



Enhancing Older Americans Act State Plans with Evaluation and Evidence

Administration for Community Living (ACL)

Nicole Becerra, Laura House, Rhonda Schwartz, Amy Wiatr-Rodriguez

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Overview of New OAA State Plan Guidance

Nicole Becerra, MPH, CHES®
AoA, Aging Services Program Specialist

Mission & Vision

Mission

Maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers.

Vision

For all people, regardless of age and disability, to live with dignity, make their own choices, and participate fully in society.

Highlights

- New State Plan Guidance applies to any new state plan taking effect on or after October 1, 2022.
- Incorporates key changes from the 2020 reauthorization of the OAA.
- Includes Biden-Harris priorities that shape ACL's work.

2020 OAA Reauthorization and the SPG

- Social Isolation
- Caregiving
- Nutrition - Malnutrition

Social Isolation

- Requires taking a closer look at the negative health effects associated with social isolation
- Focus on screening for social isolation
- Title III-B adds supportive services that reduce social isolation



Caregiving

- New term – caregiver assessment
- Caregivers can care for individuals of any age with Alzheimer's



Nutrition - Malnutrition

- Reducing malnutrition
- States and AAAs should reduce administrative burdens so that resources are where they are needed the most



Biden-Harris Administration Priorities and the New SPG

- COVID-19 Recovery
- Advancing Equity
- Expanding Access to HCBS
- Building a Caregiving Infrastructure

Advancing Equity

- Broad approach
- Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer persons; persons with disabilities; and persons who live in rural areas
- individuals with limited English proficiency
- at risk of institutionalization

Expanding Access to HCBS

- How is the state:
 - building HCBS capacity?
 - improving HCBS program quality through innovation, partnerships with other state and local agencies, community-based organizations (both within and outside the aging network)?

Building a Caregiver Infrastructure

- Build off the key findings from the RAISE Family Caregiving Advisory Council and other national efforts.

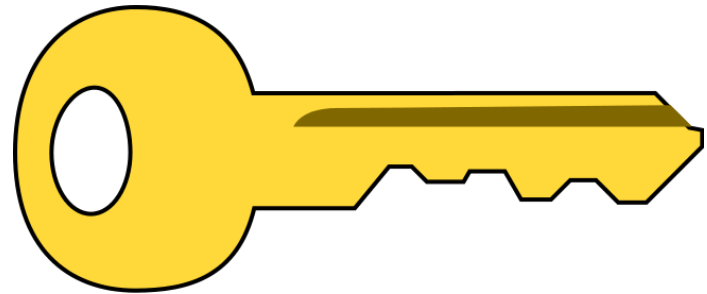
State Plan Content

- Signed Verification of Intent
- Narrative
 - Executive Summary
 - Context
 - Quality Management
 - Goals, Objectives, Strategies and Outcomes-States should have at least one goal, objective, strategy, and outcome measure for each key topic



State Plan Key Topic Areas

- OAA Core Programs Topic Area
- COVID-19 Topic Area
- Equity Topic Area
- Expanding Access to HCBS Topic Area
- Caregiving Topic Area



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	<p>Describe plans and include objectives and the measures (data elements and sources) that you will use to demonstrate your progress towards:</p> <ul style="list-style-type: none">○ 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.

COVID-19 Topic Area

Overview	<p>COVID-19 highlighted the overall importance of the services that make it possible for older adults to live independently, created a national awareness of the impact of social isolation on older adults and caregivers, and increased awareness of the need to plan for future disasters. It also transformed the aging network; drove rapid innovation and creation of new approaches that will endure beyond recovery; and increased awareness of the need to plan for future disasters. Finally, Congress provided significant increases in funding some of which remain available until expended.</p>
Areas to Address	<p>Describe plans and include objectives and the measures (data elements and sources) that you will use to demonstrate your progress towards:</p> <ul style="list-style-type: none">○ Educating about the prevention of, detection of, and response to negative health effects associated with social isolation (Sec. 321(a)(8));○ Dissemination of information about state assistive technology entity and access to assistive technology options for serving older individuals (Sec. 321(a)(11));○ Providing trauma-informed services (Sec. 102(41));○ Screening for suicide risk (Sec. 102(14)(G));○ Inclusion of screening of immunization status and infectious disease and vaccine-preventable disease as part of evidence-based health promotion programs (Sec. 102(14)(B) and (D));○ Providing services that are part of a public health emergency/emerging health threat and emergency preparedness (Sec. 307(a)(28) and (29)).○ Expending American Rescue Plan funding and any other COVID-19 supplemental funding still available for expenditure; and○ Incorporating innovative practices developed during the pandemic that increased access to services particularly for those with mobility and transportation issues as well as those in rural areas.

Equity Topic Area

Overview	Serving individuals with the greatest economic and social need means ensuring equity in all aspects of plan administration. The State Plan should address activities to support these goals.
Areas to Address	<p>Describe plans and include objectives and the measures (data elements and sources) that you will use to demonstrate your progress towards:</p> <ul style="list-style-type: none">○ Determining services needed and effectiveness of programs, policies and services for older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019 (Sec. 307(a)(30)(A))¹;○ Engagement in outreach with older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019 (Sec. 307(a)(30)(C));○ Impacting social determinants of health of older individuals (Sec. 301(a)(1)(E));○ Ensuring meals can be adjusted for cultural considerations and preferences and providing medically tailored meals to the maximum extent practicable (Sec. 339(2)(A)(iii));○ Preparing, publishing, and disseminating educational materials dealing with the health and economic welfare of older individuals (Sec. 202(a)(7));○ Supporting cultural experiences, activities, and services, including in the arts (Sec. 202(a)(5));○ Serving older adults living with HIV/AIDS; and○ Supporting participant-directed/person-centered planning for older adults and their caregivers across the spectrum of LTSS, including home, community, and institutional settings.

Expanding Access to HCBS Topic Area

Overview	HCBS are fundamental to making it possible for older adults to age in place.
Areas to Address	<p>Describe plans and include objectives and the measures (data elements and sources) that you will use to demonstrate your progress towards:</p> <ul style="list-style-type: none">○ Securing the opportunity for older individuals to receive managed in-home and community-based long-term care services (Sec. 301(a)(2)(D));○ Promoting the development and implementation of a state system of long-term care that is a comprehensive, coordinated system that enables older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of the older individuals and their family caregivers (Sec. 305(a)(3));○ Ensuring that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services for older individuals who: reside at home and are at risk of institutionalization because of limitations on their ability to function independently; are patients in hospitals and are at risk of prolonged institutionalization; or are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them (sec. 307(a)(18(A)-(C));○ Working towards the integration of health, health care and social services systems, including efforts through contractual arrangements; and○ Incorporating aging network services with HCBS funded by other entities such as Medicaid.

Caregiving Topic Area

Overview	Enhancing services and supports for caregivers.
Areas to Address	<p>Describe plans and include objectives and the measures (data elements and sources) that you will use to demonstrate your progress towards:</p> <ul style="list-style-type: none">○ Documenting best practices related to caregiver support (Sec. 373(e)(1));○ Strengthening and supporting the direct care workforce (Sec. 411(a)(13))○ Implementing recommendations from the RAISE Family Caregiver Advisory Council;○ Coordinating Title III caregiving efforts with the Lifespan Respite Care program; and○ Coordinating with the National Technical Assistance Center on Grandfamilies and Kinship Families.



Strengthening State Plans with Evidence and Outcomes

Laura House, PhD, MSW

Senior Management and Program Analyst
ACL Office of Performance and Evaluation

Federal Focus on Evidence

- Presidential Memorandum on Restoring Trust in Government Through Scientific Integrity and Evidence-Based Policymaking
- Foundations for Evidence-Based Policymaking Act of 2018 (“Evidence Act”)

Defining Evidence

- The Foundations for Evidence-Based Policymaking Act of 2018 (Evidence Act) and the Office of Management and Budget describe four interdependent components of evidence: foundational fact finding, policy analysis, performance measurement, and program evaluation.

Types of Evidence

- Foundational fact finding
- Policy analysis
- Performance measurement
- Program evaluation

Importance of Evidence

- Furthers the mission, programs, policies, and operations of an organization.
- Helps organizations determine what is and what is not working well
- Answers questions regarding why, for whom, and under what circumstances.

Focusing on Performance Measurement in State Plans

- Systematic measuring of a program's activities, outputs, and outcomes and their relationship to the agency or program objectives.
- Process of regular collection of outcome and/or output data (preferably both) throughout the year (not only at the end of the year) of programs and services.

Source: Hatry, 2014

Three Questions Answered by Performance Measurement

- How much did the program or grant do (services delivered or activities conducted)?
- How well did you do (improved knowledge, skills, or behaviors)?
- Did recipients improve?

Source: Clear Impact, 2016

Benefits of Performance Measurement

- Accountability
- Informs stakeholders
- Monitors and assesses programs and operations
- Compliance
- Public confidence
- Decision-making

Defining Performance Management

- Informs decisions and makes improvements.
- Ensures that goals are consistently being met in an effective and efficient manner.
- Includes tools such as logic models, performance measurement, and program evaluation.

Source: Hatry, 2014

ACL Updated Guidance for Developing State Plans on Aging



ACL Guidance for Developing State Plans on Aging

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).

States should have at least one goal, objective, strategy, and outcome measure for each key topic.

(ACL, August 5, 2021, p. 5)



Defining Outputs and Outcomes

- Outputs: Indicators of activities conducted through the intervention or program. For example, number of people served, number of staff trained, or educational materials developed. They measure process.
- Outcomes: Changes or benefits resulting from activities and outputs. Programs typically have multiple, sequential outcomes, sometimes called the program's outcome structure.

Types of Performance Measure Data

	QUANTITY How much did we do?	QUALITY How well did we do it?
EFFORT	How much service did we deliver? #	How well did we deliver it? %
IMPACT	How much change did we produce? #	What quality of change did we produce? %

Is anyone better off?

(Clear Impact, 2016a)

Measuring What Matters

QUANTITY

QUALITY

How much did we do?

How well did we do it?

EFFORT

clients served
activities conducted
\$ amount spent

Timeliness
Standardization
Completion rates
Cost per unit

#

%

IMPACT

Behavior
Attitude
Circumstances
Knowledge
Skills

Behavior
Attitude
Circumstances
Knowledge
Skills

#

%

Is anyone better off?

(United Way, 2018)

Ensuring Quality Performance Measures

- Are your performance measures SMART?
 - Specific, Measurable, Attainable, Realistic and Timely
- Do you have high quality performance measures?
 - Meaningful, understandable, relevant, comparable, reliable, and practical

Tool #1: SMART Checklist

SMART Performance Measure Checklist

(U.S. Agency for International Development, n.d.-2)

- Is the metric objectively measurable?

- Does the measure include a clear statement of the results expected?

- Does the metric allow for meaningful trend or statistical analysis?

- Does the metric include milestones and/or indicators to express qualitative criteria?

- Are the metrics challenging but, at the same time, attainable?

- Are assumptions and definitions specified for what constitutes satisfactory performance?

- Have those responsible for measuring performance been fully involved in the development of this metric?

Example: SMART Measure

Goal: Prioritize resources to promote social interaction and connectedness, including expanding access to technology and transportation

-Objective 1: By December 2022, the agency and aging network partners will increase participation in programs to promote social interaction and connectedness by 10%, with older adults and caregivers who identify as belonging to diverse racial and ethnic minority groups, making up 50% of the increase.

-Outcome Measure: % of participants in the targeted group who report feeling less isolated due to program participation by race and ethnicity.

SMART:

-Specific: Increase participation in programs to promote social interaction and connectedness

-Measurable: At least 10% increase in program participation; 40% of participants are BIPOC

-Attainable: Increased participation

-Realistic: 10% increase in participation in programs to promote social interaction and connection

-Timely: December 2022

Other Issues:

Directional: Shows a directional change, an increase

Meaningful: Focuses on important issue during pandemic

Understandable: Clear goal is for an increase in the measure

Tool #2: Performance Measure Reference Sheet

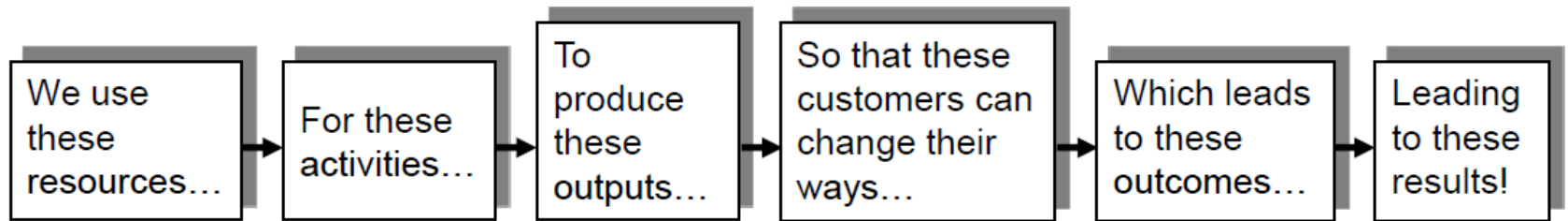
USAID Performance Indicator Reference Sheet	
Name of Indicator:	
Name of Result Measured (DO, IR, sub-IR, Project Purpose, Project Outcome, Project Output, etc.):	
Is This a Performance Plan and Report Indicator? No ___ Yes ___ for Reporting Year(s) _____	
If yes, link to foreign assistance framework:	
DESCRIPTION	
Precise Definition(s):	
Unit of Measure:	
Data Type:	
Disaggregated by:	
Rationale for Indicator <i>(optional)</i> :	
PLAN FOR DATA COLLECTION	
Data Source:	
Method of Data Collection and Construction:	
Reporting Frequency:	
Individual(s) Responsible at USAID:	
TARGETS AND BASELINE	
Baseline Timeframe:	
Rationale for Targets <i>(optional)</i> :	
DATA QUALITY ISSUES	
Dates of Previous Data Quality Assessments and Name of Reviewer(s):	
Date of Future Data Quality Assessments <i>(optional)</i> :	
Known Data Limitations:	
CHANGES TO INDICATOR	
Changes to Indicator:	
Other Notes <i>(optional)</i> :	
THIS SHEET LAST UPDATED ON:	

Helpful Tool: Logic Models

- A logic model is a visual and systematic way to describe the relationships between available resources, program activities, and anticipated changes or results.
- Logic models show how a program is intended to “work” and how a series of activities is intended to achieve expected outcomes.

Source: W.K. Kellogg, 2008

Helpful Tool: Logic Models

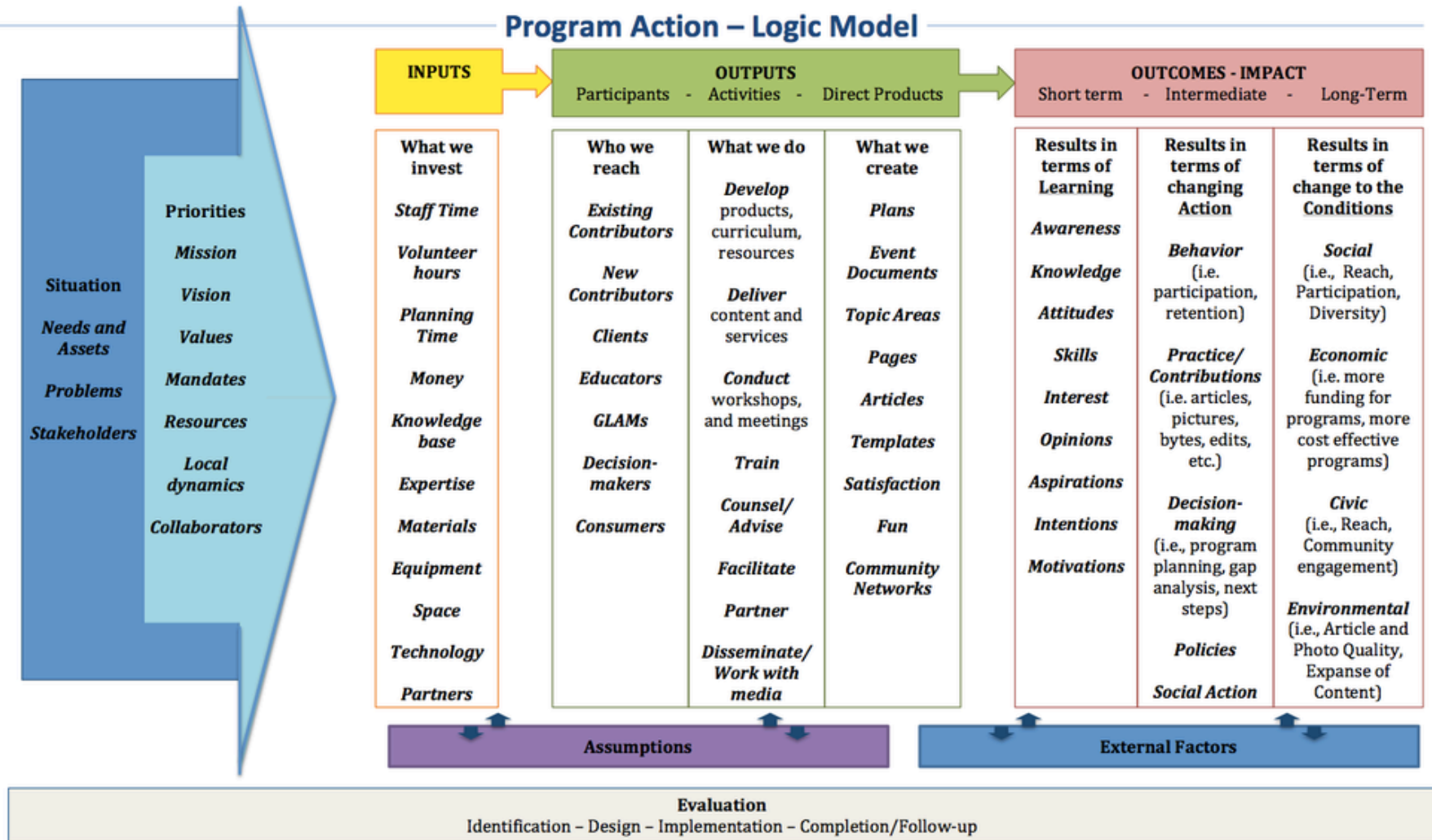


Source: W.K. Kellogg, 2008

Benefits of Logic Models

- Logic or theory of the program
- Important connections between actions and results.
- Common understanding among staff and stakeholders.
- Framework for performance measurement and evaluation.

Tool #3: Logic Model



Key Take-Aways

- Include strong evidence in your state plan, especially outcomes, to show the measurable benefits, results or changes that older adults receive from your state plan
- Use a participatory approach with leaders, staff and stakeholder identify the most relevant evidence
- Make sure that your performance measures are appropriate, SMART, and high quality.
- Use existing and new tools to help you with planning
- Include short, intermediate and long-term outcomes in your state plan to the extent possible and one goal, objective, strategy and outcome for each key topic.

Resources

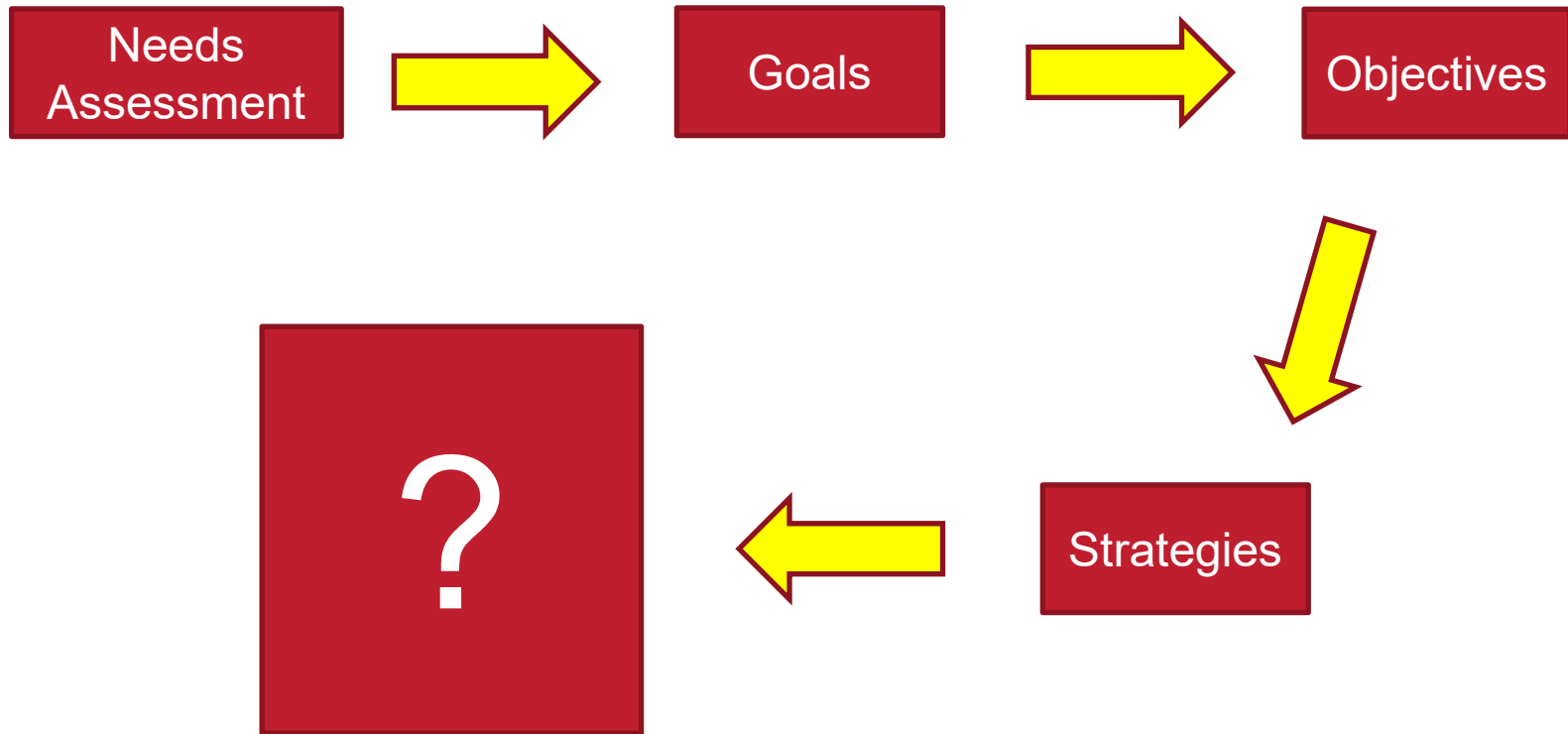
- Clear Impact (2016a). What are the differences between the 4 quadrants of performance measures? <https://clearimpact.com/3-8-what-are-the-differences-between-the-4-quadrants>
- Foundations for Evidence-Based Policymaking Act of 2018, H.R.4174, 115th Congress, 2018. [https:// www.congress.gov/bill/115th-congress/house-bill/4174](https://www.congress.gov/bill/115th-congress/house-bill/4174)
- Hatry, H.P. (2014, July 19). Transforming performance measurement for the 21st century. The Urban Institute. <https://www.urban.org/sites/default/files/publication/22826/413197-transforming-performance-measurement-for-the-21st-century.pdf>
- ACL Office of Performance and Evaluation (2020). Performance Measure Guide. Administration for Community Living.
- United Way (2018, July) Performance measures technical assistance, Ready Children Impact Council Request for Proposals. <https://www.unitedwaysatx.org/wp-content/uploads/RCIC-RFP-PerformanceMeasure-Technical-Assistance-Presentation.pdf>
- U.S. Agency for International Development. (n.d.-2). Performance monitoring & evaluation: Tips: Selecting performance indicators. https://pdf.usaid.gov/pdf_docs/Pnadw106.pdf
- W.K. Kellogg Foundation. (2004). Using logic models to bring together planning, evaluation and action: logic model development guide. <https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide>



Evaluation and State Plan Development

Rhonda Schwartz, JD, MSW
ACL Regional Administrator, Regions II & III

State Plan Development - Elements



State Plan Guidance - Outcomes

Outcomes document the measurable benefit older individuals should derive from the State Plan goals, objectives and strategies

State Plan Guidance – Outcome Measures

- 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).

Example #1

- Goal: Empower older adults to continue to live independently in the community
- Objective: Improve older adults' ability to manage chronic conditions
- Strategy: Offer at least two (2) CDSME programs in each PSA annually

Example #1 – Output Measures

- At least two (2) CDSME programs are held in each PSA annually
- At least XX older adults participate in CDSME classes each year during the plan period

Example #2

- Goal: Empower older adults to continue to live independently and to remain active
- Objective: Reduce Falls Among Older Adults
- Strategy: Implement Evidence-Based Fall Prevention Program among older adults who are at risk for falls

Example #2 – Outcome Measures

- Short-term: At least 500 older adults who are at risk for falls complete the Fall Prevention Program each year and demonstrate an increase in knowledge regarding the importance of preventing falls upon the completion of the program.
- Intermediate Term: At least 75% of the participants in the program report, 1 to 3 months after completing the program, that they have taken steps as a result of the program to reduce their likelihood of falling.
- Long Term: Hospitalizations in the state among older adults due to injuries from falls decreases.

Quick Links

- State Plan Guidance Letter

https://acl.gov/sites/default/files/about-acl/2021-08/State%20Plan%20Guidance_Plan%20Due%20Oct%202022%20-%20ACL%20SUA%20Directors%20Letter%20%2301-2021.pdf

- ACL State Plan Guidance Webpage

<https://acl.gov/about-acl/administration-aging-program-instructions>



Using Evidence in Implementing & Monitoring State Plans

Amy Wiatr-Rodriguez, MSW
ACL Regional Administrator, Region V

Implementing & Monitoring State Plans

- Design with the end in mind:
 - What evidence will allow you to evaluate progress on your State Plan?
 - Do you have access to that evidence? On a timely basis?
 - Consider using existing data sets/resources:
 - State Program Report - <https://acl.gov/programs/state-program-reports>
 - BRFSS - <https://www.cdc.gov/brfss/index.html>
 - NCI-AD - <https://nci-ad.org/>
 - State health, planning, or other state departments
 - University partnerships
 - If creating or modifying data collection methods, is your timeframe for implementing changes (including any grant/contract language and/or training plans) realistic?

Implementing & Monitoring State Plans

- What is your project management methodology?
 - Assigning responsibility for individual items and overall coordination
 - Setting timeframes for review – stand alone and/or as part of other existing meetings
 - Internal Staff Meetings
 - As part of Advisory Council or other meetings
 - Using review tools to collect and organize evidence/data



Other Considerations

- Who needs to be a part of your State Plan implementation & monitoring team?
 - Data contacts
 - Program contacts
 - Monitoring contacts
 - Communications contacts
 - Other? (E.g., fiscal, field, planning, or management staff)
- 

Implementing & Monitoring State Plans

STATE PLAN ON AGING | REPORTING FORM

Name:

Underline Goal#: 1 2 3 4 Specify Objective# e.g. 2A:

Topic:

Underline Presentation Date: March 6 April 3 May 2 June 5 July 10

 August 1 September 14 October 2 November 15 December 4

Use more pages as needed

Explain progress made in meeting this goal/objective. If progress has not been made to date, explain your plans and timeline.

Explain challenges, if any, in meeting this goal/objective, and suggestions for addressing them.

If applicable, explain any State Plan changes that may be necessary and why. List additions/deletions.

Indicate SUA staff who could be helpful to you in meeting your State Plan obligations, and the nature of help requested.

Project Summary

Project Name:	Title III-C1 and C2: Nutrition Program for Older Adults, Goal 1: Address Malnutrition	Date of Report:
Organization:	State Unit on Aging	Project Start Date:
Executive Sponsor:	OAA Manager	Target Completion Date:
Project Manager:	Nutrition Coordinator	

Description: To assure the health and safety of nutrition program recipients, SUA will complete a quality improvement project related to provision of malnutrition training, guidance, and monitoring that will assist at least 85% of nutrition programs in achieving compliance with SUA malnutrition policy by June 30, 2023.


Objectives for Plan:

1. By January 1, 2023, in collaboration with the Department of Agriculture, identify requirements for compliance with malnutrition guidance for nutrition program dining centers and central kitchens.
2. By March 1, 2023, develop guidance and agreed upon timelines to AAAs on how to achieve compliance in coordination with local public health departments.
3. By June 30, 2023, release an updated version of SUA's training and certification for AAA staff and volunteers who work in nutrition programs.

Project Milestones	Status Key:	Green On Time	Yellow Caution, milestone overdue	Red Milestone not met, re-evaluate	Blue Complete
	Milestone	Status:	Planned Completion Date	Current Forecast	Actual Completion Date
1)	By January 1, 2023, in collaboration with the Department of Agriculture, identify requirements for compliance with malnutrition guidance for nutrition program dining centers and central kitchens.				
	1a. Conduct baseline evaluation to determine where compliance issues currently exist.				
	1b. Meet with Nutrition Advisory Committee to determine issues and potential solutions.				
	1c. Share results of baseline evaluation & potential solutions with AAAs and LSPs for feedback.				

Implementing & Monitoring State Plans

Implementing & Monitoring State Plans

- Incorporate State Plan monitoring into your other monitoring efforts (e.g., AAA & other recipients)
 - Track issues to be addressed in future State/Area Plan cycles
 - Compare to national data and trends (e.g., NSOAAP)
- 

Outputs vs. Outcomes

- Outputs are not bad!
 - Outputs are an important performance indicator, AND should be a starting point, not a stopping point, in the evidence you collect.
- Consider leading vs. lagging indicators
 - “Lagging indicators take a long time to change, and show the later-stage results of your efforts [i.e., outcomes]. Leading indicators, on the other hand, measure the activities you think will help you reach your goal, and can be tracked on a more ongoing basis [i.e., outputs].”

<https://www.geckoboard.com/blog/leading-lagging-or-lost-how-to-find-the-right-key-performance-indicators-for-your-sales-team/>

Evidence to Consider

- Basic information that the Aging Network collects to meet SPR requirements can help you in evaluating state plan progress:
 - What **volume** of services are we providing?
 - Are we **targeting** clients appropriately?
 - How **intensely** are we providing services?
 - How **efficiently** and **reasonably** are we using resources?
 - Are we **leveraging** other resources?

Data & Performance: Maintaining Balance



Education & Advocacy

Narrative stories about the people you serve +
Supporting evidence = Powerful education & advocacy

If the statistics are boring, then you've got the wrong numbers.

**- Edward Tufte, statistician and professor emeritus,
Yale University**

Thank you for your work to use
evidence in State Plans on Aging!
Please contact us with any
questions:

Nicole.Becerra@acl.hhs.gov

Laura.House@acl.hhs.gov

Rhonda.Schwartz@acl.hhs.gov

Amy.Wiatr-Rodriguez@acl.hhs.gov