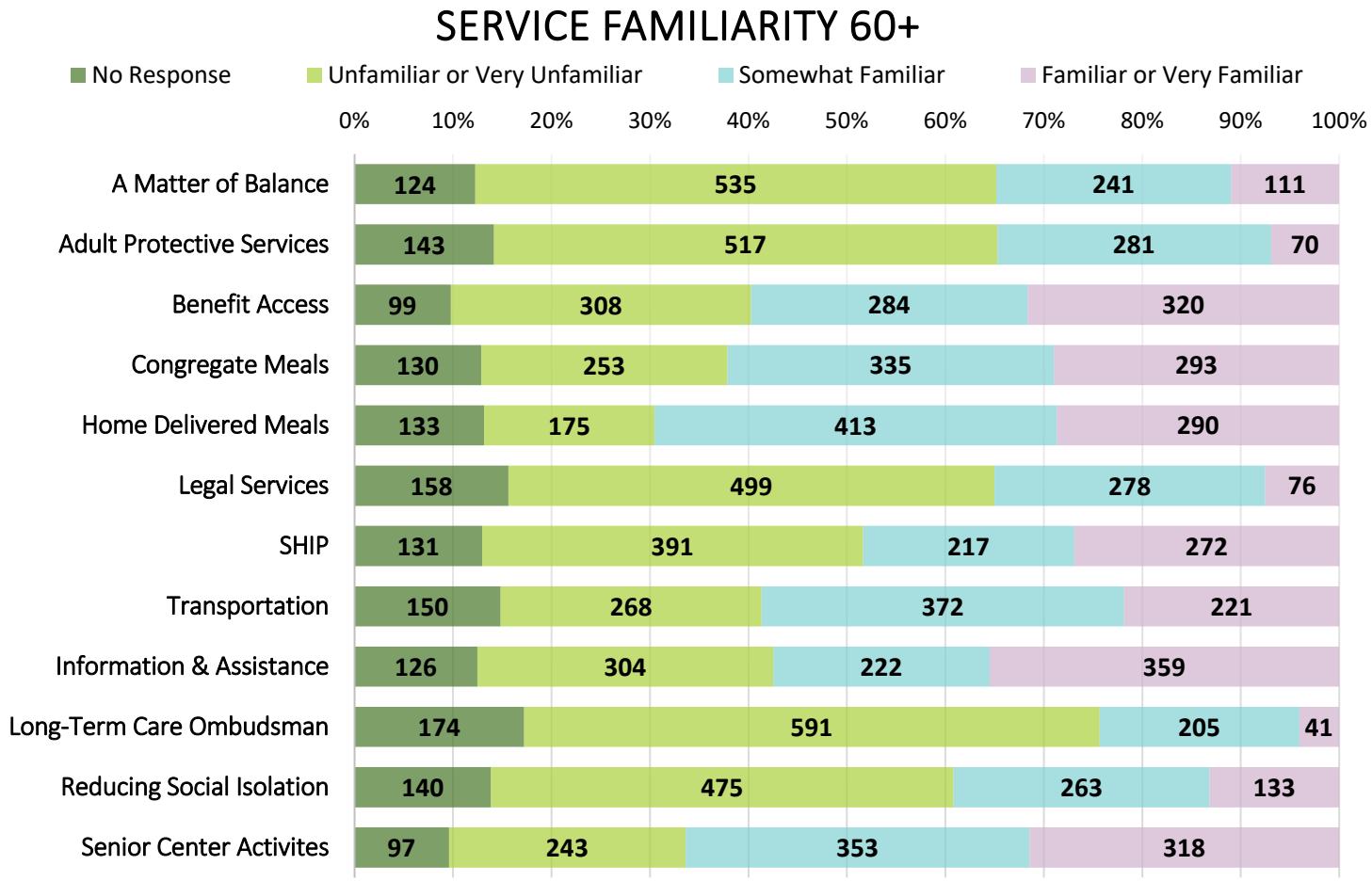
When looking at responses, we noticed a trend among those who left services unmarked (labeled "No Response"). There were 228 respondents who left at least one service blank. The majority (61%) of those did not utilize the "Very Unfamiliar" category for any of the services. This leads us to believe that in lieu of marking "Very Unfamiliar," respondents simply did not mark anything. That being said, we cannot be absolutely positive that this is true, so we have kept "No Response" as its own label. The chart on the following page shows the scall of service familiarity among respondents.

The most highly used service (Familiar and Very Familiar only) was Information and Assistance, with 36% of respondents indicating they had used the service. However, the most well-known services were Home Delivered Meals, Senior Center Activities, and Congregate Meals. These three services each surpassed 60% of respondents either having used the service (Familiar and Very Familiar label) or knowing about the service without having used it (Somewhat Familiar label).

On the other hand, there were five programs that more than 60% of respondents were unfamiliar with or did not respond. Those services were:

- Long-Term Care Ombudsman
- Adult Protective Services

- A Matter of Balance
- Legal Services and
- Reducing Social Isolation



We identified negative stigma as a contributing factor to a lack of awareness of services. Each Community Input Meeting began with the icebreaker question, "What age do you think of when you think of an older adult?" As attendees introduced themselves the majority would respond with an age older than themselves. For example, a respondent from Meeting F said, "I would say the age is 80 because I'm 77." At Meeting B, a respondent said, "I think ten years older than whatever I am at the moment." During Meeting E, someone said, "I didn't think I was old [until I heard these responses]. I'm 86."

The term "older adult" and the idea of aging in general carry negative connotations and stigma with them. An attendee from Meeting B said no one wants to be considered old, "unless I can get a discount." Thinking about our age reminds us of our mortality, which makes most people uncomfortable. In Meeting B, we discussed the stigma of the word "senior" and the term "Senior Center." The term itself seems to be a barrier to getting people in the door.

In our needs assessment survey 794 people had received services from at least one Community Focal Point (CFP), and yet 255 respondents (32%) did not indicate that they were familiar with any of the five

CFP services in the Service Familiarity question. Those services being Benefit Access, SHIP, Information & Assistance, Reducing Social Isolation, and Senior Center Activities. Even more people, 496 of the 794 (62%), did not indicate that they had participated in Senior Center Activities.

2. GENERAL HEALTH CONCERNS

Health was another top concern. The survey asked respondents in the last six month have they worried about their health. 63% of respondents said they worried about their health sometimes, often or always in the last six months. Additionally, 32% of respondents indicated that they had a chronic illness.

2a. Falls, Balance & Mobility

The open-ended survey question resulted in 30 respondents specifically mentioning falls as concern. Among survey respondents who were 60+, just under 50% of respondents said in the last six months they worried about having a serious fall sometimes, often, or always.

2b. Social Isolation

We know that social isolation can negatively impact one's overall health. In Meeting H a woman mentioned the need for mental health services. She prefaced her statement by saying, "I know some people don't like to talk about these things, but it is important." There were nods throughout the room but not much discussion. This is a trend that we have seen with older generations; however, mental health is coming to the forefront.

Many survey respondents indicated feeling lonely. In fact, 559 respondents indicated feeling depressed sometimes, often, or always in the last six months, and 416 respondents indicated feeling isolated sometimes, often, or always in the last six months. Only 14% (81) of those who indicated feelings of depression were familiar with programs that reduce social isolation. And, of those who indicated feeling isolated, only 15% (65) were familiar with programs to reduce social isolation.

3. TRANSPORTATION

Using Likert scales, we asked a series of questions about community, accessibility, concerns, and habits. There were 157 respondents who disagreed with the statement, "I can get where I need to go without any issues." Of those 88 respondents indicated that they do not have access to public transportation. Additionally, 93 of those 157 respondents indicated that they have limited mobility.

Transportation was the most discussed service throughout the Community Input Meetings. Something that was often paired with concerns about transportation was accessing services. A few people identified depending on others to get them to their doctors' appointments. One woman said she felt guilty because her children take time off work in order to take her to appointments. Another woman shared that she was completely dependent on her caregivers to help get her places, in fact she was more than 30 minutes late to Meeting D because she had to wait until her caregiver's shift began. A woman at that same meeting expressed fear of needing to be so dependent upon someone else. She said she was afraid of being unable to drive or get up and down the stairs at her house. Fear was a very common theme that we picked up on in seven of the eight meetings. Often fear was coupled with an idea of losing independence.

4. CAREGIVERS

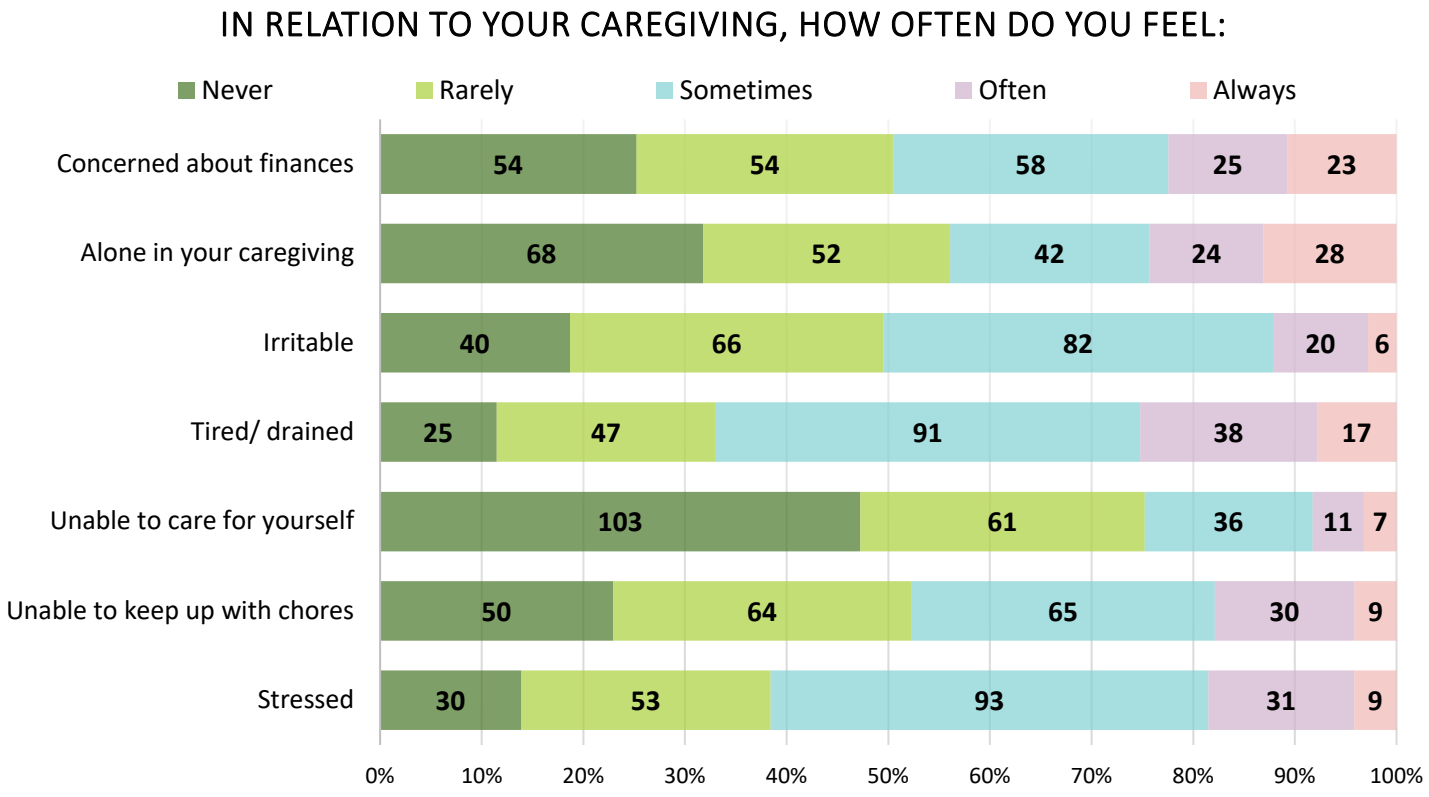
Prior to the collection of this data, we knew that one serious barrier to reaching caregivers is the lack of individuals identifying themselves as a caregiver. When we asked survey respondents if they considered themselves to be a family caregiver, we included this statement:

> *We define a family caregiver as someone who provides care for a loved-one. Family is not limited to those you are related to. Care can include anything that you do to assist your loved-one. You do not have to be the primary caregiver to be considered a caregiver.* ***Anything from helping a neighbor with yardwork and groceries to helping your parent with their medications can be considered caregiving.***

We also included this statement when asking caregiving questions during the community input meetings.

In our survey 259 respondents identified themselves as a caregiver. In an earlier question, 66% of respondents said they had worried about the health of a loved one sometimes, often or always in the last six months. That is 757 people. Worrying about the health of a loved one does not automatically make someone a caregiver, but 80% of self-identified caregivers said they had sometimes, often or always worried about the health of a loved one.

The chart below shows how often caregivers identified with common feelings and stressors associated with caregiving.



More than 60% of caregivers identified feeling tired/ drained and stressed sometimes, often, or always in relation to their caregiving. Around 50% identified feeling concerned about finances and irritable sometimes, often, or always. More than 40% of caregivers identified feeling alone in their caregiving and unable to keep up with chores sometimes, often, or always.

In our community input meetings, caregivers expressed a need for respite options, but very few knew of the existing respite services available. In some cases, participants thought there was an income threshold in order to qualify for respite services, but that is not the case. Our survey showed that less than 8% of self-identified caregivers had utilized respite services. Less than that (7%) had utilized the Stress Busting Program, which is an evidence-based program designed to help caregivers manage their stress and learn coping strategies.

CONCLUSION

The data collected in the Needs Assessment Survey and Community Input Meetings has provided WIAAA with immeasurable insights into the needs of older adults and caregivers in our ten-county area. These findings have assisted in the completion of the Full Area Plan for Fiscal Years 2025 - 2027, and this data will continue to inform our work for years to come.

Many of the concerns identified in our findings can be addressed with existing services and programs in our area. The barrier is that many people do not know that our services and programs are available to them. To bridge this gap, we will prioritize increasing awareness for all programs and services offered in PSA 03. The lack of awareness to services in our area will provide a foundational piece of the future of WIAAA. The need for these services is there, as can be seen in so much of our findings. The key to providing services will be educating the community on the availability of these services. Our goals and strategies for how we will complete this task can be found in our Public Information Document, available on our website.

Our top priority has always been to provide high quality services to older adults, adults with disabilities, and caregivers. We cannot do that if those who need the services most, do not know we exist and are here to provide those services.