Nutrition and Aging Resource Center

Webinar Tip Sheet

Don't Let Long-Term Plans Sit on the Shelf: Giving Life to Long-Term Planning

Watch the webinar recording.

Speakers:

Alexandra Bauman, RD, LDN
Navigation & Supportive Services Director
Iowa Department of Health and Human Services

Eugenia Kendall, MSW
Strategic Planning and Assessment Coordinator
Iowa Department of Health and Human Services

What is a long-term plan?

A Long-Term or Long-Range Plan is a concrete set of strategic goals, objectives, strategies, performance measures, and shot-term, intermediate, and long-term outcomes that impacts the direction of the agency over multiple years. This type of planning usually involves input from multiple entities including, but not limited to, subject matter experts, advisory boards, board of directors, consumers, general public, service providers, and community partners.

Examples of a Long-Term or Long-Range Plan include strategic plans, business plans, State Plans on Aging and Area Plans on Aging, and Multisector Plans for Aging

> *Alex's tip! If you are writing a plan in silo without the input of program people and other organizations that you work with, we cannot have a plan that is really reflective of what we're trying to do.*

What tools are helpful for creating a long-term plan?

1. ADvancing States Resource: Developing a State Plan on Aging
   - This includes a planning process and copies of all other state plans on aging which provides a quick snapshot of other state's priorities, populations they serve, and their funding resources
2. Administration for Community Living (ACL) Administration on Aging Program Instructions
   - This includes an overview on Older Americans Act (OAA) programs, grant opportunities, Aging Independence and Disability data portal (AGID) which includes special tabulations from the American Community Survey that specifically hit 60 and over, a strategic framework for the National Plan on Aging, profiles of older Americans, reports to Congress, a link for how to develop a State Plan on Aging.

> *Alex's tip! In addition, scan what other States are doing by looking at other State's websites, read Area Agency on Aging (AAA) Area Plans on Aging and State's public health plans.*

3. ADvancing States' Key Decision Points
   - Click on each decision point for a definition of what it is, key considerations, questions to be asking other entities, and suggestions on individuals/groups to involve in each decision point.

4. A logic model helps us to work in concert to achieve that long-term goal!

> *Alex's tip! A logic model provides a visual way to conceptualize and digest the content as plans can get really text heavy.*

Example Logic Model

Persons or Organization	Activities	Short-Term Outcomes	Intermediate Outcomes
Consumer	• Receive accurate info to make informed choices about long-term supports and services and how to obtain them • Participate in developing own care plan • Easily apply for and receive Medicaid HCBS services	• Increase knowledge of No Wrong Door system • Access to in-home supports to perform ADLs/ IADLs • Access to affordable housing and transportation options • Access to Medicaid HCBS services	• Improve access to services • Increase ability to use self-determination in caring for oneself • Increase independence in community of choice
Area Agency on Aging/ Community Provider	• Outreach to target populations • Consumer referrals • Staff training and development • Community education ADRCs and No Wrong Door to gain access to LTSS	• Deliver person-centered culturally appropriate, trauma informed services • Improve services provided to older adults, adults living with disabilities, and their caregivers	• Increase capacity to improve health and independence for underserved and other targeted populations • Remove barriers to accessing services
ADRCs/ No Wrong Door/ Community Care Hubs	• Provide referrals across agencies to support target populations and address social determinates of health factors	• Engage with community partners and advocate on behalf of target populations • Improve coordination among providers	• Improve environments and conditions in which services are being delivered
Iowa HHS Division of Aging and Disability Services/ Aging and Disability System	• Allocate OAA funding based on target population needs and gaps in service • Improve and monitor policy changes to OAA services • Increase partnerships and intergration across HHS Divisions • Mobilize support among statewide partners	• Secure additional resources to support the aging and disability system • Engage with nontraditional partners to have a broader impact on aging and disability issues • Partner in efforts to leverage and maximize resources	• Improve access to OAA services • Develop a Multisector Plan for Aging • Blend and braid funding across community partners to increase impact on target populations

Long-Term Outcomes:

Older Adults, individuals with disabilities, and informal caregivers:

- have timely and convenient access to services and supports that are responsive to their needs and preferences, and are provided by qualified, well-trained, and supported workforce
- live in integrated settings of their choice that are safe, decent, affordable, and accessible
- are supported and empowered to make informed choices about their personal goals, daily activities, individualized services plans, and civic involvement

How to make usable long-term plans, so they don't "sit on a shelf"?

Tips:

- Sit down as a team to break down a four-year plan into yearly action steps. Keep these yearly action steps in a very visible location to help infuse the plan daily. This is not a hypothetical plan, but an actual plan to use to inform work.
- Chose a certain goal or objective to discuss on a quarterly basis. Consider bringing a section of the plan to monthly team meetings.
- Create data dashboards to show how data relates back to the long-term plan.
- Be flexible! Keep track and monitor progress on a regular basis. This allows the use of this information to adjust strategies.

Case Study: Developing Iowa's State Plan on Aging

The State of Iowa shared how they developed their State Plan on Aging and the steps they took.

- Research other State Unit on Aging (SUA) plans
  - What are their goals and how many do they include?
  - How many strategies do they identify?
  - How do they measure their work?
- Review current plan achievements
  - Did we accomplish our goals?
  - What do we need to carry forward into our new plan?
  - What do we need to discontinue because the nature of our work has changed?
- Review service gaps within Area Plans and identify common themes to help develop strategies to address those gaps.
- Draft a new, streamlined view of State Plan on Aging. Utilize research from other State Plans, staff feedback, guidance from ACL and common themes from Area Plans.
- Hold a series of "Reimagine State Plan on Aging" sessions with program staff to review a crosswalk of current and proposed goals and objectives.
- Work with program staff to develop and add strategies, performance measures and short, medium, and long-term outcomes.
- Create a conceptual logic model to connect the dots on how SUAs and AAAs work together to achieve long-term outcomes.
- Use results from Multi-sector Plan for Aging community engagement process to shape strategies.
- Receive input from ADvancing States, AAAs, SAGECare; Post for public and provider feedback.

SUAs provide AAAs templates for Area Plans on Aging and in Iowa. It includes:

- Common Statewide goals / objectives / measures
  - This allows for a collective impact rather than a widely varied one
- Drop down boxes to select the objectives
- Drop down boxes to select populations
- Pre-populated strategies based on objectives
  - Additional conversations are required on what is doable
- Pre-populated measures based on objectives
  - Additional conversations are required on what is doable
- Option for "Other" to write in own language
  - Because in a streamlined world we still need to leave in flexibility

Nutrition Example

Objectives and goals should be specific, measurable, achievable, relevant, and time-bound (SMART). Tasks are the individual actions that need to be taken to achieve the objective. Tasks should be specific and actionable.

Objective 1.4: Improve the reach of nutrition education and counseling to older Iowans at high nutrition risk by 2%.

Task 1: Consult with the AAAs on implementing an automated process to identify consumers whose intake or assessment responses show high nutrition risk indicators and refer them to additional service interventions on a monthly basis, such as nutrition counseling or options counseling to increase the percentage of high nutrition risk participants that receive nutrition counseling by 2%.

Task 2: Provide quarterly technical assistance to the AAA nutrition directors on developing effective outreach materials to improve awareness and benefits of nutrition counseling services targeting consumers at high nutrition risk or those who have been underserved, and those in poverty.

Task 3: Evaluate and expand the number of partnerships with the Department of Public Health's SNAP-Ed program, Iowa's food banks, and Iowa's AAAs to provide wrap-around nutrition services for older Iowans experiencing or who may face food insecurity and malnutrition. This includes establishing, at a minimum, an annual meeting with each of the listed partners.

Other helpful resources:

Older Americans Act (OAA) of 1965, as amended through P.L. 116-131

- Section 306 – gives details on Area Plan requirements
- Section 307 – gives details on State Plan requirements

How to Implement the Older Americans Act

This resource was supported in part by a cooperative agreement No 90PPNU0002 from the Administration on Aging (AoA), Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official AoA, ACL, or HHS policy.