# Content Charts

## III. B. Context

Use this chart in the Context portion of your Regional Area Plan. This will represent a summary of services currently provided by county. As you complete the chart for each county and service, details regarding an absence of service by county or specific location/site may be described in the narrative.

**Current Service Coverage Charts**

An “X” indicates the service is offered in the county listed**.**

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| **Supportive Services** | **[COUNTY 1]** | **[COUNTY 2]** | **[COUNTY 3]** | **[COUNTY 4]** | **[COUNTY 5]** | **[COUNTY 6]** |
| Assessment |  |  |  |  |  |  |
| Transportation |  |  |  |  |  |  |
| Congregate |
| Medical |  |  |  |  |  |  |
| Essential |  |  |  |  |  |  |
| Assisted |  |  |  |  |  |  |
| Homecare |  |  |  |  |  |  |
| Personal Care |
| Homemaker |  |  |  |  |  |  |
| Chore |  |  |  |  |  |  |
| Minor Home Repair |  |  |  |  |  |  |
| Information & Referral |  |  |  |  |  |  |
| Legal Services |  |  |  |  |  |  |

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| **Nutrition Services** | **[COUNTY 1]** | **[COUNTY 2]** | **[COUNTY 3]** | **[COUNTY 4]** | **[COUNTY 5]** | **[COUNTY 6]** |
| Congregate Meals |  |  |  |  |  |  |
| Home Delivered Meals |  |  |  |  |  |  |
| Home Delivered Meals (Family Caregiver) |  |  |  |  |  |  |
| Nutrition Education |  |  |  |  |  |  |
| Nutrition Counseling |  |  |  |  |  |  |

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| **Health Promotion Services** | **[COUNTY 1]** | **[COUNTY 2]** | **[COUNTY 3]** | **[COUNTY 4]** | **[COUNTY 5]** | **[COUNTY 6]** |
| **Evidenced-Based Programs** |  |  |  |  |  |  |
| Health Promotion & Disease Prevention |  |  |  |  |  |  |

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| **Family Caregiver** | **[COUNTY 1]** | **[COUNTY 2]** | **[COUNTY 3]** | **[COUNTY 4]** | **[COUNTY 5]** | **[COUNTY 6]** |
| Information & Assistance |  |  |  |  |  |  |
| Assessment |  |  |  |  |  |  |
| Respite |  |  |  |  |  |  |
| Supplemental Services |  |  |  |  |  |  |
| Counseling |  |  |  |  |  |  |
| Support Groups |  |  |  |  |  |  |
| Caregiver Training |  |  |  |  |  |  |

## III. D. Goals, Objectives, and Performance Measures

Use this chart to help delineate your goals, objectives, strategies, and challenges. The State Plan goals and objectives have already been filled in for your convenience. As part of your Regional Area Plan, include your strategies and any foreseen or suspected barriers that may impact accomplishing those items during the two-year period. It is also expected that the region will include its own goals and objectives, along with the strategies and challenges in addition to those listed from the State Plan. (All of the provided empty charts may not be needed, or you can copy if more items are needed.)

**Goals, Objectives, Performance Measures, Strategies, and Challenges**

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| **State Plan Goal 1** | Maintain effective and responsible management of Older Americans Act (OAA) services offered through the Department on Aging (SCDOA) and within the 10 service regions in South Carolina. |

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| State Plan Objective 1.1 | Evaluate, monitor, and modify aging service programs to maximize the number of people served with state and federal funding, and to ensure programs and services are cost effective and meet best practices, as well as to achieve greater accountability and transparency. |
| Annual Performance Measures | |
| State Plan – SCDOA and AAAs conduct needs assessments to evaluate state and regional concerns and service demands. | |
| State Plan – AAAs submit Quality Assurance Reports to SCDOA annually. | |
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| Strategies and Actions | |
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| Challenges and Barriers | |
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| State Plan Objective 1.2 | The client assessment program is the gateway to most services provided by the Aging Network. An assessment is necessary to determine a client’s eligibility for services and it determines the level of need by establishing a priority score. The AAAs are responsible for conducting client assessments in their respective regions, thereby ensuring greater accountability and providing a holistic approach to how each client is matched to services. |
| Annual Performance Measures | |
| State Plan – Expand the number of seniors assessed annually by 5% or as needed. | |
| State Plan – Decrease the number of seniors on waiting lists for services. (It should be noted that regional waiting lists can be a result of many factors, including funding and/or lack of capacity in rural areas. | |
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| Regional Objective |  |
| Annual Performance Measures | |
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| **State Plan Goal 2** | | Empower older adults and persons with disabilities, their families, caregivers, and other consumers by providing information, services, education, and counseling on their options to live as independently as possible in the community. |

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| State Plan Objective 2.1 | Information and Referral/Assistance (I&R/A); SC ACT |
| Annual Performance Measures | |
| State Plan – Increase the number of contacts accessing I&R/A services by 5% annually. | |
| State Plan – Increase the I&R/A outreach by 5% annually. | |
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| Challenges and Barriers | |
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| State Plan Objective 2.2 | Insurance and Medicare Counseling |
| Annual Performance Measures | |
| State Plan – Increase by 5% annually, the number of older adults and adults with disabilities enrolled in prescription drug coverage that meets their financial and health needs. | |
| State Plan – Increase by 5% annually, the number of beneficiaries who contact the SHIP program for assistance. | |
| State Plan – Three regional outreach events pare required per quarter (36 annually). | |
| State Plan – Increase by 5% annually, the number of consumers and caregivers receiving SMP counseling. | |
| State Plan – Increase by 5% annually, the number of consumers reached in rural, isolated areas. | |
| State Plan – Increase by 5% community partnerships to assist in raising awareness of fraud. | |
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| Challenges and Barriers | |
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| State Plan Objective 2.3 | Nutrition Program and Services | |
| Annual Performance Measures | | |
| State Plan – Track and identify service gaps for Congregate and Home delivered meal services. | | |
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| Challenges and Barriers | |
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| State Plan Objective 2.5 | Evidence-Based Health Promotion and Disease Prevention Programs |
| Annual Performance Measures | |
| State Plan – Track and identify service gaps for Evidenced-Based Health Promotion and Disease Prevention Programs including their causes and geographic distribution. | |
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| Challenges and Barriers | |
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| State Plan Objective 2.6 | Transportation Services |
| Annual Performance Measures | |
| State Plan – Increase the number of clients utilizing transportation services by 5% annually, depending on available funding sources. | |
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| State Plan Objective 2.7 | Family Caregiver Support Program |
| Annual Performance Measures | |
| State Plan – Expand the number of family caregiver support recipients by 5% annually. | |
| State Plan – Increase outreach events by 5% annually. | |
| State Plan – Increase utilization of the Seniors Raising Children funding by 5%. | |
| State Plan – Increase partnerships and collaboration with other human-service agencies by 3%. | |
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| Strategies and Actions | |
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| State Plan Objective 2.10 | Home Care |
| Annual Performance Measures | |
| State Plan – Increase the number of seniors receiving home care services by 5% annually. | |
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| Challenges and Barriers | |
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| State Plan Objective 2.11 | Minor Home Repairs |
| Annual Performance Measures | |
| State Plan – Increase the number of seniors receiving home repair services by 5% annually. | |
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| **State Plan Goal 3** | Ensure the rights of older adults and persons with disabilities and prevent their abuse, neglect, and exploitation through the State Long Term Care Ombudsman Program, and elder abuse awareness and prevention activities including legal services and the Vulnerable Adult Guardian ad Litem program. |

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| State Plan Objective 3.2 | Legal Assistance Program |
| Annual Performance Measures | |
| State Plan – Increase the number of outreach activities directed at the most vulnerable senior victims of abuse, neglect, and exploitation. | |
| State Plan – Increase the number of formalized partnerships between aging/disability and elder rights groups. | |
| State Plan – Develop and implement a continuous quality improvement component within the program. | |
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| Challenges and Barriers | |
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| State Plan Objective 3.3 | Long Term Care Ombudsman Program |
| Annual Performance Measures | |
| State Plan – Increase and efficiently track the resident satisfaction outcomes and complaint resolution rate by 5% annually. | |
| State Plan – Increase the number of quarterly visits to facilities by Ombudsmen representatives by 5% annually. | |
| State Plan - Increase the number of trained Volunteer Ombudsmen by 5% annually. | |
| State Plan – Each local Ombudsman program will conduct eight educational trainings for residents/families on long-term care services and/or developing self-advocacy skills. | |
| State Plan – Improve targeted educational activities that raise awareness of the Ombudsman program in the communities by 5% annually. | |
| State Plan – Expand the number of Resident and Family Councils by 5% annually. | |
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| **Regional Goal** |  |

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