

**SAMPLE "LETTER OF INTRODUCTION"  
POMP VI PROVIDER SURVEY  
DRAFT**

Dear Senior Services Provider:

For over 40 years older adults have received Home and Community Based Services funded by the Older Americans Act. These services are provided by an array of organizations ranging from senior centers, area agencies on aging, home health agencies, faith-based organizations, health departments and many others. These organizations vary greatly, but they do have one thing in common; the services they provide enable older adults to continue to live independently in their own homes and communities. For some providers this is their sole mission, for others serving older adults is part of a greater organizational mission.

It is important to understand the composition, capacity, diversity and connectivity of this country's network of senior services providers. This is especially important as we are entering a period when the aging network will be asked to serve both the frailest of the Greatest Generation and the aging and active baby boomer generation.

The Administration on Aging has asked a group of state units on aging and area agencies on aging participating in AoA's Performance Outcomes Measures Project (POMP) to develop, test and pilot a comprehensive senior services provider survey that will help paint a picture of what our aging services provider network looks like and enumerate the positive impact this network has on the lives of Older Americans. If this pilot is successful and provides meaningful results, AoA will consider administering all or portions of the survey nationally.

This group which includes, the Ohio Department of Aging and the Western Reserve Area Agency on Aging, has developed and tested the attached survey. Now we are ready to administer it to providers who have contracts with our pilot group of area agencies on aging. These contracts can include contracts funded by the Older Americans Act, Medicaid and/or other federal, state and local funds.

While this may only be a pilot effort, the results will be valuable to the AAA and providers in the Planning and Service Areas (PSAs) in which it is administered. Since we are surveying 100% of the providers under contract with the participating AAAs, the results of this pilot will be significant and produce comparable information. The collective results of this survey will be shared with all providers who complete the survey.

As a provider of services under a contract with the Western Reserve Area on Aging, we ask you to please complete and return the enclosed survey. In order for you to respond to certain questions included in the survey, it is advisable to have on hand information pertaining to your organization's funding, as well as information regarding the number of employees and volunteers.

If you have questions about this survey, please contact Susan Schwarzwald on (216) 621-8010 x 109 or [sschwarzwald@age.state.oh.us](mailto:sschwarzwald@age.state.oh.us).

**SURVEY OF PROVIDERS OF HOME AND COMMUNITY-BASED SERVICES**

This survey is to be completed by home and community-based services providers that have contracts with an area agency on aging funded by the Older Americans Act, other state and local funds, and Medicaid Waivers.

In the space below, please enter your contact information.

Name of your organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Website Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of Staff Person Completing Survey: \_\_\_\_\_

Title and Position: \_\_\_\_\_

**SECTION A: INFORMATION ABOUT THE ORGANIZATION**

A1. Which of the following best describes your organization? (Please circle the number that corresponds to your answer.)

- Not-for-profit agency ..... 1
- Division of state, county or municipal  
(e.g., cities, towns, villages) government..... 2
- For-profit organization..... 3
- Faith-based organization..... 4
- Other ..... 5
- (SPECIFY) \_\_\_\_\_

Provider ID: \_\_\_\_\_ Date: \_\_\_\_\_

\*Assigned by AAA

A2. Please identify your organization’s fiscal year. (Please circle the number that corresponds to your answer.)

- January 1 to December 31..... 1
- July 1 to June 30 ..... 2
- October 1 to September 30 ..... 3
- Other ..... 4
- (SPECIFY) \_\_\_\_\_

A3. Are you a senior service(s) program operating within a larger organization?

- Yes ..... 1
- No ..... 2 [GO TO A4]

A3a. If yes, please name the parent organization and circle the number that corresponds to the category which best describes the parent organization:

Name of parent organization: \_\_\_\_\_

- Recreation department ..... 1
- Council on aging/department of aging..... 2
- Community center..... 3
- Social and/or human service agency  
(e.g. dept. of social services, community  
action agency and neighborhood/settlement  
house)..... 4
- Senior housing ..... 5
- Hospital..... 6
- Home health agency..... 7
- Local health dept./district ..... 8
- Other ..... 9
- (SPECIFY) \_\_\_\_\_

A4. Please identify the geographic area in which your organization provides senior services. (Please circle the number that corresponds to your answer.)

- Single neighborhood ..... 1
- More than one neighborhood ..... 2
- Small town/village (less than 10,000  
inhabitants)..... 3
- Large town/city (larger than 10,000  
inhabitants)..... 4
- Countywide..... 5
- More than one county ..... 6

A5. From the list below, please select the area where your organization primarily (over 50%) provides senior services. (Please circle the number that best corresponds to your answer.)

- Urban ..... 1
- Suburban ..... 2
- Rural ..... 3
- Mixed (Urban/Suburban/Rural) ..... 4
- Other ..... 5
- (SPECIFY)\_\_\_\_\_

A6. Please provide an estimate of the total number of clients served in your last completed fiscal year by your senior services programs:

\_\_\_\_\_ (unduplicated)

A7. Does your organization operate one or more satellite program locations where senior services are available or delivered from? (Please circle the number that corresponds to your answer.)

- Yes ..... 1
- No ..... 2

A7a. If yes, how many sites? \_\_\_\_\_.

OAS. In the space provided, please enter the approximate year your organization first began operations.

|\_|\_|\_|\_|  
YYYY

**SECTION B: FUNDING SOURCES FOR SENIOR SERVICES**

When completing Questions B1, B2, and B3, include only those funds that support the delivery of senior services.

B1. Please estimate and list below your total annual operating budget for senior services for the last completed fiscal year.

\$ |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_| , |\_\_|\_\_|\_\_|

B2. If you are a senior services program that operates within a larger organization, what percent of your total organization's budget is dedicated to senior services?

|\_\_|\_\_|\_\_| % dedicated to senior services

OB3. What entities provide senior services funds directly to your organization?

	<u>Yes</u>	<u>No</u>
a. Area Agency on Aging.....	1	2
b. State government.....	1	2
c. Local government.....	1	2
d. Agency that administers local levy funds.....	1	2
e. Insurance companies .....	1	2
f. Foundations .....	1	2
g. United Way .....	1	2
h. Private business .....	1	2
i. Consumers and family members .....	1	2
j. Public at large.....	1	2
k. Faith-based organization .....	1	2
l. Other.....	1	2
(SPECIFY) _____		

**SECTION C: SERVICE DELIVERY FOR SENIOR SERVICES**

In the spaces below, please circle the number that corresponds to your answer.

Service	A. Do you provide this service?		B. If "yes," has demand for service over last 5 years increased?		C. Do you have waiting lists for this service at the present time?	
	Yes	No	Yes	No	Yes	No
C1. Personal Care	1	2	1	2	1	2
C2. Homemaker	1	2	1	2	1	2
C3. Chore	1	2	1	2	1	2
C4. Home-Delivered Meals	1	2	1	2	1	2
C5. Adult Day Services	1	2	1	2	1	2
C6. Case Management	1	2	1	2	1	2
C7. Congregate Meals	1	2	1	2	1	2
C8. Nutrition Counseling	1	2	1	2	1	2
C9. Nutrition Education	1	2	1	2	1	2
C10. Assisted Transportation	1	2	1	2	1	2
C11. Transportation	1	2	1	2	1	2
C12. Legal Assistance	1	2	1	2	1	2
C13. Information and Assistance	1	2	1	2	1	2
C14. Disease Prevention and Health Promotion	1	2	1	2	1	2
C15. Caregiver Support	1	2	1	2	1	2
OC17. Respite Services	1	2	1	2	1	2
OC19. Home Repair	1	2	1	2	1	2

**SECTION D: CHALLENGES TO SERVICE DELIVERY**

Providers often have service delivery challenges because of service rules and regulations, client eligibility requirements, shortage of workers, or other reasons.

D1. Using the list below, please identify and rate your agency’s challenges to service delivery by circling the response that most accurately describes your agency’s current situation.

<u>Challenges to Service Delivery</u>	<u>Major Challenge</u>	<u>Somewhat of a Challenge</u>	<u>Not a Challenge</u>	<u>N/A</u>
a. Service rules and regulations .....	1	2	3	-1
b. Service delivery scheduling difficulties .....	1	2	3	-1
c. Shortage of qualified workers.....	1	2	3	-1
d. Reporting requirements/timelines.....	1	2	3	-1
e. Funding shortages.....	1	2	3	-1
f. Client eligibility requirements .....	1	2	3	-1
g. Other ..... (SPECIFY)_____	1	2	3	-1
h. Other ..... (SPECIFY)_____	1	2	3	-1
i. Other ..... (SPECIFY)_____	1	2	3	-1

**SECTION E: CLIENT-BASED INFORMATION SYSTEM AND PERFORMANCE MEASUREMENT**

For the questions below, please circle the appropriate answer.

E1. Does your agency have a computerized client-based information system?

- Yes ..... 1 **[GO TO E1a]**
- No ..... 2 **[GO TO E2]**

E1a. Does your agency maintain more than one computerized client-based information system?

- Yes ..... 1
- Please specify \_\_\_\_\_
- No ..... 2

If E1a is “yes,” please answer the following questions based on your most frequently used information system.

E1b. What types of information are tracked in your computerized client-based information system? Please circle “yes” or “no” for each category.

	<u>Yes</u>	<u>No</u>	<u>DK</u>
a. Intake.....	1	2	-8
b. Assessment.....	1	2	-8
c. Referral.....	1	2	-8
d. Case Management.....	1	2	-8
e. Units of service.....	1	2	-8
f. Billing.....	1	2	-8
g. Other.....	1	2	-8
(SPECIFY) _____			

E1c. Does your computerized client-based information system incorporate/comply with the following assessments? Please circle “yes” or “no” for each category.

	<u>Yes</u>	<u>No</u>	<u>DK</u>
a. Minimum Data Set (MDS).....	1	2	-8
b. National Aging Program Information System (NAPIS) .....	1	2	-8
c. Mini-Mental Status Examination (MMSE).....	1	2	-8
d. Outcome and Assessment Information Set (OASIS) .....	1	2	-8
e. Nutrition Screening Instrument (NSI).....	1	2	-8
f. Other.....	1	2	-8
(SPECIFY) _____			

E1d. Does your computerized client-based information system collect the following client information? Please circle “yes” or “no” for each category.

	<u>Yes</u>	<u>No</u>
a. Demographic data .....	1	2
b. Physical functioning (ADL/IADL) data.....	1	2
c. Cognitive functioning.....	1	2
d. Social functioning .....	1	2
e. Emotional well-being .....	1	2
f. Unmet needs data .....	1	2
g. Service delivered .....	1	2
h. Consumer satisfaction .....	1	2
i. Consumer outcomes .....	1	2
j. Other.....	1	2
(SPECIFY) _____		

E1e. Does your computerized client-based information system produce an unduplicated count of aging program participants across all services?

Yes .....	1
No .....	2

E2. In what form does your agency submit client data to your Area Agency on Aging? Please circle "yes" or "no" for each category.

	<u>Yes</u>	<u>No</u>
a. Paper reports.....	1	2
b. Mail in disk, CD or other computer readable media .....	1	2
c. Email electronic file .....	1	2
d. Key our own data into a central data base.....	1	2
e. Other data submission procedure .....	1	2
(SPECIFY) _____		

**SECTION F: STAFFING AND VOLUNTEERS**

(Please circle the numbers to the right that provide the best response to these questions)

OF1. In your last completed fiscal year and just for your seniors programs, how many paid full-time equivalent employees<sup>1</sup> did your organization employ?

- Less than 1 ..... 1
- 1 to 5 ..... 2
- 6 to 25 ..... 3
- 26 to 50 ..... 4
- 51 to 100 ..... 5
- 101 to 500 ..... 6
- Over 500 ..... 7

OF2. In your last completed fiscal year, approximately how many volunteers worked for your organization?

\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| Volunteers

<sup>1</sup> Full-time equivalent employment is a computed statistic representing the number of full-time employees that could have been employed if the reported number of hours worked by part-time employees had been worked by full-time employees. This statistic is calculated by dividing the "part-time hours paid" by the standard number of hours for full-time employees and then adding the resulting quotient to the number of full-time employees.

**SECTION H: PARTNER AGENCIES**

This section is about the agencies you partner with and the activities that you work on together with your partners.

Column OH1 – For each agency in the table below, please indicate the kind of relationship your agency has with it by answering “yes” or “no” to each of the 3 response categories. Category A (Self) would also include parent organizations and other departments within your organization. You will mark “yes” for both self and partner if you partner with other agencies of your type.

Columns OH2-OH11 – If you marked Category C (Partners), please identify the shared activities that you accomplish together. *It may be that the partner does this for you or that you do it for the partner* Within a category of organization (e.g., religious organizations or senior housing facilities), there may be multiple individual organizations with which you partner. You may have many activities with some and fewer with others. If so, please mark “Yes” for activities that you share with **any** of your partners in this type of organization and mark “No” only if you do not do this with any partners in this type of organization.

OH1. What is your agency’s relationship with this kind of organization?				Answer these only for types of organizations with which you partner!																			
				OH2. Referrals		OH3. Shared Outreach		OH4. Public Education		OH5. Training		OH6. Advocacy		OH7. Serve on Board of Directors		OH8. Activities for seniors		OH9. Strategic Planning		OH10. Fund-raising		OH11. Other?	
A. Self, Our Agency, or part of our agency		B. No Relationship		C. Partners		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Check box and specify	
a. Religious organizations	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
b. Senior centers	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
c. Adult protective services	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
d. County or city social services agency	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
e. SSI, Food Stamps, and Medicaid Offices	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
f. Homemaker and home health care providers	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>

OH1. What is your agency's relationship with this kind of organization?			Answer these only for types of organizations with which you partner!																						
			OH2. Referrals		OH3. Shared Outreach		OH4. Public Education		OH5. Training		OH6. Advocacy		OH7. Serve on Board of Directors		OH8. Activities for seniors		OH9. Strategic Planning		OH10. Fund-raising		OH11. Other?				
A. Self, Our Agency, or part of our agency	B. No Relationship		C. Partners		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Check box and specify		
g. Public Health Service/Community Health Center	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
h. Hospital discharge planning, emergency room care, and other services	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
i. Social security and Medicare offices	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
j. Low income home energy assistance programs/we atherization	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
k. Center for Independent Living	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
l. Mental retardation/Development disabilities	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
m. Mental Health	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>

OH1. What is your agency's relationship with this kind of organization?			Answer these only for types of organizations with which you partner!																					
			OH2. Referrals		OH3. Shared Outreach		OH4. Public Education		OH5. Training		OH6. Advocacy		OH7. Serve on Board of Directors		OH8. Activities for seniors		OH9. Strategic Planning		OH10. Fund-raising		OH11. Other?			
A. Self, Our Agency, or part of our agency		B. No Relationship		C. Partners		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Check box and specify
n. Public housing agency	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
o. Senior housing facilities (e.g., nursing homes, assisted living, congregate housing, group homes)	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
p. Public transit and para-transit programs	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
q. Council of government or regional planning and development agency	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
r. College or university	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
s. Primary or secondary schools	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	

OH1. What is your agency's relationship with this kind of organization?			Answer these only for types of organizations with which you partner!																					
			OH2. Referrals		OH3. Shared Outreach		OH4. Public Education		OH5. Training		OH6. Advocacy		OH7. Serve on Board of Directors		OH8. Activities for seniors		OH9. Strategic Planning		OH10. Fund-raising		OH11. Other?			
A. Self, Our Agency, or part of our agency		B. No Relationship		C. Partners		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Check box and specify
t. Emergency management services (EMS)	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
u. Police/Fire departments	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
v. Cooperative Extension	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
w. Media organizations	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
x. Parks and recreation	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
y. Legal services	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
z. Ombudsmen	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
aa. Financial planning organization	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
ab. Food bank	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	
ac. Other (please specify) _____ _____ _____	Yes	No	Yes	No	Yes	No	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>	

OH1. What is your agency's relationship with this kind of organization?				Answer these only for types of organizations with which you partner!																				
				OH2. Referrals		OH3. Shared Outreach		OH4. Public Education		OH5. Training		OH6. Advocacy		OH7. Serve on Board of Directors		OH8. Activities for seniors		OH9. Strategic Planning		OH10. Fund-raising		OH11. Other?		
A. Self, Our Agency, or part of our agency		B. No Relationship		C. Partners		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Check box and specify		
ad. Other (please specify)						1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	<input type="checkbox"/>
_____		Yes No		Yes No																				
_____																								
_____																								

OH12. In general are your partnerships through contracts or less formal arrangements?  
(Please circle the number that best corresponds with your answer.)

- We don't partner with any of these types of organizations..... 1
- Mostly or entirely by contract..... 2
- A mix of both (contract and less formal)..... 3
- Mostly or entirely by less formal arrangements... 4

**SECTION I: STRATEGIC PLANNING, OUTREACH AND MARKETING, CAPACITY BUILDING**

OI1. Please review the list below and circle “yes” or “no” for each outreach and marketing category that you have employed within your last completed fiscal year.

	<u>Yes</u>	<u>No</u>
a. Branding .....	1	2
b. Newsletter .....	1	2
c. Pamphlets/Brochures .....	1	2
d. Video/CD/DVD materials .....	1	2
e. Group presentations (speakers, PowerPoint, etc.)	1	2
f. Website .....	1	2
g. Public advertising (radio, TV, bus, billboards, etc.)	1	2
h. Door-to-door .....	1	2
i. Referral agreements with other agencies .....	1	2
j. Newspaper articles and columns .....	1	2
k. Other .....	1	2
(SPECIFY) _____		

OI1a. In your last completed fiscal year, what percentage of your organization’s budget was allocated to outreach and marketing?

|\_|\_|\_| % of budget allocated to outreach and marketing

OI4. Please review the strategies and resources below and circle the expected trend for each over the next fiscal year.

	<u>Increase</u>	<u>Maintain</u>	<u>Decrease</u>	<u>N/A</u>
a. Outreach/Marketing efforts .....	1	2	3	-1
b. Staffing .....	1	2	3	-1
c. Number of volunteers .....	1	2	3	-1
d. Number of units produced/served .....	1	2	3	-1
e. Number of clients .....	1	2	3	-1
f. Number of partner agencies.....	1	2	3	-1
g. Collaboration efforts.....	1	2	3	-1
h. Capability of client tracking .....	1	2	3	-1
i. Capability of client reporting.....	1	2	3	-1
j. Outcome measures .....	1	2	3	-1
k. Other.....	1	2	3	-1
(SPECIFY) _____				
l. Other.....	1	2	3	-1
(SPECIFY) _____				

**Thank you very much for your participation.**