Appendix B

Aging Network Partnerships and Effectiveness Survey

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WELCOME SCREEN

Aging Network Partnerships and Effectiveness Survey

This survey is sponsored by the Administration for Community Living (ACL). It is part of a larger study to learn about how the Aging Network collaborates to improve the lives of older adults, and how it determines the value and effectiveness of the services it provides. Findings from this survey will help ACL make informed decisions about ways to better support the Aging Network.

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

The survey will take about 15 minutes to complete. Please answer each question to the best of your knowledge. If needed, ask others in your organization who have the content knowledge to help answer the questions. You can save and exit the survey to complete it in more than one sitting.

You may preview the questions covered in the survey here.

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

SECTION A – CHARACTERISTICS AND PARTNERSHIPS

ALL

The following questions are about [ENTITY NAME] characteristics.

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

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

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

Select all that apply

☐ Aging and Disability Resource Center (ADRC) 1

☐ Direct Service Provider 2

○ None of the above...NA

IF A1 = 1 (ADRC)

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

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

○ Yes 1

○ No..0

IF SAMPLETYPE = AAA

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

Select one only

○ An independent, nonprofit agency 1

○ A part of county government 2

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

○ A part of city government 4

○ Other (SPECIFY) 99

Specify [   ] (STRING 150)

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

Select all that apply

☐ Frontier/remote 1

☐ Rural...2

☐ Suburban 3

☐ Urban 4

ALL

A4Intro. The next questions are about partnerships [ENTITY NAME] has formed to achieve the Aging Network mission. This mission promotes home and community-based services that allow older adults to live where they choose, with the people they choose, and with the ability to participate fully in their communities.

ALL

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

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

Select all that apply

☐ Federal government agencies...1

☐ State government agencies..2

☐ Local government agencies 3

☐ Health care providers (public or private) 4

☐ Meal providers or food assistance providers (public or private) ..5

☐ Housing providers (public or private) 6

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

☐ Transportation providers (public or private)..............................8

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

☐ Health insurance programs (public or private)...........................10

☐ Private foundations 11

☐ Advocacy groups 12

☐ Universities 13

☐ Faith-based organizations 14

☐ Coalitions, collaboratives, or networks (e.g., multiple organizations or agencies partnering to address the needs of older adults) 15

☐ Other (SPECIFY) 99

Specify [   ] (STRING 150)

A5. **What is the focus of the coalitions, collaboratives, or networks that [ENTITY NAME] partners with?**

Select all that apply

☐ Community-based integration of health care and social supports 1

☐ Older adult hunger or food insecurity 2

☐ Elder abuse prevention 3

☐ Affordable housing with health and social services 4

☐ Livable communities for older adults 5

☐ Workforce development of home and community-based service providers 6

☐ Caregiver support 7

☐ Social isolation 8

☐ Advocacy 9

☐ Other (SPECIFY) 99

Specify [   ] (STRING 250)

ALL

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

Select all that apply

☐ Continuity of leadership at my organization or partner organizations 1

☐ Funding availability 2

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

☐ Rules and regulations of my organization or partner organizations 4

☐ Successful communication between partners 5

☐ Previous good relationships 6

☐ Other (SPECIFY) 99

Specify [ ] (STRING 150)

A7Intro.In the past year, you may have participated in a survey about [ENTITY NAME]'s response to the COVID-19 pandemic. That survey provided valuable information about how agencies adapted to address rapidly emerging needs. The next few questions are specifically about how [ENTITIY NAME]'s <u>partnerships</u> may have changed to address emergent needs due to COVID-19.

A7. Please indicate which <u>emergent needs from COVID-19</u> [ENTITY NAME] and its various partners are <u>currently</u> working together to address.

Select all that apply

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

☐ Providing groceries, personal care and PPE supplies (e.g., incontinence products, masks, hand sanitizer). 2

☐ Medication delivery 3

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

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

☐ Supporting family caregivers 6

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

☐ Providing support, training, and PPE to home care workers..8

☐ Promoting or supporting vaccination...9

☐ Facilitating hospital discharge..10

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

☐ Assisting with obtaining or maintaining public benefits 12

☐ Assisting clients to maintain housing 13

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

Specify [_____] (STRING 150)

○ None of the above...NA

A7 = ANYTHING BUT NA

A8. Is [ENTITY NAME] currently working to address this emergent need through new partnership(s) that formed since March 2020, or partnership(s) that existed before March 2020?

[DISPLAY RESPONSE FROM A7_[1-13, 99]

Select all that apply

☐ New partnership(s) that formed since March 2020 1

☐ Partnership(s) that existed before March 2020 2

ALL

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

A9. Please enter the names of up to two of [ENTITY NAME]'s closest partners.

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

[Open ended box for partner 1 name]

[Open ended box for partner 2 name]

Note: Partner names are only used to fill in the next survey questions and will not be used in any study reports.

A10. Which best describes [PARTNER 1/2]?

PROGRAMMER: DISPLAY LIST OF SELECTED PARTNER TYPES FROM A4

Select only one

A11. Why did [ENTITY NAME] form a partnership with [PARTNER 1/2]?

Select all that apply

☐ To serve the needs of older adults 1

☐ To jointly leverage funding opportunities 2

☐ To work toward shared goals 3

☐ To target specific underserved populations 4

☐ To address emergent needs due to COVID-19 5

☐ To promote organizational sustainability 6

☐ Because the partnership is required as part of the Aging Network or other requirements in my state 7

☐ Other (SPECIFY) 99

Specify ⬚ (STRING 150)

◯ Don't know .... d

A12. Which of the following best describes [ENTITY NAME]'s relationship with [PARTNER 1/2]?

Mark all that apply

☐ We have a contractual relationship with [PARTNER 1/2] (IF A9 = 15 (PARTNER IS A COALITION), FILL "or members of [PARTNER 1/2]") 1

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

☐ We have an informal relationship ("handshake" agreement) 3

☐ Other (SPECIFY) 99

Specify ⬚ (STRING 150)

◯ Don't know .... d

A13. **Which of the following activities does [ENTITY NAME] jointly engage in with [PARTNER 1/2]?** (Adapted from ENSP State Unit on Aging (SUA) Survey)

Select all that apply

☐ Fundraising...1

☐ Advocacy 2

☐ Strategic planning 3

☐ Public education...4

☐ Referrals..5

☐ Service delivery 6

☐ Shared outreach 7

☐ Training or technical assistance 8

☐ Volunteer recruitment or retention 9

☐ Respond to public health emergency..10

☐ OTHER...99

Specify [   ] (STRING 150)

A14. **What resources does [PARTNER 1/2] contribute toward shared goals with [ENTITY NAME]?**

Select all that apply

☐ Funding 1

☐ Physical space, equipment, or goods 2

☐ Knowledge or expertise 3

☐ Information/data...4

☐ Paid staff time 5

☐ Volunteers 6

☐ Connections to people, organizations, or groups 7

☐ Showing support for programs or services 8

☐ Convening necessary stakeholders 9

☐ Other 99

Specify [   ] (STRING 150)

◯ None of the above...NA

SECTION B – RETURN ON INVESTMENT

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

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

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

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

  ❍ Yes 1
  ❍ No..0

B2. Did [ENTITY NAME] or another organization/entity collect and analyze the data for the ROI assessment?

Select all that apply

  ☐ [ENTITY NAME] collected and analyzed the data.......................1
  ☐ Another organization/entity collected and analyzed the data...2
  ☐ [ENTITY NAME] and another organization/entity collaborated to collect and analyze the data 3

B3. **Please indicate all of the <u>services</u> included in any ROI assessment your agency has participated in during the past <u>three years</u>.**

Select all that apply

- ☐ Case management, care coordination, or service coordination ... 1
- ☐ Evidence-based programs (e.g., falls prevention programs, Chronic Disease Self-Management, medication management)... 2
- ☐ Care transitions or discharge planning 3
- ☐ Personal care 4
- ☐ Homemaker services 5
- ☐ Chores 6
- ☐ Home delivered meals 7
- ☐ Congregate meals 8
- ☐ Nutrition counseling 9
- ☐ Assisted transportation 10
- ☐ Adult day care 11
- ☐ Legal services 12
- ☐ Home modifications or repairs 13
- ☐ Services and programs to address social isolation 14
- ☐ Family caregiver support services (e.g. identifying and accessing services, counseling and training, respite care) 15
- ☐ OTHER 99
  Specify [   ] (STRING 150)

B4. **Please indicate all of the <u>benefits</u> that were included in the ROI assessment(s).**

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

Select all that apply

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

☐ Improved or maintained functional status (ADLs/IADLs).............2

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

☐ Increased socialization or reduced loneliness 4

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

☐ Improvements in self-reported physical or mental health 6

☐ Increased life expectancy 7

☐ Improved quality of life 8

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

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

Specify [   ] (STRING 250)

B5. **Please indicate all of your agency's <u>costs</u> that were included in the ROI assessment(s).**

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

Select all that apply

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

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

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

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

☐ Development and maintenance of data systems 5

☐ Other (SPECIFY) 99

Specify [   ] (STRING 250)

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

Select all that apply

☐ To determine whether to continue (or discontinue), expand, or improve a program 1

☐ To demonstrate the value of our services, or make a business case, to potential <u>private</u> partners 2

☐ To justify funding requests from <u>government or foundation</u> funders 3

☐ Other (SPECIFY) 99

Specify [   ] (STRING 250)

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

Select up to three

☐ Lack of agreement on how to monetize benefits 1

☐ Lack of technical skills to conduct an assessment 2

☐ Lack of data on costs 3

☐ Lack of data on benefits..4

☐ Lack of funding to conduct an assessment 5

☐ Lack of time or staff to conduct an assessment 6

☐ Assessing benefits and costs is not a current interest of my organization 7

☐ Other (SPECIFY) 99

Specify [   ] (STRING 250)

B1 =1

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

[   ] (STRING 500)

SECTION C: CONTACT INFORMATION

> B1 = 1 (has conducted an ROI assessment)

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

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

❍ Yes 1

❍ No 0

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

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

First Name: [   ]

Last Name: [   ]

Title: [   ]

Organization: [   ]

Telephone: [   ]

Email Address: [   ]

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

CLOSING SCREEN 1.

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