NEKCOA Area Plan 2026-2029

Section A: Executive Summary

Area Plan 2026-2029 Executive Summary

The Northeast Kingdom is an area where both poverty and isolation due to rurality of the region create unique challenges. To that end we find the need to ensure that we are providing access to information and services through a diverse means. Reaching out to where people go (town clerks, general stores, post office, doctors' offices, libraries) and ensuring that information is readily available is one way to ensure that those with greatest need are provided the opportunity to secure assistance. The geographic challenges result in greater social need to remain connected in the communities.

This area plan presents a unique set of experiences that lead us into the next area plan. The NEK is a unique region as it is the most rural part of our state and the smallest in terms of population. The result is often a lack of adjusted resources to meet the needs of the region in terms of statewide allocation of funding to take those factors into account. This plan also is the first one that incorporates the impact of COVID as we work to develop more integrated resources for those in our communities. That was and is a valuable lesson learned from the pandemic.

This plan is developed in a truly collaborative approach of gaining input and insights from those we serve, our community at large, and other nonprofits that we partner with in our region. As we work to be more efficient and mindful of limited resources, we work to reduce duplication of services, increase community awareness, and development of resources that provide for meeting needs.

Highlighted accomplishments:

We have joined with the local hospital, medical practices, mental health agency, department of health and community action to have an OCHA agreement that helps to coordinate services for clients and offer opportunity for increased collaboration through team-based care efforts effective May of 2025. This allows for us to be informed and inform of changes regarding clients occurring so that planning and coordination of services can be achieved, thus helping to reduce the clients who "fall through the cracks". Additionally, as a result of the needs assessment process we have developed a "transitions coordinator role" which is working to expedite community partner referrals as the agency is the primary case management agency through the conflict free case management requirement from CMS. This position has been key in moving referrals through the helpline system with a closed loop referral process ensuring that communication is effective in handling unique needs of the consumer and with improved timely responses. This also

provides an opportunity to educate referral sources regarding appropriate referrals to our agency as well as other sources such as APS, Home care, etc. As many are referred for services, this position helps to facilitate referrals that are accurately referred to appropriate services.

Additionally, we are actively working with community partners in team-based care ensuring that duplication of services is eliminated, appropriate referrals to the correct service and coordination that is led by the consumer is paramount to success.

The need to provide continuous information and awareness of service options is a significant need in the world of misinformation and misleading information. We find the need for continued sharing of information key to responding to the needs assessment concerns raised around this issue.

Tech for today is a money follows the person volunteer grant that we received for a two-year grant and due to the success of the model has now entered its fourth year of funding. This program uses a part time staff person who coordinates volunteers that are knowledgeable of computer/cell phone/internet usage and problem solving. It continues to be a program where demand is steady as more and more people seek internet for exploring options to meet their needs and use of application systems that require internet usage. While the program works to educate and support smart technology usage, it is a war against the scammers sending false invoices, romance scams and other misleading entrapments that consumers need education to avoid.

Home share is a program that works as an alternative to the housing crisis that we see in the NEK and beyond. We were fortunate to receive an opportunity through the legislature for 25/26 fiscal year to partially fund a case manager position to bring Home Share to the NEK and have begun to develop this resource. Initial work was so highly successful that the impetus for the request for funding showed the need and desire for people to participate in this program. It is one of many unique programs working to help with the housing crisis in our state.

The NEKCOA has been and continues to be a leader in wellness options throughout the communities. This work has been in existence for over 20 years and a robust network of options such as Arthritis Foundation Exercise Program, Falls Prevention Tai Chi, and several non-evidence-based offerings such as Chair Yoga, Line Dancing, and Golden Ball Tai Chi. This effort results in forty-seven times per week classes are offered throughout the NEK. The VT Dept of Health through a grant has helped to increase the outreach for both volunteer leaders and participants. These programs are all led by volunteer leaders which presents it own challenge in supporting them and further developing programs to meet needs in the far reaches of our region.

Nutrition services continue to be a program that balances needs to providing healthy meals, provides food security for those in need and a safety check. This program runs through a large volunteer contingent and we contract with fourteen sites that comprise both home delivered and congregate meals. The NEK is fortunate to be the initial site for Veggie Van Go, Church meals, and food pantries such as the refrigerator program that offers an anonymous way to secure food at a number of sites without the stigma of needing food.

We face challenges as we continue to be asked to do more with less which has an impact on services and resources limits growth and development. For 6 years we have faced level funding that equates to a reduction in funding when one considers increased cost of living. We have worked tirelessly to streamline our work, be more efficient and at the same time respond to an increased aging population in the state. The nutrition program comprises about 45% of our spending and relies on a contract system with local meal providers who experience increased costs. While global commitments funds have assisted in raising reimbursement rates, the sustainability is a challenge to maintain this higher level of funding.

The Older Americans act relies heavily on volunteer network to support the home delivered meals, community meals, and wellness programs. While this is a cost-effective strategy, the means to keep volunteers in place requires a substantial amount of efforts in the constant cycle of volunteerism. As the cost of living continues to rise, the increased cost needed for many in their own homes becomes burdensome and a challenge to maintain leaving many living in dilapidated housing stock. Poverty has a significant impact with relation to upkeep of housing and resources for repair/replacement are quite limited. Additionally, as the state has focused efforts on the ability to “age in place”, the resources to develop staffing needs falls far short of the need thus leaving people without the full complement of staffing needed to remain in the community.

Good old Yankee pride can also be a hinderance and challenge for those who are facing increased isolation and poverty to reach out for assistance. To this end, we work to use a communication strategy that provides for presentations, postering, social media, newspapers, and radio to get the word out about resources.

Conflict free case management has been both an accomplishment and a challenge for the agency. Being the smallest agency of the area agencies on aging translates to less funding with the same expectations that are needed to meet the standards set forth by the state and federal government. As with any large systemic change, there is an adjustment period

and relationship building to ensure that people are being served using a person-centered approach.

We would be remiss not to mention the challenges brought on by the efforts in Washington to downsize government through elimination of programs and staffing that support them. The amount of news that creates heightened anxiety for those struggling to survive is palpable and causes additional worry on an already complex system. This is not only true for the consumers of services but staff who are repeatedly dealing with consumer anxiety.

Section B: Needs Assessment;

This area plan explores the future needs of Northeast Kingdom residents as we work to support their aging well in our local communities with dignity and respect. To gain perspective, the population of this tri-county region is estimated to have 22% of its residents over the age of 60. Additionally, the fact that we are a large significantly rural section of the state adds to the complexity of need in an area that spans the geographic equivalent of the state of Rhode Island. We also border New Hampshire and Canada which add to the challenges faced by those who live in our region as the inter-collaborative process has been challenging with staffing turnover and thus a need to re-educate those partners outside of our service region.

To help inform us of needs, challenges, and opportunities, we participated in two needs assessments this year.
Community Health Needs Assessment; Our work with our local NEK Prosper accountable health initiative found us seeking to work with community partners in an effort to gain insights without overwhelming the consumer with multiple surveys. The Northeast Kingdom Coordinated CHNA Steering Committee formed in January 2024 and led this inaugural CHNA approach. The participating member organizations include NVRH, North Country Hospital, Northeast Kingdom Human Services, Northern Counties Health Care, Northeast Kingdom Community Action, Northeast Kingdom Council on Aging, and the Vermont Department of Health. Between February and May, extensive secondary data analysis occurred to better inform the issues in our region. While the timing took longer, that was largely driven by the work of the committee coming to clear work ensuring that a relevant and thoughtful approach to secondary data moved us forward in focusing the survey. Primary data collection approaches were developed and a survey developed and implemented between April and August. Final data analysis and development of the HSA-level report occurred between August and September 2024. In addition to further explore elder issues two focus groups occurred during that time. This project yielded close to five hundred surveys.
DAIL Statewide needs assessment;

This needs assessment was conducted via DAIL which helped to inform a more focused and statewide assessment of need around the need of older residents and caregivers. We participated by sending the survey out to participants and caregivers.

The responses from both assessments highlighted the needs being experienced by consumers in our region.

Food Security and nutrition

30% of older adults in the NEK report concerns around food insecurity. Many rely on social supports such as home delivered, congregate meals and community food pantries. Limited access to healthy and affordable food was a finding of the community needs assessment. This was also connected to cost of living and lack of awareness of resources. Transportation in our region is served by RCT and funding is provided through the federal and state government. While we work with RCT, we see a monthly budget from the federal and state funds that often surpassed by requests from riders to medical appointments and grocery shopping(2 times per month). While Medicaid provides transportation, those who do not have Medicaid are constricted to the federal /state funding availability. In our region where there are limited options for food stores this issue is even more concerning. The snap program while a valuable resource is fraught with bureaucracy that for many is untenable and leaves them dropping the program. This occurs as a result of demands of documentation that leaves people making a choice not to participate. We are fortunate to have the resource of the VT Foodbank in their veggie van go program as well as commodity programs. In the NEK a movement to have refrigerators with food in communities began several years ago, which provided an unbiased option for those with food insecurity to access food. In St. Johnsbury, the community has come together to provide free community meals at least 4 nights per week through the local churches. The highlighted need for increasing awareness within our community of resources to address social drivers of health is seen in both assessments. Awareness of 3sqVt, Commodities food program and other resources to meet food scarcity needs was a key component of the findings.

Action Steps for NEKCOA:

- Educate and inform meal sites to produce therapeutic and healthy meals.
- Partner with NEKProsper to focus education to the public around food security resources in the region as well as a public education plan to help inform health benefits of enhanced nutritional choices.
- Explore additional resources to provide transportation options beyond what is currently offered.
- Continue with community partners to engage in a communications strategy to inform the public of resources to meet their needs.

Health and wellness related challenges
Continued challenges by providers in our region to staff professional level doctors, nurses, and other professionals' results in challenges for those attempting to access treatment. The current wait list for a neurology appt with both memory centers (Dartmouth and UVM) is over 4 months and are an hour and a half drive one way. Given the challenges of health care and the provider shortage there are many who end up needing hospitalization due to putting off or not following through with care. This coupled with a workforce shortage for in home care providers results in many struggling to receive care or giving up. This coupled with higher rates of cardiovascular disease, diabetes, COPD and obesity in our region make this a significant issue.

NEKCOA action steps;

- Expand the use of team-based care to develop a collaborative approach to the client needs helping to reduce obstacles.
- Increase public awareness campaign around health and well-being topics to better inform of services and resources such as wellness classes.
- Further develop the use of OCHA for a more informed ability to respond to changing needs of clients.

Access to care and affordability in the areas of mental health and dental care were also highlighted as needs to be addressed.

Action steps for NEKCOA

- Develop material to disseminate of resources for both mental health and dental care to better inform of options available.
- Advocate for increased services around mental health as the Eldercare Clinician program is underfunded.
- Advocate for improved access to dental services in the region.

Transportation as shared above is an issue for those seeking treatment and shopping. Given the limited funding through the state/federal system it is disheartening that we do not have resources to help support those seeking to lessen social isolation by participating in community activities. We are inspired by the 'on demand' service developing for those in specific areas and hope that it will be further developed to expand beyond the more densely populated area of Newport where it is being piloted.

Action steps for NEKCOA

- Advocacy to focus on informing legislature regarding needs to increase this resource through use of options such as the on-demand service.
- Explore volunteer opportunities with RCT to increase number of volunteer drivers available wareness of resources is another focus area.

Caregiving support; Increased demand on families and communities to provide support for those living at home creates quite a challenge, especially as caregivers have limited

options for care. With significant care needs of a growing population of people experiencing dementia/Alzheimer's this creates a challenge in efforts to both educate and support caregivers. 53% of those responding provided care for more than 4 years. 70% of caregivers were above age 60. The limited respite program has constraints that occur due to income limits, limited assistance, and limited options for caregiving support by trained individuals.

Action steps for NEKCOA

- We will develop a comprehensive communications plan to raise awareness of services and resources in the community to raise an inclusive awareness that meets the needs of those of greatest need.
- We will continue to increase awareness of Trualta and as a strategy to help inform of options for self-care and caregiving learning/problem solving in the caregiving role.
- Continue to expand the volunteer respite program as an alternate source of caregiver support.

Limited broadband and the cost of this is a challenge for those seeking to use internet as a means of connecting with others, learning new things, and accessing services in general. Through an MFP pilot program we have developed a model using volunteers that has been successful in supporting this, however it does not provide for financial support to pay for internet services. The increased challenges faced by elders with the manipulation of information, pressured phone calls, and relentless false advertising raise another challenge for older residents is concerning.

Action steps for NEKCOA

- Explore means to continue pilot Tech for today program.
- Explore funding options to support broadband access as a grant that was a collaborative effort of community action agencies and AAA's was cancelled by the federal government.
- Promote information on safe use of computers and cell phones using public outreach tools.
- Inform public of scams to reduce the number of people falling for them by increasing awareness of the state's attorney information on current scams.

A**ccess to services;** In both needs assessments not knowing where to turn for assistance or resources was a barrier which then limits people's ability to access benefit programs.

Action steps for NEKCOA

- Develop a communications strategy plan to better inform of the helpline and options at the community level for assistance through our focal points. This plan will include multiple avenues of communication.

Housing; lack of affordable options leads to many older residents being forced to remain in homes that need routine maintenance often left deferred due to income/resources. We continue to see a significant wait list for those seeking alternatives.

Action steps for NEKCOA;

- Develop HomeShare VT in the NEK region to raise another option for those facing the housing crisis.
- Participate in community activities to further develop housing resources in our region through advocacy and raised awareness of needs.

Section C; Community Focal Points;

We continue to see the need for a multi-faceted approach to informing the public of resources and options for aging well in their communities. While we work with focal points in our region, the limited resources and stagnant funding result in smaller meal sites that are not able to provide full service. We provide presentations to each meal partner and to other outside community groups as requested. As the Older Americans Act emerged long before computers and 800 numbers, we work to ensure that we are meeting the needs through a collaborative effort. Our helpline continues to manage calls for those seeking the privacy of a phone conversation or in person meeting place at their convenience (for some that is in our office). Limited meal options in parts of our region requires us to expand our outreach to town offices, community led meals, and other community focused opportunities to share information. Additionally, we find a need to be where people go and have worked to be a presence within the health care entities in our region. A collaboration with Northern Counties healthcare provides us with an opportunity to work in their offices in both Hardwick and Island Pond which are a distance from our offices. From the success of those efforts, we've been invited to now provide staffing for the Concord and Danville Health Centers to meet with clients, consult on team-based care and collaborate with care coordinators. Additionally, we've found that tabling at public events and presentations to community groups also serve to disseminate information regarding service options. We have a staff member present at each of the 4 sites once per week to meet with clients, consult with care team members, or participate in team-based care conferencing.

Focal Point Name: **Northern Counties Health Care: Concord Health Center**
Focal Point Address: **201 E Main St, Concord, VT 05824**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? **We staff the site 1 full day per week.**

OAA Programs	Non-OAA Programs
Information and Referral Care Coordination	

Options Counseling Health Insurance Support	

Focal Point Name: **Northern Counties Health Care: Hardwick Area Health Center**
Focal Point Address: **4 Slapp HI, Hardwick, VT 05843**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? **We staff the site 1 full day per week.**

OAA Programs	Non-OAA Programs
Information and Referral Care Coordination Options Counseling Health Insurance Support	

Focal Point Name: **Northern Counties Health Care: Island Pond Health & Dental Center**
Focal Point Address: **82 Maple St, Island Pond, VT 05846**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? **We staff the Site 1 full day per week.**

OAA Programs	Non-OAA Programs
Information Referral Care Coordination Options Counseling Health Insurance Support	

Focal Point Name: **Northern Counties Health Care: Danville Health Center**
Focal Point Address: **26 Cedar Ln, Danville, VT 0528**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? **We staff the site 1 full day per week.**

OAA Programs	Non-OAA Programs
Information Referral Care Coordination Options Counseling Health Insurance Support	

Focal Point Name: **Lyndon Area Senior Meal Center**
Focal Point Address: **76 Depot St. Lyndonville, 05851**
Key Agency Staff at the Focal Point: **Cindy Santaw- Brown**
Key Staff Contact Information: **802-626-8700**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? We provide information that is distributed at the site and do presentations on services 2 times during the year and additional times when requested. Brochures and material are present at the site and site staff are trained in the referral process

OAA Programs	Non-OAA Programs
Congo meals HDM presentations	Bingo Music Blood Pressure checks

Focal Point Name: **Good Living Senior Center**
Focal Point Address: **1207 Main St. St. Johnsbury, VT 05819**
Key Agency Staff at the Focal Point: **Vicki Giella (board chair)**
Key Staff Contact Information: **802-748-8470**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? All wellness program leads are trained in referral process and how to contact I&R. We additionally provide presentations on our services as requested.

OAA Programs	Non-OAA Programs
AFEP classes Bone Builder classes Presentations	Music Bingo Golden Ball Tai Chi Game days with local schools

Focal Point Name: **St. Johnsbury Nutritional Center**
Focal Point Address: **St. J House 1207 Main St. St. Johnsbury, VT 05819**
Key Agency Staff at the Focal Point: **Diane Coburn, Manager**
Key Staff Contact Information: **802-748-5467**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request.

OAA Programs	Non-OAA Programs
HDM presentations Congo meals	

Focal Point Name: **South Rygate Senior Meals**
Focal Point Address: **Church St., South Rygate, VT**
Key Agency Staff at the Focal Point: **Mary Lou Boyce**
Key Staff Contact Information: **802-584-3727**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request.

OAA Programs	Non-OAA Programs

Congo meals HDM presentations	Music

Focal Point Name: **W. Barnet Senior Meal Site**
Focal Point Address: **W. Barnet Presbyterian Church. W. Main St, W. Barnet, VT 05821**
Key Agency Staff at the Focal Point: **Jean Warner, Manager.**
Key Staff Contact Information: **802-748-2565**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process

OAA Programs	Non-OAA Programs
Congo Meals HDM Presentation	Music

Focal Point Name: **Burke Senior Meal Program**
Focal Point Address: **Community Building. 212 School St. W. Burke, VT 05871**
Key Agency Staff at the Focal Point: **Wendy Bean, SM. Lynn Welch, Board Chair.**
Key Staff Contact Information: **802-467-3423**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.

OAA Programs	Non-OAA Programs
Congo meals HDM presentations	Music Line dancing Wii Bowling cards

Essex:
Focal Point Name: **Lunenburg, Gilman & Concord Sr. Center.**
Focal Point Address: **19 Parrish St**. **Gilman, VT 05904**
Key Agency Staff at the Focal Point: **Pam Kathan, SM. Sharon Eaton, Board Pres.**
Key Staff Contact Information: **802-892-5300**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.

OAA Programs	Non-OAA Programs

Congo meals HDM presentations	Bingo Book club

Focal Point Name: **Island Pond Community Services**
Focal Point Address: **Sunrise Senior Housing. 94 main St., Island Pond, VT 05846**
Key Agency Staff at the Focal Point: **Melinda Gervais- Lamoureux, Manager.**
Key Staff Contact Information: **082-723-6130**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.

OAA Programs	Non-OAA Programs
Congo meals HDM wellness classes Presentations	Music Cards Bingo Crafts

Orleans:
Focal Point Name: **Barton Areas Sr. Sys(BASSI) and Glover Senior Meals**
Focal Point Address: **Old Town Hall. Rte. 16, Glover, VT 05839**
Key Agency Staff at the Focal Point: **Patsy Tompkins**
Key Staff Contact Information: **802-334-6029**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.

OAA Programs	Non-OAA Programs
Congo meals HDM meals	Music Cards Bingo Crafts

Focal Point Name: **Newport Senior Center Forever Young Club**
Focal Point Address: **222 Main St. Newport, VT 05855**
Key Agency Staff at the Focal Point: **Ethel Searles**
Key Staff Contact Information: **082-334-6029**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point? Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.

OAA Programs	Non-OAA Programs
Wellness classes	Drop in center Bingo Intergenerational activities Cards Hot meals

Section D; Goals Section in RBA report card format;

Goal 1; **Information and referral services to improve, expand, and innovate outreach to the community will be a focus to disseminate information more effectively.**

Headline Performance measure; # of consumers contacting the helpline as a result of increased outreach efforts. Baseline to be developed in first year of plan.

Headline Performance measure; 80% of those surveyed after a helpline interaction will report increased awareness of options available to them.

Story behind the Curve: Having access to information that supports consumers connecting with resources, services and supports is essential in helping to ensure aging in place. Through the needs assessment process, the need for access to information and unbiased assistance is a significant need. As people learn and explore options, the need to learn of all available resources realizes the need for community collaboration to inform the public of resources, services and supports.

What works: social media, newspaper articles, and newsletters help to inform options for gaining access and information for services needed. Coordinated information shared with community partners for their own publications.

Partners; Community partners such as accountable care networks we participate in will ensure that we can develop a coordinated effort to inform.

Action plan; Increase awareness of the helpline and options counseling to help people be aware of resources. Through this we will increase our efforts year over year.

Goal/Outcome 2; Title III-B: Case Management

Who does the program serve? This program serves individuals who need case management assistance to ensure success in fulfilling their person-centered planning goals.

What does this program do? Works with the individual to develop a plan for aging in place and take actions to support the client in achieving their goals. This is done through a collaborative process of advocacy, assessment, planning and action.

Person Centered Planning Common Goal: OAA Case management clients will report health related social need (HRSN) improvements related to at least one social/health related goal in their person-centered plan.

Headline Performance Measures:

- % of clients who establish at least one social/health related goal on their person-centered plan.
- % of clients who *achieve* at least one social/health related goal on their person-centered plan. Establish stretch targets in Years 2 and 3 compared to baseline in year 1.
- # of clients reporting received support to address their goals.

Story behind the curve: Case management should focus on person-centered goals, ensuring that clients' choices and preferences are at the core of the care process. Clients should be fully informed about all available care options, enabling them to make empowered decisions that align with their values and goals. Supporting clients in maintaining control over their health decisions is crucial to helping them remain engaged. As individuals' needs change, navigating the complexities of care can become more challenging. Case managers must work closely with clients to assess their evolving needs and provide support, all while respecting the client's goals and maintaining their autonomy. Building and nurturing a strong, trusting relationship between case managers and clients is vital to ensure that care is tailored to meet the individual's unique needs, ultimately improving their quality of life.

What works; The person-centered planning process involves a degree of skill on the part of the Case Manager to synthesize the information into a meaningful document that can be the foundation of the work of the team of care.

Partners: We are working with community partners to establish team-based care approach to reduce redundancy of services and efficiently meet the client's needs most effectively based on their goals.

Action Plan: Train staff to increase the comfort and assistance in developing meaningful plans with clients. Ensure that the team-based care approach works to disseminate coordinated information and supports to help the client attain their goals.

Goal 3; Title III-C Nutrition: Home Delivered Meals

Goal/Outcome: Clients receiving HDM medically tailored/therapeutic meals will report an improvement in their health condition for which the medically tailored /therapeutic meals address.

Who does the program serve; The hdm program serves those who meet the stated criteria to receive home delivered meals. Any person is eligible who is age 60 or over and is **unable** to obtain or prepare meals on a temporary or permanent basis due to a physical, mental, or cognitive condition that requires assistance to leave home.

What does the program do: Provides 1/3 of the daily rda for clients in their home and a safety check completed by the meal's driver.

Performance Measures:

- # of clients receiving medically tailored/therapeutic meals.
- % of clients who report they have benefited from these meals. Establish stretch goals in Years 2 and 3.
- # of sites that demonstrate improved menu focus on healthy options

Story behind the curve: Approximately 75% of American's dietary intake is insufficient in fruits, vegetables, and dairy. Furthermore, 63% of Americans exceed the recommended limit for added sugars, 77% surpass the limit for saturated fats, and 90% exceed the Chronic Disease Reduction limits for sodium intake. Additionally, 6 in 10 Americans are living with one or more diet-related chronic diseases, and while many Americans express a desire to improve their diet, many lack the knowledge to do so. Factors such as diminished appetite, a reduced sense of taste and smell, difficulty chewing or swallowing, and mobility loss contribute significantly to malnutrition in older adults. For many seniors, the issue is not overeating but failing to consume sufficient nutrients at a time when proper nutrition is more crucial than ever. A growing body of research supports the positive impact of home-delivered meals on the health and well-being of homebound older adults. This research serves as the foundation for exploring specialized interventions designed to address the unique medical and nutritional needs of individuals living with chronic illnesses, regardless of age—known as therapeutic meal options. Our goal is to expand our therapeutic meal offerings to continue supporting clients with chronic illnesses. Research has shown that such meals can help individuals with current medical conditions maintain or even improve their health. Additionally, that expansion requires us to increase awareness of healthy options for meal sites in terms of meal preparation/offerings.

What works; Teaching people that there are healthier options available to assist with their ability to manage their health and wellbeing.

Partners; We will work with all meal providers, our RD and staff to increase awareness and options to improve hdm's.

Action Plan; We will develop trainings for meal sites as well as educational materials that support healthier diet choices through our monthly hdm newsletter. Through measurement of the rba goals we will re evaluate and adjust our strategy to improve successful outcomes.

Goal 4; Goal/Outcome: Improved wellness program impact on health and wellbeing

Increased Percentage of OAA Health Promotion Program participants that join, complete an evidence-based wellness program and set a measurable goal.

Program: Title III-D Health Promotion and Disease Prevention

WHAT do the programs do? The benefits of wellness programs include social and physical health which have a positive impact in reducing the likelihood of falls, increasing balance and strength while supporting the ability to maintain the participant's independence and social health.

WHO does the program serve? Community members (60+) who want to participate in evidence-based wellness programs:

Headline Performance measures;

- Total # of clients who participate annually in Health Promotion evidence-based programming.
- # of clients that set a measurable goal.
- Target 5-10% increase in client participation year over year.

Story behind the curve: While a number of OAA clients have expressed interest in, and do participate in evidence-based programs, a gap remains in terms of increasing engagement, program completion, and specific goal setting. Many clients start the programs but do not finish, and fewer still set measurable goals that are tracked over time. Several factors may contribute to this, including limited awareness of available programs, difficulty in accessing resources, and, for some, a lack of motivation or understanding of how to set

achievable health and wellness goals. There may also be an underlying issue of inconsistent communication with participants regarding program benefits, as well as barriers like transportation challenges, cognitive limitations, and a lack of confidence in using technology for virtual program participation.

What works; offering free accessible classes to those who choose to participate. Increased advertising the benefits and options also helps people to understand what options are available.

Partners; Volunteer leaders and participants are the best word of mouth advocates to share with the community the benefits. Additionally we will promote the classes through distribution of schedules and highlighting the benefits of classes available through community partners.

Action plan; We will work with the participants and program to establish goals through an initial survey of people as they begin the program. Additionally, we will work to increase awareness of this community resource option through outreach and advertising both with community partners and the public at large.

Goal 5; Program: Title III-E National Family Caregiver Supports

Who does the program serve: Any caregiver in the NEK who requests support, resources and education around caregiving.

What does the program do? provides a meaningful opportunity to focus on wellness and socialization with peers.

Goal/Outcome: Unpaid Caregivers will have improved access to information, support and services.

Headline Performance Measures:

- # of caregivers who access information and resources as evaluated by internal tracking systems/database including TCARE. Establish stretch targets in Years 2 and 3 compared to baseline in Year 1.
- # of public engagement /outreach activities provided to the public that contain information and resources available to caregivers. Establish stretch targets in Years 2 and 3 compared to baseline in Year 1.

Story behind the curve: National data indicates that many caregivers face challenges in accessing information, support, and services. Approximately 39.8 million Americans, or 16.6% of the population, provide care to adults with disabilities or illnesses as reported by the Alzheimer's Association. While caregivers provide invaluable support to older adults and individuals with disabilities, many report challenges in accessing the information, resources, and services they need to effectively care for their loved ones. Feedback from caregivers indicates a gap in available resources, insufficient guidance on available services, and difficulty navigating complex systems of care. As a result, caregivers may feel overwhelmed, unsupported, and unsure of where to turn for assistance. By addressing the barriers caregivers face in accessing necessary information and support, we aim to empower caregivers with the tools and resources they need to provide high-quality care while reducing their stress and isolation. This will improve the caregiver's well-being and enhance the care they can provide for their loved ones.

What works: Continued communication to community partners and individuals allows for the promotion of discussions and resources. We believe that access and increased awareness to this valuable resource helps achieve the ability to participate and benefit from wellness classes. We believe that increased communication of these programs will increase participation /awareness of resources available.

Partners; Direct work with community partners(hospitals, doctors, home health, mental health) to increase awareness of this option is key to expanding the use of these programs.

Action plan; We will increase the work with participants to mindfully set goals and achieve positive results.

Goal 6: Program; Title VII: Prevention of Elder Abuse, Neglect and Exploitation.

Who does the program serve? Anyone over 60 who may be exposed to or aware of abuse, neglect and exploitation.

What does the program do; by providing education and awareness community members become empowered to say something if they see something going on that appears abusive, neglectful or exploitive.

Goal/outcome; Education and information reduce the incidence of elder abuse, neglect and exploitation to the community at large deters these situations.

Headline performance measures;

# of public service information announcements to combat abuse, neglect and exploitation to create a baseline for increasing the campaign as the second and third year move forward.

# of people outreach provided to informing of the need for prevention of abuse, neglect and exploitation.

Story behind the curve; Abuse, neglect and exploitation are often the hidden challenges that elders face. The vulnerability of those seeking to meet their needs at times puts people in compromising situations that leave them exposed to one of these vulnerabilities. Given the focus on aging in place, along with economic challenges, and poverty leave many highly susceptible to these challenges. By addressing the need for information to alert communities of signs of these situations allowing intervention to occur that is both timely and sensitive to the unique situation. At times the lack of desire to report or awareness of rights impacts the ability of the elder to protect themselves from such atrocities. Education to improve awareness of options and resources is key to creating a community response of intolerance to such behaviors towards elders.

What works: Public facing information campaigns raise awareness of behaviors/situations that may indicate abuse, neglect or exploitation.

Partners; We will use social media, outward facing communications and news media outlets to call attention to these serious infractions that can occur to elders.

Action plan; A targeted media campaign to run on a regular basis raising awareness of these situations. We will use an approach that promotes awareness during public presentations to focal points, social media, newsletters, and web site to inform and have available information through this campaign. We will use the US Dept of Justice elder abuse materials as part of the campaign in addition to WEADD materials also provided on the topic.