State Plan Guidance Training Series

ACL
Administration for Community Living

Measuring Progress Towards Achieving Your State Plan Goals/Objectives

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Agenda

1. What does the state plan guidance say about results?
2. What are outputs and what are outcomes?
3. Categories of outcomes and how can they be measured/reported
4. What are baseline data and why are they important?
5. What next?

The Lesson from Alice in Wonderland

What does the state plan guidance say about results?

The State Plan:

a. Documents the tangible outcomes expected from state long-term care reform efforts;
b. Translates activities, data, and outcomes into proven best practices, which can be used to leverage additional funding;
c. Provides data on the number and types of people and organizations that will be targeted for such efforts and the measures to determine if these efforts have been successful;
d. Describe plans and include objectives and the measures (data elements and sources) that you will use to demonstrate your progress towards the areas that the plan is to address

(BackGround Section on Page 1)

What does the Older Americans Act say about results?

The plan shall provide that the State agency will conduct **periodic evaluations** …**including evaluations of the effectiveness of services** provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(Section 307)

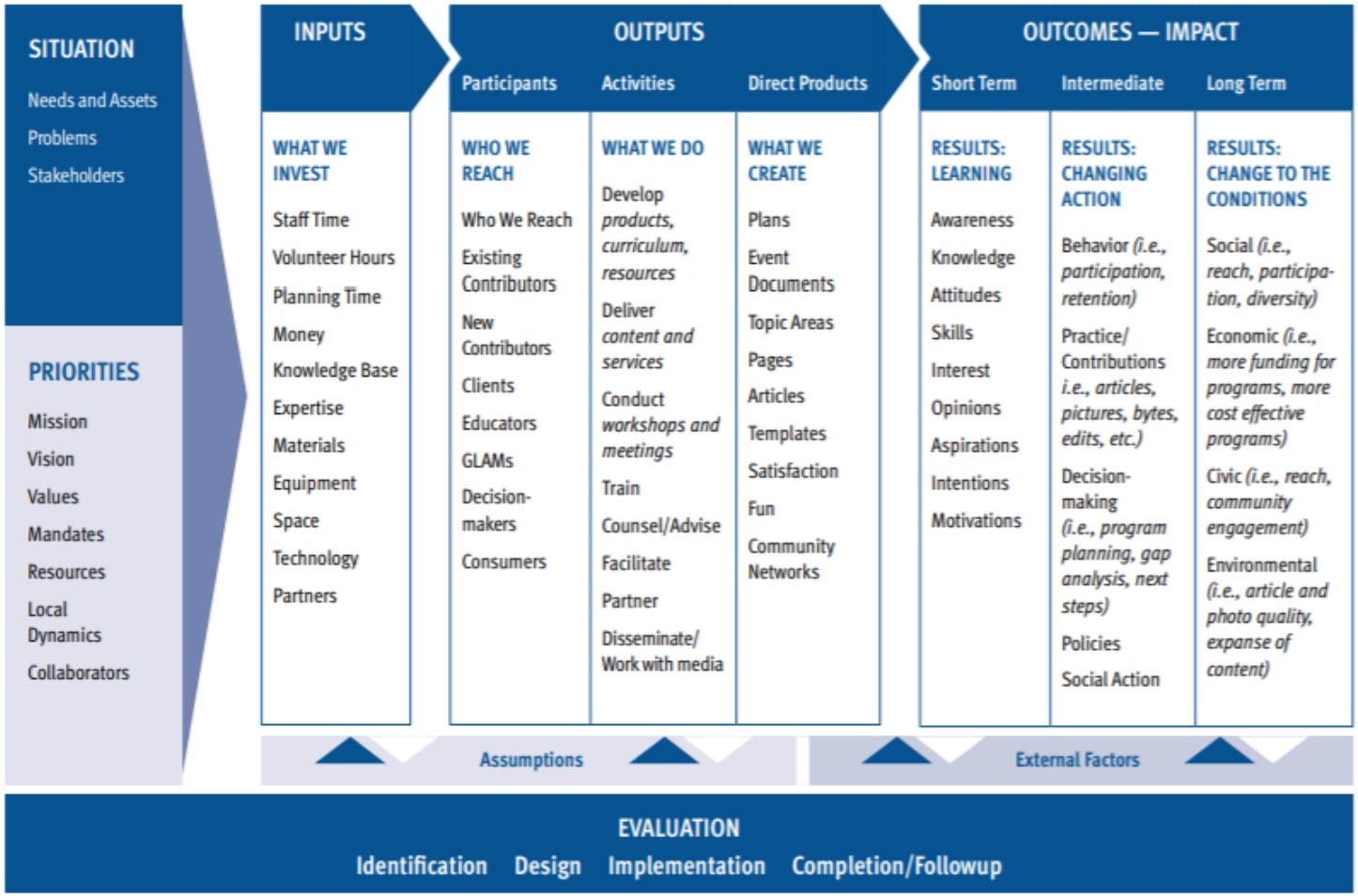
What does the Older Americans Act say about results?

- (18) provide assurances that the area agency on aging will collect data to determine—
  - (A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and
  - (B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals;…

(Section 306)

What are outputs and what are outcomes?

Figure 3. **W.K. Kellogg Foundation Logic Model Structure**[4]



Source: https://acl.gov/programs/program-evaluations-and-reports#

State Plan Guidance Language

Goals, Objectives, Strategies, and Outcomes – Goals are visionary statements that describe the strategic direction in which the state is moving. Objectives are the attainable, specific, and measurable steps the state will take to achieve its goals. Strategies outline how the state will achieve the goals and objectives. Outcomes document the measurable benefit older individuals should derive from the State Plan goals, objectives and strategies. To the extent possible, outcome measures should include short-, intermediate-, and long-term outcomes:

- *Short-term outcomes* typically include improvements in knowledge, awareness, or perceptions (such as increased knowledge about the benefits of exercise or increased awareness of residents' rights among staff at long-term care facilities).
- *Intermediate outcomes* typically include changes in behaviors, policies or processes (such as eating a healthier diet or better coordination of services).
- *Long term outcomes* should reflect the goals of the OAA and/or specific programs (such as individuals who receive OAA services being able to remain in the community longer)

(Page 4)

Hope is not a strategy

Categories of outcomes and how can they be measured/reported: An Example

If

the OAA was developed to address “a lack of community social services for older persons.”

Then

examples of outcomes (changes in conditions) would be increased services that meet the needs of older persons

- **What are those needs?**
- **How do we know that we met them?**

Categories of Outcomes

Organizational

- Better integrate health and social services delivery systems
- Increased capacity for long-term care efforts.
- Improve coordination of community-based, long-term care services.
- Disrupt the hospital-to-nursing home pipeline.
- Improve the quality and availability of HCBS
- Build off the key findings from the RAISE Family Caregiving Advisory Council and other national efforts.

Examples of measures: staffing, efficiency, capacity, service quality.

Individual

- Address social isolation, caregiving, malnutrition, and other key priorities
- Address the needs of formal and informal caregivers and strengthening the direct care workforce.
- Help people who live in institutions to return to living in the community.

Examples of measures: health, well-being, ability.

Real World Examples

- “From housing to transportation, we have **streamlined and improved** existing programs to make sure they reach [people] of all ages and abilities in a more effective way.”

- Define streamline and improve
- Set targets
- Measure status now and overtime
- Compare values over time
- Report quantitative data

Real World Examples (2)

- Husband has dementia and has been falling a lot.
- Specialist helped the family define their concerns and goals.
- Concerns: housing issues, accessibility difficulties, and a need for respite.
- Helped the family identify both formal and informal caregiving resources.
- Referral made to the Alzheimer's Disease Caregiver Services Initiative (ADCSI).
- At follow up the family reported that ADCSI was providing temporary in-home respite care, care technology safety services and education.
- Per the family's request, [PROGRAM] is working with the family to explore possible veterans in-home respite and to explore Medicaid Long Term Care.
- Additionally, the family chose to have a referral made to Department of the Aging who assisted with referrals to USDA for the roof and for assistance with a ramp.

Suggested improvements from a performance perspective:

- Problems identified but no baselines or outcomes
- Activity identified but it is unclear which problem the Education activity addresses
- It would be a stronger statement with information about the degree to which the services addressed the problems.
  - Did the respite help improve the caregiver's health or wellbeing or allow the caregiver the continue providing in home care longer?
  - Did the safety services reduce the number or severity of the falls?

Moving From the Individual to the State-Level

1. Link the pieces of the individual example to your current or planned data collections
2. Add context from your existing data
   - How many people do you serve who have housing issues, accessibility difficulties, and a need for respite.
   - How many formal and informal caregiving resources do you provide .
   - Referral made to the Alzheimer's Disease Caregiver Services Initiative (ADCSI).
3. Build your examples around planned or existing data

Moving From the Individual to the State-Level

4. Map the categories from your examples to the Topic Areas in the State Plan Guidance

The **Expanding Access to HCBS Topic Area** includes

“Securing the opportunity for older individuals to receive managed in home and community-based long-term care services (Sec. 301(a)(2)(D));” and

“Incorporating aging network services with HCBS funded by other entities such as Medicaid.”

How can they be measured/reported

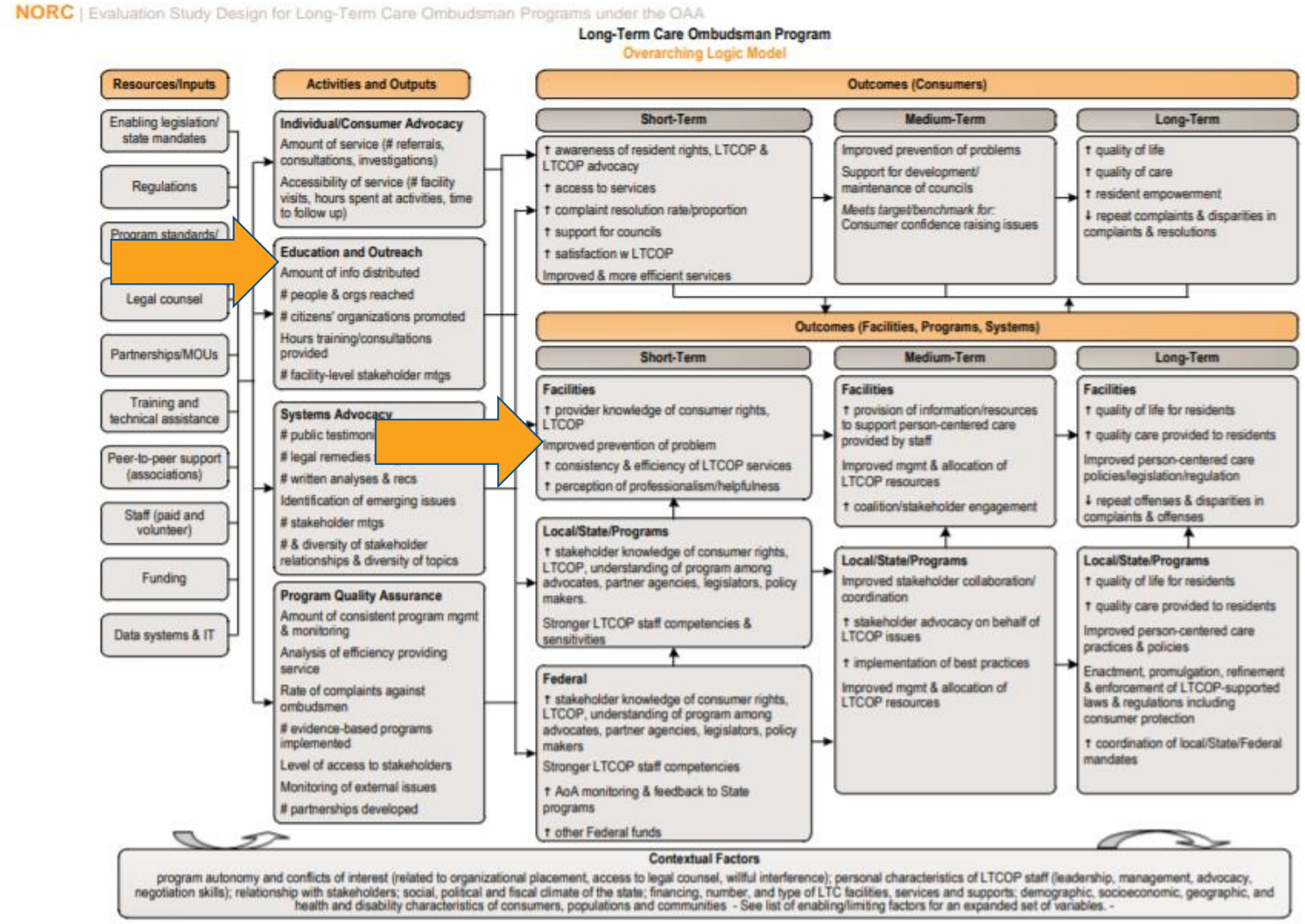
Older Americans Act (OAA) Core Programs Topic Area

Overview	OAA core programs are found in Titles III (Supportive Services, Nutrition, Disease Prevention/Health Promotion and Caregiver Programs), VI (Native American Programs), and VII (Elder Rights Programs) and serve as the foundation of the national aging services network. All core programs must be addressed in the State Plan.
Areas to Address	Describe plans and include objectives and the measures (data elements and sources) that you will use to demonstrate your progress towards: ○ Coordinating Title III programs with Title VI Native American programs (Sec. 307(a)(21)); ○ Ensuring incorporation of the new purpose of nutrition programming to include addressing malnutrition (Sec. 330); ○ Preventing, detecting, assessing, intervening, and/or investigating elder abuse, neglect, and financial exploitation (Sec. 721(a)); ○ Supporting and enhancing multi-disciplinary responses to elder abuse, neglect and exploitation involving adult protective services, LTC ombudsman programs, legal assistance programs, law enforcement, health care professionals, financial institutions, and other essential partners across the state (Sec. 721(b)(10)(C)(v)); ○ Age and dementia friendly efforts (Sec. 201(f)(2)); ○ Screening for fall related TBI (Sec. 321(a)(8)); ○ Strengthening and/or expanding Title III & VII services; ○ Improving coordination between the Senior Community Service Employment Program (SCSEP) and other OAA programs; and ○ Integrating core programs with ACL's non-formula based grant programs.

Preventing, detecting, assessing, intervening, and/or investigating elder abuse, neglect, and financial exploitation

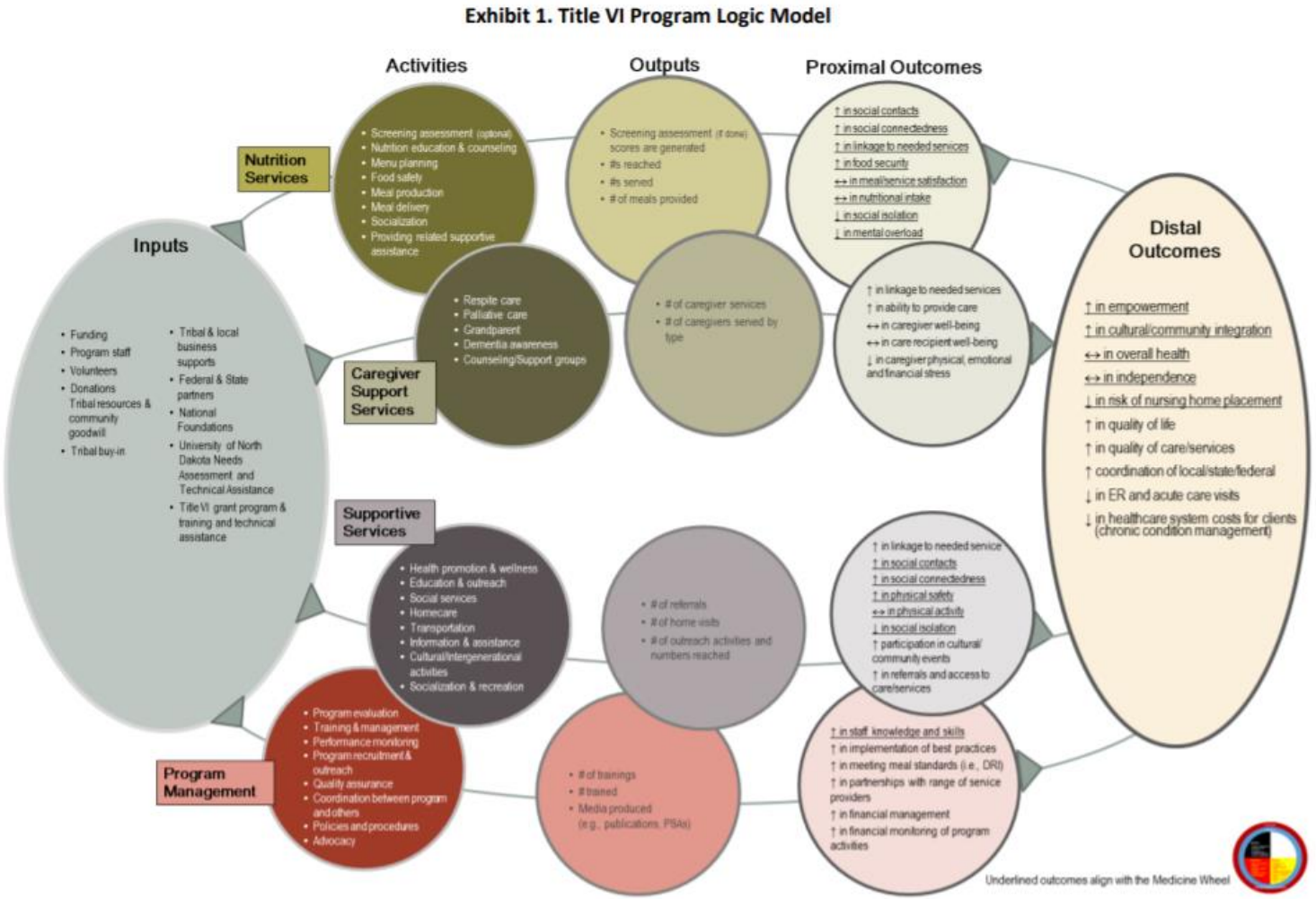
- **Activity**: Providing training and resources to staff to better prevent abuse/neglect/exploitation
- **Short term outcome:** Increased staff knowledge/skills
- **Intermediate term outcome:** Improved staff intervention
- **Long term outcome:** Individuals experience fewer issues and improved well being

Adopting Existing Outcomes



Source: Evaluation Study Design for Long-Term Care Ombudsman Programs under the Older Americans Act: Research Design Options
https://acl.gov/sites/default/files/programs/2016-11/LTCOP_Evaluation_Study_Design_01312013.pdf

Adopting Existing Outcomes



Source: Evaluability Assessment of the Title VI Grant Program
https://acl.gov/sites/default/files/programs/2017-02/EA-of-TitleVI-v2.pdf

Outcomes From the NSOAAP

ACL's National Survey of Older Americans Act Participants (NSOAAP) also has questions that you can use to gather outcome data.

The survey tools are available at: https://agid.acl.gov/DataFiles/NPS/

Outcomes From the NSOAAP

1. As a result of the services you receive, are you able to live independently?
2. As a result of the services you receive, do you feel more secure?
3. As a result of the services you receive, are you better able to care for yourself?
1. Since you started receiving services, do you have a better idea of how to get any additional help that you need?

(Source:Case Management Survey: https://agid.acl.gov/DataFiles/Documents/NPS/CaseManagement2019/Codebook_Case_Management_2019.pdf)

What are baseline data and why are they important?

- Collected before you implement your State Plan/specific initiative
- Frames the level of problem you will address
- Compared against outcomes to show change
- Can help you set realistic targets

Comparative information is crucial

Setting Targets

- Proportionality
- Consistent increase from previous year (e.g., +/- 1% each year)
- Change based on prior year averages

Data Sources

- Administrative data
- Surveys
- Census data
- Needs Assessments

What is Next

1. Review your State Plan for the changes you are expecting to see based on your efforts
2. Look at your needs assessment to identify the needs that you will meet
3. Map each funded activity/program to one of those changes or needs
4. Map the results of steps 1-3 to the Topic Areas in the State Plan guidance
5. Identify existing data and data gaps
6. Plan how you will fill in your data gaps (esp. related to the intermediate and long term outcomes)

ACL Tools and Resources

- ACL Performance Measure Guidance
- ACL Data Quality Guidance
- ACL Logic Model Guidance
- ACL Strategic Planning Guidance
- ACL Systems Change Measurement Guidance

Data can show us where we have been and where we are going.

Data help us to stay on track.

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