Priority Area (Please choose from drop down)	Reliable transportation
Goal #1	Expand and strengthen rural transportation access so older adults can reach medical care, nutrition sites, essential errands, and community activities across the 8-county PSA.
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	Transportation was the most frequently identified service need in the assessment, and survey comments emphasized barriers related to availability, reliability, timing, accessibility, cost, short-notice trips, evening/weekend service, wheelchair-accessible vehicles, and cross-county travel. In a dispersed rural PSA with older populations, lower incomes, and long travel distances to specialists and services, improving transportation is essential to reaching older adults with the greatest social and economic need.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Identify transportation gaps by county and trip purpose using survey findings, provider input and consumer referral data	Jan 2027- April 2027	OAA Title III B, local coordination	Planning staff; Mobility Managers, Program Managers, Intake and Referral Specialists, Communications	Convene county-level partners, review referrals, denials/waitlists and any gaps for essential trips.	Analysis completed for the 8 county region and partner list finalized.
Increased access to coordinated transportation and mobility options for older adults with emphasis on medical and nutrition trips.	May 2027- Dec 2027	OAA Title III B, contracted transportation; mobility management; local focal points	Mobility Managers; Provider Network; Focal Point Staff; Information and Assistance Specialists	Coordinate with local transit partners; volunteers drivers; senior transportation partners.	Increase in completed ride referrals; documented partner coordination activities.
Improve public awareness of transportation resources and how to request rides.	April 2027-Dec 2027	Outreach/education; OAA Title III-B; partner-supported communications	Outreach staff; Information & Assistance staff; Mobility Managers; Local Focal Points	Develop simple county-specific transportation information, distribute through senior centers, healthcare providers, caregivers, and community partners, and include telephone-based assistance for those without internet access.	Transportation resource materials distributed in all counties; increase in inquiries/referrals; consumer feedback shows improved understanding of options.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Barriers may include driver shortages, provider capacity limits, funding constraints, long travel distances, and limited evening/weekend service. AAA will mitigate these issues through early partner coordination, phased implementation, use of mobility management, targeted outreach to highest-need areas, and routine monitoring of denials, missed trips, and emerging service gaps.
Expected outcome(s) of this goal:	Older adults, including those in rural and low-income households, will have better access to rides for healthcare, meals, and essential errands; improved knowledge of transportation options; and fewer transportation-related barriers to remaining independent in the community.

Priority Area (Please choose from drop down)	Safe and accessible housing
Goal #2	Support older adults in maintaining safe, affordable, and accessible homes through stronger referral pathways, home safety interventions, and coordination around repairs and modifications.
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The assessment identified housing costs, utilities, property taxes, home repairs, and accessibility improvements as leading concerns. Home repairs/modifications were also among the most common service access barriers. Many respondents live alone, increasing risk when homes are unsafe or difficult to maintain. A first-year housing goal aligns with the needs assessment and helps target older adults with the greatest social and economic need who may be at risk of falls, displacement, or premature institutional care.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Refresh a regional referral network for home repair, accessibility modification, and housing-related assistance.	Jan 2027- April 2027	Planning; Ohio Housing Trust Fund; ARC; partner coordination; OAA Title III-B supportive services where allowable	Housing Coordination Staff; Information & Assistance staff	Formalize referral contacts with community action agencies, housing partners, local governments, and nonprofit repair resources in each county.	Updated housing/resource directory completed; referral pathways documented for all 8 counties.
Expand home safety and fall-risk reduction activities for older adults at highest risk.	March 2027- Dec 2027	OAA Title III-B; evidence-based health promotion/falls prevention; partner programs	Program staff; Information and Assistance Specialists; Community Partners, Housing Coordination Staff	Promote home safety assessments, falls prevention programming, and in-home safety modification referrals through senior centers, hospitals, discharge planners, and community providers.	Increase in home safety referrals and falls prevention participation; consumers report improved safety or confidence remaining at home.

Improve access to housing-related benefits and problem-solving support for financially vulnerable older adults	May 2027-Dec 2027	Improve access to housing-related benefits and problem-solving support for financially vulnerable older adults.	Information and Assistance Specialists; Community Health Worker	Integrate screening/referral for utility assistance, benefits enrollment, and housing counseling into outreach and case contacts.	Increase in completed referrals/applications; documented assistance to low-income older adults with housing-related need
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Key challenges include limited housing stock, scarce contractors in rural counties, long wait times for repairs, and restricted flexible funding for major modifications. AAA will mitigate these barriers by strengthening cross-sector referral relationships, prioritizing lower-cost safety interventions first, coordinating with community action and housing partners, and tracking unresolved cases to inform future resource development.				
Expected outcome(s) of this goal:	More older adults will receive timely referrals and support for repairs, modifications, fall prevention, and housing-related benefits, helping them remain safely housed and reducing risks associated with unsafe home conditions.				

Priority Area (Please choose from drop down)	Community supports and services
Goal #3	Improve access to community-based supports, benefits information, nutrition, and in-home assistance through stronger outreach, screening, and service navigation across the PSA.
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The assessment found high demand for homemaker assistance, benefits counseling, home-delivered meals, congregate meals, legal assistance, and clearer information about what services exist and how to access them. Barriers included cost, provider shortages, lack of information, complex paperwork, and uncertainty about eligibility, while broadband limitations also affect access. Strengthening navigation and outreach in year one is a practical system-level strategy that can improve access across multiple need areas.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Standardize outreach and referral messaging on key aging services in accessible formats across the 8 counties.	Jan 2027- May 2027	Outreach/education; OAA Title III-B; partner-supported communications	Outreach staff; Information & Assistance staff; Communications Staff	Create plain-language print, phone, and digital materials covering transportation, meals, in-home help, benefits counseling, caregiver supports, and how to enter the aging services system.	Core outreach package completed and deployed region-wide; partner distribution network established

Increase screening, information and assistance, and benefits navigation for older adults with the greatest social and economic need.	Feb 2027- Dec 2027	OAA Title III-A, B, D, E; information & assistance; benefits counseling	Information & Assistance staff; Case Managers; Community Health Workers	Use telephone, in-person, and partner-based screening to identify needs related to meals, in-home help, caregiver strain, legal services, and benefits; prioritize rural, low-income, isolated, and homebound older adults.	Increase in screened consumers, referrals, and benefits assistance contacts; tracking shows reach into high-need counties/populations.
Strengthen connections to nutrition and in-home support services for consumers with identified unmet needs.	May 2027- Dec 2027	OAA Title III-C and III-B; provider coordination	Nutrition staff; Community Health Worker; Provider Network staff; Assessment Staff, Information and Asisstance Specialist	Coordinate with meal providers, senior centers, homemaker providers, and community partners to reduce missed connections, improve follow-up, and address wait lists or service handoffs where possible.	Increase in successful service linkages to meals and in-home supports; reduced unresolved referrals; consumer follow-up indicates improved access.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include limited provider workforce, uneven broadband access, confusion about eligibility rules, and difficulty reaching isolated older adults. AAA will mitigate these issues through multi-channel outreach that does not rely solely on internet access, stronger partner referral networks, warm handoffs for high-need consumers, and regular review of referral outcomes and service gaps.				
Expected outcome(s) of this goal:	Older adults and caregivers will have clearer pathways into the aging services network, improved awareness of available supports, and better access to meals, benefits counseling, in-home services, and other core supports needed to age safely in place.				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #1	Strengthen coordinated health access and launch a community-based navigation approach that helps older adults obtain care earlier and remain in the community with less reliance on				
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The assessment identified chronic health conditions, access to medical care and specialists, transportation barriers, paperwork complexity, and limited awareness of services as major concerns. Respondents also described difficulty connecting to in-home help, benefits, and practical supports that affect health outcomes. A coordinated healthcare goal in year two builds on year one access work and supports the desired future state of improving access through new pathways such as community health worker or non-waiver case management approaches.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Design and launch a non-waiver community-based navigation or case management pilot for older adults with rising support needs.	Jan 2028- Dec 2028	OAA Title III-B supportive services; ADRC/I&R; partner-supported care coordination; hospital/community partnerships	Program Managers; Community Health Worker; Information and Assistance Specialists; Assessment Staff; Hospital Liaison	Define pilot scope, referral criteria, documentation standards, follow-up expectations, and non-duplication safeguards; begin pilot referrals with healthcare and community partners.	Pilot model approved and operational; number of pilot participants enrolled; referral completion and follow-up tracked.
Strengthen coordination between healthcare providers, discharge planners, AAA programs, and community partners for high-risk older adults.	Feb 2028- Dec 2028	Partner coordination; OAA Title III-B; local system collaboration	Program staff; Hospital Liaison; Information & Assistance staff; Community Partners	Develop shared referral contacts, warm handoff protocols, and regular coordination meetings focused on older adults with repeated access barriers or complex support needs.	Number of partner coordination activities completed; increase in successful healthcare-related referrals; reduction in unresolved high-risk referrals.
chronic disease, falls	March 2028- Dec 2028	programs	Senior Center staff; Community Health	and connect consumers to available	participation or
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include provider capacity constraints, difficulty coordinating across systems, uncertainty about scope for a non-waiver model, and transportation barriers that still limit care access. AAA will mitigate these barriers through pilot design before scale-up, written partner workflows, targeted use of community health worker functions, and routine monitoring of unresolved referrals and service gaps.				
Expected outcome(s) of this goal:	Older adults with emerging health and functional needs will experience stronger care coordination, earlier connection to community supports, and improved ability to remain safely in the community.				

Priority Area (Please choose from drop down)	Caregiver supports

Goal #2	Improve support for family and informal caregivers through earlier identification, stronger referral pathways, and better access to education, respite information, and problem-solving				
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The assessment found that caregiving needs are an important concern for households across the PSA, including some respondents under age 60. Caregiver strain is closely tied to whether older adults can remain at home safely, especially in rural communities with workforce shortages and limited formal supports. A year two caregiver goal aligns with the need to stabilize households before crises lead to institutional placement.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Expand caregiver screening and identification through intake, outreach, and partner referral processes.	Jan 2028- June 2028	OAA Title III-E; outreach and information & assistance	Non Waiver Case Management Program staff; Information & Assistance staff; Outreach staff; Community Health Worker	Add caregiver-related screening questions to routine contacts and educate partners on when and how to refer caregivers for support.	Updated screening process implemented; increase in identified caregivers and caregiver-related referrals.
Increase caregiver awareness of respite, education, support groups, and disease-specific resources.	March 2028- Dec 2028	OAA Title III-E; caregiver outreach/education; partner-supported activities	Non Waiver Case Management Program staff; Outreach staff; Senior Center staff; Community Partners	Provide printed, digital, and partner-distributed caregiver information; coordinate educational sessions and outreach through healthcare and community sites.	Number of caregiver education/outreach activities completed; number of caregiver contacts or referrals documented.
through for caregivers	May 2028- Dec 2028	coordination	staff; Case Managers;	caregivers connected to high-risk	caregiver referrals and
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include caregiver time constraints, limited respite capacity, stigma or reluctance to seek help, and uneven awareness of available supports. AAA will mitigate these barriers through flexible outreach channels, trusted partner engagement, simple referral pathways, and follow-up for caregivers with high levels of stress or burden.				
Expected outcome(s) of this goal:	Caregivers will have better awareness of available supports, earlier access to assistance, and stronger connections to services that help them continue caring for older adults in the community.				

Priority Area (Please choose from drop down)	Healthy food access
Goal #3	Improve access to meal and nutrition supports for older adults facing food affordability, isolation, transportation, or functional barriers.

Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The assessment found that food affordability is a recurring concern and that home-delivered meals and congregate meals are among the services most often identified as needed. Nutrition access is affected by transportation, income, rural distance, and awareness of available services. A year two nutrition goal supports both health and community stability for high-need older adults.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Strengthen screening and referral for nutrition risk, food insecurity, and meal access barriers.	Jan 2028- May 2028	OAA Title III-C; information & assistance; nutrition coordination	Nutrition staff; Information & Assistance staff; Outreach staff	Integrate food access questions into outreach, intake, and follow-up contacts and route identified needs to meal providers or partner resources.	Nutrition screening approach updated; increase in meal-related referrals or screenings completed.
Improve coordination with meal providers and community partners to reduce missed connections and clarify access pathways.	Feb 2028- Dec 2028	OAA Title III-C; provider coordination; partner-supported nutrition access	Nutrition staff; Provider Network staff; Senior Center staff; Community Partners	Review referral handoffs, wait list issues, service area gaps, and consumer communication practices with providers and partner sites.	Number of coordination actions completed; improved documentation of successful meal service linkages.
nutrition supports to	April 2028- Dec 2028	partner communications	Community Health Worker; Senior Center	health providers, and partner	completed in all

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include provider capacity, long rural routes, volunteer shortages, and limited consumer awareness. AAA will mitigate these barriers by improving referral coordination, prioritizing high-need households, using multiple outreach channels, and reviewing gaps with providers during the year.
Expected outcome(s) of this goal:	Older adults with nutrition-related needs will have clearer access pathways to meal services and related supports, helping reduce food insecurity and support aging in place.

Priority Area (Please choose from drop down)	Financial well-being				
Goal #1	Improve access to benefits, legal, and financial stabilization resources that help older adults remain safely housed and economically secure in the community.				
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The assessment identified housing costs, utilities, property taxes, and food affordability as major concerns, and benefits counseling and legal assistance were among the services most often identified as needed. Cost, paperwork complexity, and uncertainty about eligibility were also common barriers. A financial well-being goal in year three helps address the economic pressures that can quickly destabilize older adults in rural southeast Ohio.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Expand screening and referral for benefits, utility assistance, and cost-relief supports for older adults with financial strain.	Jan 2029- Dec 2029	OAA Title III-B; benefits counseling; information & assistance; partner coordination	; Information & Assistance staff; Community Health Worker; Outreach staff	Use outreach, intake, and navigation contacts to identify financial stress related to utilities, housing, food, and other essential needs and connect consumers to appropriate assistance.	Increase in benefits or financial assistance referrals; documented outreach to financially vulnerable older adults.
Strengthen connections to legal assistance and problem-solving support for older adults facing housing, consumer, or benefits-related issues.	Feb 2029- Dec 2029	Legal assistance coordination; OAA Title III-B; partner referrals	Information & Assistance staff; ; Legal partner contacts; Community Partners	Maintain updated referral pathways and coordinated handoffs to legal and advocacy resources where available.	Number of legal assistance referrals documented; updated legal resource network maintained.
awareness of benefits	March 2029- Dec 2029	communications	Local Focal Points	and distribute them through trusted	materials distributed;
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include complex eligibility rules, changing program requirements, limited legal capacity, and difficulty reaching households before problems worsen. AAA will mitigate these barriers through staff training, plain-language materials, warm referrals, and routine review of unresolved financial assistance needs.				
Expected outcome(s) of this goal:	Older adults will have improved access to benefits counseling, legal referrals, and other supports that reduce financial strain and help them remain in their homes and communities.				

Priority Area (Please choose from drop down)	Reliable transportation				
Goal #2	Build on prior transportation improvements by targeting persistent county-level gaps and strengthening access for high-need trips and harder-to-serve rural areas.				
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	Transportation remained one of the strongest themes in the needs assessment and affects whether older adults can access healthcare, food, services, and social connection. After initial year one improvements, year three should focus on counties and trip types where barriers remain most severe, especially for medical care and essential errands.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Use year one and year two data to identify unresolved transportation barriers by county, trip type, and consumer need.	Jan 2029- April 2029	OAA Title III-B; mobility management; planning and analysis	Mobility Managers; Planning staff; Information & Assistance staff	Review denials, missed trips, unresolved referrals, partner input, and consumer feedback to identify the highest-priority transportation gaps.	Updated transportation gap analysis completed; priority issues identified for targeted action.
Implement targeted coordination improvements in counties or trip categories with the greatest unmet need.	May 2029- Dec 2029	OAA Title III-B; contracted transportation; partner coordination	Mobility Managers; Provider Network; Local Focal Points; Community Partners	Work with transportation providers and community partners to address access barriers such as cross-county trips, wheelchair accessibility, or medical appointment scheduling issues.	Documented targeted improvements completed; increase in successful ride connections in focus areas.
transportation	June 2029- Dec 2029	partner-supported communications	staff; Mobility Manager	and provide partner training on	distributed; partner
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include sustained driver shortages, provider turnover, high trip costs, and continued rural distance barriers. AAA will mitigate these issues through targeted rather than diffuse interventions, practical coordination with existing providers, updated public information, and continued monitoring of unmet trip needs.				
Expected outcome(s) of this goal:	Older adults in focus counties or higher-need situations will experience better transportation access and fewer unresolved barriers to essential trips.				

Priority Area (Please choose from drop down)	Community supports and services
Goal #3	Scale and refine community-based service coordination and navigation so older adults can more consistently connect to practical supports before needs escalate.

Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	Year one and year two activities are intended to strengthen referral pathways and test more coordinated navigation approaches. By year three, the region should use what it has learned to improve follow-through, reduce unresolved referrals, and expand practical service coordination for older adults with multiple barriers.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Evaluate and refine the community-based navigation or service coordination model based on prior implementation experience.	Jan 2029- June 2029	ADRC/I&R; OAA Title III-B; local coordination	Program Managers; Community Health Worker; Assessment Staff; Information & Assistance staff	Review participant outcomes, referral completion, staffing impacts, and partner feedback to determine what should be continued, changed, or expanded.	Evaluation completed; refinement recommendations documented and adopted where feasible.
Expand coordinated navigation or warm handoff processes to additional high-need populations, partners, or counties as capacity allows.	July 2029- Dec 2029	OAA Title III-B; partner-supported care coordination; local system collaboration	Program staff; Community Health Worker; Partner Liaisons; Information & Assistance staff	Use phased expansion tied to operational capacity and focus on older adults with multiple barriers to meals, in-home help, benefits, or healthcare access.	Number of new partners/counties/populations included; increase in successful service linkages.
tracking of unresolved	Jan 2029- Dec 2029	planning; ADRC/I&R	Information & Assistance staff	quarterly reviews to identify patterns	produced; unresolved

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include staff workload, inconsistent partner participation, and difficulty sustaining follow-up across a large rural region. AAA will mitigate these barriers by focusing on the highest-value coordination activities, clarifying partner roles, and review to adjust workflow as needed.
Expected outcome(s) of this goal:	Older adults and caregivers will experience more consistent service navigation, improved follow-through, and stronger access to community supports that help them remain independent.

Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #1	Sustain and strengthen housing, home safety, and accessibility supports so older adults with ongoing risks can remain safely housed in the community.				
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	Housing, home repair, accessibility, utilities, and home safety were recurring needs in the assessment and remained central to whether older adults can age in place safely. Year four should consolidate referral improvements, focus on unresolved gaps, and position the region for the next planning cycle.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Review housing and home safety referral trends and target unresolved gaps in the highest-need counties or populations.	Jan 2030- April 2030	Planning; OAA Title III-B supportive services; partner coordination	Housing Coordination Staff; Planning staff; Information & Assistance staff	Analyze referral patterns, unresolved cases, and partner feedback to identify remaining housing and home safety barriers.	Housing/home safety review completed; priority unresolved issues identified.
Sustain and refine referral pathways for repairs, accessibility modifications, utility-related risks, and home safety supports.	May 2030- Dec 2030	Partner coordination; OAA Title III-B where allowable; housing/resource coordination	Housing Coordination Staff; Community Partners; Information & Assistance staff	Update referral contacts, communication materials, and follow-up practices with housing and repair partners.	Updated pathways maintained; documented referrals and partner coordination activities continue.
into next-cycle housing	July 2030- Dec 2030	Planning	Leadership	county experience to identify future	next plan cycle
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include limited rural contractor capacity, funding limits for major repairs, and persistent shortages of affordable accessible housing. AAA will mitigate these barriers by prioritizing practical safety interventions, maintaining strong referral partnerships, and using plan-cycle findings to inform future resource development.				
Expected outcome(s) of this goal:	Older adults with housing and home safety needs will benefit from more reliable referral pathways and continued support that helps them remain safely in their homes.				

Priority Area (Please choose from drop down)	Community supports and services
Goal #2	Institutionalize effective community-based outreach, navigation, and support coordination practices across the PSA and prepare them for the next planning cycle.

Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The assessment showed that service awareness, referral complexity, and follow-through barriers affect access across multiple need areas. By year four, the region should consolidate its strongest outreach and navigation practices, document what worked, and prepare the next cycle of improvements.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Complete a plan-cycle review of outreach, navigation, and service coordination activities across core support areas.	Jan 2030- June 2030	Planning; ADRC/I&R	Planning staff; Program Managers; Information & Assistance staff; Leadership	Review four-year performance, county variation, partner feedback, and unresolved service barriers across meals, in-home supports, benefits, transportation, caregiver access, and related supports.	Plan-cycle review completed and shared internally.
Standardize high-value outreach and referral practices for continued use after the current cycle ends.	July 2030- Dec 2030	ADRC/I&R; outreach/education; OAA Title III-B; local coordination	Outreach staff; Information & Assistance staff; Program Managers; Communications staff	Document effective scripts, materials, workflows, and partnership practices that improved access for high-need older adults.	Standard operating practices documented; core materials updated for ongoing use.
recommendations for	Aug 2030- Dec 2030	Planning and leadership review	Managers	recommend future goals, target	prepared for next

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include competing year-end workload, incomplete data, or uneven documentation of partner practices. AAA will mitigate these barriers by starting evaluation early in the year, using a limited set of practical measures, and assigning clear internal responsibility for synthesis and documentation.
Expected outcome(s) of this goal:	AAA8 will enter the next planning cycle with better-documented practices, clearer service access pathways, and stronger evidence on what improves outcomes for older adults and caregivers.

Priority Area (Please choose from drop down)	Caregiver supports
Goal #3	Sustain caregiver support improvements and incorporate caregiver needs more consistently into the region’s long-term aging services approach.

Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	Caregiver strain affects whether older adults can remain at home, and year two activities should improve identification and support. Year four should assess what worked, maintain effective caregiver pathways, and carry forward practical improvements into the next cycle.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Review caregiver outreach, referral, and support activity over the plan cycle to identify strengths and remaining gaps.	Jan 2030- May 2030	OAA Title III-E; planning	Non Waiver Case Management Program staff; Planning staff; Information & Assistance staff	Assess caregiver contacts, education activities, referral completion, and high-need caregiver situations encountered during the cycle.	Caregiver review completed; key findings documented.
Maintain effective caregiver outreach and referral practices through partner networks and routine intake processes.	May 2030- Dec 2030	OAA Title III-E; outreach/education; partner coordination	Caregiver staff; Outreach staff; Community Partners; Senior Center staff	Continue caregiver screening, partner education, and practical information sharing through established pathways.	Ongoing caregiver outreach and referral activity documented; effective practices sustained.
inform next-cycle	Aug 2030- Dec 2030	Planning and leadership review	Management Program staff; Planning	into future goal-setting, including	recommendations

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Challenges may include limited respite supply, caregiver burnout, and under-identification of caregivers in routine contacts. AAA will mitigate these barriers by maintaining simple caregiver screening, using trusted partners for outreach, and focusing on practical supports that can be sustained within local capacity.
Expected outcome(s) of this goal:	Caregivers will remain more visible within the aging services system, with stronger ongoing support pathways and clearer future planning priorities.