Utah Commission on Aging

Quarterly Summit Agenda

Thursday – November 07, 2024

12:00 PM - 01:30 PM

Community Partner and Member Networking Meeting

Join Zoom Meeting https://zoom.us/j/640416337

Or Dial 669 900 6833

Meeting ID: 640 416 337

(Zoom conference information will remain the same for all UCOA quarterly meetings)

Agenda

12:00 Welcome to members and partners — Darlene Curley

First time attendees – please put name and organization in chat.

12:05 Statutory appointments – Dr. Tim Farrell — Rob Ence

Briefing packet overview

November is Family Caregivers Month

12:15 Community Partner Updates and Announcements

12:25 MPA Conversations — Rob Ence

1. Annual Report and Updated MPA:
   - Legislature and Executive Branch by November 15
   - HHS Interim Committee update November 20 (tentative)
   - Governor Cox planned initiative for second term
2. Selected Topics
   a. Plan for Life – *Sector 4* — Rob Ence
      Uniform Health-Care Decisions Act (2023)
   b. Networks of Care– *Sector 5* — Leda Rosenthal
      Resource – Trualta Care Network Presentation
   c. DAAS/DHHS Collaboration
      2024 State Needs Assessment Discussion — Nels Holmgren

01:25 Participant comments and input — Darlene Curley

Next meeting Thursday – Feb 13, 2025, at Noon – via Zoom

(Public and partner comment and input welcomed throughout. Session will be recorded.)

Spencer J. Cox

Governor

Declaration

Whereas, the month of November is celebrated and recognized nationally as Family Caregivers Month;

Whereas, about one in five Utahns provide unpaid care for family members, friends, neighbors, and community members, supporting older adults, individuals with dementia, children and adults with disabilities, veterans, individuals dealing with substance abuse or mental health concerns, children living in a home without a parent present, and individuals with cancer;

Whereas, 40% of Utah caregivers report financial stress stemming from out-of-pocket care expenses, lost wages, reduced social security and retirement benefits, and, in some cases, decreased hours or leaving the workforce altogether due to caregiving responsibilities;

Whereas, the need for family caregivers is expected to increase 30% by 2030. That same year, the economic value of the care they provide is estimated to surpass $6.5 billion;

Whereas, enhancing the current support structure for family caregivers, including access to respite care, would improve the economic and social wellbeing of families, businesses, and communities across Utah; and,

Whereas, support for family caregivers depends on statewide partnerships that increase public awareness and ensure family caregivers in Utah have the resources, support, and flexibility they need to continue providing care to families;

Now, therefore, I, Spencer J. Cox, governor of the state of Utah, do hereby declare November 2024 as

Family Caregivers Month in Utah

Spencer J. Cox
Governor

October 31, 2024

A Proclamation on National Family Caregivers Month, 2024

Family caregivers are the backbone of our Nation, making tremendous sacrifices to be there for the people who need and cherish them most. This month, we honor their selfless love and courage, and we recommit to getting them the support they deserve. They should know their country has their backs.

For far too long, the cost of care in this country has been too high. Today, millions of Americans are part of the so-called sandwich generation, caring for both young kids and aging parents at the same time. Too many families struggle to afford help, spending their own retirement savings to pay for the care of their loved ones or quitting their own jobs to stay home and provide it themselves. Most often, it is women who bear the brunt of care work. And the pay for professional care workers is far too low.

In the United States of America, no one should have to choose between caring for a parent who raised them, a child who depends on them, and a paycheck that they need. That is why I signed the American Rescue Plan, which made the biggest investment in child care ever. It delivered historic support to over 225,000 child care programs serving as many as 10 million children across the country, helping keep their doors open for millions of working families who rely on them. It expanded the Child Tax Credit, which helped cut the child poverty rate nearly in half. Overall, my Administration increased funding for child care by nearly 50 percent while helping States expand and strengthen programs that enable low-income families afford child care as well. We also required companies seeking significant Federal funding from our CHIPS and Science Act to submit a plan on how they will help employees access affordable child care.

We have finalized new rules that strengthen staffing standards in nursing homes to ensure residents can age with dignity. We have made sure that home care workers get a bigger share of Medicaid payments so more Americans can keep living in their own communities and homes. And we have worked to increase Medicare resources to promote equitable access to care and caregiver training.

But we have to do more to ease the load on America's 50 million unpaid family caregivers, who too often still shoulder the burden of care all alone. Through the American Rescue Plan, we devoted $145 million to the National Family Caregiver

Support Program, which delivers counseling, training, and short-term relief to family caregivers and other informal care providers. Furthermore, my Administration released the first-ever National Strategy to Support Family Caregivers, which includes new initiatives that directly support family caregivers and strengthen existing programs. And I signed a historic Executive Order, representing the most comprehensive set of administrative actions ever to increase access to high-quality child care and long-term care and support for caregivers, including military and veteran caregivers. The Executive Order is working to make sure caregivers get the support they deserve while building the supply of high-quality care so families have options. My Administration is continuing to work toward lowering the cost of care across the country and providing stronger paid family and medical leave.

How we treat our young children, aging parents, and loved ones and how we value those who care for them are fundamental to who we are as a Nation. During National Family Caregivers Month, we pledge to get every family caregiver in this country the same kind of relief, respect, and support that they give so selflessly to others.

NOW, THEREFORE, I, JOSEPH R. BIDEN JR., President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim November 2024 as National Family Caregivers Month. I encourage all Americans to reach out to those who provide care for our Nation's family members, friends, and neighbors in need to recognize, honor, and thank them.

IN WITNESS WHEREOF, I have hereunto set my hand this thirty-first day of October, in the year of our Lord two thousand twenty-four, and of the Independence of the United States of America the two hundred and forty-ninth.

JOSEPH R. BIDEN JR.

IT'S EXPO TIME

2024 SENIOR EXPOS ARE BACK

SPONSORED BY selecthealth.

SENIOR EXPO™

by SENIORS Blue Book™

Resources for Aging Well | Engage | Educate | Empower

ASK THE EXPERTS

- Medicare & Medicaid
- Property Tax Reduction (66+)
- Housing, Care and Financial Services
- Government Resources & Housing
- Property Tax Discounts
- Instant Home Value Assessments
- Tips for Handling Inflation

HEALTH SCREENINGS

- Hearing & Balance
- Blood Pressure & Blood Sugar
- Cognition
- Joint Care
- Driving Safety
- Vaccination Station
- +10 Additional Screenings

FUN ACTIVITIES

- Pampering Stations
- Bingo
- Cooking Demonstrations
- +More

NOVEMBER
13 & 14, 2024

9AM-4PM

ST GEORGE CONVENTION CENTER

FREE DEMENTIA CAREGIVER CLINIC

WE CONNECT CAREGIVERS AND INDIVIDUALS WITH SUPPORTIVE RESOURCES

Our team includes specialists in

- Mental Health
- Audiology
- Finance
- Speech and Language Pathology
- Community Supports

SERVICES OFFERED IN PERSON AND VIA TELEHEALTH

PLEASE CONTACT US FOR MORE INFORMATION:

KJ Uluave, LCSW

Email: kj.uluave@usu.edu

Phone: 435-797-2088

Emma Eccles Jones College of Education & Human Services
Sorenson Legacy Foundation Center for Clinical Excellence
UtahStateUniversity

JOIN THE COMPASSION COMPASS STUDY!

WE ARE LOOKING FOR PARTICIPANTS TO TEST OUR ONLINE MENTAL HEALTH SUPPORT PROGRAM FOR **ADULTS WITH DEMENTIA**

Earn up to $60 for participating!

WHO CAN PARTICIPATE?

PARTICIPANTS MUST:

- HAVE RECEIVED A DEMENTIA DIAGNOSIS WITHIN THE PAST YEAR
- BE FLUENT IN READING ENGLISH
- HAVE INTEREST IN COMPLETING AN ONLINE SELF-HELP PROGRAM

INTERESTED? COMPLETE OUR SCREENER:

email:
CMHP@usu.edu

visit:
https://utahact.com/CompassionCompass

PI: Heather Kelley, PhD
heather.kelley@usu.edu
IRB #14297

MASTER OF SCIENCE: GERONTOLOGY

IMAGINE

Aging influences everything. Business, law, engineering, architecture and even art have a stake in issues related to an aging society.

An MS in Gerontology prepares you to be a gerontological leader in health care, business, and your community.

Gerontology students pursue active learning in health promotion and self-care, palliative care, bereavement, Alzheimer's disease and other dementias, special populations with disabilities, and long-term care quality.

With this fully online program, you can live anywhere in the US and still enjoy resident tuition rates.

As a master's student in Gerontology, you will experience:

- Interdisciplinary curriculum providing a comprehensive view of older adults and the aging process, including specific changes common in aging and its broader psychological and social issues.
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A 15-credit-hour Gerontology Interdisciplinary Certificate is also available.

GERONTOLOGY PROGRAMS ARE OPEN TO STUDENTS FROM ALL ACADEMIC DISCIPLINES AND PROFESSIONS.

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SCAN FOR MORE

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nursing.utah.edu/gerontology

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Same tuition nationwide

katarina.felsted@nurs.utah.edu
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Gerontology Interdisciplinary Program
10 S 2000 E
Salt Lake City UT 84112
801.585.7438 – Dr Felsted's direct line

Top 12 Reasons to Choose the Master of Science in Gerontology from the University of Utah Gerontology Interdisciplinary Program

1. **Flexibility**. Our degree is fully online and asynchronous, so you log in and learn on your own time. You are part of a close-knit cohort. You choose your program of study, your electives, your practicum site, and your project/ thesis topic.
2. **Affordability**. The UOnline tuition rate excludes otherwise mandatory student fees. You pay a flat fee per credit lower than in-state tuition, while living anywhere in the country.
3. **Interdisciplinary.** Learners from all backgrounds are welcome. We have students with as varied backgrounds as architecture to zoology. While we are located in the College of Nursing, we are not a nursing degree, we are a gerontology degree. You do not need a medical or nursing background.
4. **Short completion time**. The entire MS degree is only 10-11 courses. You could complete the masters in as little as one year (3 semesters).
5. **Follow your bliss.** You will tailor your master's degree experience to focus on what your real interest or passion is in the field of aging, through electives, practicum, and thesis/ project (non-thesis) topics.
6. **Consistent faculty mentor** from before you begin until you graduate. You are assigned a supervisory chair from the very first day, who serves as faculty mentor during your entire time in the program. You will also meet regularly with the assistant dean of the program to facilitate your success.
7. **High caliber professors and researchers**. In addition to your faculty mentor, the professors you take classes from are leading experts in their field, often nationally and internationally. Many professors are also scholarly researchers, involved in externally funded aging research.

8. **Respect**. We see you as our future colleagues, and you'll have opportunities to work as teaching and research assistants while earning your degree, should you be interested.
9. **Top research university**. The University of Utah is a Research 1 (R1) institution, a university classified by the *Carnegie Classification of Institutions of Higher Education* as having the highest level of research activity, considered a top-tier research university with significant funding and capacity for advanced research endeavors.
10. **Leadership opportunities**. When you earn your MS degree from the Gerontology Interdisciplinary Program, you also have the opportunity to participate in Sigma Phi Omega, the international academic honor and professionals' society in gerontology, as well as the local student chapter of the Gerontological Society of America (GSA). These organizations have student officers, national and international networks, and the chance to grow as a leader in the field of aging.
11. **Perks**. All MS students have the opportunity to apply for scholarships as well as travel funding. All incoming MS students receive free GSA membership, paid attendance to the Rocky Mountain Geriatrics Conference when it is held in Utah (every other year), and a copy of the book *101+ Careers in Gerontology*.
12. **Support**. Integration in the College of Nursing and UOnline connects you with our academic advising coordinator, program manager, student success manager, connections specialist, and many other helpful and supportive staff, faculty, and students.

Learn more:
https://online.utah.edu/graduate-programs/gerontology/index.php , or
https://nursing.utah.edu/programs/overview-program-study

Application Deadline: **March 1, 2025**
Info Sessions: https://nursing.utah.edu/programs/gerontology
(see white box in red band)

2024 Report to Congress

Progress Report: Federal Implementation of the 2022 National Strategy to Support Family Caregivers

From the:

Recognize, Assist, Include, Support, and Engage Family Caregiving Advisory Council

and the

Advisory Council to Support Grandparents Raising Grandchildren

Technical assistance provided by the Administration for Community Living | September 2024

Contents

Letter From Alison Barkoff

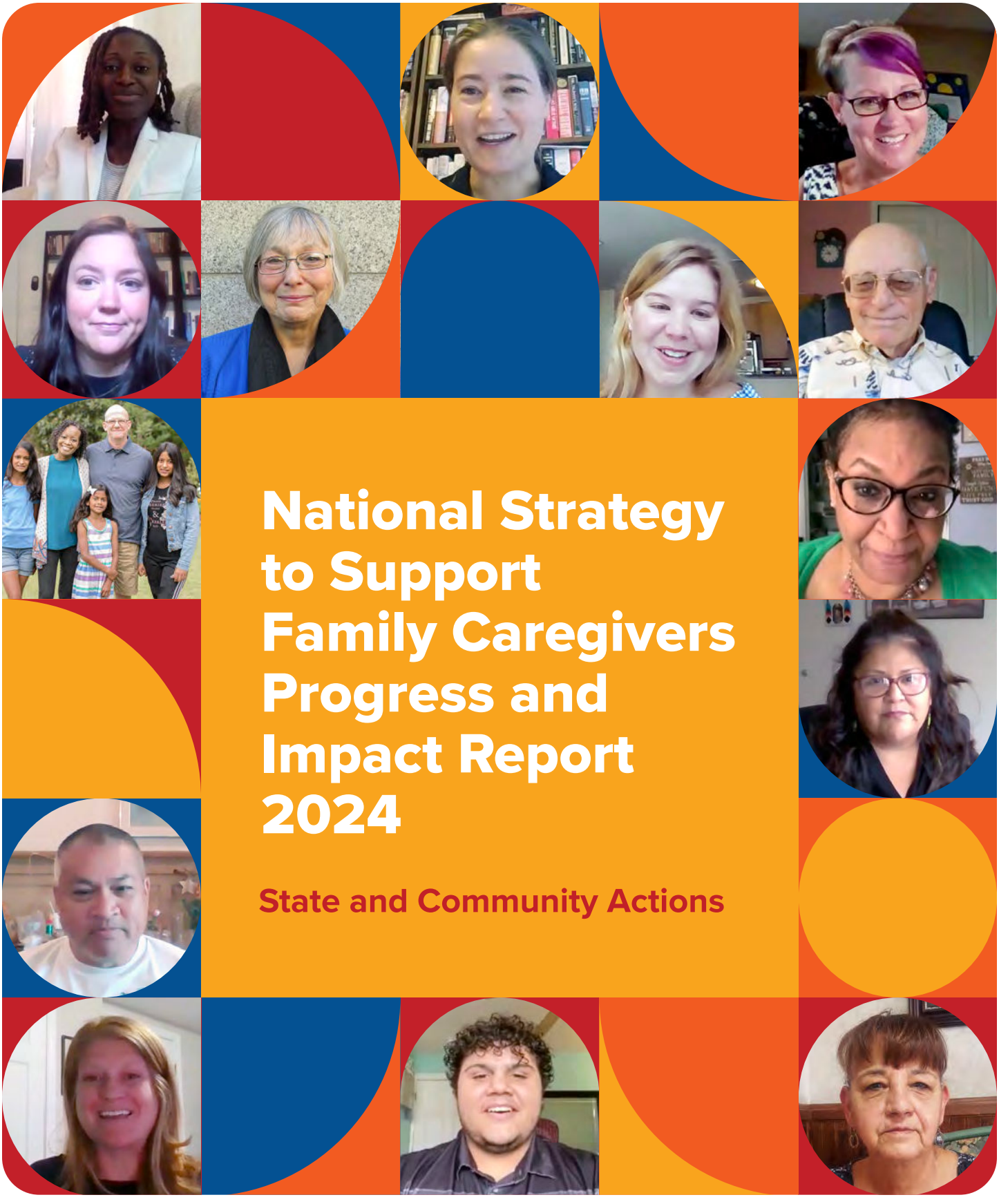
Each year, more than 53 million Americans provide a broad range of assistance to support the health, quality of life, and independence of an older adult or person with a disability. In addition, millions of grandparents — and an unknown number of other kinship caregivers — open their arms and homes each year to children who cannot remain with their parents. The number of family caregivers continues to increase as the populations of disabled people and older adults grow, and the overdose crisis and other issues create thousands of new "grandfamilies" each year.

Family caregivers are the backbone of the nation's system of long-term care — replacing the support they provide with paid services would cost an estimated $600 billion each year. But when they do not have training, support, and opportunities for rest and self-care, their health, well-being, and quality of life often suffer. Their financial future can also be put at risk; lost income due to family caregiving is estimated to be a staggering $522 billion each year. And if they are unable to continue to provide care, the people they support may have no option but to move to nursing homes and other facilities or, for children, to enter foster care. This deprives the person receiving support of their right to live in their community and often results in poorer health, usually at an increased cost to public programs.

We must improve the way we support family caregivers in this country.

The National Strategy to Support Family Caregivers was released in 2022 as a first step in a coordinated national effort to address this critical public health issue. The strategy was developed by the advisory councils established by the RAISE Family Caregiving Act and the Supporting Grandparents Raising Grandchildren Act with extensive input from stakeholders, including family caregivers and the people they support. It presented a vision, established goals, and provided recommendations for ensuring family caregivers have the support and resources they need. The strategy also included commitments from 15 federal agencies to nearly 350 actions to implement these recommendations. Recognizing that federal agencies alone cannot address the issue, the strategy also includes more than two dozen recommendations for legislative and policy changes, like federal legislation to improve paid family leave policies and expand access to services, along with over 150 recommendations that can be implemented by states, communities, businesses, philanthropy, and others.

ACL is pleased to provide this report, which focuses on federal implementation of the strategy. Today, nearly all of the 350 federal actions have been completed or are in progress, and federal agencies have committed to almost 40 new actions since the strategy's release nearly two years ago. This has created new programs and initiatives to directly support caregivers, improved efficiency and coordination, opened doors to international engagement and collaboration, and more.



National Strategy to Support Family Caregivers Progress and Impact Report 2024

State and Community Actions

RAISE FAMILY CAREGIVING ADVISORY COUNCIL

GRANDPARENTS RAISING GRANDCHILDREN ADVISORY COUNCIL

The John A. Hartford Foundation

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

Executive Summary

To increase awareness of the vital role of caregivers, the first-of-its-kind National Strategy to Support Family Caregivers lists hundreds of actions that federal agencies, state and local governments, businesses, and communities can take to improve their lives.

To drive change, the Strategy describes **five goals**:

- Increase awareness and outreach
- Build partnerships and engagement with family caregivers
- Strengthen services and supports
- Ensure financial and workplace security
- Expand data, research, and evidence-based practices

This Report highlights some of the initial impacts of the National Strategy on states, communities, providers, employers, and others in assisting the 53 million family caregivers, millions of grandparent caregivers, and an unknown number of other relative caregivers. This piece serves as a companion to the Federal Progress report published by the Administration for Community Living (ACL) on implementing the National Strategy, which showcases the significant progress **15** federal agencies have made in increasing support for family caregivers. Although the National Strategy is a catalyst for strengthening support to family caregivers, more work needs to be done. Results from a recent National Poll on Healthy Aging showed that most older adults do not know about the resources available to them or their caregivers.

▶ To learn what you can do, go to SupportCaregiving.org.

Uniform Health-Care Decisions Act (2023) ("UHCDA")	Utah Advance Health Care Directive Act (uniform and subst. similar language is highlighted)	Analysis of Substantive Differences
SECTION 1. SHORT TITLE. This [act] may be cited as the Uniform Health-Care Decisions Act (2023).	**Utah Advance Health Care Directive Act (not Uniform)**	
SECTION 2. DEFINITIONS. In this [act]: (1) "Advance health-care directive" means a power of attorney for health care, health-care instruction, or both. The term includes an advance mental health-care directive. (2) "Advance mental health-care directive" means a power of attorney for health care or health-care instruction, or both, created under Section 9. (3) "Agent" means an individual appointed in a power of attorney for health care to make a health-care decision for the individual who made the appointment. The term includes a co-agent or alternate agent appointed under Section 20. (4) "Capacity" has the meaning in Section 3. (5) "Cohabitant" means each of two individuals who have been living together as a couple for at least one year after each became an adult or was emancipated and who are not married to each other[or are not [domestic partners] with each other]. (6) "Default surrogate" means an individual authorized under Section 12 to make a health-care decision for another individual. (7) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities. (8) "Family member" means a spouse,[domestic	**75A-3-101: Definitions for this chapter:** As used in this chapter: (1) "Adult" means an individual who is: (a) at least 18 years old; or (b) an emancipated minor. (2) "Advance health care directive": (a) includes: (i) a designation of an agent to make health care decisions for an adult when the adult cannot make or communicate health care decisions; or (ii) an expression of preferences about health care decisions; (b) may take one of the following forms: (i) a written document, voluntarily executed by an adult in accordance with the requirements of this chapter; or (ii) a witnessed oral statement, made in accordance with the requirements of this chapter; and (c) does not include an order for life sustaining treatment. (3) "Agent" means an adult designated in an advance health care directive to make health care decisions for the declarant. (4) "APRN" means an individual who is: (a) certified or licensed as an advance practice registered nurse under Subsection 58-31b-301(2) (e); (b) an independent practitioner; and (c) acting within the scope of practice for that individual, as provided by law, rule, and specialized certification and training in that individual's area of practice. (5) "Best interest" means that the benefits to the individual resulting from a treatment outweigh the	Definitions of agent are substantively similar. The UHCDA includes a mental-healthcare directive in the definition of a "advance health-care directive", while the AHCDA does not. The UHCDA also provides a definition for "advance mental health-care directive". The UHCDA includes a co-agent or alternate appointed agent under its definition for "agent" while the AHCDA definition does not mention these additional options. The UHCDA provides a broader and singular definition for "capacity", while Utah bifurcates the term into capacity to appoint an agent and "health care decision making capacity." The UHCDA provides a more succinct definition of "default surrogate."

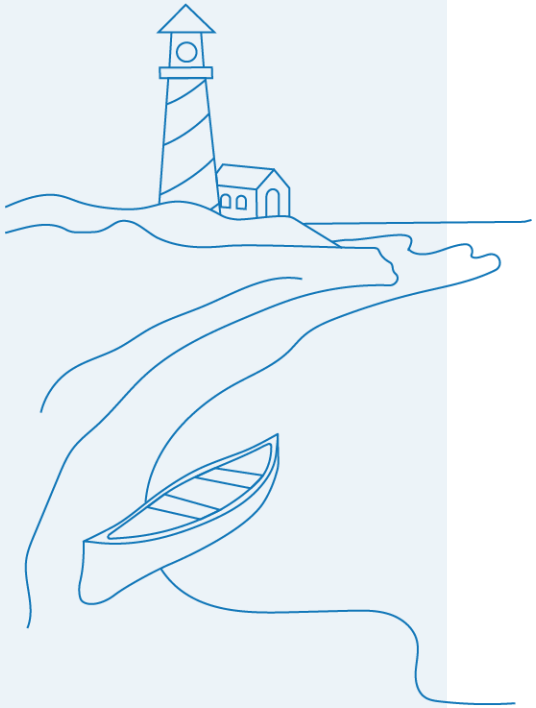
partner,] adult child, parent, or grandparent, or an adult descendant of a spouse,[domestic partner,] child, parent, or grandparent. (9) “Guardian” means a person appointed under other law by a court to make decisions regarding the personal affairs of an individual, which may include health-care decisions. The term does not include a guardian ad litem. (10) “Health care” means care or treatment or a service or procedure to maintain, monitor, diagnose, or otherwise affect an individual’s physical or mental illness, injury, or condition. The term includes mental health care. (11) “Health-care decision” means a decision made by an individual or the individual’s surrogate regarding the individual’s health care, including: (A) selection or discharge of a health-care professional or health-care institution; (B) approval or disapproval of a diagnostic test, surgical procedure, medication, therapeutic intervention, or other health care; and (C) direction to provide, withhold, or withdraw artificial nutrition or hydration, mechanical ventilation, or other health care. (12) “Health-care institution” means a facility or agency licensed, certified, or otherwise authorized or permitted by other law to provide health care in this state in the ordinary course of business. (13) “Health-care instruction” means a direction, whether or not in a record, made by an individual that indicates the individual’s goals, preferences, or wishes concerning the provision, withholding, or withdrawal of health care. The term includes a direction intended to be effective if specified	burdens to the individual resulting from the treatment, taking into account: (a) the effect of the treatment on the physical, emotional, and cognitive functions of the individual; (b) the degree of physical pain or discomfort caused to the individual by the treatment or the withholding or withdrawal of treatment; (c) the degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment, result in a severe and continuing impairment of the dignity of the individual by subjecting the individual to humiliation and dependency; (d) the effect of the treatment on the life expectancy of the individual; (e) the prognosis of the individual for recovery with and without the treatment; (f) the risks, side effects, and benefits of the treatment, or the withholding or withdrawal of treatment; and (g) the religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining the best interest. (6) “Capacity to appoint an agent” means that the adult understands the consequences of appointing a particular individual as agent. (7) "Child" means the same as that term is defined in Section 75-1-201. (8) "Declarant" means an adult who has completed and signed or directed the signing of an advance health care directive. (9) "Default surrogate" means the adult who may make decisions for an individual when either: (a) an agent or guardian has not been appointed; or (b) an agent is not able, available, or willing to make decisions for an adult. (10) "Emergency medical services provider" means a person that is licensed, designated, or certified under Title 53, Chapter 2d, Emergency Medical Services Act.	The UHCDA provides a definition of “family member” while Utah does not despite using the term within the law. The UHCDA provides a more clear definition of the term “guardian.” The UHCDA includes a definition for “health-care professional”, while Utah uses the term “health care provider” that is in a different law and much more complicated with a similar meaning. The UHCDA provides a more concrete message in its definition of “health-care institution”, while the uses a more confusing definition found within another provision of the state law under “health-care facility”. The UHCDA provides a definition for the term “health-care instruction”, while Utah lacks a definition for the term “instruction” Utah does not specifically address mental health care. The UHCDA provides a definition of “person”, while Utah uses the term person numerous times but does not provide a definition. Utah does not define Power of attorney [for health care].

conditions arise. (14) “Health-care professional” means a physician or other individual licensed, certified, or otherwise authorized or permitted by other law of this state to provide health care in this state in the ordinary course of business or the practice of the physician’s or individual’s profession. (15) “Individual” means an adult or emancipated minor. (16) “Mental health care” means care or treatment or a service or procedure to maintain, monitor, diagnose, or otherwise affect an individual’s mental illness or other psychiatric, psychological, or psychosocial condition. (17) “Nursing home” means a nursing facility as defined in 42 U.S.C. Section 1396r(a)(1)[, as amended] or skilled nursing facility as defined in 42 U.S.C. Section 1395i– 3(a)(1)[, as amended]. (18) “Person” means an individual, estate, business or nonprofit entity, government or governmental subdivision, agency, or instrumentality, or other legal entity. (19) “Person interested in the welfare of the individual” means: (A) the individual’s surrogate; (B) a family member of the individual; (C) the cohabitant of the individual; (D) a public entity providing health care case management or protective services to the individual; (E) a person appointed under other law to make decisions for the individual under a power of attorney for finances; or (F) a person that has an ongoing personal or	(11) "Estate" means the same as that term is defined in Section 75-1-201. (12) "Generally accepted health care standards": (a) is defined only for the purpose of: (i) this chapter and does not define the standard of care for any other purpose under Utah law; and (ii) enabling health care providers to interpret the statutory form set forth in Section 75A-3-303; and (b) means the standard of care that justifies a provider in declining to provide life sustaining care because the proposed life sustaining care: (i) will not prevent or reduce the deterioration in the health or functional status of an individual; (ii) will not prevent the impending death of an individual; or (iii) will impose more burden on the individual than any expected benefit to the individual. (13) "Guardian" means the same as that term is defined in Section 75-1-201. *(a) "Guardian" means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or court appointment, or by written instrument as provided in Section 75-5-202.5.* *(b) "Guardian" does not include a person who is merely a guardian ad litem.* (14) "Health care" means any care, treatment, service, or procedure to improve, maintain, diagnose, or otherwise affect an individual's physical or mental condition. (15) "Health care decision": (a) means a decision about an adult's health care made by, or on behalf of, an adult, that is communicated to a health care provider; (b) includes: (i) selection and discharge of a health care provider and a health care facility; (ii) approval or disapproval of diagnostic tests, procedures, programs of medication, and orders not to resuscitate; and (iii) directions to provide, withhold, or withdraw artificial	The UHCDA definition of “reasonably available” provides additional information regarding what “reasonably available” means as it pertains to an agent or default surrogate that is not included in the Utah definition. Utah does not define “record.” Utah does not define “sign,” a definition most useful with non-traditional signatures.

TRUALTA

Trualta Demo for Utah

November 7, 2024



ABOUT TRUALTA

A flexible caregiver engagement platform to help families build skills, increase confidence, and feel less alone.

- **Easy to navigate, holistic approach to caregiver support** with multiple types of content (video, audio, eLearning, print) and social connections
- **Scalable, on-demand,** intervention available 24/7 in English & Spanish
- **Dedicated, white-labeled platform** for your plan to add custom content, connect members to local or plan-specific resources, and monitor usage
- **Evidence-based approach with proven outcomes** for caregivers

Engagement

Proactive outreach & webinars

Micro-assessments

Support

Chat Room

Caregiver Support Groups

Skills-training

Education

Certifications

Bio:
Leda Rosenthal is the Director of Growth at Trualta. For almost 4 years, Leda has led Trualta's growth strategy to serve more caregivers through partnerships with area agencies on aging, community-based organizations, payers, and providers. Leda became passionate about supporting family caregivers when her mother was diagnosed with Alzheimer's, leading her to found a caregiver-focused technology discovery company in 2016 that served over 10,000 caregivers across the country

Chris Kwapis is the Account Executive at Trualta, managing all government AAA and SUA partnerships nationwide. With a background in process automation and digital transformation consulting, Chris brings a blend of technical expertise and a strong commitment to meaningful impact. Drawn to Trualta by its unique mission of merging technology with transformative support for caregivers, Chris plays a key role in expanding access and building valuable partnerships across the country.

Summary:
Trualta will demonstrate its innovative, outcome driven caregiver engagement platform tailored to support informal family caregivers through skills based education and peer-support. This session will provide an in-depth overview of how Trualta's evidence-based platform supports caregivers across conditions and caregiving across the lifespan.

Key Highlights of the Trualta Platform:

- **Comprehensive, Multi-Format Content:** Trualta offers a range of resources—video, audio, eLearning, and print—to engage caregivers. Available in both English and Spanish, these materials address needs across conditions like Alzheimer's, dementia, diabetes, grandparents raising grandchildren, IDD and more.
- **Customizable and Scalable:** Trualta can be tailored to meet specific community needs with local resource integration. The platform is accessible 24/7 from any device and can provide highly personalized learning journeys.
- I**mpactful Outcomes:** Proven results show benefits such as reduced emergency department usage, improved caregiver wellness, and better care recipient health. Trualta's "Power Users" have achieved meaningful improvements in health and engagement metrics.
- **Funding Opportunities:** Trualta's work is supported by Title III-E funding, grants, and collaborative contracts, making it accessible to agencies through various funding pathways.

Utah Department of Health and Human Services, Division of Aging and Adult Services
Community Needs Assessment of Vulnerable Adults: 2024 Results Brief

Prepared By: Market Decisions Research (MDR)

Utah Department of
Health & Human Services
Aging & Adult Services

This results brief summarizes the key findings from two community needs surveys completed for Utah DHHS. These surveys were administered to identify the service needs, gaps, and barriers of vulnerable adults in Utah. A full comprehensive report will be available in September 2024.

Project Overview and Methodology

The desired outcome of this project was to improve and enhance the effectiveness of the Utah Department of Health and Human Services, Division of Aging and Adult Services (DHHS DAAS) programs. A mixed methods study was conducted including an online survey for vulnerable adults (n=767), a separate online survey of stakeholders who work with vulnerable adults in Utah (n=182) and focus groups and in-depth interviews with respondents who were interested in participating in further research. Data collection for the online surveys was from January 30 to March 30, 2024. Focus groups were held with 10 vulnerable adults on July 20th and August 1st, 2024, and 11 in-depth interviews were conducted throughout July 2024 with stakeholders from across the state of Utah.

Key Findings: Stakeholders Survey

- Stakeholders believe it would be most important to collaborate with mental health partners (76%), healthcare workers (72%), and APS providers (69%) at an Enhanced-Multidisciplinary Team (E-MDT) to improve outcomes for vulnerable adults who are victims of abuse, neglect, and exploitation.
- Of those who participate in aging and disability services training, 61% believe there are aging and disability topics that are lacking where training would be valuable.
- Stakeholders pointed to social isolation, a lack of respect and dignity, and financial limitations as the biggest challenges faced by vulnerable adults in their community, especially among rural adults.

Key Findings: Vulnerable Adults Survey

- Only 49% of vulnerable adult respondents said they are familiar with Adult Protective Services (APS).
- Many respondents have either never contacted the Area Agency on Aging (62%) or are not familiar with the agency and its services (31%). Of those who contacted the agency, over three-quarters (77%) said they received the help and resources they needed.
- The primary trusted informational sources for vulnerable adults regarding aging or disability services are healthcare professionals (60%), followed by family members (45%) and the internet (42%).

Service Needs

The top-needed service reported by both vulnerable adults and stakeholders is low-income housing, at 40% and 57%, respectively.

Service	Vulnerable Adult	Stakeholder
Housing (low income)	X	X
Financial services	X	X
Day service	X	X
Transportation	X	X
Advocacy services	X	
Legal services	X	X
Caretaking/respite	X	X
Court services	X	X
In-home services	X	
Residential/ facility services	X	X

*Not in true ranked order; reported by 18% or more of each survey group

Service Needs (Continued)

Non-white rurally located vulnerable adults with an income of less than $20,000 are more likely to indicate they are unaware if services are offered and more likely to report that they need services, particularly housing, financial services, and day service.

Service Barriers

The primary barrier in accessing services experienced by vulnerable adults is disqualification due to high income (29%). The primary barrier in accessing services for vulnerable adults as reported by stakeholders is funding (82%).

Barrier	Vulnerable Adult	Stakeholder
Do not qualify	X	
Lack of information/ guidance	X	
Not enough money, long waitlists, or staffing capacity	X	X
Availability/ access in rural areas	X	X
Transportation, distance, or language difficulty	X	X
Access/Lack of services for older adults	X	X

*Not in true ranked order; combines overlapping categories; reported by 14% or more of each survey group

Non-white vulnerable adults with an income less than $20,000 are more likely to report they experienced barriers in accessing services, particularly a lack of information, not enough money for services to be available immediately or long waitlists, and transportation difficulties.

Unfamiliarity with Service Availability

Many vulnerable adults are generally unaware if services are available in their area, particularly professional advocacy (51%), court (47%), and

legal services (41%). Stakeholders are similarly unaware if court services (31%), and legal services (22%) are available in their area.

Service	Vulnerable Adult	Stakeholder
Advocacy services	X	X
Court services	X	X
Legal services	X	X
Day service	X	X
Caretaking/ respite services	X	
Housing (low income)	X	

*Not in true ranked order; combines overlapping categories; reported by 21% or more of each survey group

Additional Research Findings

- In the last 12 months, one-third (33%) of vulnerable adults said they have struggled to pay for food. Another 27% have struggled to pay their mortgage or rent and 25% have struggled to pay for transportation.
- Among vulnerable adults, the majority reported it is at least somewhat important to them (88%) to remain in their home as they get older.
- For them to remain in their home as they get older, the assistance needed by vulnerable adults includes outdoor labor (43%), household organization and cleaning (39%), and home safety modifications (31%).
- Most vulnerable adults rated their overall physical health (69%) and emotional well-being (76%) as “Good” or better. Only 9% said their physical health was “Poor” and 8% said their emotional well-being was “Poor”.
- Most vulnerable adult survey responses were from non-rural counties (Davis, Salt Lake, Utah, and Weber counties). 21% (n=236) of vulnerable adult survey respondents indicated they were a caregiver of a vulnerable adult, while 66% (n=744) indicated they were an adult over 60 and 27% (n=311) said they were an adult with a disability.