SUA Resource Library:

High-level Administrative Materials

Foreword

In 2012, the Administration for Community Living (ACL), an operating division of the US Department of Health and Human Services, began a comprehensive evaluation of its National Family Caregiver Support Program (NFCSP). This was the first comprehensive federal evaluation of the NFCSP, which serves over 800,000 family caregivers annually. The NFCSP evaluation has three broad goals to benefit policy and program decision-making:

1. Collect and analyze information on program processes and site operations;
2. Evaluate program efficiency and cost issues for approaches best suited to specific contexts; and
3. Evaluate effectiveness of the program's contribution to family caregivers in terms of maintaining their health and well-being, improving their caregiving skills, and avoiding or delaying institutional care of the care recipient.

As part of the evaluation survey, State Units on Aging (SUAs) were asked to submit relevant documents if they answered 'yes' to any of the following five questions:

- Do you have a statewide task force, commission or coalition specifically to examine family caregiver issues?
- Have community needs assessments for caregiver support services been conducted?
- Does your state have a standardized caregiver assessment?
- Does your SUA conduct routine programmatic monitoring of the NFCSP program?
- Do you use a uniform caregiver satisfaction survey across all AAAs?

ACL received assessment tools and grouped them into the following categories:

1. Community Assessment Materials
2. General Customer Satisfaction Survey Materials
3. Grandparent Assessment Materials
4. High-Level Administrative Materials
5. Program Monitoring Materials
6. State Caregiver Assessments
7. State Care Recipient Assessments
8. Task Force Materials
9. Uniform Satisfaction Materials
10. Other Materials

While ACL does not specifically endorse these tools, we are sharing them because they may be helpful to other programs. For more information on the NFCSP please go to: http://www.aoa.acl.gov/. For more information on the evaluation of the NFCSP please go to: http://www.aoa.acl.gov/Program_Results/Program_Evaluation.aspx

High-level Administrative Materials

SECTION II: AREA PLAN ON AGING

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EXHIBIT II-1

Area Agency Mission Statement

Exhibit II-1

MISSION STATEMENT

Instructions: Explain your agency's mission and role within the communities you serve. Describe how the 4 Year Plan relates to the mission, how the two will be integrated to meet your stated goals and outcomes, and how these will be implemented to ensure compliance with the intent and purpose of the Older Americans Act.

EXHIBIT II-2

The Agency's Vision for Older People

Exhibit II-2

The Agency's Vision for Older People

Instructions: Explain what the agency's vision is for older people. How did the agency arrive at this vision?

EXHIBIT II-3

The Agency's Core Values

Exhibit II-3

The Agency's Core Values

Instructions: What are the agency's core values? Explain how the agency in its ongoing management of programs and its strategic planning process is guided by core values. How do the agency's core values define the Area Agency's organizational culture?

EXHIBIT II-4

Review of Area Agency's Accomplishments

Exhibit II-4

Review of Area Agency's Accomplishments

Instructions: Describe the primary accomplishments of the Agency in terms of the organization and as a planning, advocacy and funding entity during the previous four years. Identify organizational strengths and strategies used to accomplish the goals that were attained. Please note areas needing improvement, how they were identified and any actions taken or plans you may have made to achieve a higher degree of successful outcomes for these areas.

EXHIBIT II-5

Description of the Planning Process

Exhibit II-5

Description of the Planning Process

Instructions: Describe the process used to assess the needs of older adults in its Planning and Service Area and to establish priorities. Outline the steps, procedures, instruments used, type of analysis and committees as applicable to your agency.

EXHIBIT II-6

Status and Needs of Area's Elders

Exhibit II-6

Status and Needs of Area's Elders

Instructions: Outline (1) the current needs [identified in priority order] among the area's elders and, (2) the needs of the area's elders projected over the planning period. Use information gathered through demographic data, needs assessment, survey instruments, community meetings/hearings, documented reports of unmet need and other sources relevant to your planning process and planning and service area. Use an organized format (such as numbers, letters, outline) so that needs may be easily referenced in the rationales. Include how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older adults during the ten-year period following the fiscal year for which the plan is submitted. Tell us the projected change in the number of older individuals in the planning and service area. An analysis of how the programs, policies, and services provided by the area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older adults.

EXHIBIT II-7

Summary of Area Objectives in Priority Order

Exhibit II-7

Summary of Area Plan Objectives in Priority Order

Instructions: List objectives in order of importance.

EXHIBIT II-8

Area Plan in Detail: Statement of Goals, Objectives and Strategies

Exhibit II-8

Instructions for Completing the Area Plan in Detail

Instructions: The Area Agency is asked to provide the State Unit on Aging with its 4 Year Goals, Objectives and Strategies. This section should reflect the needs identified in Exhibit II-6. All objectives listed in Exhibit II-7 should be addressed. Please use a separate page for each objective.

The Plan should be written to reflect the Agency's Goals, Objectives and Strategies to meet the needs of elders in its region.

Definition of Goal, Objective and Strategy for the purpose of the Area Plan:

Goal**:** Goals describe the impact an AAA will have within a given service area for a specific period of time to address identified needs. A goal statement is broad and does not include the specific outcome(s) or objective(s) and/or stated strategies to reach the goal/objectives.

- Goals should be related to the topical areas of need addressed by the Plan;
- Goals should be listed in order of their importance;
- The rationale, objectives, and strategies related to a given goal should be together under the appropriate goal;
- The rationale for each goal should clearly explain how and why an objective was selected;
- The rationale should relate the goal to the findings of the AAA during the planning process and specifically cite reference;
- The rationale should outline the goal's basis for development (i.e. gaps in service identified as a need through planning process, follow up on AAA accomplishments/initiative, coordination effort;
- **The State Unit on Aging is not requiring the AAA to submit a specific number of goals. The AAA should determine its own goals.**

Objective: Objective statements provide a specific description of what the AAA intend to do to accomplish a particular goal in a specific period of time. Generally these statements will include a 'countable outcome by which a goal can be measured'. There may be only one stated objective identified to ensure a stated goal is met.

- The AAA should list the objectives to be address during the four-year panning period. These objectives should relate directly to the goals established for the region. They should summarize the accomplishments to be expected at the end of the plan and serve as a tool to evaluate the agency's performance throughout the next four years;
- **The State Unit on Aging is not requiring the AAA to submit specific plan objectives for program areas. The AAA should develop its objectives based on information gathered through its planning process;**
- **Routine administrative functions of an Area Agency are not to be included as objectives.**

Strategies: An activity undertaken to accomplish a particular objective that enables the AAA to meet its stated goal. In almost all cases, more than one strategy will need to be identified to meet each goal/objective.

- Strategies listed should be specific, single focused, measurable or verifiable task/milestones planned to achieve each objective;
- Each strategy should stand independently , rather than be an action step;
- Include numerical targets where appropriate and dates of completion. If the strategy is ongoing throughout the duration of the Area Plan, please indicate as such.

Note: Timeframes for strategies should correspond to reasonable completion dates, not necessarily one year or year-end increments. Annual updates will be required thereafter. As stated above, if an activity will take eighteen months, please note appropriate date of completion.

Example:

Goal 1: Increase the number of older people who have access to an integrated array of health and social supports.

Objective 1.1 Strengthen the AAA's capacity to provide information to older individuals and their caregivers that can help them access health and social support, and educate the public about the importance of improving older people's access to an integrated array of health and social supports.

Strategies the AAA will use to accomplish its objective:

- Disseminate information to older people, including low-income, minority, rural, limited English speaking older people and caregivers to help them access health and social supports**. Ongoing**
- Educate the public, including policy makers about the challenges that older people face in trying to access services and the resources that can be used to address these challenges. The AAA will host four (4) Town meetings in its region and one (1) meeting at the State Legislature in collaboration with others in the Aging Network.

Exhibit II-9

Summary of Public Comment on Area Plan

Exhibit II-9

SUMMARY OF PUBLIC COMMENT ON AREA PLAN

Instructions: Include the following: Publicity date(s), location(s) of hearing(s), number in attendance, briefly describe proceedings, and note number of people giving verbal and written testimony. Summarize main points/focus of testimony noting significance (i.e. number of times mentioned)

APPENDIX

IDAHO COMMISSION ON AGING

STRATEGIC PLAN

For the Fiscal Years Ending June 30, 2014 – June 30, 2017

Submitted July 3, 2013

Signed: Sam Haws

Sam Haws, Administrator
Idaho Commission on Aging

MISSION
To set priorities, develop policy, coordinate, and evaluate state activities relative to the objectives of the Older Americans Act and the Idaho Senior Services Act.

OUTCOME BASED VISION
To provide the services and supports that improve the quality of life for seniors and people with disabilities, so they can live independent, meaningful, and dignified lives within the community of their choice.

KEY EXTERNAL FACTORS:

- Legislation can impact State and Federal programs administered by the Idaho Commission on Aging.
- Additions or reductions in federal appropriations or program mandates are unpredictable and directly impact the activities and expenditure plans of the Commission.
- Expansion of the aging population increases the demand for aging services, impacting the quantity and diversity of aging services that can be provided with level funding.
- Rising healthcare costs and economic variations impact the affordability of independent living.

OPERATING PHILOSOPHY
ICOA administers and ensures compliance of federally funded programs under the Older Americans Act and state funded programs under the Idaho Senior Services Act. ICOA plans and coordinates opportunities for individuals to access private and public pay long term care support services, monitors a statewide program of services to address the present and future needs of older Idahoans, and serves as a catalyst for improvement in the organization, coordination, and delivery of aging services in Idaho.

STRATEGIC PLAN: GOALS, OBJECTIVES, STRATEGIES, PERFORMANCE MEASURES AND BENCHMARKS
In developing the performance measures and benchmarks for the Strategic Plan, ICOA used demographic data from the 2010 Census and Idaho's Vital Statistics along with client demographics from Social Assistance Management Software (SAMS). ICOA also used the 2012 Needs Assessment prepared by the Center for the Study of Aging at BSU to identify focus areas across the state addressing needs for services and access to information. All financial program data was collected by ICOA's fiscal officer and used as a baseline for coordination and future opportunities. ICOA used the Aging and Disability Resource Center (ADRC) as a consumer access point for public review and comment on the development of the Senior Services State Plan for Idaho. ICOA used Google Analytics to gather website usage statistics to evaluate consumer interest. ICOA conducted an analysis identifying partnering agencies and community organizations to be used as the baseline for the development of strategies to strengthen the Aging and Disability network in Idaho.

State Fiscal Year 2014 Update

GOAL 1: Improve opportunities to access up-to-date community resources addressing health and long-term care options for Idahoans.		
Objective 1: Increase outreach efforts to target population		
Strategy 1: Partner with the Idaho Assistive Technology Project, Community Action Partnership and other technology groups to identify and market ways for older individuals residing in rural areas to access available assistive technologies through senior center newsletters, calendar of events, Twitter, on-site events and websites such as the ADRC.	**Performance Measure:** 1. Number of partners who market assistive technology to rural communities. 2. Number of methods used that provide access to available assistive technologies.	**Benchmark:** 1. Increase the number of partners marketing assistive technology to rural communities. 2. Increase the number of methods used to provide access to assistive technologies.
Strategy 2: Implement the use of multi-generational media to reach caregivers, as well as older individuals with greatest social needs through Facebook, Twitter, Google +, youth groups, education programs and large employers around the state. Develop sharable content and focus on community partners to expand outreach.	**Performance Measure:** 1. Number of community partners who use multi-generational media. 2. Implementation of multi-generational media.	**Benchmark:** 1.Increase the number of community partners using multi-generational media. 2. Increase the visibility of existing social media resources.
Strategy 3: Collaborate with partnering agencies to coordinate outreach programs for seniors with low-income: For example, increase volunteerism and inform clients about Medicare benefits and how to identify Medicare fraud through the SMP grant in collaboration with the Department of Insurance's SHIBA program.	**Performance Measure:** 1. Number of collaborative partnerships with agencies that provide outreach programs for seniors with low income.	**Benchmark:** 1. Increase partnerships with agencies that provide outreach programs for seniors with low income.
Objective 2: Strengthen and sustain the ADRC website and services as the single entry point for public and private resources.		
Strategy 1: Modify AoA Options Counseling Standards for Idaho and incorporate into	**Performance Measure:** 1. Development of AoA Options Counseling standards into	**Benchmark:** 1. Finalize Option Counseling standards for Idaho in 2013.

referral procedures and implement through collaboration with the ADRC and Centers for Independent Living (CIL) sites.	referral procedures.	
Strategy 2: Provide 211 Careline with ADRC taxonomy and ADRC site referral training to support streamline access for consumers. In particular, strengthen database to cover resources for seniors with limited income.	**Performance Measure:** 1. Number of ADRC referral and aging network training provided to 211 CareLine.	**Benchmark:** 1. Quarterly provide 211 Careline Training.
Strategy 3: Establish website tools such as the online self-assessment and online MIPPA training and link to other agency directories to sustain ADRC functions. Utilize website tools to generate management report to track progress.	**Performance Measure:** 1. Number of established website tools. 2. Number of links to other agency directories established.	**Benchmark:** 1. Increase the number of website tools, such as: individual needs assessments. 2. Increase links to other agency directories.
Strategy 4: Sustain the ADRC by identifying new partners with mutual benefits: For example Medicaid, CILs, Idaho Legal Aid Services, Transportation, etc.	**Performance Measure:** 1. Number of identified partners with mutual benefits.	**Benchmark:** 1. Increase number of new partnerships and include their information on the ADRC website.
Strategy 5: Coordinate ADRC outreach information and education resources with other agencies, including PERSI, in health promotion fairs and outreach events: For example, assisting low-income older minority individuals through Hispanic and Tribal community health fairs, Central District Health immunization events/promotions and senior centers for low-income older individuals, etc.	**Performance Measure:** 1. Number of coordinated ADRC outreach presentations that distribute information and educational resources.	**Benchmark:** 1. Annually conduct a minimum of 4 ADRC presentations.
Objective 3: Improve the collection and distribution of resource information on the ADRC website and local AAA offices.		
Strategy 1: Make sure technical Alliance of Information and Referral Systems (AIRS) standards are incorporated into data collection systems: For example, standards for options counseling, assessment tools, directories, key word searches, multi-agency	**Performance Measure:** 1. Number of AAA Information & Referral resource databases that are AIRS standards compliant.	**Benchmark:** 1. All AAA's employ AIRS compliant resource databases by SFY 2015.

terminology, etc.		
Strategy 2: Establish online FAQ's, calendar of events, links to manuals and references on ADRC website	**Performance Measure:** 1. Frequency of ADRC website review/update activities. 2. Frequency of website validation activities.	**Benchmark:** 1. ADRC website is reviewed/updated monthly. 2. ADRC website content is validated quarterly.
Strategay 3: Contact tribes and incorporate their senior services linkds to the ADRC website.	**Performance Measure: 1.** Number of tribes that have provided senior services links on ADRC website.	**Benchmark: 1.** Increase number of tribes and their senior programs on ADRC website.
Strategy3: Utilize consumer evaluations and feedback on ease of use and material content of the ADRC website, for site management. Engage state and local consumer groups and collaborate with ICOA's administrator to play key roles in the content and usability of the ADRC services, and provide a semi-annual report to the Administrator with corrective action plan if needed.	**Performance Measure:** 1. Evaluate all consumer responses on the ADRC website content and usability.	**Benchmark:** 1. All critical website evaluations are reviewed by management and Annual report is given to ICOA's administrator.
GOAL 2: Strengthen existing home and community-based and evidence-based services.		
Objective 1: Increase the efficiency and effectiveness of home and community-based services.		
Strategy 1: Identify baseline units of service and develop goals with the AAAs to strengthen services to the target population: for example, all service providers prioritize service delivery to older low-income minority individuals, older individuals residing in rural areas, individuals with Alzheimer's and their caregivers.	**Performance Measure:** 1. Track strategies that are being used to reach target population.	**Benchmark:** 1. Identify if there are increase registered service enrollment in rural and low income population.
Strategy 2: Coordinate with Friends in Action and the BSU Center for the Study of Aging to develop and expand a Life Span Respite coalition.	**Performance Measure:** 1. Provide access to coalition membership and services through the ADRC website and resource database.	**Benchmark:** 1. Access to the Life Span Respite coalition membership and services through the ADRC website and resource database.
Strategy 3: Identify those service areas that are not "dementia capable". Utilize the	**Performance Measure:** 1. Number of service	**Benchmark:** 1. Increase the number of

dementia toolkit for evaluation and implementation, then provide best practices to our partners to better serve individuals such as those with Alzheimer's and their caregivers.	areas that are "dementia capable".	"dementia capable" services.
Objective 2: Build participation in evidence-based services.		
Strategy 1: Match evidence-based program information to agencies and organizations for implementation: For example, provide Chronic Disease and Self- Management Program (CDSMP) to SCSEP participants, explore option of providing work experience credit for CDSMP participation hours, and provide to IDOL One-Stop Career system to encourage involvement.	**Performance Measure:** 1. Number of agencies matched to evidence-based program information.	**Benchmark:** 1. Increase the number of evidence based programs that are linked to agencies.
Strategy 2: Collaborate with the Veterans Administration, Vocational Rehabilitation, local Veterans Administration medical centers and network with AAAs, home health and non-profit organization to implement the Veteran-Directed Home and Community Based Service (VD-HCBS) program.	**Performance Measure:** 1. Number of operational VD-HCBS sites.	**Benchmark:** 1. One operational site in SFY 2014.
Strategy 3: Increase evidence-based programs at State and local levels that will focus on the health and social needs of older individuals of Idaho.	**Performance Measure:** 1. Number of evidence-based programs that focus on economic and social needs of older individuals of Idaho.	**Benchmark:** 1. Increase the number of Evidence-based programs focused health and social needs.
Strategy 4: Coordinate programs with the Idaho Food Bank, Idaho Hunger Coalition, Idaho Hunger Task Force and the Community Action Partnership Association of Idaho to improve nutritional services provided to low-income seniors through the Home Delivered and Congregate Meal programs.	**Performance Measure:** 1. Number of strategies to improve nutritional services.	**Benchmark:** 1. Implementation of new strategies to reach target population through the Home Delivered and Congregate meal programs.

GOAL 3: Promote healthy and active lifestyles for Idahoans.		
Objective 1: Provide additional opportunities for older adults to engage in social and physical activity to develop healthy behaviors.		
Strategy 1: Identify existing evidence-based programs and make them accessible through the ADRC website.	**Performance Measure:** 1. Number of AAA evidence-based programs incorporated on the ADRC website.	**Benchmark:** 1. Include all AAA operated evidence-based programs and provide descriptions and links on ADRC website.
Strategy 2: Support senior centers in their efforts to increase the number of participants engaged in their services. Increase the visibility of senior centers through AAA/ADRC websites integration.	**Performance Measure:** 1. Number of Senior Centers on ADRC and AAA websites.	**Benchmark:** 1. Incorporate senior center information on the local ADRC websites.
Objective 2: Increase volunteerism to support long-term care and home and community based services.		
Strategy 1: Develop and implement an annual statewide ICOA aging network volunteer recognition award program.	**Performance Measure:** 1. Volunteer recognition program.	**Benchmark:** 1. Implement recognition program.
Strategy 2: Increase volunteer recruitment and the development of volunteer programs through agency coordination, marketing, outreach, and utilizing social media (i.e. Facebook networking).	**Performance Measure:** 1. Number of volunteer recruitment events. 2. Types of outreach.	**Benchmark:** 1. Increase volunteer recruitment events. 2. Implement new types of outreach.
Strategy 3: Incorporate volunteer organization services in the online resource database.	**Performance Measure:** 1. Online resource database.	**Benchmark:** 1. Access to the resource database through the ADRC website.
Objective 3: Increase employment opportunities by connecting employers with unemployed older Idahoans.		
Strategy 1: Provide access to Senior Community Service Employment Program (SCSEP) and Idaho Department of Labor's (IDOL) One Stop Shop employment sites.	**Performance Measure:** 1. ADRC links to IDOL's one-stop-shop employment sites.	**Benchmark:** 1. Provide links to all IDOL's employment sites.
Strategy 2: Increase options for On-the-Job training, identify prioritization for placement of participants at Host sites who have a record of hiring participants and identify funding to be used to provide occupational skill training.	**Performance Measure:** 1. Employment training options 2. Training site placement	**Benchmark:** 1.Increase training options. 2. Link host agencies to training options.
Strategy 3: Link volunteer programs to	**Performance Measure:** 1. Number of	**Benchmark:** 1. Increase the number of

training opportunities for low- income seniors through the Senior Community Service Employment Program (SCSEP), SERVE Idaho, and Foster Grandparent Programs.	volunteer program training opportunities.	training opportunities.
Strategy 4: Collaborate with the Idaho Hispanic Commission, Idaho State Veterans Administration, Idaho Division of Vocational Rehabilitation, the Idaho Department of Labor and the Community Council of Idaho to increase training and employment opportunities for older low-income minority individuals and older individuals with limited English proficiency.	**Performance Measure:** 1. Number of collaborative partnerships established.	**Benchmark:** 1. Increase the number of collaborative partnerships.
Objective 4: Increase health promotion and disease prevention outreach through materials and education.		
Strategy 1: Coordinate the distribution of free community fitness and health programs and technical assistance to seniors through the ADRC website.	**Performance Measure:** 1. Number of community fitness and health programs represented on the ADRC website.	**Benchmark:** 1. Increase the number of community fitness and health programs represented on the ADRC website.
Strategy 2: Develop resources and partnerships to provide statewide nutrition education and counseling through the ADRC website, meetings, and training.	**Performance Measure:** 1. Number of resources developed. 2. Number of nutrition education and counseling partnerships established.	**Benchmark:** 1. Increase resources 2. Increase partnerships.
Strategy 3: Provide Title III-D (Health and Disease Prevention Program) guidance and assistance based on AoA evidence-based criteria.	**Performance Measure:** 1. Number of Evidence-Based (EB) programs.	**Benchmark:** 1. Increase number of eligible EB programs in Idaho.
Strategy 4: Partner with Friends in Action to incorporate Living Well in Idaho and Building Better Caregivers into other community-based service programs.	**Performance Measure:** 1. Number of other community-based service programs.	**Benchmark:** 1. Increase number of other community-based programs that use Living Well in Idaho and Building Better Caregivers programs.
Strategy 5: Coordinate with Idaho State University and other institutions that provide free medical screening and education. Include access to this information on ADRC calendar	**Performance Measure:** 1. Number of partnerships with institutions that provide free medical screening and education.	**Benchmark:** 1. Include free screening and education events on ADRC calendar.

of events		
Objective 5: Identify opportunities to increase community transportation options to enable seniors to travel to community events, volunteer work, services, shopping and medical appointments.		
Strategy 1: Develop partnerships to increase resources for transportation, and participate in state and local transportation planning. In particular, target older individuals residing in rural areas and low-income seniors.	**Performance Measure:** 1. Number of transportation partnerships. 2. Attendance of local transportation planning events.	**Benchmark:** 1. Stay engaged with the Idaho Mobility Council, increase transportation links from ADRC website. 2. Increase participation at state and local transportation planning activities.
Strategy 2: Link to an online transit directory and other transportation resources from the ADRC website.	**Performance Measure:** 1. Number of ADRC website link(s) to transportation resources.	**Benchmark:** 1. Increase state and local links to transportation resources through ADRC website.
GOAL 4: Protect the rights of older people and prevent their abuse, neglect and exploitation.		
Objective 1: Increase coordination with state entities, organizations, and institutions that protect vulnerable adults from abuse, neglect, and exploitation.		
Strategy 1: Identify partners who are active in preventing the abuse, neglect, and exploitation of vulnerable adults and establish a community resource network accessible from the ADRC website and through face to face coordination with partnering agencies.	**Performance Measure:** 1. Number of active partners identified. 2. Establish community resource network.	**Benchmark:** 1. Increase number of partners and access to information on ADRC website. 2. Establish community resource network accessible through the ADRC website.
Strategy 2: Incorporate links on ADRC website to resources that provide information concerning advance directives, power of attorney, guardianship, abuse, consumer scams and other legal aid services.	**Performance Measure:** 1. Number of legal service links from ADRC website to community resources.	**Benchmark:** 1. Increase resources and links to partnering agencies.
Objective 2: Provide additional resources to help people make informed decisions about long-term care or assisted living facilities.		
Strategy 1: Develop educational materials for Adult Protection, local Ombudsman and Tribal Services to provide public education for staff and residents of assisted living facilities about rights, prevention of abuse, neglect, and exploitation.	**Performance Measure:** 1. Number of educational publications.	**Benchmark:** 1. Increase public education material with collaborative partners.

Strategy 2: Increase the frequency of regular visitation to assisted living facilities by increasing the number of qualified Ombudsman volunteers.	**Performance Measure:** 1. Number of Ombudsman volunteers. 2. Number of visits to assisted living facilities.	**Benchmark:** 1. Increase volunteer programs to all six AAAs. 2. Increase quarterly visitations of Skilled Nursing Home and Assisted Living Facility. Must meet minimum quarterly visits.
Objective 3: Increase public outreach to recognize and report signs of elder abuse, neglect and exploitation.		
Strategy 1: Support other organizations who provide education and outreach to the public concerning elder abuse, neglect, and exploitation of adults, including individuals with Alzheimer's and their caregivers through the posting of pertinent information on the ADRC website and specific training with the 211 Careline operators: For example, Justice Alliance for Vulnerable Adults (JAVA), Ada County Abuse in Later Life.	**Performance Measure:** 1. Number of postings on ADRC. 2. Number of specialty area trainings for 211 Careline.	**Benchmark:** 1. Increase postings on ADRC. 2. Provide specific area training to 211.
GOAL 5: Maintain an effective and responsive management and administrative structure.		
Objective 1: Update state and federal quality assurance review processes.		
Strategy 1: Review ICOA's external compliance requirements. Update the onsite review monitoring toolkits. Implement monitoring to include annual onsite reviews.	**Performance Measure:** 1. Maintenance of monitoring toolkits.	**Benchmark:** 1. Update monitoring tool kit to be used in 2013.
Objective 2: Implement systematic changes to establish administrative and service continuity.		
Strategy 1: ICOA defines data quality needs for the state and federal reporting. Develop data quality assurance plan with AAAs.	**Performance Measure:** 1. Determine missing data elements.	**Benchmark:** 1. Reduce missing data.
Strategy 2: Maintain statewide Program Manual that identifies federal and state regulations and provides policies, guidance, reports and forms to implement Senior Services Act and OAA services in Idaho.	**Performance Measure:** 1. Frequency of Program Manual updates.	**Benchmark:** 1. Semi-annual Program Manual Updates.

340:105-10-90.1. National Family Caregiver Support Program
Revised 6-1-08

(a) **Policy.** The Area Agency on Aging (AAA) awards grants to entities to provide support services, including information and assistance, counseling, support groups, respite, and other home- and community-based services to families caring for their frail older members. The National Family Caregiver Support Program (NFCSP) also recognizes the needs of a grandparent or step-grandparent who is a relative caregiver of a child or other older person who is a relative caregiver of a child who is not more than 18 years of age or who is a person with a disability. NFCSP services include:

- (1) information to caregivers about available services;
- (2) assistance to caregivers in gaining access to services;
- (3) individual counseling, organization of support groups, and training to assist caregivers in areas related to their caregiver roles of:
    - (A) health;
    - (B) nutrition;
    - (C) financial literacy;
    - (D) decision making; and
    - (E) problem solving;
- (4) respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- (5) supplemental services, on a limited basis, to complement the care provided by caregivers.

(b) **Authority.** The authority for this Section is the Office of Management and Budget Notice of Action 0985-0008 and Sections 371 through 374 of the Older Americans Act of 1965, as amended, Public Law 109-365, Grants for State and Community Programs on Aging.

(c) **Procedures.** The requirements for implementing this Section are outlined in this subsection. The AAA:

- (1) incorporates the provisions of this Section into the Title III policies and procedures manual;
- (2) provides technical assistance to prospective and funded Title III projects regarding this rule;
- (3) monitors Title III project compliance according to OAC 340:105-10-43, except on specific projects where the State Agency has agreed with the AAA to provide a service and monitoring is not required. The project:
    - (A) gathers information on an approved intake form, including, at a minimum:
        - (i) the family caregiver's identifying information;
        - (ii) the caregiver's relationship to the care receiver;
        - (iii) the care receiver's identifying information; and
        - (iv) a written description of the caregiver's current situation, including the care receiver's need for assistance due to inability to perform specific activities of daily living (ADLs) or need for supervision due to Alzheimer's disease or other neurological and organic brain dysfunction or disability;

    - (B) conducts a reassessment of NFCSP service recipients annually, at a minimum, to evaluate service provision and update participant status;
    - (C) ensures the safety and protection of the participants; and
    - (D) receives in-service training each fiscal year specifically designed to increase the project's knowledge and understanding of the programs and participants served;
- (4) targets services to caregivers who are older persons in greatest social and economic need, giving priority to:
    - (A) family caregivers providing care for persons with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
    - (B) grandparents or older persons who are relative caregivers providing care for a person or child with a severe disability;
- (5) may provide support services to caregivers providing care for frail older family members who are 60 years or older and unable to perform at least two ADLs without substantial human assistance or require substantial supervision due to a cognitive or other mental impairment. ADLs include:
    - (A) dressing;
    - (B) bathing;
    - (C) eating;
    - (D) transferring;
    - (E) toileting; and
    - (F) walking;
- (6) may provide support services on a limited basis to grandparents and older persons who are relative caregivers of a child who is 18 years of age or younger.
    - (A) Child means a person who is not older than 18 years of age or who is a person with a disability.
    - (B) Grandparent or older person who is a relative caregiver means a grandparent or step-grandparent of a child, or a relative of a child by blood, marriage, or adoption who is 55 years of age or older and:
        - (i) lives with the child;
        - (ii) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and
        - (iii) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally;
- (7) ensures the cost of carrying out the program meets the requirement of a minimum non-federal share of 25 percent. The non-federal share is provided from state and local sources;
- (8) may not use funds to supplant, replace, or in substitution for, any funds expended under any federal, state, or local law for the same purposes; and
- (9) considers awarding funds to expand successful caregiver activities currently in communities, such as respite providers, support groups, outreach, information and assistance, adult day services, counseling, and case management.

(d) **Cross references.** See OAC 340:105-10-37, 340:105-10-38, 340:105-10-40, 340:105-10-41, 340:105-10-43, 340:105-10-44, and 340:105-10-50.1(a)(15)(F).

Statewide Family Caregiver Support Program
Best Practices Identified through Monitoring

Note: The most successful III-E Family Caregiver Support Programs in Oregon are those with strong and varied community partnerships that support both elders and children. These partnerships include local health care systems, agencies that serve ethnic and "at risk" populations, local APD offices, newspapers, and schools

ADRC Integration:

- Most AAAs have moved towards integrating the Family Caregiver Support Program (FCGSP) into their ADRC. Options Counseling is now being provided where traditional case management has been provided.

Caregiver Training:

- Many of the Coordinators are trained in leading Powerful Tools for Caregivers or Savvy Caregiver classes; however many work with a community partner, such as a staff person from a local hospice, or Parrish nurse, to provide the training.
- AAAs work with Coordinated Care Organizations to refer clients for caregiving classes.
- Some AAAs have collaborated with partners to provide one day retreats or conferences to "Celebrate Caregivers" that provides training and support that may not be covered in Powerful Tools or Living Well classes. Topics include legal planning, community services, providing personal care.
- Some AAAs provide services for people with dementia and their care partners such as Reducing Disability in Alzheimer's Disease (RDAD) or Star-C. In addition AAAs refer caregivers to the Alzheimer's Association or Alzheimer's Network of Oregon for additional support and training.

Caregiver Support:

- AAAs partner or contract with local therapists or counselors to provide support groups for family caregivers.
- AAAs work with local entities that have support groups for caregivers of people with Alzheimer's disease or Parkinson's disease.
- AAAs partner with local Boys and Girls clubs that provide support groups for relatives raising children and fund "respite" or day care so relatives can attend the support groups.

Outreach:

- AAAs conduct outreach by going into key office buildings for several hours a day to provide information on the services and programs available to family caregivers and those who are relatives raising children.
- AAAs partner with a local pharmacy to put information about the FCGSP into RX medication bags.
- AAAs provide flyers re: FCGSP in medical clinics.
- AAAs partners with local senior newspapers to provide information on FCGSP program.
- AAAs participate in monthly respite event for caregivers of tribal elders.

Family Caregiver Support Program Standards

Older Americans Act

Prepared by:
Family Caregivers Support Program Advisory Committee
In Partnership with Department of Human Services
Seniors and People with Disabilities
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Table of Contents

I. Background

A. Introduction

The National Family Caregiver Support Program (NFCSP) was established in November 2000. The NFCSP, administered by the Department of Health and Human Services Administration on Aging (HHS), was officially launched by HHS Secretary Tommy Thompson in February 2001.

B. Program Eligibility Definitions

With the Older Americans Act 2006 Reauthorization, the NFCSP has broadened the populations served. The following is a comprehensive list of unpaid caregivers that can be served through the FCSP:

- Caregivers of individuals with Alzheimer's Disease (and related disorders with neurological and organic brain dysfunction). The care receiver and caregiver can be of any age.
- Grandparents or older relative caregivers (55 years of age or older) caring for a child related by blood, marriage, or adoption. Child is an individual 18 years or younger or of any age if the individual has a disability. Adult Child With a Disability – A child who is 18 years of age or older who has a disability and is financially dependent on an older individual. (OAA 102(a) (3)(A-C)) This includes grandparents or older relative caregivers who receive financial support payments, such as Temporary Assistance to Needy Families (TANF), Foster parent payments, Child Support, Social Security for children, etc.
- Adult family member or another individual, who is a provider of in-home and community care to older individuals (age 60 years or older).

Care Receiver	Caregiver
Person age 60 or older	Adult of any age
Child age 18 or younger	Grandparent/Relative Caregiver, age 55 and older, does not include parent
Adult or Child with disabilities of any age	Grandparent/Relative Caregiver, age 55 and older, does not include parent
Alzheimer's (or related disorder) any age	Adult of any age
Adult Child With a Disability – A child who is 18 years of age or older who has a disability and is financially dependent on an older individual. (OAA 102(a)(3)(A-C))	Grandparent/Relative Caregiver, age 55 and older, does not include parent

Caregiver: A 'family caregiver' means an adult family member or another individual, who is an "informal" provider of in-home and community care to an older individual. An individual who "informally" has the responsibility for the care of an older individual or individual of any age suffering from Alzheimer's or related disorder; or a grandparent/relative caregiver, age 55 and older who has the responsibility for the care of children or adult child with disabilities. "Informally" means the care is not provided as part of a public or private service program. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Grandparent or Other Older Relative Caregiver of a Child – A grandparent, step grandparent or other relative of a child by blood or marriage who is 55 years of age or older and lives with the child, is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and has a legal relationship to the child, such as legal custody or guardianship or is raising the child informally. (AoA Title III/VII Reporting Requirements Appendix **–** www.aoa.gov**)**

- lives with the child;
- is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and
- has a legal relationship to the child, as such legal custody or guardianship or is raising the child informally.

II. Program Authority

Sections 371, 372, 373, and 374 of the Older Americans Act of 1965, as Amended (P.L.106-501), Grants for State and Community Programs on Aging, and W.S. 9-2-1204.

III. Program Overview

A. Program Purpose

- To assist family caregivers in their expanding roles by providing program components that will ease family caregiver stress and increase coping.

B. Program Goals

- Assist family caregivers to successfully meet the challenges of their caregiving role, while being supported in that role.
- To deter institutionalization, when feasible, and promote continued care within the home and in alternative community settings for seniors for as long as possible or desirable by family caregivers.
- Provide highest service levels possible.

IV. Federal Requirements and Reporting

PROGRAM REPORTING

AAA shall collect and report National Aging Program Information System ("NAPIS") data as directed by DHS for all caregiver services provided, using DHS provided software or a DHS approved alternative collection and reporting method. For full details on reporting criteria see Group 1 and Group 2 Caregiver Services detail published in DHS SPD AR-11-047 (http://www.oregon.gov/DHS/spwpd/sua/docs/oaa-opi-serv-def.pdf)

Program Income

All recipients of Title III-E caregiver services will be provided an opportunity to voluntarily contribute towards cost of service. Said contribution, hereby referred to as program income shall be used for the sole purpose of expanding caregiver services.

Maximum Expenditures

a) Administration - No more than 10% of expended Title IIIE funds may be utilized for administration purposes.
b) Caregivers serving children - No more than 10% of expended Title IIIE funds may be utilized to support services to caregivers serving children (under age 18).

Matching Funds

Federal funds may not pay for more than 75% of total caregiver expenditures. The required match is calculated as shown in the following example for $100 of Title IIIE funds expended equals $100 divided by .75 equals $133; $133 minus $100 equals $33; the required match to spend $100 of Title IIIE is $33.

V. Service and Unit Descriptions

GROUP 1 CAREGIVER SERVICES

Requires reporting caregiver's age, gender, rural, race, ethnicity, relationship to service recipient, unduplicated caregiver count, and units of service.

EXCEPTIONS: CG Cash & Counseling requires unduplicated client count only – units of service optional.

CAREGIVER CASH & COUNSELING
Matrices #73 (serving elderly) 73a (serving children) (1 unit = 1 client served)
Services provided or paid for through allowance, vouchers, or cash which is provided to the client so that the client can obtain the supportive services which are needed. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

CAREGIVER COUNSELING
Matrices #70-2a (serving elderly) 70-2b (serving children) (1 unit = 1 session per participant)
Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. This includes counseling to individuals, support groups, and caregiver training (of individual caregivers and families). (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

CAREGIVER SUPPLEMENTAL SERVICES
Matrices #30-7 (serving elderly) 30-7a (serving children) (1 unit = 1 payment)
Services provided on a limited basis that complement the care provided by family and other informal caregivers. Examples of supplemental services include, but are not limited to, legal assistance, home modifications, transportation, assistive technologies, emergency response systems and incontinence supplies. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Note: Home-delivered meals and transportation to caregivers serving elderly or caregivers serving children are to be reported under this matrix. Refer to Caregiver Standards for expanded list of examples.

No ADL/IADL is required for supplemental services to caregivers serving children. For caregivers serving elderly, service priority should always be given to caregivers providing services to individuals meeting the definition of 'frail'. (See General Terms and Definitions)

CAREGIVER SUPPORT GROUPS
Matrices #30-6 (serving elderly) 30-6a (serving children) (1 unit = 1 session per participant)
Peer groups that provide opportunity to discuss caregiver roles and experiences and which offers assistance to families in making decisions and solving problems related to their caregiving roles. (DHS/SPD/SUA definition)

CAREGIVER TRAINING
Matrices #70-9 (serving elderly) 70-9a (serving children) (1 unit = 1 session per participant)
Training provided to caregivers and their families that supports and enhances the care giving role. For example: Powerful Tools training; Communicating Effectively with Health Care Professionals; conferences, etc. (A session for conferences would be equal to one day's attendance at the conference). (DHS/SPD/SUA definition)

Note: This does not include training to paid providers.

RESPITE CARE
Matrices #30-4 (OPI) #30-5 (serving elderly) 30-5a (serving children) (1 unit = 1 hour see notes)
Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite Care includes: (1) In-home respite (personal care, homemaker, and other in-home respite); (2) respite at a senior center or other nonresidential program; (3) respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time; (4) and for grandparents/relatives caring for children – day or overnight summer camps. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov & SPR Q&A #28, 2008)

Note: OAA 373 (a)(2)(A & B) states priority shall be given to caregivers providing services to individuals whom meet the definition of 'frail'. (See General Terms and Definitions).

SPR Q&A #28, 2008 states units of service for overnight institutional respite and overnight summer camps are more appropriately reported by days than hours. Example: Two days of institutional respite is 2 units (not 48 units) and six days at camp equal 6 units instead of 144.

GROUP 2 CAREGIVER SERVICES

Requires reporting service units and estimated unduplicated caregiver count or when applicable, an estimated number of caregivers and service units. No demographics required.

CAREGIVER ACCESS ASSISTANCE
Matrices #16 (serving elderly) 16a (serving children) (1 unit = 1 contact)
A service that assists caregivers in obtaining access to the available services and resources within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Note: Case management and information and assistance to caregivers is an access service.

INFORMATION FOR CAREGIVERS
Matrices #15 (serving elderly) and 15a (serving children) (1 activity)
A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Note: Service units for information services are for activities directed to large audiences of current or potential caregivers such as disseminating publications, conducting media campaigns, and other similar activities.

A. General Terms and Definitions

The following terms and definitions are related to Oregon's Older Americans Act (OAA) and Oregon Project Independence (OPI) service programs. The source follows each definition.

Act: National Family Caregiver Support Program (NFCSP)

ADL (Activities of Daily Living) – Personal functional activities required by an individual for continued well being, which are essential for health and safety. For the purposes of these rules, ADLs consist of eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management)), and cognition/ behavior as described in Oregon Administrative Rule (OAR) 411-015-0007. (OAR 411-032-0000). For more information on ADL's, you can visit: www.dhs.state.or.us/policy/spd/home.htm or find information on OAR 411-015-0006 (1).

Adult Child With a Disability – A child who is 18 years of age or older who has a disability and is financially dependent on an older individual. (OAA 102(a)(3)(A-C)).

Adult Day Services – A community-based group program designed to meet the needs of adults with functional impairments through service plans. These structured, comprehensive, non-residential programs provide health, social and related support services in a protective setting during part of a day, but for less than 24 hours per day. (OAR 411-066)

Aging and Disability Resource Center – A point of entry to comprehensive information on the full range of available public and private long-term care services, service providers, and resources within a community and options counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances. (OAA 102(a)(4)(A-C))

Alzheimer's Disease and Other Related Disorders – A progressive and degenerative neurological disease characterized by symptoms of short-term memory loss, confusion and behavior and personality changes. It includes all other related disorders recognized by the National Alzheimer's Association including dementia caused from Multi-Infarct Dementia (MID), Normal Pressure Hydrocephalus (NPH); Inoperable Tumors of the Brain; Parkinson's Disease; Creutzfeldt-Jakob Disease; Huntington's Disease; Multiple Sclerosis; Uncommon Dementia such as Pick's Disease, Wilson's Disease, and Progressive Supranuclear Palsy. (OAR 411-032-000)

Caregiver – An individual who "informally" has the responsibility for the care of an older individual or individual of any age suffering from Alzheimer's or related disorder; or a grandparent/relative caregiver, age 55 and older who has the responsibility for the care of children or adult child with disabilities. "Informally" means the care is not provided as part of a public or private service program. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Child – An individual who is not more than 18 years of age or an individual 19 to 59 years of age who has a severe disability. This definition relates to the caregiver services. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Civic Engagement – Individual or collective action designed to address a public concern or an unmet human, educational, health care, environmental, or public safety need. (OAA 102(a)(12))

Disability – Except when such term is used in the phrase ''severe disability'', ''developmental disability", ''physical or mental disability'', ''physical and mental disabilities'', or ''physical disabilities'' - a disability is attributable to mental or physical impairment, or a combination of mental and physical impairments, that results in substantial functional limitations in one (1) or more of major life activity. (OAA 102(a)(13)(A-I))

Disease Prevention & Health Promotion Services – Individual or group programs based on best practices and/or evidence-based research, that identify health risks and needs, prevent health problems, and/or help older adults manage their health conditions. Programs should address identified health needs of older adults in the community, and where possible, should use evidence-based approaches and evaluated outcomes to address needs. These may include health risk assessments and screening linked to referrals and/or follow-up education; health promotion programs that help participants prevent and/or manage chronic conditions, alcohol and substance abuse, health risks such as smoking cessation, weight loss; physical activity programs to promote activity and prevent falls; educational programs on health risks and conditions or use of preventive health services and medication management. (Condensed from OAA 102 (a)(14)(A-L))

Elderly Client – A service recipient who is 60 years of age or older or who is less than 60 and has a diagnosis of Alzheimer's or a related disorder. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Ethnicity – Consistent with OMB requirements ethnicity categories are *Hispanic or Latino* or *Not Hispanic or Latino.* (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Evidence-based Program – Evidence-based programs are interventions that have been tested through randomized control trials and have been shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits. (DHHS FFY2011 AoA *Justification of Estimates for Appropriations Committees*)

Focal Point – A community center, senior center, or multi-purpose center/facility established to encourage the maximum co-location and coordination of services for older individuals. (OAA 102(a)(21) and 306(a)(3)(A))

Frail – Functionally impaired because the individual is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. (OAA 102(a)(22)(A)(i) & (B))

Grandparent or Other Older Relative Caregiver of a Child – A grandparent, step grandparent or other relative of a child by blood or marriage who is 55 years of age or older and lives with the child, is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and has a legal relationship to the child, such as legal custody or guardianship or is raising the child informally. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Greatest Economic Need – A need resulting from an income level at or below the poverty line. (OAA 102(a)(23))

Greatest Social Need – A need caused by non-economic factors, which include physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently. (OAA 102(a)(24)(A-C))

HCW (Homecare Worker) – A provider, as described in OAR 411-030-0020 and 411-031-0040, who is directly employed by the eligible individual via the Client Employed Provider Program, and who provides hourly services to eligible individuals. Homecare Workers also include providers in the Spousal Pay Program. (OAR 411-032-0000 (31))

Note: Homecare worker and Client Employed Provider (CEP) are synonymous and depending upon age of the document or data collection means – either term may be present or appear in DHS publications and DHS-owned software applications.

High Nutritional Risk – A score of six (6) or higher on the Determine Your Nutritional Risk checklist published by the Nutrition Screening Initiative.
See http://edis.ifas.ufl.edu/he944 for the checklist and risk summaries. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Note: Nutritional Risk Assessment is on the DHS/SPD NAPIS Registration and OACCESS under the Nutrition tab (accessed by selecting the Service Icon).

IADL (Instrumental Activities of Daily Living) aka "Self Management Housekeeping, including laundry, shopping, transportation, medication management and meal preparation as described in OAR 411-015-0007. (OAR 411-032-0000)

In-Home Care Agency – A licensed agency (by DHS Public Health Division) that provides in-home care services for compensation to an individual in that individual's place of residence. “In-home care agency" does not include an agency providing home health services as defined in ORS 443.005. (OAR 333-536)

To request list of licensed agencies serving Oregon send e-mail to: mailbox.hclc@state.or.us

Living Alone – A one person household. Household as defined by the U.S. Census Bureau - living quarters in which the occupant(s) live and eat separately from any other persons in the building and which have direct access from the outside of the building or through a common hall. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov); Household is defined and found at www.census.gov.

NAPIS: (National Aging Program Information System) – Information describes the services provided under Older Americans Act funding titles in collaboration with an aging network that includes 56 State Units on Aging, 655 Area Agencies on Aging, 244 Tribal organizations, and over 29,000 local community service organizations., expenditures, client demographics and staffing profiles for each state and U.S. territory. (Definition crafted by SUA from information available at www.aoa.gov.)

NSIP (Nutritional Services Incentive Program) Meal – A congregate or home-delivered meal prepared in compliance with nutritional requirements as outlined in the Older Americans Act (OAA) and served to an eligible individual as defined in the OAA. (Definition based on OAA and condensed by SUA)

Note: Eligible NSIP meals include those served to the under 60 spouse in the company of the 60 years of age or older spouse; any age adult with disability who resides with or is in the company of an individual 60 years of age or older; caregivers and care recipients aged 60 or older; caregivers who are the spouse of the care recipient - regardless of age; and any age volunteer assisting with meal site or delivery of meals.

Poverty – Persons considered to be in poverty are those whose income is below the official poverty guideline (as defined each year by the Office of Management and Budget) in accordance with subsection 673 (2) of the Community Services Block Grant Act (42 U.S.C. 9902 (2)). The annual HHS Poverty Guidelines provide dollar thresholds representing poverty levels for households of various sizes and is typically released each February. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Poverty Level: The income level indicated in the Federal Poverty Income Guidelines developed and annually updated and published in the Federal Register by the United State Department of Health and Human Services.

Program Income – Gross income received by the grantee (AAA) or sub-grantee (AAA contractor) such as voluntary contributions or income earned as a result of a program supported by the OAA grant. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov; condensed by SUA)

Provider – An organization or person which provides a service to clients under a formal contractual arrangement with the AAA. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Race – Consistent with OMB requirements, race categories are *American Indian* or *Alaskan Native*; *Asian*; *Black* or *African American*; *Native Hawaiian* or *Other Pacific Islander*; and *White*. Respondents should ideally be given the opportunity for self-identification, and are to be allowed to designate all categories that apply to them. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Registered Client – An individual who received one or more units of Cluster 1, Cluster 2, or Group 1 or Group 2 Caregiver services: (Definition developed by SUA)

Rural – Any area that is not defined as urban. Urban areas comprise (1) a central place and its adjacent densely settled territories with a combined minimum population of 50,000; (2) an incorporated place or census designation with 20,000 or more inhabitants. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov)

Target Population – Older individuals, with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, older individuals at risk for institutional placement and older individuals residing in rural areas. (OAA 305(a)(2)(E))

Note: 45 CFR 1321.69(a) states the following shall be given priority in the delivery of services: Persons age 60 or over who are frail, homebound by reason of illness or incapacitating disability, or otherwise isolated.

Unduplicated Client Count– Counting a recipient of a service only once during the reporting period. (Definition crafted by SUA)

Unit Count – The number of units of service received by an unduplicated client during the reporting period. (Definition developed by SUA)

Volunteer – An uncompensated individual who provides services or support to AAA and/or AAA service providers. (AoA Title III/VII Reporting Requirements Appendix – www.aoa.gov; enhanced by SUA)

Voluntary Contributions – A non-coerced monetary sum provided toward the cost of service. (OAA 315(a)(5)(b)(1))

B. Target Priorities

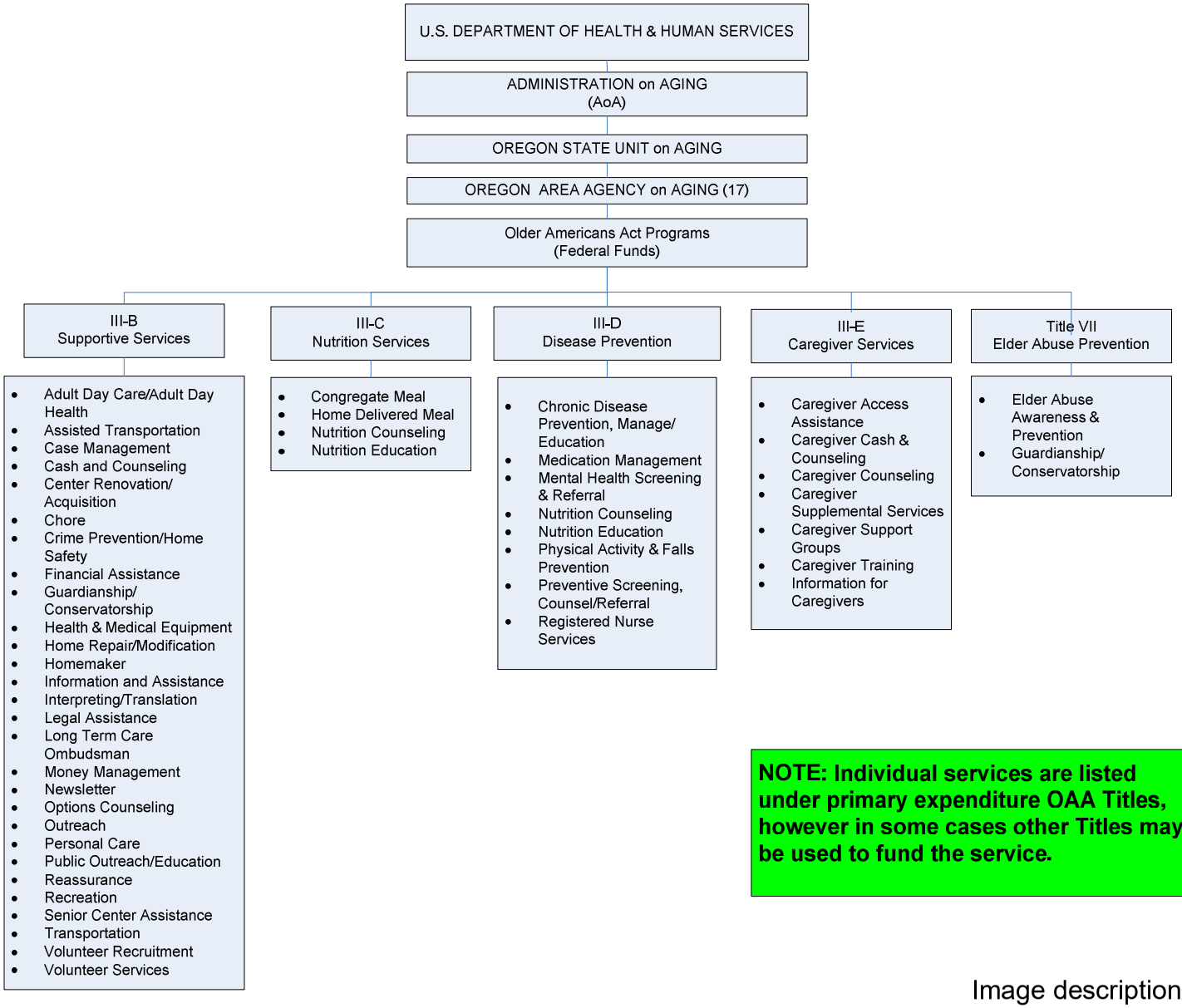
Priorities were also established with the NFCSP:

- Caregivers who are older individuals with greatest social need and/or greatest economic need with particular attention to low-income older individuals and to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
- For family caregivers who provide care for individuals with Alzheimer's Disease and related disorders with neurological and organic brain dysfunction, the Area Agency on Aging (AAA) or State involved shall give priority to caregivers who provide care for older individuals with such disease or disorder; and
- For grandparents or older individuals who are relative caregivers, the AAA/State involved shall give priority to caregivers who provide care for children with severe disabilities.

Priority: In providing services under this subpart, the State, in addition to giving the priority described in Section 372(b) shall give priority to:

- Caregivers who are older individuals with greatest social need, and older individuals with greatest economic need (with particular attention to low-income older individuals); and
- Older individuals providing care to individuals with severe disabilities, including children with severe disabilities.

VI. Roles of the Aging Network



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A. Administration on Aging (AoA)

Under the authority of the Older Americans Act (OAA), the Administration on Aging (AoA) works closely with other partners in the national aging network to plan, coordinate, and provide home and community-based services to meet the unique needs of older persons and their Agencies on Aging (AAA) and Indian Tribal Organizations (ITO).

Under the NFCSP, AoA, through its central office staff and nine regional offices, performs a number of tasks, including policy development, technical assistance, research and demonstrations, and systems development.

AoA has provided technical assistance through a number of activities, including:

- Establishing a technical advisory group (TAG) comprising researchers and aging network representatives who informed the content of the 2001 Resource Guide and advised on other AoA technical assistance activities;
- Created a web page devoted to the NFCSP;
- Commissioned more than 20 issue briefs from prominent researchers and staff of the aging network and posting them to the NFCSP web site;
- Sponsoring the September 2001 National Family Caregiver Support Program: from Enactment to Action conference at which more than 700 participants exchanged information and generated new ideas;
- Organized a structured listserv to disseminate research-based information and to generate the exchange of information among network staff; and
- Commissioned the Resource Guide, which brings together information gained from all of the above activities in a practical, easy-to use format.

AoA also is administering the National Innovation Program under the NFCSP and is engaged in systems development work related to caregivers with other federal agencies. For example: Centers for Medicare and Medicaid Services [CMS] and the Office of the Assistant Secretary for Planning and Evaluation [ASPE] and national organizations.

B. State Unit on Aging (SUA)

A state's governor designates a state government agency as the SUA to serve as the focal point for all matters relating to older persons within the state. SUA's are located within a multipurpose state agency and in Oregon this agency is the Department of Human Services, Seniors & People with Disabilities. SUA's are responsible for ensuring effective implementation of the NFCSP broad policy objectives. SUA functions include:

- **Management and Administration**: With input from the AAA's local plans, advisory bodies, and consumers of services, SUA's develop a state

plan inclusive of the NFCSP. SUA's also assume the primary role for the development of an Intrastate Funding Formula (IFF), approving the AAA area plans, and monitoring the activities and expenditures under the approved area plans.

- **Service System Development**: SUA's develop a state-level multi-faceted service system in keeping with the NFCSP and integrate this system into the social and health services system for older persons.
- **Services Development**: SUA's set policies on quality assurance, provide guidance, and facilitate information exchange between AAA's to make resources available that help shape services development in the state.
- **Advocacy**: SUA's identify areas in which caregiver support programs might need legislative support and might advocate greater state funding. SUA's also advocated for programs with other public agencies and private organizations and promote caregiver support programs with the public at large.

C. Area Agencies on Aging (AAA)

AAA's are public or private nonprofit agencies designated by SUA's to carry out the OAA at the sub-state level. AAA's assume many of the same broad responsibilities as the SUA management and administration, service system development, services development, and advocacy but focus more on the local area and on direct involvement in services development and delivery. AAA's can be public agencies located within county governments, a regional planning council, a unit of city government, an office within an educational institution or an independent nonprofit organization.

How AAA's carry out their role in implementing the NFCSP likely will be heavily influenced by their role relative to other OAA functions. For example: needs assessment, contract development, and monitoring will be foremost for AAA's that primarily fund providers to deliver services. For AAA's more active in service delivery, e.g., provision of information and referral and care management by in-house staff, issues regarding staff development, assessments, and service coordination might be of primary concern. AAA's at both ends of the spectrum will benefit from improved understanding of caregiver needs and strategies for meeting their needs.

D. Service Providers (SP)

All local SP's concerned with older persons should consider their role in NFCSP implementation. AAA's will fund some SP's directly. These and other SP's and community organizations might consider serving as a potential referral source as they identify a caregiver in need, raising public awareness of caregivers, offering support groups, training caregivers or generating funds to supplement caregiver programs. AAA's can foster this type of service development through small service development grants, training providers, regular information exchange meetings or co-location of services.

VII. Resources and Useful Links

ADRC – Aging and Disability Resource Connection

The Aging and Disability Resource Connection of Oregon (ADRC) is the first call to make to get information on all aspects of aging or living with a disability. By contacting the ADRC you will reach trained professionals who will be able to provide you with the information you are seeking or help you determine what services might work best for you.

Eldercare Locator

http://eldercare.gov/Eldercare.NET/Public/Index.aspx

Are you a family caregiver in need of information or assistance? Are you interested in learning more about the programs and services that may be of assistance to you or your loved one? The Eldercare Locator, a public service of the U.S. Administration on Aging, is the first step to finding resources for older adults in any U.S. community. Just one phone call or Website visit provides an instant connection to resources that enable older persons to live independently in their communities. The service links those who need assistance with state and local area agencies on aging and community-based organizations that serve older adults and their caregivers.

Family Caregiver Alliance - National Center on Caregiving

http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=368

Established in 2001 as a program of the Family Caregiver Alliance, the National Center on Caregiving (NCC) works to advance the development of high-quality, cost-effective policies and programs for caregivers in every state in the country. Uniting research, public policy and services, the NCC serves as a central source of information on caregiving and long-term care issues for policy makers, service providers, media, funders and family caregivers throughout the country.

National Alliance for Caregiving

http://www.caregiving.org/

Established in 1996, The National Alliance for Caregiving is a non-profit coalition of national organizations focusing on issues of family caregiving. Alliance members include grassroots organizations, professional associations, service organizations, disease-specific organizations, a government agency, and corporations.
The Alliance was created to conduct research, do policy analysis, develop national programs, increase public awareness of family caregiving issues, work to strengthen state and local caregiving coalitions, and represent the US caregiving community internationally. Recognizing that family caregivers provide important societal and financial contributions toward maintaining the well-being of

those they care for, the Alliance's mission is to be the objective national resource on family caregiving with the goal of improving the quality of life for families and care recipients.

The National Family Caregivers Association
http://www.thefamilycaregiver.org/index.cfm

The National Family Caregivers Association educates supports, empowers and speaks up for the more than 50 million Americans who care for loved ones with a chronic illness or disability or the frailties of old age. NFCA reaches across the boundaries of diagnoses, relationships and life stages to help transform family caregivers' lives by removing barriers to health and well being.

Generations United
http://www.gu.org/OURWORK.aspx

Generations United is the national membership organization dedicated to improving the lives of children, youth, and older people through intergenerational strategies, programs, and public policies. Generations United represents more than 100 national, state, and local organizations representing more than 70 million Americans. With its emphasis on public policy, advocacy and programming, Generations United has served as a resource for policymakers and the public on the economic, social, and personal imperatives of intergenerational cooperation.

The Brookdale Foundation Group – Relatives as Parents Program (RAPP)
http://www.brookdalefoundation.org/RAPP/rapp.html

Established in 1996 in response to a growing understanding of the need for enhanced services and supports for grandparents raising grandchildren, The Brookdale Foundation Group established the Relatives as Parents Program (RAPP) to encourage and promote the creation or expansion of services for grandparents and other relatives who have taken on the responsibility of surrogate parenting due to the absence of the parents. Currently RAPP provides supportive services, primarily to relative caregivers caring for children outside the foster care system, through an extensive network of support groups across the country.

Extension
http://www.extension.org/family_caregiving

This website was created by the United States Department of Agriculture (USDA), Cooperative Extension System. Here, caregivers and advocates can access a wide range of information and materials designed to help them learn about and provide supportive services to family and relative caregivers. Topics include disaster preparedness, military families, and grandparents raising grandchildren, housing, and nutrition.

WORKSHEET - FCSP BUDGET FOR UPCOMING FISCAL YEAR July 1 __ to June 30 __

	CG IIIE	SRC IIIE	Combined Budget	CG Other Funding Source	SRC Other Funding Source
I Information (To Groups) [ACTIVITIES]					
Community / Outreach					
Participation in Community Events					
Publicity Campaign					
Resource Development / Community Assessment & Planning					
TOTAL INFORMATION TO GROUPS					
II Assistance [CONTACTS]					
Assessment / Screening					
Assessment / Screening - Home					
Care Coordination					
Follow-Up / Evaluation					
Information & Assistance					
TOTAL ASSISTANCE					
III Support Groups [SESSIONS] (1 session/cg)					
Support - Group					
Support - Individual					
Support - Individual-Home					
TOTAL SUPPORT					
Training [SESSIONS] (1 session/cg)					
Training - Group					
Training - Individual					
TOTAL TRAINING					
Counseling [SESSIONS] (1 session/cg)					
Counseling - Group					
Counseling - Individual					
TOTAL COUNSELING					
IV Respite [HOURS]					
Respite at Adult Day Care/ Adult Day Health					
After School /Summer Programs/Child Day Care					
Group Respite					
In-Home Respite					
Facility Respite					
TOTAL RESPITE					

Supplemental Services					
Assistive Technology					
Emergency Response Installation-Monitoring					
Home Modification					
Incontinence Supplies					
Legal Services					
Nutrition-Supplements					
Other Support Linked to Caregiving					
School Related					
Transportation					
TOTAL SUPPLEMENTAL SERVICES					
TOTAL (I + II + III + IV + V)					

Description of the Roles of the Aging Network Flow Chart

Tier 1 in hierarchical order (top to bottom):

U.S. Department of Health & Human Services > Administration on Aging (AoA) > Oregon State Unit on Aging > Oregon Area Agency on Aging (17) > Older Americans Act Programs (Federal Funds).

Older Americans Act Programs (Federal Funds) leads to Tier 2, which consists of five sections.

Tier 2:

III-B Supportive Services, III-C Nutrition Services, III-D Disease Prevention, III-E Caregiver Services, Title VII Elder Abuse Prevention.

All five sections lead to their sub-sections; Tier 3.

Tier 3:

III-B Supportive Services:

- Adult Day Care/Adult Day Health
- Assisted Transportation
- Case Management
- Cash and Counseling
- Center Renovation/Acquisition
- Chore
- Crime Prevention/Home Safety
- Financial Assistance
- Guardianship/Conservatorship
- Health & Medical Equipment
- Home Repair/Modification
- Homemaker
- Information and Assistance
- Interpreting/Translation
- Legal Assistance
- Long Term Care Ombudsman
- Money Management
- Newsletter
- Options Counseling
- Outreach
- Personal Care
- Public Outreach/Education
- Reassurance
- Recreation
- Senior Center Assistance
- Transportation
- Volunteer Recruitment
- Volunteer Services

III-C Nutrition Services:

- Congregate Meal
- Home Delivered Meal
- Nutrition Counseling
- Nutrition Education

III-D Disease Prevention:

- Chronic Disease Prevention, Manage/Education
- Medication Management
- Mental Health Screening & Referral
- Nutrition Counseling
- Nutrition Education
- Physical Activity & Falls Prevention
- Preventive Screening, Counsel/Referral
- Registered Nurse Services

III-E Caregiver Services:

- Caregiver Access Assistance
- Caregiver Cash & Counseling
- Caregiver Counseling
- Caregiver Supplemental Services
- Caregiver Support Groups
- Caregiver Training
- Information for Caregivers

Title VII Elder Abuse Prevention:

- Elder Abuse Awareness & Prevention
- Guardianship/Conservatorship

NOTE: Individual services are listed under primary expenditure OAA Titles, however in some cases other Titles may be used to fund the service.