hor

OMB NO. XXXX-XXXX

Exp. Date MM/DD/YYYY

Aging Network Partnerships and Effectiveness Survey

DRAFT

June 2021

|  |
| --- |
| An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is XXXX-XXXX. Public reporting burden for this information collection is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Administration for Community Living/Administration on Aging, Washington, DC 20201 Attn: Caryn Bruyere, 202-795-7393. |

**WELCOME SCREEN**

Aging Network Partnerships and Effectiveness Survey

This survey is sponsored by the Administration for Community Living (ACL). It is part of a larger study to learn about how the Aging Network collaborates to improve the lives of older adults, and how it determines the value and effectiveness of the services it provides. Findings from this survey will help ACL make informed decisions about ways to better support the [Aging Network](https://eldercare.acl.gov/Public/About/Aging_Network/Index.aspx).

The information you provide will only be accessible to the evaluation team and ACL. Individual responses will be grouped with others in published evaluation reports.

The survey will take about 10 minutes to complete. Please answer each question to the best of your knowledge. If needed, ask others in your organization who have the content knowledge to help answer the questions. You can save and exit the survey to complete it in more than one sitting.

If you have any questions about the survey, please contact Mathematica at [TOLL FREE NUMBER] or email [STUDY ADDRESS]@mathematica-mpr.com.

Section a –characteristics and partnerships

|  |
| --- |
| ALL |

**The following questions are about [ENTITY NAME] characteristics.**

A1. Does [ENTITY NAME] also function as an Aging and Disability Resource Center (ADRC) or direct service provider?

ADRCs provide information, advice, counseling and assistance to help people make decisions about long-term services and supports, and help accessing public and private programs.

Direct service providers deliver home- and community-based services, training, and education to support older adults’ health and independence at home.

Select all that apply

🞏 Aging and Disability Resource Center (ADRC) 1

🞏 Direct Service Provider 2

🔾 None of the above NA

|  |
| --- |
| IF A1 = 1 (ADRC) |

A1a. Does the ADRC also operate a center for independent living (CIL)?

CILs provide independent living services for people with disabilities and are designed and operated by individuals with disabilities*.*

🔾 Yes 1

🔾 No 0

|  |
| --- |
| IF SAMPLETYPE = AAA |

A2. How would you classify [ENTITY NAME]? (Question source: AAA National Survey Report -2020)

Select one only

🔾 An independent, nonprofit agency 1

🔾 A part of county government 2

🔾 A part of a council of governments or regional planning and development agency 3

🔾 A part of city government 4

🔾 Other (SPECIFY) 99

Specify (STRING 150)

|  |
| --- |
| IF SAMPLETYPE = AAA OR TITLE VI |

A3. Which of the following geographic areas does [ENTITY NAME] predominantly serve?

Select all that apply

🞏 Frontier/remote 1

🞏 Rural 2

🞏 Suburban 3

🞏 Urban 4

|  |
| --- |
| ALL |

**The next questions are about partnerships [ENTITY NAME] has formed to achieve the Aging Network mission of promoting home and community-based services that allow older adults to live where they choose, with the people they choose, and with the ability to participate fully in their communities.**

A4. Which of the following does [ENTITY NAME] partner with?

*Partners are organizations or groups of organizations with which you jointly engage in some of the following activities: fundraising, shared resources, advocacy, strategic planning, public education, referrals, service delivery, shared outreach, including outreach to special populations, training or technical assistance, volunteer recruitment or retention.* (adapted from: Elderly Nutrition Services Program State Unit on Aging (SUA) Survey)

Select all that apply

🞏 Federal government agencies 1

🞏 State government agencies 2

🞏 Local government agencies 3

🞏 Health care providers (public or private) 4

🞏 Meal providers or food assistance providers (public or private) 5

🞏 Housing providers (public or private) 6

🞏 Organizations that provide assistance with utilities (public or private) 7

🞏 Transportation providers (public or private) 8

🞏 Adult protective services or legal services (public or private) 9

🞏 Health insurance plans 10

🞏 Private foundations 11

🞏 Advocacy groups 12

🞏 Universities 13

🞏 Coalitions, collaboratives, or networks (e.g., multiple organizations or agencies partnering to address the needs of older adults) 14

🞏 Other (SPECIFY) 99

Specify (STRING 150)

|  |
| --- |
| IF A4 = 14 |

A5. Please describe the focus of all coalitions, collaboratives, or networks with which [ENTITY NAME] partners.

|  |
| --- |
| ALL |

A6. What factors have helped [ENTITY NAME] to form and maintain partnerships? (Adapted from Title VI and Title III Grantee Collaboration Study Final Report-2020)

Select all that apply

🞏 Continuity of leadership at my organization or partner organizations 1

🞏 Funding availability 2

🞏 Compatible visions (organizations share mutual goals or missions) 3

🞏 Rules and regulations of my organization or partner organizations 4

🞏 Successful communication between partners 5

🞏 Previous good relationships 6

🞏 Other (SPECIFY) 99

Specify (STRING 150)

|  |
| --- |
| ALL |

A7. In the past year, you may have participated in a survey about [ENTITY NAME]’s response to the COVID-19 pandemic, which provided valuable information about how agencies adapted to address rapidly emerging needs.

The next few questions are specifically about how [ENTITIY NAME]’s partnerships may have changed to address emergent needs due to COVID-19. Please indicate which emergent needs from COVID-19 [ENTITY NAME] and its various partners are currently working together to address.

Select all that apply

🞏 Assisting with nutrition services (e.g., grab and go meals, prepared meal delivery, providing nutrition education or counseling) 1

🞏 Providing groceries, personal care and PPE supplies such as incontinence products, masks, hand sanitizer, etc. 2

🞏 Medication delivery 3

🞏 Addressing social isolation (e.g., telephone reassurance program, tablets or smart devices for connecting with friends and family) 4

🞏 Assisting clients with telehealth access (e.g. providing technology, Internet access) 5

🞏 Supporting family caregivers 6

🞏 Identifying home care aides or direct care workers to support clients in their homes 7

🞏 Providing support, training, and PPE to home care workers 8

🞏 Promoting or supporting vaccination 9

🞏 Facilitating hospital discharge 10

🞏 Assisting with health promotion programs (e.g., evidence-based workshops, health presentations, or exercise classes) 11

* Other change to address a need emerging from COVID-19 (SPECIFY) 99

Specify (STRING 150)

🔾 None of the above NA

|  |
| --- |
| A7 = ANYTHING BUT NA |

A8.  Which of these emergent needs from COVID-19 are [ENTITY NAME] currently working to address through new partnership(s) that formed since March 2020?

Select all that apply

[DISPLAY RESPONSES FROM A7]

🔾 None of the above NA

|  |
| --- |
| A7 = ANYTHING BUT NA |

A9. Which of these emergent needs from COVID-19 are [ENTITY NAME] currently working to address through partnership(s) that existed before March 2020?

Select all that apply

[DISPLAY RESPONSES FROM A7]

🔾 None of the above NA

|  |
| --- |
| ALL |

In the following questions, we would like to learn more about a few of [ENTITY NAME]’s closest partnerships. These are the partners that [ENTITY NAME] interacts with the most.

A10. Please enter the names of up to two of [ENTITY NAME]’s closest partners.

*Partners are organizations or groups of organizations with which you jointly engage in some of the following activities: fundraising, shared resources, advocacy, strategic planning, public education, referrals, service delivery, shared outreach, including outreach to special populations, training or technical assistance, volunteer recruitment or retention.*

[Open ended box for partner 1 name]

[Open ended box for partner 2 name]

|  |
| --- |
| PROGRAMMER: LOOP THROUGH QS A10-A15 FOR EACH PARTNER LISTED IN A9 |

|  |
| --- |
| IF A10 ANSWERED (at least one close partner) |

A11. Which best describes [PARTNER 1/2]?

PROGRAMMER: DISPLAY LIST OF SELECTED PARTNER TYPES FROM A4

Select only one

|  |
| --- |
| IF A10 ANSWERED (at least one close partner) |

A12. Why did [ENTITY NAME] form a partnership with [PARTNER 1/2]?

Select all that apply

🞏 To serve the needs of older adults 1

🞏 To jointly leverage funding opportunities 2

🞏 To work toward shared goals 3

🞏 To target specific underserved populations 4

🞏 To address emergent needs due to COVID-19 5

🞏 To promote organizational sustainability 6

🞏 Because the partnership is required, as part of the Aging Network structure 7

🞏 Other (SPECIFY) 99

Specify (STRING 150)

🔾 Don’t know d

|  |
| --- |
| IF A10 ANSWERED (at least one close partner) |

A13. Which of the following best describes [ENTITY NAME]’s relationship with [PARTNER 1/2]?

Select only one

🔾 We have a contractual relationship with [PARTNER 1/2] (IF A9 = 9 (PARTNER IS A COALITION), FILL “or members of [PARTNER 1/2]”) 1

🔾 We have a Memorandum of Understanding that describes each of our roles 2

🔾 We have an informal relationship (“handshake” agreement) 3

🔾 Other (SPECIFY) 99

Specify (STRING 150)

|  |
| --- |
| IF A10 ANSWERED (at least one close partner) |

A14. Which of the following activities does [ENTITY NAME] jointly engage in with [PARTNER 1/2]? (Adapted from ENSP State Unit on Aging (SUA) Survey)

Select all that apply

🞏 Fundraising 1

🞏 Advocacy 2

🞏 Strategic planning 3

🞏 Public education 4

🞏 Referrals 5

🞏 Service delivery 6

🞏 Shared outreach 7

🞏 Training or technical assistance 8

🞏 Volunteer recruitment or retention 9

🞏 OTHER 99

Specify (STRING 150)

|  |
| --- |
| IF A10 ANSWERED (at least one close partner) |

A15. What resources does [PARTNER 1/2] contribute toward shared goals with [ENTITY NAME]?

Select all that apply

🞏 Funding 1

🞏 Physical space, equipment, or goods 2

🞏 Knowledge or expertise 3

🞏 Information/data 4

🞏 Paid staff time 5

🞏 Volunteers 6

🞏 Connections to people, organizations, or groups 7

🞏 Endorsements (showing support for programs or services) 8

🞏 Convening power (bringing together necessary stakeholders) 9

🞏 Other 99

Specify (STRING 150)

🔾 None of the above NA

Section B – Return on Investment

|  |
| --- |
| ALL |

**We are also interested in how [ENTITY NAME] determines the value and effectiveness of services and non-service activities (e.g. advocacy, streamlining access) to support older adults and family caregivers in achieving the goals of the Older Americans Act. This includes promoting health and wellness so that persons can live and fully participate in their communities.**

**When determining the effectiveness of services and non-service activities, cost and benefit analyses consider not only the person receiving services but also their caregivers, families, and the broader community.**

**The next questions are about how [ENTITY NAME] may evaluate the costs and benefits of services and non-service activities.**

B1. Has [ENTITY NAME] ever conducted or participated in an assessment to determine how much value or benefit a program provides relative to the cost of program services? This often referred to as a “return on investment” (ROI) or “cost-benefit” analysis.

🔾 Yes 1

* No 0

|  |
| --- |
| B1 = 1 |

B2. Did [ENTITY NAME] collect and analyze the data for the ROI assessment on its own, or did another agency collect and analyze the data?

Select all that apply

🞏 [ENTITY NAME] collected and analyzed the data 1

* Another agency collected and analyzed the data 2

|  |
| --- |
| B1 =1 or 2 |

B3. Please indicate all of the services included in the ROI assessment.

*If your agency has conducted or participated in more than one ROI assessment, include assessments from the past three years.*

Select all that apply

🞏 Case management, care coordination, or service coordination 1

🞏 Evidence-based programs (e.g., falls prevention programs, Chronic Disease Self-Management, medication management) 2

🞏 Care transitions or discharge planning 3

🞏 Personal care 4

🞏 Homemaker services 5

🞏 Chores 6

🞏 Home delivered meals 7

🞏 Congregate meals 8

🞏 Nutrition counseling 9

🞏 Assisted transportation 10

* Adult day care 11
* Legal services 12
* Home modifications or repairs 13

🞏 Family caregiver support services (e.g. identifying and accessing services, counseling and training, respite care) 14

🞏 OTHER 99

Specify (STRING 150)

|  |
| --- |
| B1 =1 or 2 |

B4. Please indicate all of the benefits that were included in the ROI assessment.

*If your agency has conducted or participated in more than one ROI assessment, include assessments from the past three years.*

Select all that apply

🞏 Improved management of chronic conditions (e.g., diabetes, high blood pressure, high cholesterol) 1

🞏 Improved or maintained functional status (ADLs/IADLs) 2

🞏 Greater independence, or delaying or avoiding entry into long-term care facilities 3

🞏 Increased socialization or reduced loneliness 4

🞏 Reduced use of costly health and social services (e.g., fewer avoidable hospital admissions and ED visits) 5

* Improvements in self-reported physical or mental health 6
* Increased life expectancy 7

🞏 Improved quality of life 8

🞏 Organizational benefits (e.g. improved member retention in health plan) 9

🞏 Other (e.g., increased employment, consumer satisfaction, food security, caregiver ability to retain employment or conserve time off) 99

Specify (STRING 250)

|  |
| --- |
| B1 =1 or 2 |

B5. Please indicate all of the costs that were included in the ROI assessment.

*If your agency has conducted or participated in more than one ROI assessment, include assessments from the past three years.*

Select all that apply

🞏 Staff costs (e.g., salaries and fringe benefits, volunteer support) 1

🞏 Direct service costs (e.g., service contracts, support services, partner and provider service costs) 2

🞏 Supply and equipment costs (e.g., supplies and/or leases on purchase of equipment) 3

🞏 Overhead and operating costs (e.g., overhead, facilities, utilities, marketing, indirect costs) 4

🞏 Development and maintenance of data systems 5

|  |
| --- |
| B1 =1 or 2 |

B6. Please indicate how [ENTITY NAME] used or plans to use the results of the ROI assessment.

Select all that apply

🞏 To determine whether to continue (or discontinue) or expand a program 1

🞏 To demonstrate the value of our services, or make a business case, to potential private partners 2

🞏 To justify funding requests from government or foundation funders 3

🞏 Other (SPECIFY) 99

Specify (STRING 250)

|  |
| --- |
| ALL |

B7. Please mark up to three of the main challenges [ENTITY NAME] faces assessing the benefits and costs of program services.

Select up to three

🞏 Lack of agreement on how to monetize benefits 1

🞏 Lack of technical skills to conduct an assessment 2

🞏 Lack of data on costs 3

🞏 Lack of data on benefits 4

🞏 Lack of funding to conduct an assessment 5

🞏 Assessing benefits and costs is not a current priority for my organization 6

🞏 Other (SPECIFY) 99

Specify (STRING 250)

|  |
| --- |
| B1 =1 or 2 |

B9. What lessons have you learned from conducting or participating in a return on investment or cost-benefit assessment that would be helpful to other Aging Network members seeking to do the same?

(STRING 500)

Section C: Contact Information

|  |
| --- |
| B1 = 1 (has conducted an ROI assessment) |

C1. Would you be willing to participate in an interview to learn more about how your agency calculates the value or benefit of program services relative to their cost?

The purpose of the interview is to inform recommendations to ACL about how the Aging Network might value costs and benefits of services. It is not an audit. It will last about one hour.

* Yes 1
* No 0

|  |
| --- |
| IF C1 = 1 (willing to be contacted for IDI) |

C2. Please confirm or update your name, title, organization, telephone number, and email address below.

First Name:

Last Name:

Title:

Organization:

Telephone:

Email Address:

|  |
| --- |
| PROGRAMMER NOTE: ALLOW A STRING OF 150 CHARACTERS FOR EACH TEXT FIELD. |

CLOSING SCREEN 1.

[IF RESPONDENT ENTERS A SURVEY WITH A FINAL CODE; Our system shows that your survey is complete.] Thank you for completing the survey! If you have any questions about the survey, please contact Mathematica at [TOLL FREE NUMBER] or email [STUDY ADDRESS]@mathematica-mpr.com.