

**AREA AGENCY ON AGING
FOUR-YEAR PLAN:
Fiscal Years 2024-2027**

**FOURTH YEAR OF THE PLAN:
Fiscal Year 2027
July 1, 2026 - June 30, 2027**

Area Agency on Aging

**for
The Older Americans Act**

**Utah Department of Health and Human Services
Division of Aging and Adult Services**

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I. APPROVAL PROCESS

The Older Americans Act of 1965, as amended through 2006, requires that each Area Agency on Aging (AAA) develop an area plan. This is stated specifically in Section 306(a) of the Act as follows:

Each area agency on aging designated under Section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with Section 307(a)(1).

In accordance with the Act, each AAA is asked to furnish the information requested on the following pages. Responses will form the report of progress in achieving goals set for the planned activities for the second year of the four-year Area Plan FY 2024 - 2027 (July 1, 2026 - June 30, 2027). Once completed, this document will be submitted to the Division of Aging and Adult Services for review and comment. The State Board of Aging and Adult Services will subsequently examine all responses and consider the document for final approval by June of 2027.

II. SIGNATURES

Appropriate signatures are requested to verify approval of the Area Plan.

AREA PLAN UPDATE

July 1, 2026 to June 30, 2027

1. The Area Plan update for Fiscal Year 2027 has been prepared in accordance with rules and regulations of the Older Americans Act and is hereby submitted to the Utah Department of Health and Human Services, Division of Aging and Adult Services, for approval. The Area Agency on Aging assures that it has the ability to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area (Ref. Section 305[c]). The Area Agency on Aging will comply with state and federal laws, regulations, and rules, including the assurances contained within this Area Plan.

Director, Area Agency on Aging _____ Date _____

Agency Name: _____

Agency Address: _____

2. The Area Agency Advisory Council has had the opportunity to review and comment on the Area Plan Update for Fiscal Year 2027 (Ref. 45 CFR Part 1321.57[c]). Its comments are attached.

Chairman _____ Date _____
Area Agency Advisory Council

3. The local governing body of the Area Agency on Aging has reviewed and approved the Area Plan Update for Fiscal Year 2027.

Chairman, County Commission or _____ Date _____
Association of County Governments

4. Plan Approval

Director _____ Date _____
Division of Aging and Adult Services

Chairman _____ Date _____
State Board of Aging and Adult Services

III. GOALS AND OBJECTIVES

Please indicate specific goals and objectives planned for the four-year plan in the following areas:

- 1. Strengthening Older Americans Act (OAA) Core Programs** – Describe plans and include objectives and measures that will demonstrate progress towards:
 - a. Coordination of Title III and Title VI Native American programs (Sec. 307(a)(21);
 - b. Ensuring incorporation of the new purpose of nutrition programming to include addressing malnutrition (Sec. 330);
 - c. Age and dementia friendly efforts (Sec. 201(f)(2);
 - d. Screening for fall related TBI (Sec. 321(a)(8);
 - e. Strengthening and/or expanding Title III and VII services;
 - f. Improving coordination between the Senior Community Service Employment Programs (SCSEP) and other OAA programs.

A. Coordination of Title III and Title VI Native American programs:

While the Bear River Area Agency on Aging does not directly administer Title VI grant funding, we maintain collaboration with Tribal communities through the BRAG Heritage Area program. This partnership provides an avenue for coordination between Title III and Title VI objectives.

B. Ensuring incorporation of the new purpose of nutrition programming to include addressing malnutrition:

Program/ Service	Goal	Objective
IIC1; IIC2 Congregate and Home Delivered Meals	Reduce the incidence of malnutrition and food insecurity among older adults in the Tri-County area by improving access to nutritious meals and targeted nutritional support through our four Senior Center Partners.	Ensure that 100% of congregate and home-delivered meals meet or exceed the updated nutritional guidelines established to combat malnutrition, as verified by quarterly audits from our Registered Dietician.
	Conduct nutrition risk screenings for new congregate and home-delivered meal participants, in accordance with OAA Section 339 requirements.	Nutrition Risk screening data collected and reported annually, with 85% of program participants.
IIB: Nutrition Education	Conduct nutrition education for congregate and home-delivered participants.	Develop/Source dietician approved nutrition education to share with participants.
IIB: Nutrition Education	Conduct nutrition risk screenings yearly for home-delivered meal participants, in accordance with OAA Section 339 requirements.	100% of identified high-risk individuals receive follow-up nutrition education.
	Work toward long-term financial sustainability and popularity of the congregate meal programs despite rising costs and workforce challenges.	Pursue SB-281 funding

C. Age and Dementia Friendly Efforts:

Program/ Service	Goal	Objective
IIIB & IIIE: Information Services; Public Education	Build a well-informed community by expanding education and outreach efforts that increase awareness available resources.	Conduct at least 12 educational presentations annually to community partners, including faith-based organizations, medical providers, and civic groups, reaching a minimum of 100 individuals per year.
		Conduct at least 4 educational presentations, including print material for Home Delivered participants, to older adults at the Senior Centers, reaching a minimum of 800 individuals per year.
IIIE: Training; Support Groups		Conduct at least 8 Dementia Live Demonstrations reaching a minimum of 32 individuals.
IIIE: Training; Support Groups		Partner with USU ADRC to share Dementia education workshops on website and social media
IIIB & IIIE: Information Services		Develop and distribute a 50 standardized "AAA 101" resource packets for community partners, ensuring consistent messaging about available services, eligibility and referral processes across the Tri-County area.
IIIE: Training; Support Groups		Support community partner's Caregiver Support Groups by distributing 12 Dementia Dialog books.

Program/ Service	Goal	Objective
III E: Training; Support Groups		Attend at least 50% of community partner Caregiver Support groups.

D. Screening for fall related TBI:

Program/ Service	Goal	Objective
IIIB & IIIE: Access Assistance, Case Management	Expand Screening Capacity Through Trained Personnel.	Train 100% of case managers on standardized TBI screening and fall risk screening protocols
		Complete TBI screening and fall risk annually with clients enrolled in a program with case management during yearly assessments
IIIB & IIIE: Providing assistance connecting to service		Establish a formal referral pathway ensuring that 100% of clients identified as at-risk for falls through screening are offered enrollment in an evidence-based balance and physical agility program.

E. Strengthening and/or expanding Title III and VII services:

Program/ Service	Goal	Objective
IIIB: Other State Services	Decrease social isolation and its associated health risks by expanding and enhancing programs that provide regular, meaningful human connection.	Expand the Telephone Reassurance program to achieve a 10% increase.
		Share community events for seniors in AAA monthly newsletters
IIID: Health Promotion	Evidence Based classes hosted at Senior Centers	Senior Centers will offer at least 2 evidence-based classes per week
IIIB: Information & Assistance	Proactively respond to the growth of the aging population in the Tri-County area by increasing the reach and efficiency of services.	Expand outreach efforts to identify and enroll older individuals with the greatest economic and social need, with particular attention to low-income, minority older adults, older adults residing in rural areas, and those with limited English proficiency.
IIIB: Providing assistance connecting to service		Review scoring methods of current intake assessment. Add additional categories to enhance prioritization of 'greatest social need. Ensure that older adults with the most complex needs receive timely access to case management services.
IIIE: Caregiver of Older Adult/Older Adult Caregiver Counseling Support Groups Training	Rebuild and expand the Caregiver Support program following recent staffing transitions, with a renewed focus on public education, support and dementia-capable services.	Implement caregiver support groups accessible to all three counties.

Program/ Service	Goal	Objective
		Coordinate with community partners through the Caregiver Coalition to ensure duplication of support is minimized by attending 50% of community partner groups.
		Implement at least one evidence-based caregiver support group annually accessible to all counties.
		Increase the number of unduplicated family caregivers served annually by 50%.
III E: Caregiver of Older Adult/Older Adult Caregiver Case Management	Ensure every CGSP client receives a holistic assessment that identifies cognitive, familial, and environmental needs, leading to more effective and sustainable care plans.	Update the intake protocol to formally document the identification of familial support systems for 100% of new clients.
IIIB: Friendly Visit, Telephone Reassurance		Provide ongoing connection for those without identifiable family support through the Friendly Visitor or Telephone Reassurance.
IIIB: Friendly Visit, Telephone Reassurance		Recruit at least 5 volunteers for Friendly Visitor or Telephone Reassurance.
IIIB & III E: Case Management	Enhance the capacity of case managers to identify and address the growing mental health needs of older adults, including depression, anxiety, and cognitive decline.	Integrate mental health screening and referral protocols into case management intake processes for 100% of new clients.

IIIB: Elder Abuse and Prevention	Strengthen Legal Education for Vulnerable Older Adults.	Conduct at least four community legal education sessions annually across the Tri-County area, addressing topics such as advance directives, guardianship, power of attorney, etc.
		Develop/source public education material on elder abuse, neglect, and financial exploitation, reaching a minimum of 3000 community members per year.
		Distribute educational materials on financial exploitation prevention and fraud prevention to home-delivered meal program participants.
IIIB: Elder Abuse Prevention	Promote Financial Literacy and Prevent Financial Exploitation	With partnerships, develop and deliver at least 4 public education sessions on financial literacy, identity theft prevention, and financial exploitation awareness, reaching at least 200 older adults annually
	Long-Term Care Ombudsman Program will educate the community about long-term care, the Ombudsman Program, and related issues, including resident rights and advocacy services.	Conduct at least 12 community outreach or education activities annually.
		Maintain a visible presence through brochures shared with community partners, website updates, health fairs, social media and media appearances.

		Offer quarterly rights education sessions in each facility.
		Recruit, train, and deploy at least 1 Volunteer Ombudsmen per year who will provide a visible, regular presence in long-term care facilities.
		Retain volunteers for 2+ years
		Use complaint data & facility demographics to prioritize outreach and education activities, ensuring that resources are directed where they are most needed.
		Conduct an annual review of complaint data and outreach activities, adjusting the annual plan to address identified gaps and emerging issues
III E: Caregiver of Older Adult/ Older Adult Caregiver Access Assistance	Coordinated services for older veterans and their families.	100% Referral of VDC Caregivers to NFCSP. Veterans direct their own care with the VDC program and Caregivers receive counseling/support and evidenced-based group education.
		Implement a cross-program data-sharing framework that allows VDC and NFCSP administrators to jointly track outcomes, including caregiver stress reduction, prevention of institutionalization, and veteran/caregiver satisfaction.

IIIE: Caregiver of
Older
Adult/Older
Adult Caregiver

Access
Assistance &
Information and
Assistance

Ensure that all OAA programs and services recognize and prioritize veterans as a distinct population by incorporating veteran status into eligibility screening, intake forms, and data collection systems.

100% of OAA intake assessments identifying Veteran Status will be referred to the County Veterans Service Officer to ensure older veterans are screened for eligibility in both systems and receive a warm handoff to the appropriate services and to jointly address service gaps not covered by VA health benefits.

IIIB

Reduce the rate of nursing facility placement among older veterans by ensuring coordinated access to home- and community-based services from both the VA (through VSO-facilitated benefits) and the OAA network (through Title III services)

IIIB

Jointly advocate for federal, state, and local funding that supports coordinated services for older veterans, using unified data and success stories to demonstrate the return on investment of VSO-OAA partnerships.

F. **Improving coordination between the Senior Community Service Employment Programs:**

SCSEP services are not directly administered by Bear River AAA but are available through the Department of Workforce Services and LDS Employment Services. While no client referrals have been needed to date, the established partnership ensures immediate access to employment services when required.

2. Post-COVID-19 Efforts – Describe plans and include objectives and measures that will demonstrate progress towards:

- a. Educating about the prevention of, detection of, and response to negative health effects associated with social isolation (Sec. 321(a)(8));
- b. Dissemination of information about state assistive technology entity and access to assistive technology options for serving older individuals (Sec. 321(a)(11));
- c. Providing trauma-informed services (Sec. 102(41));
- d. Screening for suicide risk (Sec. 102(14)(G));
- e. Inclusion of screening of immunization status and infectious disease and vaccine-preventable disease as part of evidence-based health promotion programs (Sec. 102(14)(B) and (D));
- f. Incorporating innovative practices developed during the pandemic that increased access to services particularly for those with mobility and transportation issues as well as those in rural areas.

Program/ Service	Goal	Objective
IIIB: Public Education	Educating about the prevention of, detection of, and response to negative health effects associated with social isolation (Sec. 321(a)(8));	Develop/source educational materials on the health risks of social isolation. Include Senior Center activities and community events as potential solutions to combat social isolation. Distributed through multiple pathways, including print, social media, newsletter and website.
IIIB: Public Education, Telephone Reassurance		Social Media campaign to recruit volunteers for telephone reassurance programs.
IIIB & IIIE: Access Assistance, Case Management	Dissemination of information about state assistive technology entity and access to assistive technology options for serving older individuals (Sec. 321(a)(11));	Establish a partnership with the Utah Assistive Technology Program (UATP) or applicable state AT entity, including regular communication and resource sharing.

Program/ Service	Goal	Objective
IIIB: Case Management	Providing trauma-informed services (Sec. 102(41));	Integrate 5 trauma-informed principles into client intake processes, care planning, and service delivery.
IIIB: Health Promotion	Screening for suicide risk (Sec. 102(14)(G));	Implement a monthly suicide risk screening protocol for all AAA case management clients.
IIIB: Public Education	Inclusion of screening of immunization status and infectious disease and vaccine-preventable disease as part of evidence-based health promotion programs (Sec. 102(14)(B) and (D));	Develop/source and distribute vaccine education materials to case management program participants, addressing common concerns and providing accurate information about vaccine safety and efficacy.
IIIB: Transportation	Incorporating innovative practices developed during the pandemic that increased access to services particularly for those with mobility and transportation issues as well as those in rural areas.	Strengthen partnerships with local transit providers, volunteer driver programs, senior centers and ride-sharing services to create a coordinated transportation network that offers multiple options for older adults needing rides to medical appointments, meal sites, and social activities

3. Expanding Access to HCBS – Describe plans and include objectives and measures that will demonstrate progress towards:

- a. Securing the opportunity for older individuals to receive managed in-home and community-based long-term care services (Sec. 301(a)(2)(D));
- b. Promoting the development and implementation of a state system of long-term care that is a comprehensive, coordinated system that enables older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of the older individuals and their family caregivers (Sec. 305(a)(3));
- c. Ensuring that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services for older individuals who: reside at home and are at risk of institutionalization because of limitations on their ability to function independently; are patients in hospitals and are at risk of prolonged institutionalization; or are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them (sec. 307(a)(18(A)-(C));
- d. Working towards the integration of health, health care and social services systems, including efforts through contractual arrangements; and
- e. Incorporating aging network services with HCBS funded by other entities such as Medicaid.

Program/ Service	Goal	Objective
IIIB & IIIE: Case Management	Securing the opportunity for older individuals to receive managed in-home and community-based long-term care services (Sec. 301(a)(2)(D));	Implement person-centered case management that assists older individuals and their families in understanding and selecting among available managed long-term care options with 100% of interested clients receiving individualized counseling.
IIIB: Public EducaProgram/ Servicetion	Promoting the development and implementation of a state system of long-term care that is a comprehensive, coordinated system that enables older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of the older individuals and their family caregivers (Sec. 305(a)(3));	Develop educational materials for facility discharge planners explaining typical timelines for service coordination and factors that may affect service initiation.

Program/ Service	Goal	Objective
IIIB: Other Services (Outreach)	Ensuring that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services for older individuals who: reside at home and are at risk of institutionalization because of limitations on their ability to function independently; are patients in hospitals and are at risk of prolonged institutionalization; or are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them (sec. 307(a)(18(A)-(C));	Identify and support older adults residing at home who are at risk of institutionalization due to functional limitations, ensuring they receive coordinated community-based services that enable continued independence.
IIIB: Homemaker, Chore Services, Transportation, Personal Care. IIE: Respite		Demonstrate that 85% of older adults identified as at risk of institutionalization remain in their homes with community-based support at 12-month follow-up.
IIIB & IIIE: Access Assistance, Case Management	Working towards the integration of health, health care and social services systems, including efforts through contractual arrangements; and	Through the Aging Advisory Council and Caregiver coalition, build partnerships with medical providers and community-based organizations to coordinate and reduce duplication of services.
IIIB: Access Assistance	Incorporating aging network services with HCBS funded by other entities such as Medicaid.	Hold 4 trainings for Senior Center staff and Home Delivered Meals volunteers at each center on Medicaid HCBS eligibility criteria, waiver services, and application processes.

4. **Caregiving Efforts – Describe plans and include objectives and measures that will demonstrate progress towards:**
- a. Documenting best practices related to caregiver support (Sec. 373(e)(1));
 - b. Strengthening and supporting the direct care workforce (Sec. 411(a)(13))
 - c. Implementing recommendations from the RAISE Family Caregiver Advisory Council (<https://acl.gov/programs/support-caregivers/raise-family-caregiving-advisory-council>); and
 - d. Coordinating with the National Technical Assistance Center on Grandfamilies and Kinship Families (<https://www.gksnetwork.org/>).

Program/ Service	Goal	Objective
IIIE: Caregiver of Older Adult/Older Adult Caregiver Access Assistance, Support, Training, Counseling Case Management	Documenting best practices related to caregiver support (Sec. 373(e)(1));	Enhance the quality and impact of direct services by identifying and utilizing interventions proven to be effective in improving caregiver well-being. Track and report outcomes for caregivers receiving services, demonstrating that 80% of caregivers reported reduced stress, increased confidence, or improved ability to continue caring for their loved ones
		Implement a standardized, evidence-based framework for monitoring caregiver support programs that ensures accountability, meets all mandated requirements, and drives continuous quality improvement.
		Host evidence-based Caregiver Support group 18 times per year.

Program/ Service	Goal	Objective
IIIB: Other Services Public Education	Strengthening and supporting the direct care workforce (Sec. 411(a)(13))	Offer Dementia Education to professional caregivers quarterly.
		Partner with ABA program at USU to offer practicum students for dementia-related behavior management strategies and professional development for direct care workforce.
IIIE: Caregiver of Older Adult/Older Adult Caregiver Access Assistance, Support, Training, Counseling Case Management	Implementing recommendations from the RAISE Family Caregiver Advisory Council (https://acl.gov/programs/support-caregivers/raise-family-caregiving-advisory-council) ; and	Ensure that 100% of caregivers enrolled in the National Family Caregiver Support Program receive a personalized assessment and care plan that addresses their unique needs for respite, training, and support.
	Coordinating with the National Technical Assistance Center on Grandfamilies and Kinship Families (https://www.gksnetwork.org/) .	

IV. ACCOMPLISHMENTS FOR THE PAST YEAR

This section should be the “state of the agency” report. Discuss the agency’s major accomplishments, what is working as planned, what effort did not work as planned, any disappointments experienced by the agency, barriers encountered, etc.

The past year was one of meaningful change and rebuilding for the Bear River Area Agency on Aging. With new leadership, we took a close look at where we stood and found several foundational gaps, including limited or rocky community connections, inconsistent training on the Older Americans Act, and not enough education, outreach or visibility in the community.

Within the first two months, our new Director identified over \$150,000 in administrative savings and moved those funds back into services. Over the next seven months, we worked to change course: building partnerships, launching new education programs, outreach initiatives, creating a stronger foundation for the future.

This report shares what we accomplished, where our efforts are paying off, the challenges we ran into, and the barriers we’re still working to overcome.

Major Accomplishments

1. Financial Stewardship and Resource Reallocation

Within 30 days of the new Director's arrival, the agency conducted a budget review and identified significant cost-saving opportunities. By streamlining operations, we reduced administrative expenditures by \$150,000+ annually.

These savings were redirected to expand direct services, including:

- Enhanced services for the Caregiver Support Program
- New community outreach initiatives
- Development and delivery of educational programming

2. Expansion of Educational Programming

The agency trained, developed or co-developed 9 new educational classes now being offered across the Senior Center network and community, facilitated by both case managers and community partners:

1. AAA 101: Overview of Agency on Aging Services
2. Dementia Live
3. Caregiver Talking Points
4. Stress Busting for Family Caregivers: Evidence-Based Caregiver Stress Reduction

5. With Love and Clarity: Planning the Next Chapter with Aging Parents
6. Navigating Your Aging Journey: A Roadmap to Local Resources
7. *Legal Essentials: Advance Directives, Powers of Attorney and More: Legal Planning for Aging Adults (to be completed by end of FY26)*
8. *Fall Prevention: Evidence-Based Falls Risk Reduction (to be completed by end of FY26)*
9. *Fraud Prevention: Protecting Seniors From Financial Exploitation (to be completed by end of FY26)*

Metric	Target/ Baseline	Status	Next Year
New community education and support groups developed	Baseline: 0 Target: 9	Achieved	4
Total community education and support groups delivered	Baseline 0 Target: 25	23	70
Participant satisfaction	Baseline 0 Target: 85% Satisfaction	Survey in development	85%

3. Partnership Development and Community Collaboration

The agency has successfully cultivated a robust network of community partners, addressing the prior gap in solid community relationships. New and strengthened partnerships include:

New Partnerships:

- USU Alzheimer's and Dementia Research Center (community education/referrals)
- ABA Program at USU (direct workforce education and support for dementia-related behaviors in long-term care facilities)
- 4 Local law firms (for legal education and pro bono referrals)
- 1 Mortuary and funeral homes (for end-of-life planning collaboration)

- 2 New Service provider (HCBS)
- 2 Local community action groups (volunteer recruitment and advocacy)
- 2 Senior Centers not receiving OAA funding (Aging Advisory Council participation and community outreach/education)
- 3 Faith-based organizations (congregation outreach, education and volunteer recruitment)

Strengthened Partnerships:

- Utah State University (USU) Center for Persons with Disabilities / Assistive Technology (new partnership for assistive technology demonstrations and referrals)
- Sunshine Terrace Foundation (strengthened relationship and caregiver support)
- Senior Corps / Senior Companions (enhanced coordination for volunteer-based socialization and support)
- 5 Senior Centers, including Hyrum, Cache County, Rich County, Brigham City and Bear River Valley (increased oversight, training initiatives, information exchange between centers, referrals and education partnerships)
- Rocky Mountain Veteran Center (community education and referrals)

Metric	Target	Status
New partnerships established	10	15
Previously struggling partnerships strengthened	5	9 total
Aging Advisory Council meetings held	Quarterly	5 total/yr
Caregiver Coalition meetings held	Quarterly	5 total/yr

4. Enhanced Senior Center Collaboration and Medicare Enrollment Support

The agency has moved toward providing more direct programming with our Senior Center partners.

Key initiatives include:

- Medicare Open Enrollment Assistance: Hosted enrollment events at all four Senior Centers, connecting older adults with one-on-one counseling and plan comparison assistance.
- Class Co-location: New educational offerings are being delivered at Senior Centers, increasing accessibility and drawing new participants into the centers.
- Regular Director Meetings: Established semi-monthly check-ins with Senior Center Directors to improve communication, share best practices, and coordinate programming.
- Increased oversight for general reporting and fiscal management.

Metric	Target/Baseline	Status
Medicare enrollment events hosted		Achieved
Seniors served through Medicare events		
Classes delivered at Senior Centers	20	14
Senior Center Director meeting attendance	75%	Achieved

5. Staff Training and Organizational Development

Recognizing the initial gap in staff training on OAA requirements, the agency has invested in comprehensive professional development:

- All case management staff completed training on OAA Title III and VII requirements, including allowable services. Training targeting requirements and documentation standards.
- Staff attended state-sponsored trainings and conferences to build knowledge and peer networks.
- Internal "Lunch and Learn" series initiated, featuring topics such as client confidentiality, mandatory reporting, trauma-informed care, mental health first aid, suicide risk screening, and assistive technology resources.

Metric	Target/Baseline	Status
Staff completing OAA core training	100%	Achieved
Staff attending external trainings	80%	Achieved
Internal trainings offered	8	Achieved
Staff reported increased knowledge and confidence in their program knowledge for OAA reporting requirements	Target: 100%	80%
Staff felt they had an increase in knowledge in overall (other program) OAA reporting requirements	Target: 60%	80%
Staff confidence in using tools required for OAA reporting (MonAmi, GetCare, Spreadsheets, etc)	Target: 100%	100%

6. Long-Term Care Ombudsman Program: First Volunteer Onboarded

Despite significant funding constraints, the Long-Term Care Ombudsman Program achieved a critical milestone this year with the recruitment, training, and onboarding of our first volunteer ombudsman. This volunteer has nearly completed all state-mandated certification requirements and will be conducting resident visits and advocating for

quality of life and care in long-term care facilities.

This volunteer expansion increases the program's capacity to reach residents who may otherwise go unseen and strengthens our ability to fulfill the Ombudsman Program's mission of protecting resident rights.

Metric	Target/Baseline	Status
Volunteer ombudsmen recruited and trained	Baseline: 0 Target: 1	Achieved
Volunteer ombudsmen actively serving	Baseline: 0 Target: 1	Achieved
Facility visits conducted by volunteer	Baseline: 0 Target: 0	Will begin with FY27
Resident Councils Attended	Baseline: 0 Target: 0	Will begin with FY27

What Is Working as Planned

Several initiatives are performing at or above expectations:

Initiative	Why It's Working	Evidence
Educational Class Development	Strong community demand; responsive topics; expert and supportive community partners	9 classes developed; 7 implemented; two evidence-based
Partnership Cultivation	Director's intentional outreach; clear value proposition for partners	15+ new partners

Medicare Enrollment Events	High need; trained counselor	17+ enrollment events held;
Administrative Cost Reduction	Fresh perspective; thorough budget review; decisive action	\$150k+ savings realized; no service disruption; increased services
Aging Advisory Council Re-establishment	Excitement from new/renewed partnerships	4 meetings; active participation; subcommittee for Caregiver Coalition formed

What Did Not Work as Planned / Disappointments

1. Direct Care Workforce Recruitment

Despite our efforts to support provider agencies with wage recommendations and technical assistance, the direct care workforce shortage remains. New providers have expressed interest, but as of year-end, no new entity has successfully filled the service gaps created by pandemic-era provider closures. The most notable service gap from providers is personal care (bathing, specifically) for Medicaid clients.

Lesson Learned: Workforce development requires longer-term, systemic intervention beyond AAA's direct control. We can, however, and plan to support the direct care workforce through partnerships at USU and education initiatives.

Medicaid reimbursement for bathing services needs to be increased for providers to offer this service, especially in rural areas.

2. Full Implementation of Trauma-Informed Care Training

While we successfully initiated training on trauma-informed care, we have not achieved full implementation within the fiscal year due to competing priorities and the need to identify appropriate training resources.

Trauma-informed principles are not yet fully integrated into all client interactions and care planning.

Lesson Learned: Phased implementation with clear milestones is necessary for

complex practice changes.

3. Medicare Enrollment at BRAG Office in Cache County

While the Medicare enrollment events in Tremonton and Brigham City exceeded expectations with strong attendance, and the Cache County Senior Center saw significant engagement, the outreach at the Logan BRAG office fell short of its projected goals.

Lesson Learned: Logistical barriers (accessible parking), market saturation from private insurance companies and a location/provider shift may have created barriers that impacted turn-out in the Cache County BRAG office. The Senior Center continued to see a high number of individuals and they have indicated a need to step back and make additional referrals to the BRAG office as their resources do not cover the work necessary to serve all the participants at their Center.

3. Suicide Risk Screening Implementation

Staff members completed 8 hours of Mental Health First Aid training. Following the training, a systematic suicide risk screening was implemented during monthly calls and quarterly visits.

Impact: Screening is in the beginning phases, and we cannot yet report reliable data on suicide risk among our clients.

Screening requires not just a protocol, but also staff training on how to ask questions compassionately. We are also establishing relationships with mental health providers for warm handoffs.

4. Aging Advisory Council: Persistent Engagement Challenges

As part of efforts to strengthen administration of OAA requirements, the agency prioritized re-establishing the Aging Advisory Council (AAC) to ensure that our planning is informed by diverse community perspectives. The council has reconvened and now meets quarterly with a committed core of professional participants, including:

- Care providers
- Senior Center Directors
- Logan's first geriatric physician
- USU's Alzheimer's and Dementia Research Center representative
- Senior Companions representative

Despite efforts to engage two key populations, the council's composition remains

incomplete:

- Elected Officials: Zero elected officials currently participate, despite multiple invitations, personal outreach, and attempts to schedule around their availability and offer virtual meetings.
- Older Adult Representation: Only two participants over the age of 60 regularly attend, falling short of our goal to have the council be genuinely reflective of the older adult population we serve.

The absence of elected officials limits our ability to build direct bridges to policymaking and resource allocation. The lack of broader senior participation means we may miss critical lived-experience perspectives that should shape our priorities.

Lessons Learned:

- Elected officials face overwhelming demands on their time; alternative engagement strategies may be necessary.
- Seniors may face transportation, scheduling, or confidence barriers to participation. Stipends, transportation assistance, or meeting location rotations could improve accessibility.
- The council's quarterly frequency may be a barrier.

5. Caregiver Coalition: Unexpected Popularity Creating a Different Challenge

In addition to the AAC, we re-established the Caregiver Coalition.

The Caregiver Coalition is highly popular. Most professionals who initially attended the AAC have expressed a preference to participate in the Caregiver Coalition, leaving the AAC with only Senior Center Director Participants. While this is indicative of the relevance and energy of the coalition, it has siphoned professional participation away from the AAC, further complicating our efforts to build a robust, multidisciplinary advisory council.

The AAC now risks becoming a forum attended primarily by those who are required to be there or who have no other venue, rather than representative of the population we serve.

Lessons Learned:

- The Caregiver Coalition's popularity suggests we have tapped into a significant need. This is worth both celebrating and nurturing.
- Clarification of the distinct purposes of the two bodies while cultivating separate participation streams is important.

Barriers Encountered

1. The Gap Between Mandates and Resources - Nutrition

Across our programs, a significant challenge is the disconnect between the funding we receive, the demand for services and most importantly, the requirements we are *mandated to meet*.

This is especially evident in rural areas like Box Elder County. With half the population, they serve 8,000 more Home Delivered meals and 19,000 more congregate meals than Cache County with significantly less funding. The disparity is even greater between Brigham City and Tremonton Senior Centers. With nearly half the funding, Tremonton serves 97% of the Home Delivered Meals and 72% of the Congregate meals that Brigham City serves. This not only leads to a reduction in other services to combat social isolation and other health-promotion activities, but it puts a greater burden on local city governments to meet the growing needs of those we are mandated to serve.

Federal and state funding for these programs has not kept pace with rising food costs or the increased community need. Every meal served represents not just a federal contribution, but a local commitment to filling the gap.

2. The Gap Between Mandates and Resources - Ombudsman

The Long-Term Care Ombudsman Program's mandate to protect resident rights, investigate complaints, and advocate for quality care in long-term care facilities is both broad and critical. The new requirement to contact additional discharged patients creates a scenario where the funding provided is wholly inadequate to support the staff and volunteer infrastructure required to do the job. As a result, counties must again step in to cover the costs of meeting federal and state requirements, from staff salaries to volunteer training and travel. This unfunded mandate places a growing burden on local resources to meet federal and state mandates. This administrative burden and lack of adequate funding limits our ability to provide the level of resident advocacy that our most vulnerable older adults deserve.

3. Rural Service Delivery Challenges

Geographic dispersion across the Tri-County area continues to pose challenges for:

- Transportation access for seniors in remote areas
- Recruitment of providers willing to serve rural clients
- Equitable distribution of educational programming
- Lack of bathing services for Medicaid clients

We are strengthening partnerships with the BRAG mobility program and exploring enhanced technology options for equitable distribution of our education series.

4. Limited Mental Health Provider Capacity

The shortage of mental health providers specializing in geriatric care, particularly those accepting Medicare and Medicaid, remains a critical barrier to addressing the mental health needs of our clients, including depression, anxiety, and trauma.

Looking Forward: Priorities for the Coming Year

Based on this year's accomplishments and lessons learned, we have identified the following priorities for Year 4:

1. Fully Implement Trauma-Informed Care: Complete staff training and integrate trauma-informed principles into all client interactions and care plans.
2. Launch Suicide Risk Screening: Train all staff, establish referral pathways, and begin systematic screening with ongoing quality monitoring.
3. Expand Educational Offerings: Use the developed classes and increase total class offerings by at least 50%.
4. Deepen Partnership Integration: Move from "partnership establishment" to "partnership integration" by developing formal referral protocols and shared programming with key partners.
5. Enhance Data Tracking: Implement improved systems for tracking outcomes across all program areas, including caregiver impact, class participant outcomes, and partnership effectiveness.

Conclusion

The Bear River Area Agency on Aging has undergone a remarkable transformation in the past year. From a starting point marked by limited or fractured partnerships, inconsistent training, and constrained outreach, the agency has built a foundation for sustainable growth and meaningful community impact. The \$150,000+ in administrative savings redirected to direct services, the nine new educational classes, the new and revitalized partnerships, and the re-established coalitions all testify to an agency that is moving forward with purpose.

At the same time, we acknowledge the challenges that remain: the persistent direct care workforce shortage, the lack of elected officials and over 60 participation in the Aging Advisory Council, slow progress on trauma-informed care and suicide screening, the ongoing barriers of rural service delivery and most notably, the lack of state and federal funding to cover program mandates. These are not failures but rather identified frontiers for our continued work.

With a clear vision, a talented and dedicated team, and a growing network of community partners, the Bear River Area Agency on Aging is well-positioned to serve the aging

adults and caregivers of the Tri-County area with excellence, compassion, and impact in the years ahead.

V. TITLE III – PROGRAM DESCRIPTION AND ASSURANCES

TITLE III AREA PLAN: PROGRAM DESCRIPTION AND ASSURANCES

Each area agency on aging (AAA) must maintain documentation to confirm the following assurance items. Such documentation will be subject to federal and state review to ensure accuracy and completeness. By signing this four-year plan document, the area agency on aging agrees to comply with each of the following assurances unless otherwise noted in the document.

Section 305(c): Administrative Capacity

An area agency on aging shall provide assurance, determined adequate by the State agency, that the Area Agency on Aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

Section 306(a)(1): Provision of Services

Provide, through a comprehensive and coordinated system for supportive services, nutrition services, and where appropriate, for the establishment, maintenance, or construction of multipurpose senior centers, within the planning and service area, covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have the greatest economic need (with particular attention to low income minority individuals and older individuals residing in rural areas) residing in such area, the number of older individuals who have the greatest social need (with particular attention to low income minority individuals) residing in such area and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community, evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior center in such area, for the provision of such services or centers to meet such need;

Section 306(a)(2): Adequate Proportions

(a) Each area agency on aging...Each such plan shall--

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

- (A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);
- (B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
- (C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

and assure that the area agency will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

Section 306(a)(4)(A): Low Economic, Minority and Rural Services

- (i) The area agency on aging will-
 - (aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
 - (bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
- (II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);
- (ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
 - (I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

- (II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
- (III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared –

identify the number of low-income minority older individuals in the planning and service area;

- (I) describe the methods used to satisfy the service needs of such minority older individuals; and
- (II) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

Section 306(a)(4)(B): Low Economic, Minority and Rural Services Outreach

Provide assurances that the area agency on aging will use outreach efforts that will:

(i) identify individuals eligible for assistance under this Act, with special emphasis on--

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

(i) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance

Section 306(a)(4)(C): Focus on Minority Older and Rural Older Individuals

Contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

Section 306(a)(5): Assurance for the Disabled

Provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, with agencies that develop or provide services for individuals with disabilities.

Section 306(a)(6)(A): Accounting for the Recipients' Views

Take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan:

Section 306(a)(6)(B): Advocacy

Serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will effect older individuals;

Section 306(a)(6)(C): Volunteering and Community Action

(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families; and

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that:

- I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or
- II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act.

Section 306(a)(6)(D): Advisory Council

Establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, representatives of older individuals, local elected officials, providers of veterans health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

Section 306(a)(6)(E): Program Coordination

Establish effective and efficient procedures for coordination of:

- (i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and,
- (ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

Section 306(a)(6)(F): Mental Health Coordination

Coordinate any mental health services provided with funds expended by the area agency on aging for part B with the mental health services provided by community health centers and by other public agencies and nonprofit private organizations; and

Section 306(a)(6)(G): Native American Outreach

If there is a significant population of older individuals who are Native Americans, in the planning and service area of area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

Section 306(a)(7): Coordination of Long-Term Care

Provide that the area agency on aging will facilitate the coordination of community based long term care services designed to enable older individuals to remain in their homes, by means including:

- (i) development of case management services as a component of the long term care services; consistent with the requirements of paragraph (8);
- (ii) involvement of long term care providers in the coordination of such services; and,
- (iii) increasing community awareness of and involvement in addressing the needs of residents of long term care facilities;

Section 306(a)(8): Case Management Services

Provide that case management services provided under this title through the area agency on aging will:

- (i) not duplicate case management services provided through other Federal and State programs;
- (ii) be coordinated with services described in subparagraph (A); and,
- (iii) be provided by a public agency or a nonprofit private agency that:
 - (1) gives each older individual seeking services under this title a list of agencies that proved similar services within the jurisdiction of the area agency on aging;
 - (2) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;
 - (3) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing the services; or,
 - (4) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii)

Section 306(a)(9): Assurance for State Long-Term Care Ombudsman Program

Provide assurance that area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year

2000 in carrying out such a program under this title;

Section 306(a)(10): Grievance Procedure

Provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

Section 306(a)(11): Services to Native Americans

Provide information and assurances concerning services to older individuals who are Native Americans (referred to in the paragraph as “older Native Americans”), including---

- (A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

- (B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

- (C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

Section 306(a)(12): Federal Program Coordination

Provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

Section 306(a)(13)(A-E): Maintenance of Integrity, Public Purpose, Quantity and Quality of Services, Auditability

Provide assurances that the area agency on aging will:

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency--

- (i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
- (ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship;

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

Section 306(a)(14): Appropriate use of Funds

Provide assurance that funds received under this title will not be used to pay any part of a cost (including administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title

Section 306(a)(15): No Preference

Provide assurance that preference in receiving services under this title will be used-

- (A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
- (B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

TITLE VII: ELDER RIGHTS PROTECTION

Chapter 1: General Provisions

Section 705(a)(6)(A): General Provisions

An assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3:

- (A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
 - (i) public education to identify and prevent elder abuse;
 - (ii) receipt of reports of elder abuse;
 - (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent, and
 - (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

Chapter 2: Ombudsman Program

Section 704(a): Organization and Area Plan Description of Ombudsman Program

Section 712(a)(5)(D)(iii): Confidentiality and Disclosure

The State agency shall develop the policies and procedures in accordance with all provisions of this subtitle regarding confidentiality and conflict of interest. [This is R510-200-8(B)(9) for confidentiality and R510-200-7(A)(e) for conflicts of interest using the definitions outlined in state and federal law]

Section 712(a)(5)(C): Eligibility for Designation

Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall:

- (i) have demonstrated capability to carry out the responsibilities of the Office;
- (ii) be free of conflicts of interest;
- (iii) in the case of the entities, be public or nonprofit private entities; and
- (iv) meet such additional requirements as the Ombudsman may specify.

Section 712(a)(5)(D): Monitoring Procedures

- (i) In General: The State agency shall establish, in accordance with the Office, policies and procedures

for monitoring local Ombudsman entities designated to carry out the duties of the Office.

Section 712(a)(3)(D): Regular and Timely Access

The Ombudsman shall ensure that the residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints;

Section 712(c): Reporting System

The State agency shall establish a statewide uniform reporting system to:

- (1) collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems, and
- (2) submit the data, on a regular basis.

Section 712(h): Administration

The State agency shall require the Office to:

- (1) prepare an annual report:
 - (A) describing the activities carried out by the Office in the year for which the report is prepared;
 - (B) containing and analyzing the data collected under subsection (c);
 - (C) evaluating the problems experienced by, and the complaints made by or on behalf of, residents;
 - (D) containing recommendations for:
 - (i) improving quality of the care and life of the residents; and
 - (ii) protecting the health, safety, welfare, and rights of the residents;
 - (E)(i) analyzing the success of the program including success in providing services to residents of board and care facilities and other similar adult care facilities; and
(ii) identifying barriers that prevent the optimal operation of the program; and
 - (F) providing policy, regulatory, and legislative recommendations to solve identified problems, to resolve the complaints, to improve the quality of care and life of residents, to protect the health, safety, welfare, and rights of residents, and to remove the barriers;
- (2) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services, and to the health, safety, welfare, and rights of residents, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;
- (3) (A) provide such information as the Office determines to be necessary to public and private agencies, legislators, and other persons, regarding:
 - (i) the problems and concerns of older individuals residing in long-term care facilities; and
 - (ii) recommendations related to the problems and concerns.

(These three assurances were added to the ombudsman section in May, 2003)

Section 712(f): Conflict of Interest

The State agency shall:

- (1) ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5), is subject to a conflict of interest;
- (2) ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;
- (3) ensure that the Ombudsman:
 - (A) does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;
 - (B) does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;
 - (C) is not employed by, or participating in the management of, a long-term care facility; and
 - (D) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and
- (4) establish, and specify in writing, mechanisms to identify and remove conflicts of interest referred to in paragraphs (1) and (2), and to identify and eliminate the relationships described in subparagraphs (A) through (D) of paragraph (3), including such mechanisms as:
 - (A) the methods by which the State agency will examine individuals, and immediate family members, to identify the conflicts; and
 - (B) the actions that the State agency will require the individuals and such family members to take to remove such conflicts.

Section 712(a)(3)(E): Representation Before Governmental Agencies

The Ombudsman shall represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

Section 712(j): Noninterference

The State must:

- (1) Ensure that willful interference with representatives of the Office in the performance of the official duties of the representatives (as defined by the Assistant Secretary) shall be unlawful.
- (2) Prohibit retaliation and reprisals by a long-term care facility or other entity with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of, the Office.

Will you assure that your agency will not interfere with the official functions of ombudsman representatives as defined in The Older Americans Act section 712 (a) (5) (B) and that representatives will be able to report any interference to the State?

Neglect and Exploitation

Section 721(a): Establishment

In order to be eligible to receive an allotment under section 703 from funds appropriated with this section, and in consultation with area agencies on aging, develop and enhance programs for the prevention of elder abuse, neglect, and exploitation.

Section 721(b)(1-2)

- (1) providing for public education and outreach to identify and prevent elder abuse, neglect, and exploitation;
- (2) ensuring the coordination of services provided by area agencies on aging with services instituted under the State adult protection service program, State and local law enforcement systems, and courts of competent jurisdiction;

VI. AREA PLAN PROGRAM OBJECTIVES

Supportive Services

Title III B Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Service Units	Estimated Number of Persons Not Served
<p>Case Management (1 case): Assistance either in the form of access or care coordination in the circumstance where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers. Activities of case management includes assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services among providers, follow-up and re-assessment, as required.</p>				
<p>Personal Care (1 hour): Provide personal assistance, stand-by assistance, supervision or cues for persons having difficulties with one or more of the following activities of daily living: eating, dressing, bathing, toileting, and transferring in and out of bed.</p>	31	719		
<p>Homemaker (1 hour): Provide assistance to persons having difficulty with one or more of the following instrumental activities of daily living: preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.</p> <p>Chore (1 hour): Provide assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy housework, yard work or sidewalk maintenance.</p>	120	701		
	33	51		

Title III B Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Service Units	Estimated Number of Persons Not Served
<p>Adult Day Care/Adult Day Health (1 hour): Provision of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a 24-hour day. Services offered in conjunction with adult day care/adult health typically include social and recreational activities, training, counseling, meals for adult day care and services such as rehabilitation, medication management and home health aide services for adult day health.</p>				
<p>Assisted Transportation (1 one-way trip): Provision of assistance, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.</p>	35	552		
<p>Transportation (1 one-way trip): Provision of a means of transportation for a person who requires help in going from one location to another, using a vehicle. Does not include any other activity.</p> <p>Legal Assistance (1 hour): Provision of legal advise, counseling and represent-ation by an attorney or other person acting under the supervision of an attorney.</p> <p>Nutrition Education (1 session): A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants or participants and caregivers in a group or individual setting overseen by a dietitian or individual of comparable expertise.</p>	15	1,799	160	

Title III B Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Service Units	Estimated Number of Persons Not Served
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- Persons assessed and determined eligible for services

<p>Information and Assistance (1 contact): A service for older individuals that (A) provides the individuals with current information on opportunities and services available to the individuals within their communities, including information relating to assistive technology; (B) assesses the problems and capacities of the individuals; (C) links the individuals to the opportunities and services that are available; (D) to the maximum extent practicable, ensures that the individuals receive the services needed by the individuals, and are aware of the opportunities available to the individuals, by establishing adequate follow-up procedures.</p> <p>Outreach (1 contact): Interventions initiated by an agency or organization for the purpose of identifying potential clients and encouraging their use of existing services and benefits.</p>			11,208	
			6,915	

* Persons assessed and determined eligible for services

TITLE III C-1

<p align="center">Title III C-1 Program Objective</p>	<p align="center">Persons Served - Unduplicated Count</p>	<p align="center">Persons Waiting for Services*</p>	<p align="center">Estimated Service Units</p>	<p align="center">Estimated Number of Persons Not Served</p>
<p>Congregate Meals (1 meal): Provision to an eligible client or other eligible participant at a nutrition site, senior center or some other congregate setting, a meal which:</p> <ul style="list-style-type: none"> a) complies with the Dietary Guidelines for Americans (published by the Secretaries of the Department of Health and Human Services and the United States Department of Agriculture; b) provides, if one meal is served, a minimum of 33 and 1/3 percent of the current daily Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; c) provides, if two meals are served, together, a minimum of 66 and 2/3 percent of the current daily DRI; although there is no requirement regarding the percentage of the current daily DRI which an individual meal must provide, a second meal shall be balanced and proportional in calories and nutrients; and, d) provides, if three meals are served, together, 100 percent of the current daily DRI; although there is no requirement regarding the percentage of the current daily DRI which an individual meal must provide, a second and third meal shall be balanced and proportional in calories and nutrients. 	<p align="center">1,397</p>		<p align="center">42,128</p>	
<p>Nutrition Counseling (1 hour): Provision of individualized advice and guidance to individuals, who are at nutritional risk because of their health or nutritional</p>				

Title III C-1 Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Service Units	Estimated Number of Persons Not Served
history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, performed by a health professional in accordance with state law and policy.				
Nutrition Education (1 session): A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants or participants and caregivers in a group or individual setting overseen by a dietitian or individual of comparable expertise.				

* Persons assessed and determined eligible for services

**TITLE III C-2
Home-Delivered Meals**

Title III C-2 Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Service Units	Estimated Number of Persons Not Served
<p>Assessment/Screening (1 Hour): Administering standard examinations, procedures or tests for the purpose of gathering information about a client to determine need and/or eligibility for services. Routine health screening (blood pressure, hearing, vision, diabetes) activities are included.</p>				
<p>Home-Delivered Meals (1 meal): Provision, to an eligible client or other eligible participant at the client's place of residence, a meal which:</p> <ul style="list-style-type: none"> a) complies with the Dietary Guidelines for Americans (published by the Secretaries of the Department of Health and Human Services and the United States Department of Agriculture); b) provides, if one meal is served, a minimum of 33 and 1/3 percent of the current daily Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; c) provides, if two meals are served, together, a minimum of 66 and 2/3 percent of the current daily DRI; although there is no requirement regarding the percentage of the current daily RDA which an individual meal must provide, a second meal shall be balanced and proportional in calories and nutrients; and 	1,013		100,474	

<p align="center">Title III C-2 Program Objective</p>	<p align="center">Persons Served - Unduplicated Count</p>	<p align="center">Persons Waiting for Services*</p>	<p align="center">Estimated Service Units</p>	<p align="center">Estimated Number of Persons Not Served</p>
<p>d) provides, if three meals are served, together, 100 percent of the current daily DRI; although there is no requirement regarding Home-Delivered Meals (cont'd): the percentage of the current daily RDA which an individual meal must provide, a second and third meal shall be balanced and proportional in calories and nutrients.</p>				
<p>Nutrition Counseling (1 hour): Provision of individualized advice and guidance to individuals, who are at nutritional risk because of their health or nutritional history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, performed by a health professional in accordance with state law and policy.</p>	<p align="center">0</p>			

* Persons assessed and determined eligible for services

**TITLE III D
Preventive Health**

Title III D Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Service Units	Estimated Number of Persons Not Served
Health Promotion- Evidence based			10,691	
Health Promotion – Non-evidence based			11,010	

* Persons assessed and determined eligible for services

TITLE III E
National Family Caregiver Support Program (NFCSP)

Title III E Program Objective	Persons Served	Persons Waiting for Services*	Estimated Service Units
Information: Estimate the number of individuals who will receive information, education and outreach activities in order to recruit caregivers into your program.	6,672		103
Assistance: Estimate the number of clients who will receive assistance in accessing resources and information which will result in developed care plans and coordination of the appropriate caregiver services.	31		118
Counseling/Support Groups/ Training: Estimate the number of individuals who will receive counseling/support groups/training.	17		139
Respite: Estimate the number of clients who will receive respite services using NFCS funds.	31	7	945
Supplemental Services: Estimate the number of clients receiving supplemental caregiver services using NFCS funds.	2		10

* Persons assessed and determined eligible for services

OTHER OLDER AMERICANS ACT

Other Services Profile (*Optional*): List other services and the funding source.

Service Name and Funding Source	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Service Units	Estimated Number of Persons Not Served
IIIE: Goods and services provided to complement care provided by caregivers Caregiver of Older Adult Unit			2,133	
IIIB: Groceries, Cleaning Supplies, Personal Hygiene Supplies - 1 Contact			5,691	
IIIB: Volunteer Services (Hour)			879	
IIIB: Oral Nutrition Supplement			516	
IIIB: Public Information			57,587	
IIIB: Socialization			17,911	
IIIB: Telephone Reassurance			327	

* Persons assessed and determined eligible for services

Note: *There are no restrictions on the number of Other services which may be reported.*

Mission/Purpose Codes:

A= Services which address functional limitations

B= Services which maintain health

C= Services which protect elder rights

D= Services which promote

socialization/participation

E= Services which assure access and coordination

F= Services which support other goals/outcomes

STATE-FUNDED PROGRAMS

Service Code	Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Number of Persons Not Served
ALM	Home and Community-based Alternatives Program:** Service designed to prevent premature or inappropriate admission to nursing homes, including program administration, client assessment, client case management, and home- and community-based services provided to clients. Volunteer: Trained individuals who volunteer in the Retired Senior Volunteer Program, Foster Grandparent Program, and Senior Companion Program.	38	17	
RVP				

* Persons assessed and determined eligible for services

** Quarterly and annual reporting requirements by service area will still be required. (Example: case management, home health aide, personal care, respite, etc.)

MEDICAID AGING WAIVER PROGRAM

Program Objective	Persons Served - Unduplicated Count	Persons Waiting for Services*	Estimated Number of Persons Not Served
Purpose: A home and community-based services waiver offers the State Medicaid Agency broad discretion not generally afforded under the State plan to address the needs of individuals who would otherwise receive costly institutional care provided under the State Medicaid plan.	19	18	

* Persons assessed and determined eligible for services

VII. REAFFIRMATION OR AMENDMENTS TO THE FOUR-YEAR PLAN

This section allows the AAA to annually reaffirm, with documentation, the information found in its four-year plan. It is important to include documentation with the request for any waivers, including descriptions and justifications for the request. This section provides an opportunity to discuss any modifications the agency is requesting to amend in the four-year plan. The following areas should be included, and any others that the AAA would like to add:

1. PRIORITY OF SERVICES

- A) Home Delivered Meals
- B) In-Home Services
- C) Information & Referral
- D) Transportation
- E) Caregiver Support
- F) Congregate Meals

2. SERVICE PROVIDERS

List all providers from whom the agency will purchase goods or services with Title III funds to fulfill area plan objectives. Specify the goods or services being purchased and the type of agreement made with the provider, i.e., subcontract, vendor, memorandum of agreement, etc.:

AGREEMENT	PROVIDER NAME	GOODS/SERVICE(S)	TYPE
	Cache County Senior Center	Title IIIB, C-1, C-2	Sub contract
	Brigham City Senior Center	Title IIIB, C-1, C-2	Sub contract
	Bear River Valley Senior Center	Title IIIB, C-1, C-2	Sub contract
	Rich County Senior Center	Title IIIB, C-1, C-2	Sub contract
	Registered Dietician	Title IIIB C-1, C-2	Sub contract
	Utah Legal Services	Title IIIB	Sub contract
	Alertline	Title IIIE	Sub contract
	Assisting Hands	Title IIIE	Sub contract
	Connect America	Title IIIE	Sub contract
	CNS Home Health	Title IIIE	Sub contract
	ComForCare	Title IIIE	Sub contract
	Independent Alert	Title IIIE	Sub contract

Sunshine Cares
Suzy's Senior Companions

Title III E
Title III E

Sub contract
Sub-contract

3. DIRECT SERVICE WAIVERS

The State Plan shall provide that no supportive services, nutrition services, or in-home services (as defined in section 342[1]) will be directly provided by the State Agency or an area agency on aging, except where, in the judgment of the State Agency, provision of such services by the State or an area agency on aging is necessary to assure an adequate supply of such services, or where such services are directly related to such state or area agency on aging administrative functions, or where such services of comparable quality can be provided more economically by such state or area agency on aging.

**Is your agency applying for any Direct Service Waivers?
Yes [x] No []**

If yes, list the services for which waivers are being requested and describe the necessity for the direct service provision.

Case Management – Due to the small numbers of clients who receive case management services under Title IIIB and Title IIIE, it is not financially feasible to contract this service to another provider. In addition, other providers who may be interested in this service are already under contract with our agency to provide other supportive services which would constitute a conflict of interest. We also ask to waive the use of the Alternatives assessment tool for Title IIIB In-Home Services as we will use the Nutrition Assessment tool.

4. PRIORITY SERVICE WAIVER

Reference(s): OAA Section 306(a)(2), 306(b)(1)(2)(A)(B)(C)(D), 307(a)(22)
State Rule R110-106-1

Indicate which, if any, of the following categories of service the agency is not planning to fund with the minimum percentage of Title III B funds specified in the State Plan, with the justification for not providing services. **Attach appropriate documentation** to support the waiver request as follows:

- 1) notification of public hearing to waive Title III B funding of a service category,
- 2) A list of the parties notified of the hearing,
- 3) A record of the public hearing, and
- 4) A detailed justification to support that services are provided in sufficient volume to meet the need throughout the planning and service area. (See State Rule R805-106 for specific requirements.)

SERVICE CATEGORY	DESCRIPTION OF REASON FOR THE WAIVER
Access:	N/A
In-Home:	N/A
Legal Assistance:	N/A

5. ADVISORY COUNCIL

References: OAA Sections 306(a)(6)(F)
FED 45 CFR Part 1321.57

Council Composition	Number of Members
60+ Individuals	2
60+ Minority Individuals	1
60+ Residing in Rural Areas	0
Representatives of Older Individuals	4
Local Elected Officials	0

Representatives of Providers of Health Care (including Veterans Health Care if applicable)	1
Representatives of Supportive Services Provider Organizations	2
Persons With Leadership Experience in the Voluntary and Private Sectors	9
General Public	0
Total Number of Members (May not equal sum of numbers for each category)	10

Name and address of chairperson: [Bryce Patten](#)

Does the Area Agency Advisory Council have written by-laws by which it operates?

Yes No

Area Agency Advisory Council meetings schedule: *Every other month*

VIII. POPULATION ESTIMATES

Population Group	Number*	Number Served in Planning and Service Area	Estimate of People Needing Services
Age 60+	32,000	3,600	1,500
Age 65+	29,500		
Minority Age 65+	1,780	210	250

*Population data from the Governor's Office of Planning and Budget are provided for each county on the attached sheet.

IX. SPECIFIC QUESTIONS ON PROGRAM ACTIVITIES