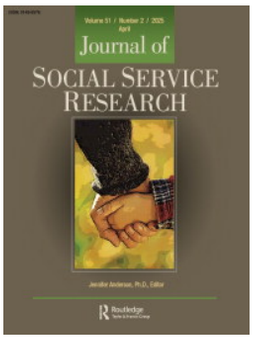

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Older Adults Who Receive Care Coordination from the Third Sector in Ireland: Who Are They, and What Do They Need?

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ABSTRACT

We know little about the older people who seek care coordination services from third sector or voluntary organizations, and their reasons for seeking services. Our aims were to characterize older adults accessing such services from a third sector organization in Ireland; describe their reasons for seeking services ("presenting issues"); and characterize them based on their presenting issues. Participants (n=4,378) were older adults who completed a comprehensive assessment of needs between 1st September 2022 and 9th June 2023. Linear regression was conducted to evaluate potential associations between sociodemographic characteristics and presenting issues. Latent class analysis was then used to identify clusters of presenting issues. Participants were mostly female, aged 60+, and living alone (60%). 62% felt lonely. 63% reported >1 presenting issue, with most issues identified in the health and housing domains. Age, home ownership, receipt of home help, and loneliness were associated with overall number of issues. Four latent classes were identified: Low Core Support Needs, Physical Issues, Psychosocial Issues, and High Core Support Needs. Loneliness was strongly associated with likelihood of belonging to the Low Core Support Needs group, potentially explaining why such a group would seek services. Results are informative for planning of service delivery among older adults.

KEYWORDS

Community; older adults; service delivery; mental health; loneliness

Introduction

Older adults will constitute one-fifth of the total global population by 2050 (World Health Organisation, 2022), an almost-doubling of current proportions. Irish figures echo such projections, with a doubling to 1.6 million expected in the numbers of Irish people aged 65+ by 2051 (Central Statistics Office, 2018). Wren et al. (2017) state that such demographic changes necessitate planning for the health and social care requirements of an increased aging population. Most older adults wish to remain living in their own homes and communities for as long as possible, a concept termed "ageing in place" (Beard et al., 2016; Menezes et al., 2023; Stones & Gullifer, 2016).

Abdi et al. (2019) have advised that considerable supports, both formal and informal, are needed to enable older people to age in place well. According to Roe et al. (2020), such formal supports include statutory services like government-funded home help, received by around 8% of those aged 70+ in Ireland. However, formal support provision is costly; according to May et al. (2023), in Ireland, healthcare for those aged 55+ costs around 10 billion euro, with 90% of these costs attributable to 20% of the population. These costs are partly due to the complex care needs experienced by some older adults as a result of multimorbidity. In Ireland, Hernández et al. (2019) state that around 73% of older adults experience multimorbidity in their lifetime, with this figure rising to above 90% among clinical populations attending geriatric services.

As such, Ireland has an aging population who desire to remain aging in place, but who have

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high rates of multimorbidity and resulting complex care needs. For instance, an older adult who is both hypertensive and diabetic may have care needs which would not apply if only one morbidity were present, so careful coordination is needed. In this context, about one third of older Irish adults report a lack of support in coordinating their healthcare, which can lead to preventable adverse events such as medication errors and unnecessary hospitalizations (HSE, 2024).

The care coordination model is a way of avoiding such adverse events. Berkowitz et al. (2018) characterize care coordination as providing continuity of care across healthcare providers with the aim of improving outcomes and reducing costs, with Abendstern et al. (2016) indicating that such care usually involves a needs assessment undertaken by a healthcare worker who then creates a support plan, and typically monitors the support plan over time.

Third sector organizations, which are non-statutory and not-for-profit, are responsible for many activities in care coordination, in the US and Australia, and more recently, in Ireland and the UK (Abendstern et al., 2018; Jasper et al., 2018). Third sector organizations account for many deficits in the statutory healthcare systems and vary in the breadth of services they offer (Abendstern et al., 2018; Chester et al., 2015). Receipt of care coordination is associated with increased quality of life and reduced institutionalisations for recipients (Owusu et al., 2023; Szanton et al., 2022), and Elston et al. (2019) state that it is associated with improved wellbeing, reduced social isolation, and with increased support for family carers.

In Ireland, ALONE is a third sector organization providing care coordination *via* their support coordinators. The ALONE care coordination model has had such success that it has recently been extended to the national health service Enhanced Community Care program which aims to ensure that all primary and secondary care services work in an integrated way to meet population health needs (HSE, 2024). The ALONE care coordination service supports older adults to age in place by developing personalized support plans and finding solutions for their presenting issues. Presenting issues are the problems or concerns that motivate older adults to refer or be referred to the care coordination service. Such issues can be very diverse—housing, physical and mental health, personal care, mobility, finances, security, and social isolation are all issues commonly reported by older adults (Agustini et al., 2020; Bhuyan & Yuen, 2022; Chandola & Rouxel, 2022; Curtis et al., 2021; Fenelon & Mawhorter, 2021; Kalu et al., 2023; Malcolm et al., 2019; Musich et al., 2018; Orr et al., 2016; Pantelaki et al., 2021; Peterson et al., 2014). We lack information on the typical number of issues of older adults presenting to care coordination services, and on the characteristics of older adults reporting diverse issues. For instance, according to Ward et al. (2019), among older adults more broadly, living in Dublin is more associated with social isolation than living rurally. Such knowledge about care coordination recipients specifically would be useful to organizations in planning provision of services.

There is currently a broader paucity of research on care coordination as provided by the third sector, despite promising evidence that such services are beneficial (Abendstern et al., 2018; Elston et al., 2019). According to Jasper et al. (2018) we know very little about who precisely seeks care coordination services, and about why they seek such care. Hughes et al. (2020) state that i is vital to answer these questions and add to the evidence base concerning care coordination. If we can characterize the users of care coordination services, then organizations will better be able to target their limited resources. By inspecting the issues that are most commonly described by older people seeking care coordination, and by characterizing older people presenting with distinct sets of issues, and those who have more presenting issues than most, we can also reflect on the needs currently unmet by statutory services.

An evidence base is growing for the impact of care coordination services, but there is as yet limited research on the characteristics of care coordination service users, and their patterns of presenting issues. Govier et al. (2024) remarked on this lack of information, and went on to characterize recipients of the care coordination service offered by the Veterans Health Administration;

most recipients were aged 65+, male, white, and living alone. We still lack information on the sociodemographic characteristics of care coordination service users, and the extent of their care needs, beyond this study.

As such, in the current study, we wanted to explore (1) to what extent sociodemographic characteristics explain the overall number of presenting issues among older adults seeking care coordination services from ALONE, (2) how such presenting issues cluster into latent classes in this population, and (3) sociodemographic profiles associated with the distinct latent classes identified in (2).

Methods

Design and Participants

The study used a cross-sectional, observational design. A secondary data analytic approach, utilizing archived data collected from older adults supported by ALONE was used. Participants ($N = 4{,}378$) were older adults who completed a comprehensive assessment of needs between 1st September 2022 and 9th June 2023. Assessments were carried out by a Support Coordinator to capture detailed information about the condition or situation of an older person. Information was recorded about the needs of the older adult, as they reported directly to the support coordinators, and formed the basis of referrals to interventions to address each reported need. As Table 1 shows, the largest proportion consisted of older adults aged between 81 and 85, which represented 21.4% of the sample group. Most participants were female ($N = 2{,}705$; 62%), and many (71%) were homeowners. Of the sample, 60% lived alone. 20% had self-referred to ALONE services, while 60% had been referred by an external agency. Only 35% were in receipt of home support. 62% indicated that they were lonely.

Procedure and Materials

Information about older people who engage with ALONE services was captured using a tailored Management Information System (MIS). The research team were facilitated to access data recorded from older people who had indicated their consent for their data to be shared for research purposes. First, older adults engaging with ALONE conducted a structured comprehensive assessment of needs with a trained support coordinator. The assessment was preceded by a scripted consent process in which the support coordinator explained to the participant the reason for the assessment, and how their data would be used. Older persons had the option to also provide consent for their data to be stored for research purposes. Consent was recorded by the support coordinator on a digital form. As such, participants in our study are those older people who underwent a comprehensive assessment of needs and who agreed for their data to be stored for research purposes.

This data included demographic characteristics (i.e., age [recorded in 5-year bins, e.g., "61–65; 66–70"], gender [recorded as male or female], home ownership, living circumstances, receipt of homecare, referral source, and presenting issues. With regards to the presenting issues, eight core domains were involved: housing, personal care, physical health, mobility, emotional/mental health, social isolation, financial issues, and safeguarding. If an older person identified challenges in any of these domains (a yes/no response), they were prompted to specify the nature of the difficulty from a predefined list of potential concerns. Within each of these categories there was a list of more specific problems from which they may identify their need. For instance, within the housing domain, an individual might identify a need related to external repairs, such as fixing windows. The older adult was then asked whether they were able to address this issue independently, or whether they required assistance from ALONE. If assistance was needed, an intervention was automatically generated, but this information was not relevant to our current research aims. Further information about how each of these variables were measured following assessment from participants is in Tables 1 and 2. Ethical approval for this research was granted by the local Research Ethics Committee.

Table 1. Sociodemographic characteristics of sample ($N = 4378$).

	N	%
Gender		
Male	1652	38
Female	2705	62
Age		
60 and under	55	1
61–65	299	7
66–70	455	10
71–75	666	15
76–80	845	19
81–85	901	21
86–90	635	15
91+	282	6
Home ownership [asked as "Do you own your own home?" followed by "if not, where are you living?"]		
Homeowner	3100	71
Approved housing body	73	2
Local authority	534	12
Private rented	155	4
Other (e.g., homeless)	196	5
Living circumstances [asked as "Is there anyone else living with you?"]		
Friend	17	0
Living alone	2635	60
Lodger	20	1
With immediate family/partner	1064	24
With extended family	109	3
Referral source [this is recorded at referral by the organization]		
external agency	5447	60
internal referral	583	7
Public (friend/family)	1293	14
Secondary referral	26	0
Self	1810	20
In receipt of home support [asked as "Do you currently receive home help support?"]		
Yes	1543	35
No	2719	62
Loneliness [asked as "Do you feel lonely?"]		
Yes	2628	62
No	1635	35
Visitors [asked as "Is there anyone who comes to visit you?"]		
Yes	2802	64
No	1456	33
Out socially [asked as "When was the last time you were out socially?"]		
In the past year	2386	56
More than a year ago	236	5
Hobbies [asked as "do you have any hobbies or activities that you do regularly, things like clubs or groups you go to regularly?"]		
Yes	1489	34
No	2766	63
Number of issues reported per person [see Table 2 for items]		
None	294	7
One issue	1301	30
Two issues	956	22
Three issues	731	17
Four issues	532	12
Five issues	302	7
Six issues	116	3
Seven issues	27	1
Eight issues	3	0

Data Analysis

Data were analyzed in SPSS Version 27 and in R Studio. To respond to the first aim ("to what extent do sociodemographic characteristics explain the overall number of presenting issues among older adults seeking care coordination services from ALONE?"), a standard multiple regression analysis was used to determine how well the overall number of presenting issues reported by older adults (a count variable) could be explained by the sociodemographic characteristics listed in Table 1: that is, gender, age, home ownership, living circumstances, loneliness, receiving visitors, social activity, hobbies, and home support. Preliminary analyses indicated some minor violations of the assumptions of normality, linearity, and homoscedasticity of the residuals, but these were judged to be within the bounds of tolerance of a regression approach to analysis.

Table 2. Presenting issues and sub-issues endorsed by participants ($N = 4378$).

	N endorsing each issue	%
Housing (asked as "Are you having any issues with your housing?")	1387	32
Cleaning/Decluttering ("Do you have any issues with cleaning and decluttering?")	715	17
Internal/external repairs ("Any issues with internal repairs?"/"Any issues with external repairs?")	455	10
Housing adaptations ("Any issues with housing adaptations?")	242	6
Personal Care ("Are you having any issues with your personal care?"; with the below subcategories listed under "Are there any specific areas you might need a bit of help with?")	1179	27
GP/Primary Care engagement	374	9
Home/carer support	281	6
Nutrition	236	5
Physical Health ("Are you having any issues with your physical health care?")	2128	58
Falls ("Have you had any falls lately?)	938	21
Memory ("Any issues with memory?")	327	8
Hearing ("Any issues with hearing?")	221	5
Mobility ["Are you having any issues with your mobility?" with the three listed areas below after "Are there specific areas you might need a bit of help with?"]	1323	30
Mobility aids	234	5
Mobility fixtures	183	4
Mobility furniture	105	2
Mental Health ("Are you having any issues with your mental health?)	1131	33
Dementia/Alzheimer's ("Any issues with dementia/Alzheimer's?")	280	6
Depression ("Any issues with depression?")	250	6
Anxiety ("any issues with anxiety?")	195	5
Finance [asked as "Are you having any issues with your finances?"] with the three listed areas below after "Are there specific areas you might need a bit of help with?"]	1308	30
Benefits	470	11
Utilities	413	11
Entitlements	266	16
Safeguarding ["are you at risk of abuse in any way?" with an illustrative list of types of abuse and a definition provided]	56	1
Social Isolation [asked as "Are you having any issues with social activities?"]	1040	24
Visitation support and befriending ["Would you like us to support you with visitation support and befriending?"]	1817	43
Telephone support and befriending ["Would you like us to support you with telephone support and befriending?"]	1237	29

To respond to the second aim ("to evaluate how the presenting issues cluster into latent classes in this population"), a latent class analysis (LCA) was planned, using the poLCA package in R (Linzer & Lewis, 2011). LCA is a statistical approach for identifying clustering classes using categorical indicators, such as the ones we have with respect to presenting issues (i.e., the "yes"/"no" responses to each issue, see Table 2 for the items). We used LCA to identify subgroups of the study sample characterized by these presenting issues. Following existing guidelines, versions of the LCA using 2–5 classes were tested using the estimation-maximisation algorithm, and models compared using the Bayesian Information Criterion, Lo-Mendell-Rubin likelihood ratio test, and a bootstrapped likelihood ratio test (Nylund et al., 2007) facilitated by the boot package in R (Canty & Ripley, 2017). Finally, to respond to the third aim (to identify the sociodemographic profiles associated with each latent class of presenting issues identified above), the LCA was repeated to establish potential associations between sociodemographic characteristics and membership of the classes identified in the first LCA.

Results

As Table 1 shows, 30% of participants reported a single presenting issue, with 22% reporting two issues, 17% reporting three issues, 12% reporting four issues, and smaller proportions reporting up to eight issues. Notably, 7% reported no issues. Further analysis indicated physical health, mental health and housing needs were most prevalent (see Table 2). A range of sub-issues emerged within each of these areas, with those concerning loneliness/social isolation (as evidenced by requirement for support and befriending services), falls, and cleaning/decluttering the most frequently endorsed.

Aim 1: To What Extent Sociodemographic Characteristics Explain the Overall Number of Presenting Issues among Older Adults Seeking Care Coordination Services from ALONE?

As Table 3 shows, a standard multiple regression examining the relationship between demographic characteristics and level of need indicated the model as whole explained 6.6% of variance in the

Table 3. Multiple regression evaluating the relationship between the overall number of issues reported and sociodemographic predictors.

	R^2	Adj R^2	β	B	SE	CI 95% (B)
	0.066	0.062				
Gender			−0.01	−0.04	0.06	−0.17/0.08
Age			−0.11*	−0.09	0.02	−0.13/−0.06
Homeownership			−0.06 *	−0.23	0.08	−0.38/−0.09
Living circumstances			0.02	0.05	0.07	−0.08/−0.18
Loneliness			0.20*	0.63	0.07	0.50/0.76
Visitors			−0.00	−0.01	0.07	−0.15/13
Out socially			0.02	0.02	0.03	−0.03-.08
Hobbies			−0.01	−0.03	0.07	−0.16/.11
Home support			0.09*	0.30	0.07	.17/.44

R^2, R-squared; Ajd R^2, adjusted R-squared; β = standardized beta value; B = unstandardized beta value; SE = Standard errors of B; CI 95% (B) = 95% confidence interval for B; $N = 398$; Statistical significance: $^*p < 0.05$.

Table 4. Comparison of latent class analyses for 2–5 classes of presenting issues ($N = 8$ issues).

Number of classes	Number of parameters	Degrees of freedom	BIC	Maximum LL	LMRA-LRT	BS LRT	Entropy
2	17	238	35348.47	−17657.23			0.68
3	26	229	35187.01	−17.567.51	172.58, $p < 0.001$	193.63, $p > 0.05$	0.64
4	35	330	35114.23	−17522.12	87.29, $p < 0.001$	102.13, $p > 0.05$	0.60
5	44	211	35330.72	−17481.49	78.14, $p < 0.001$	80.44, $p > 0.05$	0.58

BIC, Bayesian Information Criterion; LMRA-LRT, Lo-Mendel-Rubin adjusted likelihood ratio test; BS LRT, Bootstrapped likelihood ratio test.

overall number of issues, $F(9, 2394) = 18.69$, $p < 0.001$. Age ($\beta = -0.11$), homeownership ($\beta = -0.06$), loneliness ($\beta = 0.20$), and home support ($\beta = 0.09$) were significantly associated with the overall number of issues reported by older adults. Of all significant predictors, loneliness yielded the largest effect on overall number of issues, followed by age, home support, and finally home ownership as the weakest effect. A shift from a "no" response to a "yes" response to the question "do you feel lonely?" resulted in an increase of 0.63 in the number of presenting issues.

Aim 2: How Do Presenting Issues Cluster Into Latent Classes among Users of the ALONE Care Coordination Service?

The eight variables representing endorsement or non-endorsement of each of the eight core domains of presenting issues (see Table 2) were then included in a latent class analysis (LCA). The aim of the LCA was to explore whether patterns of responding to these eight issues clustered in the sample. Models with 2–5 classes were all run and compared (see Table 4). As can be seen, the bootstrapped likelihood ratio tests comparing these models were not significant ($\chi^2 = 193.6$, $p > 0.05$; $\chi^2 = 102.13$, $p > 0.05$; $\chi^2 = 80.44$, $p > 0.05$), so to further differentiate the classes, the BIC was used as an optimal comparator (Nylund et al., 2007). Lower BIC scores indicate relatively better fit, and the four-class model yielded the lowest BIC. As such the four-class model was deemed the best performing model.

Within the four-class model (see Figure 1), Class 1 ($N = 626$, 14.7%) was characterized by low probabilities of most of the eight core issues assessed, with some higher (<0.3) probabilities of endorsing Financial and Housing issues—these were termed the Low Core Support Needs group and ordering was applied to the latent classes to ensure this class was the referent group for the below regression analyses. Class 2 ($N = 1971$, 46%) was the largest class and had high probability of endorsement of mental health issues and social prescribing issues. This class was labeled the Psychosocial Issues group. Class 3 ($N = 1200$, 28%) was the second largest, and was characterized by high probability of endorsement of both physical health and mobility issues; this class was labeled the Physical Issues group. Class 4 ($N = 468$, 11%) was characterized by a high probability of physical health, personal care, and housing issues—these were labeled the High Core Support Needs group.

Aim 3: What Are the Sociodemographic Profiles of Each of the Latent Classes Identified in Aim 2?

To assess the sociodemographic profiles of these four latent classes, we added their characteristics (age, gender, ownership of home, living status,

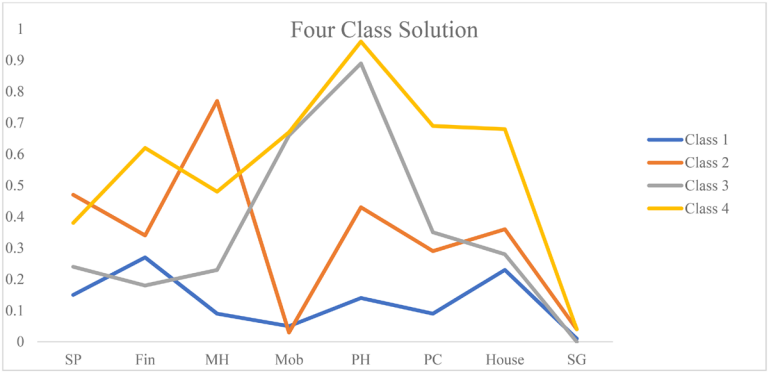

Figure 1. Profile plot of estimates from latent class analysis of presenting issues (SP, Social Isolation; Fin, Financial Issues; MH, Mental Health issues; Mob, Mobility Issues; PH, Physical Health; PC, Personal Care issues; House, Housing issues; SG, Safeguarding issues).

Table 5. Multinomial Logistic Regression of Pathways from demographic characteristics to class membership probability (four class solution).

	B	SE	*T*	OR	*p*
Psychosocial Needs versus Low Core Support Needs					
Intercept	−0.16	0.43	−0.39	0.85	0.697
Age	0.26	0.05	5.52	1.30	<0.001
Gender	0.09	0.14	0.64	1.09	0.520
Home owner	0.35	0.15	2.26	1.41	0.025
Living status	0.02	0.03	0.52	1.02	0.607
Loneliness	−2.23	0.27	−8.32	0.11	<0.001
Physical Issues versus Low Core Support Needs					
Intercept	0.69	0.76	0.89	1.98	0.37
Age	0.14	0.09	1.55	1.15	0.12
Gender	0.06	0.28	0.22	1.06	0.82
Home owner	−0.19	0.29	−0.64	0.83	0.52
Living status	−0.15	0.07	−2.31	0.86	0.022
Loneliness	−11.97	0.001	−420740.11	0.000006	<0.001
High Core Support Needs versus Low Core Support Needs					
Intercept	−4.11	0.66	−6.21	0.016	<0.001
Age	0.61	0.06	9.67	1.83	<0.001
Gender	−0.19	0.18	−1.09	0.82	0.275
Home owner	0.19	0.21	0.91	1.21	0.366
Living status	0.06	0.04	1.68	1.07	0.095
Loneliness	−1.52	0.31	−4.92	0.22	<0.001

and loneliness) as predictors of class membership, in a multinomial logistic regression with the four classes identified above as outcomes. Inclusion of these characteristics improved model fit somewhat (BIC 29400 versus 35114, max. log-likelihood −14650; see Table 5). The odds of being in the Psychosocial Needs group relative to being in the Low Core Support Needs group were higher with increasing age (OR = 1.3, $p<0.001$) and with being a home owner (OR = 1.41, $p<0.05$), but lower with endorsement of loneliness (OR = 0.11, $p<0.001$). The odds of being in the Physical Issues group relative to being in the Low Core Support Needs group were lower with living alone (OR = 0.86, $p<0.05$), and lower with endorsement of loneliness (OR = 0.000006, $p<0.001$). Finally, the odds of being in the High Core Support Needs group relative to the Low Core Support Needs group were higher with increasing age (OR = 1.83, $p<0.001$), and lower in those who endorsed loneliness (OR = 0.22, $p<0.001$).

Discussion

The primary aims of this research were to understand (1) whether sociodemographic characteristics are associated with the overall number of presenting issues among older adults seeking ALONE community support services to age at home, (2) whether such presenting issues clustered into latent classes in this population, and (3) the sociodemographic profiles of each latent class. This research was conducted in the context of a paucity of knowledge about who uses care coordination services, and their presenting issues.

In our findings, we report that the largest proportion (30%) of participants had a single presenting issue. The issues most commonly identified as presenting issues were those concerning physical and mental health, and housing support.

The demographic profile of the sample reflects a broad representation of older adults, with a significant proportion aged 81–85, female and homeowners. As has previously been found with respect to the ALONE older person base, most lived alone, and one third received home help. However, the proportion of older people engaging with ALONE who are homeowners is lower than observed among the national population (83.4%; (Central Statistics Office, 2022)). This could suggest that older people living in precarious or rented accommodation may have a higher degree of need for support. A substantial proportion of the sample lived alone, while loneliness was a prevalent issue, and over one-third of older people did not have someone who regularly visited them.

Congruent with previous research, findings from this study indicate there are myriad and sometimes overlapping challenges experienced by older adults, relating to their physical and psychological health, self-care, and social lives. While over half the sample reported one or two main presenting issues, over 40% reported three or more issues. Physical health, mental health and housing issues were reported most often, while the study indicated mental health issues were a predictor for six of the seven other main presenting issues. This underscores the need for comprehensive approaches that consider the social and psychological dimensions of aging, alongside physical health. Unfortunately, O'Regan et al. (2011) have indicated that mental health difficulties among older adults are often under-recognised, under-diagnosed and under-treated.

The association between presenting issues and various demographic factors shed light on the complexity of needs within different subgroups of the older population. Age, home ownership, receipt of home support and loneliness were all significant predictors of higher need among older adults. Findings indicated younger participants, those who did not own their own homes, who were lonely, and who were receiving home support had a higher level of need. Loneliness was the strongest predictor of numbers of presenting issues. While it may be obvious that those with home help and those who do not own their own homes are likelier to need support, loneliness is a distinct risk factor. Prior research on loneliness in later life indicate that it precedes numerous adverse health events (Baarck & Kovacic, 2022) including early mortality (Wang et al., 2023; Zhou et al., 2023). Loneliness has also been shown to predict health and social care utilization among older adults (Christiansen et al., 2023; Wang et al., 2019). As such our finding that loneliness is associated with greater overall levels of need among older adults is not surprising. What was surprising was the strength of the effect of loneliness on level of need—it exerted a stronger association with overall number of issues than any other predictor explored in our models. This finding is intriguing in the context of increased national and international attention on loneliness as a public health issue (e.g., Holt-Lunstad, 2017, but see Jentoft et al., 2025, for a critical review of the public health approach to loneliness). Interventions for loneliness may yield significant impacts on level of need for services among older adults living in the community.

These results align with Abdi and colleagues' (2019) previous emphasis on the multifaceted nature of older adults' requirements and indicating that a nuanced understanding of demographic factors is essential for tailoring interventions effectively. It should be noted that overall these sociodemographic predictors accounted for very little of the variance in number of presenting issues, however, so other factors not explored here may be worth reviewing to better understand correlates of presenting issues in users of care coordination.

In the results of the latent class analysis, the largest group identified was the Psychosocial Needs group, suggesting that mental and social support needs are driving older adults who are aging at home the most to seek community supports. There was a minority (15%) of participants who were classified as low core support needs; that is, they did not seem to have a high probability of endorsing any of the eight core domain presenting issues. This group were characterized

as lonelier than all three other classes and this could mean that there is a subgroup of older participants who seek community support to age at home because of feelings of loneliness rather than the other eight core domain presenting issues. This may potentially explain the 7% of participants who did not endorse any presenting issue upon seeking community support. A previous evaluation of ALONE services demonstrated that a significant minority of older adults were seeking befriending services without endorsing any clear presenting issue (Burke, 2015). It appears that loneliness may be driving service-seeking in care coordination services, which makes sense in the context of the broader body of existing evidence linking loneliness to higher healthcare utilization more generally (Christiansen et al., 2023). Given that current loneliness interventions are yielding small to moderate effect sizes only (Beckers et al., 2022), we urge further research on how best to respond to loneliness among older adults, so that it does not increase the burden in healthcare utilization in other domains. This pattern of results could suggest that statutory services are not currently meeting the need for loneliness interventions in Ireland.

Our findings highlight the importance of adopting a comprehensive person-centered approach in the provision of support to older adults, as there was considerable overlap between many presenting issues. Lines et al. (2015) define person-centered care as meeting the multidimensional needs and preferences of older people dependent on care, by acknowledging the carers as well as the family—considering individual needs, goals, and abilities. Many studies and reports discuss the effectiveness of PCC, with holistic or whole person care often described as a core domain (Ebrahimi et al., 2021; Kogan et al., 2016). Hobden et al. (2022) highlight the limited research which has to date explored PCC among community-dwelling older adults, although a deeper comprehension of PCC could enhance the development of policies and initiatives to support aging in place.

Study Strengths

We used a dataset with a large sample size of older adults seeking care coordination from a third sector organization. This is a considerable strength given that the sample is quite specific. We used a suitable analytic strategy to allow us to comment effectively on the clustering of presenting issues among community-dwelling older adults seeking care coordination services. Data were collected by trained support coordination staff at ALONE during a structured, holistic assessment of needs. We also focused our research questions on a clear and critical gap in the literature; characterizing the demographics and needs of older people seeking care coordination services from third sector organizations.

Study Limitations

Nonetheless, there are some limitations. Because this study is a secondary data analysis, we did not have input into the assessment design and as such we lack information on several characteristics of interest such as socioeconomic status, employment/education status, and ethnicity. The cross-sectional nature of the study also limits the ability to establish causation or capture changes over time. Given the unique nature of the cohort, inspection of their characteristics indicates that the results here could not be generalized to the broader aging Irish population.

Study Implications

The study carries implications for both practice and research. Given that aging in place and care coordination approaches are increasingly predominant frameworks for the care and support of older adults globally, this study holds both national and international relevance. In terms of practice, third sector organizations like ALONE who are delivering care coordination to older adults aging at home will benefit from increased knowledge of the characteristics of those adults. Most participants needed support with physical or mental health, or with housing. As such support coordinators working with ALONE should be prepared to provide a broad range of possible solutions within these presenting issues. 7% of participants had no presenting needs; ALONE could focus more explicitly on identifying the motivations of such participants for receiving a

care coordination assessment to avoid wasting resources in other areas. Among participants with low core support needs, loneliness was a strong correlate; ALONE offer a visitation and support "befriending" service which may be a valuable way of supporting such individuals. Statutory services should also be reviewed for their effectiveness in reducing loneliness among older Irish adults. Finally, given that most participants only had one presenting issue, with a small minority presenting more than one issue, providers of care coordination could bear this in mind when assigning resources to assessments.

With respect to research, this study is an important attempt to fill the current gap in what we know about who receives care coordination, and their pattern of presenting issues. Further research is required to explore the longitudinal sequelae of such presenting issues, and to establish the success of care coordination contingent on baseline patterns of presenting issues, to further comment on the best way to provide such resources in the context of limited third-sector organization funding and service provision. Further research is also required on the prevalence of housing needs issues among older people in Ireland, in the context of decreases in numbers of older adults nationally who own their own homes (Central Statistics Office, 2023).

Conclusion

To summarize, we report that in Ireland, care coordination from the third sector is typically sought by female adults who own their own homes and live alone, report feeling lonely, and are referred by someone else. Loneliness was the strongest predictor of high overall levels of need among older adults seeking services from the third sector. Loneliness was also associated with falling into a low core support needs cluster, while increasing age was associated with falling into a higher core support needs cluster. In addition, older adults living at home tend to seek care coordination services for a single presenting issue, usually in the physical or mental health domain, or related to a housing need. This research contributes to our understanding of the delivery of community services to support aging in place. A multidimensional and integrated approach that considers housing, health, social, and economic aspects is essential for addressing the diverse and complex needs of the aging population.

Disclosure statement

Dr Aileen O'Reilly is employed by ALONE. Other than this, the authors report there are no competing interests to declare.

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Data availability statement

Data available on request from the authors.

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