Title III-A

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 484,344.00
Transfer to B, C1, C2, D or E, if applicable (please explain below and enter negative amount)	$ -
Anticipated FY26 Carryover Amount, if applicable (please explain below)	$ -
Revised FY27 Base Funding	$ 484,344.00

Detailed Rationale for Additional Transfer Amount

Please explain the rationale for any additional transfers between funds:

Detailed Rationale for Carryover Amount

Please explain the rationale for the total carryover amount from FY26:

Breakdown of Administration Dollars		% of Total	% Check	
Title III-A	$ 484,344.00	63.10%		
Title III-E	$ 81,696.00	10.64%		
Total	$ 566,040.00	73.75%	True	**This percentage may not be greater than 75%**
Local Match for Title III-A Funds				
Cash Match	$ 100,000.00	13.03%		
Inkind Match	$ -	0.00%		
SCS Administration	$ 89,610.00	11.67%		
Alzheimer's Administration (from Alzheimer's tab)	$ 11,888.00	1.55%		
Total Match for AAA Administration Funds	$ 201,498.00	26.25%	True	**This percentage may not be less than 25%**
Total Administration and Match Funds	$ 767,538.00	100.00%		

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Title III-B

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 1,585,821.00
Transfer from/(to) Title III-C1, if applicable (please explain below)	$ 523,601.00 **30% maximum transfer between B/C**
Transfer from/(to) Title III-C2, if applicable (please explain below)	$ 319,912.00 **30% maximum transfer between B/C**
Transfer from Title III-A (admin), if applicable (please explain below)	$ -
Anticipated FY26 Carryover Amount, if applicable (please explain below)	$ 177,492.68
Revised FY27 Base Funding	$ 2,606,826.68

Detailed Rationale for Transfer(s)

Please explain the rationale for transferring funds:

Detailed Rationale for Carryover Amount

Please explain the rationale for the total carryover amount from FY26:

Note: **In the table below, please enter the dollar amount for each category that is anticipated to be spent over the course of the Progam Year.**
Please ensure that the total dollar amount of funds allocated agrees to the Revised FY27 Base Funding amount above.

	Title III-B		Senior Community Services					
Service Category Allocations	**Contract**	**AAA**	**Contract**	**AAA**	**Total Funds**	**% of Funds**	**III-B % of Base Funding**	
Service Categories								
Access- Information & Assistance	$ 12,574.00	$ 188,013.00	$ -	$ -	$ 200,587.00	6%		
Access- Case management (Care Trans/Transportation Serv Coordination)	$ -	$ 283,000.00	$ -	$ 67,300.00	$ 350,300.00	11%	85%	Minimum of 5% Title III-B **base funding** (for all Access categories combined)
Access- Outreach	$ -	$ 8,104.00	$ -	$ -	$ 8,104.00	0%		
Access- Other Transportation	$ 856,930.00	$ -	$ 454,911.00	$ -	$ 1,311,841.00	42%		
In-Home- *homemaker, home health aide, visiting, telephone reassurance,adult day, home maintenance, and supportive services*	$ 406,891.00	$ -	$ -	$ -	$ 406,891.00	13%	26%	Minimum of 5% Title III-B **base funding**
Legal	$ 220,100.00	$ -	$ -	$ -	$ 220,100.00	7%	14%	Minimum of 5% Title III-B **base funding**
Other Community (Soc Isol, Healthy U)	$ 356,214.68	$ -	$ 7,965.00	$ -	$ 364,179.68	12%		
Ombudsman	$ 225,000.00	$ -	$ -	$ -	$ 225,000.00	7%		
Congregate Meals					$ -	0%		
Home Delivered Meals	$ -	$ -	$ -	$ -	$ -	0%		
Housing Administration	$ -	$ -	$ -	$ -	$ -	0%		
Training/Education	$ -	$ -	$ -	$ -	$ -	0%		
Equipment for AAA Providers, including computers and software	$ -	$ -	$ -	$ -	$ -	0%		
Volunteer Placement	$ -	$ -	$ -		$ -	0%		
Other: (Please Explain)	$ -	$ -	$ -	$ -	$ -	0%		
Unobligated	$ 50,000.00	$ -	$ -	$ -	$ 50,000.00	2%		
Total	$ 2,127,709.68	$ 479,117.00	$ 462,876.00	$ 67,300.00	$ 3,137,002.68	100%		
Total Allocation Agrees with Revised FY27 Base Funding		True						

$ 2,606,826.68 0
$ -
$ (1,000.00)

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Title III-C1

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 1,773,590.00
Transfer from/(to) Title III-B, if applicable (please explain below)	$ (523,601.00) **30% maximum transfer between B/C**
Transfer from/(to) Title III-C2, if applicable (please explain below)	$ - **40% maximum transfer between C1/C2**
Transfer from Title III-A (admin), if applicable (please explain below)	$ -
Anticipated FY26 Carryover Amount, if applicable (please explain below)	$ -
Revised FY27 Base Funding	$ 1,249,989.00

Detailed Rationale for Transfer(s)

Please explain the rationale for transferring funds:

Detailed Rationale for Carryover Amount

Please explain the rationale for the total carryover amount from FY26:

Note: In the table below, please enter the dollar amount for each category that is anticipated to be spent over the course of the Progam Year. Please ensure that the total dollar amount of funds allocated agrees to the Revised FY27 Base Funding amount above.

	Title III-C1		Senior Community Services			
Service Category Allocations	**Contract**	**AAA**	**Contract**	**AAA**	**Total Funds**	**% of Funds**
Service Categories						
Congregate Meals	$ 1,195,359.00	$ -	$ -	$ -	$ 1,195,359.00	96%
Nutrition Screening	$ -	$ -	$ -	$ -	$ -	0%
Nutrition Education	$ -	$ -	$ -	$ -	$ -	0%
Nutrition Counseling	$ -	$ -	$ -	$ -	$ -	0%
Menu Review/Development	$ -	$ -	$ -	$ -	$ -	0%
Unobligated	$ 54,630.00	$ -	$ -	$ -	$ 54,630.00	4%
Total	$ 1,249,989.00	$ -	$ -	$ -	$ 1,249,989.00	100%
Total Allocation Agrees with Revised FY27 Base Funding		True				

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Title III-C2

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 1,552,214.00
Transfer from/(to) Title III-B, if applicable (please explain below)	$ (319,912.00) **30% maximum transfer between B/C**
Transfer from/(to) Title III-C1, if applicable (please explain below)	$ - **40% maximum transfer between C1/C2**
Transfer from Title III-A (admin), if applicable (please explain below)	$ -
Anticipated FY26 Carryover Amount, if applicable (please explain below)	$ -
Revised FY27 Base Funding	$ 1,232,302.00

Detailed Rationale for Transfer(s)

Please explain the rationale for transferring funds:

Detailed Rationale for Carryover Amount

Please explain the rationale for the total carryover amount from FY26:

Note: In the table below, please enter the dollar amount for each category that is anticipated to be spent over the course of the Progam Year.
Please ensure that the total dollar amount of funds allocated agrees to the Revised FY27 Base Funding amount above.

	Title III-C2		Senior Community Services			
Service Category Allocations	**Contract**	**AAA**	**Contract**	**AAA**	**Total Funds**	**% of Funds**
Service Categories						
Home Delivered Meals	$ 1,176,636.00	$ -	$206,554.00	$ -	$ 1,383,190.00	96%
Nutrition Screening	$ -	$ -	$ -	$ -	$ -	0%
Nutrition Education	$ -	$ -	$ -	$ -	$ -	0%
Nutrition Counseling	$ -	$ -	$ -	$ -	$ -	0%
Menu Review/Development	$ -	$ -	$ -	$ -	$ -	0%
Unobligated	$ 55,666.00	$ -	$ -	$ -	$ 55,666.00	4%
Total	$ 1,232,302.00	$ -	$ 206,554.00	$ -	$ 1,438,856.00	100%
Total Allocation Agrees with Revised FY27 Base Funding		True				

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Title III-D

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 91,845.00
Transfer from Title III-A (admin), if applicable (please explain below)	$ -
Anticipated FY26 Carryover Amount, if applicable (please explain below)	$ -
Revised FY27 Base Funding	$ 91,845.00

Detailed Rationale for Transfer(s)

Please explain the rationale for transferring funds:

Detailed Rationale for Carryover Amount

Please explain the rationale for the total carryover amount from FY26:

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Note: In the table below, please enter the dollar amount for each category that is anticipated to be spent over the course of the Progam Year. Please ensure that the total dollar amount of funds allocated agrees to the Revised FY27 Base Funding amount above.

	Title III-D		Senior Community Services			
Service Category Allocations	**Contract**	**AAA**	**Contract**	**AAA**	**Total Funds**	**% of Funds**
Service Categories						
Evidence-Based Classes	$ 75,313.00	$ 16,532.00	$ -	$ -	$ 91,845.00	100%
Total	$ 75,313.00	$ 16,532.00	$ -	$ -	$ 91,845.00	100%
Total Allocation Agrees with Revised FY27 Base Funding		True				

Title III-E

	Administration	Services
FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 81,696.00	$ 735,260.00
Transfer from Title III-A (admin), if applicable (please explain below)	$ -	$ -
Anticipated FY26 Carryover Amount, if applicable (please explain below)	$ -	$ 22,299.00
Revised FY27 Base Funding	$ 81,696.00	$ 757,559.00

Detailed Rationale for Transfer(s)

Please explain the rationale for transferring funds:

Detailed Rationale for Carryover Amount

Please explain the rationale for the total carryover amount from FY26:

Note: In the table below, please enter the dollar amount for each category that is anticipated to be spent over the course of the Progam Year.
Please ensure that the total dollar amount of funds allocated agrees to the Revised FY27 Base Funding amount above.

	Title III-E - Services		Senior Community Services				
Service Category Allocations	**Contract**	**AAA**	**Contract**	**AAA**	**Total Funds**	**% of Funds**	
Service Categories							
Information	$ 16,788.00	$ 77,969.00	$ -	$ -	$ 94,757.00	10.23%	
Assistance	$ 20,000.00	$ 101,743.00	$ -	$ 35,800.00	$ 157,543.00	17.01%	
Counseling/Support Groups/Training	$ 173,578.00	$ -	$ -	$ -	$ 173,578.00	18.74%	
Respite Services	$ 367,481.00	$ -	$ 132,947.00	$ -	$ 500,428.00	54.02%	
Supplemental Services	$ -	$ -	$ -	$ -	$ -	0.00%	**20% maximum**
Other: (Please Explain)	$ -	$ -	$ -	$ -	$ -	0.00%	
Unobligated	$ -	$ -	$ -	$ -	$ -	0.00%	
Total	$ 577,847.00	$ 179,712.00	$ 132,947.00	$ 35,800.00	$ 926,306.00	100.00%	
Total Allocation Agrees with Revised FY27 Base Funding		True					

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NSIP

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 709,512.00

Anticipated FY26 Carryover Amount, if applicable (please explain below)	$ -

Revised FY27 Base Funding	$ 709,512.00

Detailed Rationale for Carryover Amount

Please explain the rationale for the total carryover amount from FY26:

Note: **In the table below, please enter the dollar amount for each category that is anticipated to be spent over the course of the Progam Year. Please ensure that the total dollar amount of funds allocated agrees to the Revised FY25 Base Funding amount above.**

Service Category Allocations	Total Funds	% of Funds
Service Categories		
Congregate Meals	$ 129,096.00	18%
Home Delivered Meals	$ 580,416.00	82%
Unobligated	$ -	0%
Total	$ 709,512.00	100%
Total Allocation Agrees with Revised FY27 Base Funding	True	

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Senior Community Services (SCS)

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 905,477.00

<u>Note:</u> The SCS funding should be allocated between the Title III-B, Title III-C1, Title III-C2, Title III-D, and Title III-E tabs.

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Alzheimer's

FY27 Base Funding (use most-recent Notice of Grant Award amount)	$ 268,729.00

Note: **In the table below, please enter the dollar amount for each category that is anticipated to be spent over the course of the Progam Year.**
Please ensure that the total dollar amount of funds allocated agrees to the FY25 Base Funding amount above.

Service Category Allocations	AAA	Contract	Total Funds	% of Funds
Service Categories				
Alzheimer's Association Core Services	$ -	$ 119,858.00	$ 119,858.00	44.60%
Personal Care	$ -	$ -	$ -	0.00%
Homemaker	$ -	$ -	$ -	0.00%
Visiting	$ -	$ -	$ -	0.00%
Institutional Care	$ -	$ -	$ -	0.00%
Other (please describe)	$ -	$ 136,983.00	$ 136,983.00	50.97%
Admininstration	$ 11,888.00	$ -	$ 11,888.00	4.42%
Unobligated	$ -	**$ -**	$ -	0.00%
Total	$ 11,888.00	$ 256,841.00	$ 268,729.00	100.00%
Total Allocation Agrees with Revised FY27 Base Funding			True	

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FY27 Initial Request to Transfer

	Title III-A	Title III-B	Title III-C1	Title III-C2	Title III-D	Title III-E Admin.	Title III-E Services	Total
FY25 Base Funding (use most-recent Notice of Grant Award amount)	$ 484,344.00	$ 1,585,821.00	$ 1,773,590.00	$ 1,552,214.00	$ 91,845.00	$ 81,696.00	$ 735,260.00	$ 8,188,488.00
Initial Transfer Request (**due with Area Plan**)	$ -	$ 843,513.00	$ (523,601.00)	$ (319,912.00)	$ -	$ -	$ -	$ -
Revised FY27 Base Funding with Transfers	$ 484,344.00	$ 2,429,334.00	$ 1,249,989.00	$ 1,232,302.00	$ 91,845.00	$ 81,696.00	$ 735,260.00	$ 8,188,488.00

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FY27 Additional Requests to Transfer

Area Agency on Aging:
Name of individual completing this form: **Email:**

	Title III-A	Title III-B	Title III-C1	Title III-C2	Title III-D	Title III-E Admin.	Title III-E Services	Total
FY27 Base Funding (Enter Amounts from NGA)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Initial Transfer Request (**due with Area Plan**)	$ -	$ 843,513.00	$ (523,601.00)	$ (319,912.00)	$ -	$ -	$ -	$ -
First Revised Transfer Request (**due no later than April 15**)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Second Revised Transfer Request (**due no later than June 15**)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Final Transfer Request (**due no later than July 15**)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Transfer Requests to Date	$ -	$ 843,513.00	$ (523,601.00)	$ (319,912.00)	$ -	$ -	$ -	$ -
Revised FY27 Base Funding with Transfers	$ -	$ 843,513.00	$ (523,601.00)	$ (319,912.00)	$ -	$ -	$ -	$ -

Detailed Rationale - Current Submission Only

Please explain all rationale for all transfers for the current submission in the box below:

Note: Use this form when submitting any additional requests for transfers and please fill in any box highlighted in 'yellow'. Enter the Area Agency on Aging name, name and email address of person competing this form, update the FY27 Base Funding amounts using the Notice of Grant Award (NGA), detail any requested transfer amounts, and add an explanation for any transfers. Send requests to the Elder Connections Division email at 'elderconnections@age.ohio.gov' on or before the due dates specified above. Please submit a transfer request for each period, regardless of whether a transfer is being requested.

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Summary

	Title III-A	Title III-B	Title III-C1	Title III-C2	Title III-D	Title III-E Admin.	Title III-E Services	NSIP	SCS	Alzheimer's	Total
FY27 Base Funding	$ 484,344.00	$ 1,585,821.00	$ 1,773,590.00	$ 1,552,214.00	$ 91,845.00	$ 81,696.00	$ 735,260.00	$ 709,512.00	$ 905,477.00	$ 268,729.00	$ 8,188,488.00
Total Initial Transfers	$ -	$ 843,513.00	$ (523,601.00)	$ (319,912.00)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FY26 Carryover	$ -	$ 177,492.68	$ -	$ -	$ -	$ -	$ 22,299.00	$ -	$ -	$ -	$ 199,791.68
Revised FY27 Base Funding	$ 484,344.00	$ 2,606,826.68	$ 1,249,989.00	$ 1,232,302.00	$ 91,845.00	$ 81,696.00	$ 757,559.00	$ 709,512.00	$ 905,477.00	$ 268,729.00	$ 8,388,279.68
Service Category Allocations											
Service Categories											
Access- Information & Assistance		$ 200,587.00							$ -		$ 200,587.00
Access- Case management		$ 283,000.00							$ 67,300.00		$ 350,300.00
Access- Outreach		$ 8,104.00							$ -		$ 8,104.00
Access- Other		$ 856,930.00							$ 454,911.00		$ 1,311,841.00
In-Home		$ 406,891.00							$ -		$ 406,891.00
Legal		$ 220,100.00							$ -		$ 220,100.00
Other Community		$ 356,214.68							$ 7,965.00		$ 364,179.68
Ombudsman		$ 225,000.00							$ -		$ 225,000.00
Congregate Meals		$ -	$ 1,195,359.00					$ 129,096.00	$ -		$ 1,324,455.00
Home Delivered Meals		$ -		$ 1,176,636.00				$ 580,416.00	$ 206,554.00		$ 1,963,606.00
Housing Administration		$ -							$ -		$ -
Training/Education		$ -							$ -		$ -
Equipment for AAA Providers, including computers and software		$ -							$ -		$ -
Volunteer Placement		$ -							$ -		$ -
III-B Other: (Please Explain)		$ -							$ -		$ -
Nutrition Screening			$ -	$ -					$ -		$ -
Nutrition Education			$ -	$ -					$ -		$ -
Nutrition Counseling			$ -	$ -					$ -		$ -
Menu Review/Development			$ -	$ -					$ -		$ -
Evidence-Based Classes					$ 91,845.00						
Information							$ 94,757.00		$ -		$ 94,757.00
Assistance							$ 121,743.00		$ 35,800.00		$ 157,543.00
Counseling/Support Groups/Training							$ 173,578.00		$ -		$ 173,578.00
Respite Services							$ 367,481.00		$ 132,947.00		$ 500,428.00
Supplemental Services							$ -		$ -		$ -
III-E Other: (Please Explain)							$ -		$ -		$ -
Alzheimer's Association Core Services										$ 119,858.00	$ 119,858.00
Personal Care										$ -	$ -
Homemaker										$ -	$ -
Visiting										$ -	$ -
Institutional Care										$ -	$ -
Alzheimer's Other: (Please Explain)										$ 136,983.00	$ 136,983.00
Administration										$ 11,888.00	$ 11,888.00
Unobligated		$ 50,000.00	$ 54,630.00	$ 55,666.00			$ -	$ -	$ -	$ -	$ 160,296.00
Total		$ 2,606,826.68	$ 1,249,989.00	$ 1,232,302.00			$ 757,559.00	$ 709,512.00	$ 905,477.00	$ 268,729.00	$ 7,730,394.68
Total Allocation Agrees with Revised FY26 Base Funding		True	True	True			True	True	True	True	

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Priority Area (Please choose from drop down)	Caregiver supports				
Goal #1	Expand overnight respite options to include facility and/or an in-home respite option.				
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 Supports and Services was an identified high need as part of the needs assessment findings.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Supports the caregiver with respite options	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Expand facility options - 51 respite stay completed in 2025	1. Increase respite stays to average of 56/year
2 - Provides needed self care for the caregiver	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Pilot in-home respite options in year 2 with home care agencies.	1. Engage interest with home care providers providing in home respite options 2. Implement in October 2028
3 - Reduce caregiver stress and burnout	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Provide overnight respite options that support caregiver relief and time away from caregiving responsibilities.	Track overnight respite utilization and caregiver access to time away for rest and self-care.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	N/A for #1 inpatient respite. In home respite- capacity issue may be a barrier. Explore short term respite 3-4 days respite options.				
Expected outcome(s) of this goal:	Provide resources and support to the caregiver to decrease burnout and CG stress.				

Priority Area (Please choose from drop down)	Caregiver supports				
Goal #2	Increase use, increase sustainability, identify barriers and provide education on Adult Day.				
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).	Adult Day Services may be underutilized due to limited awareness and barriers to access. Education and collaboration across counties can support increased use and service sustainability.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Increase Care Coordinator knowledge of Adult Day services	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Title 3/OAAA/ESP	ESP Supervisor	Create and provide education to Care Coordinators on Adult Day Services and referral considerations.	Adult Day education will be distributed or presented across all 4 counties.
2 - Increase appropriate Adult Day Referrals	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Title 3/OAAA/ESP	ESP Supervisor	Coordinate Adult Day Provider Tours for staff.	Staff will be provided the opportunity to participate in tours/site visits with at least 2 Adult Day Providers.

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What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Limited awareness of Adult Day Services. Client/caregiver hesitation or misconceptions about Adult Day. Transportation barriers and provider availablity and program capacity.
Expected outcome(s) of this goal:	Increased staff understanding of Adult Day services and improve appropriate utilization.

Priority Area (Please choose from drop down)	Caregiver supports
Goal #3	Increase awareness of the Caregiver Support Program to help reduce stress and CG burnout
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).	Caregivers reported strong need for support as they navigate caring for their loved one. Increased awareness and education for caregivers will help decrease their stress.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Increase awareness of CG Support program in our area through community events	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Title 3/OAAA/ESP	Care Managers	Attend community events and promoting CG Support program.	Track outreach efforts and caregiver enrollments connected to program promotion.
2 - Reduce stress and burnout through access to supports and resources.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Title 3/OAAA/ESP	Care Managers	Provide caregivers with education, resources, and referrals through the CG Support Program.	Track how and when education, resources, and referrals through the CG Support Program.
3 - Strengthen unpaid caregiver's ability to provide care.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Title 3/OAAA/ESP	Care Managers	Provide education and support to unpaid caregivers to build caregiving skills and confidence.	Track how and when education and support is provided to unpaid caregivers through the program.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Workload management for care managers.
Expected outcome(s) of this goal:	Increased CG enrollments and awareness of community supports and services for caregivers in our area

Priority Area (Please choose from drop down)	Financial well-being
Goal #1	Provide utility assistance and resources to older adults
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).	Costs of utilities has continued to rise and has caused increased financial strain

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Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Assist eligible Hamiton County Older Adults with a one-time credit towards their utility bill	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
2 - Reduce some financial burden of utility expenses for older adults through outreach.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Funding each year is not necessarily guaranteed. Funding is available at the beginning of each calendar year and not availabe throughout the year due to high demand. Funding is also limited to Hamilton County.				
Expected outcome(s) of this goal:	Older adults will have awareness of utility credits and understand how to apply. Older adults that are eligible and receive the one time credit will have reduced financial burden.				

Priority Area (Please choose from drop down)	Financial well-being				
Goal #2	Assist individuals with understanding benefit programs and assist with the application process				
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).	Older adults often times are not aware of the financial benefits that they are eligible for. The benefits enrollment center can help individuals determine if they appear eligible for savings programs and assist with the application process.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Conduct outreach events for awareness of the support this program can provide	Year 1 (of a Year 1-2 Goal) 10/1/2026 - 9/30/2027	NCOA grant	ADRC Manager Benefits Enrollment Specialist	Engage with community partners to provide education to send referrals	Conduct 1 event per month
2 - Assist eligible individuals with applying for financial benefits to help reduce some financial burden	Year 1 (of a Year 1-2 Goal) 10/1/2026 - 9/30/2027	NCOA grant	ADRC Manager Benefits Enrollment Specialist	Work with local programs that serve older adults and provide education and opportunities to send referrals	900 applications submitted by 7/31/2028
3 -Educate individuals on benefits and continuation of those benefits	Year 1 (of a Year 1-2 Goal) 10/1/2026 - 9/30/2027	NCOA grant	ADRC Manager Benefits Enrollment Specialist	When providing assistance to individuals on applications, education will be provided of what to expect and how to ensure benefits continue	Talking points to be developed that will be incoporated into steps when assisting indivduals.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	In order to meet the 900 applications, a large number of individuals will have to be screened as not all referrals will be financially eliglble for benefit programs.				
Expected outcome(s) of this goal:	Individuals age 65 and over will understand benefits programs, the application process and maintaining eligibility.				

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Priority Area (Please choose from drop down)	Financial well-being				
Goal #3	Connect inviduals with available resources through their Medicare Advantage plan				
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 is a great need for older adults. Many individuals with medicaid advantage plans are unaware of how to access the transportation benefit along with other available benefits that can help them maintain support and independence.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Provide assistance to individuals with medicare advantage plans and connect them with benefits	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide internal resource to assist individuals with understanding and connecting with their Medicare benefits.	Assist 1500 individuals through 9/30/30
2 - Educate individuals on the benefits that their advantage plan may provide	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide education, awareness and referral process	Assist 1500 individuals through 9/30/30
3 - Connect individuals to transportation benefit that will provide individual ability to routinely attend necessary appointments	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide connection to health plan to get needed services set up. Call health plan with client if assistance is needed.	Assist 1500 individuals through 9/30/30
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Navigation of medicare advantage plans can be diffucult. Individuals often don't know which exact advantage plan they are enrolled with. Coordination on some may take longer.				
Expected outcome(s) of this goal:	Individuals with medicare advantage plan will be connected to available resources				

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Priority Area (Please choose from drop down)	Healthy food access				
Goal #1	Increase in redemption rate in the 5 counties in our region for the Senior Farmers Market Nutrition Program (SFMNP)				
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).	Insert needs assessment language- Redemption rates for the 2025 SFMNP did not meet expectations, indicating that program participants were not fully utilizing their allotted benefits.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Use Ohio Farmers Market Network (OFMN) map of approved markets to identify gaps in communities of greatest need. Partner with OFMN to identify markets and promote application and approval of new markets	Year 1 (of a Year 1-4 Goal) 4/1/2026 - 9/30/2027	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Use Policy Mapplatform/website to map out farmers markets and roadside stands. Use Policy Map platform/website to map out residents age 60+ in low economic areas.	Increase in number of farmers markets/roadside stands that are in close proximity to those in greatest need. # of new markets in communities of greatest need

2 - Survey 2025 participants who did not use the benefits on barriers	Year 1 (of a Year 1-4 Goal) 4/1/2026 - 9/30/2027	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, social media platforms and during community outreach to identify barriers to program participation.	Conduct data analysis to identify barriers and develop strategies to address them.
3 - Investigate alternative methods of redemption- such as produce delivery, transportation to market	Year 1 (of a Year 1-4 Goal) 4/1/2026 - 9/30/2027	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, and social media platforms to gather input from the following stakeholders: •Farmers and markets to assess interest and capacity to deliver produce •Community senior housing managers to evaluate the ability to accept and distribute produce •Contracted providers to support produce distribution efforts	Conduct data analysis to identify interest and capacity to provide/promote alternative methods of benefit redemption
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Lack of approved markets in areas of great need Lack of available resources to transport participants to market Limited alternative methods such as produce delivery Delay in distribution of physical cards				
Expected outcome(s) of this goal:	Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region				

Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #1	Provide individuals with a resource to search available housing options in their 5 county region.				
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 is a need that has been continuously identified as limited. While housing options are limited, individuals need information to search all housing options that are in the community				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Individuals will be able to search COA housing database to assist with the exploration of housing	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	ADRC/PSP	Director - Community and Business Services Operations	Add new housing options as we are made aware.	10,000 inviduals accessing the database
2 - ADRC specialist will have the resource to navigate and provide information to callers	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	ADRC/PSP	Director - Community and Business Services Operations	Ensure database is always accessible	Database is active
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Affordable and quality housing availablity is limited. Buildings have waitlists and tracking of that can be difficult				
Expected outcome(s) of this goal:	Individuals will be able to access database with list of housing resources and have needed information to contact buildings to ascertain what is available.				

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Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #2	Provide older adults and caregivers with resources and information to assist them in making decisions when needing assisted living or nursing home care.				
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).	Older adults and caregivers often times struggle finding the right place when having to transition to assisted living or nursing facility. They need tools to help them navigate through the process. There are tools available but may not be a widely known resources				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Provide Education to applicable COA staff on the AGE Long-Term Care Quality Navigator	Year 1 (of a Year 1 only goal) 10/1/2026 - 9/30/2027	ADRC/PSP	Director - Community and Business Services Operations	Develop a training session for staff to understand the navigator tool and sharing information with individuals that are looking for placement options	Training developed and provided to staff by end of year 1
2 - Ensure staff understand the navigator tool and are explaining tool to individuals that are looking for placement options	Year 1 (of a Year 1 only goal) 10/1/2026 - 9/30/2027	ADRC/PSP	Director - Community and Business Services Operations	Education to staff	Staff educated by end of year one
3 - Ensure older adults and caregivers have the needed resources to help make informed decisions when searching for other housing options.	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	ADRC/PSP	Director - Community and Business Services Operations	Provide talking points to staff	Talking points created and given to staff
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Difficult to ensure all staff are provding the education when needed.				
Expected outcome(s) of this goal:	Individuals and caregivers will understand the Long-Term Care Quality Navigator is a resource to help them make decisions when needing to access Assisted Living and Nursing Home Care.				

Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #3	Provide options and explore all grant opportunities that support home modifications and repairs and provide those oportunities to enable older adults to remain safe, independent and at home in				
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).	Based on the community needs assessments, older adults expressed a desire to age in place and to remain in their homes but face housing challenges. Home modifications are allowing older adults to remain in their home.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Focus on home modificiations that address barriers to aging in place.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
2 - Maximize independence for older adults in day-to-day activities	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
3 - Explore other funding opportunities to expand accessibility to home modifications and repairs for older adults to age in place.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Explore all potential grant and funding opportunities to support home modifications	We will explore funding opportunities for a minumum of 3-5 different areas

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What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	1.) Funding availability and priority shifts 2.) Needs of community exceeds available funding resources
Expected outcome(s) of this goal:	Our expected outcome is we are able to meet our targets and measures so that older adults can remain in their homes and age succesfully in place.

Priority Area (Please choose from drop down)	Reliable transportation
Goal #1	Expansion of home52 Transportation Coordination Services to other counties in our service area
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 is identified and recogized as a social determinant of health in our service area. home52 Transportation Coordination Center's model has been successful in Hamilton County based on rider feedback. We want to maintain this service in Hamilton County and expand the model in our service area.

Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Explore funding opportunities, with grants and traditional program funding, to provide free transportation services to older and disabled adults residing in Hamilton and Clermont County. This goal also extends to any other county expansion during this period.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Hamilton County Levy, Medicaid NEMT, Grants	Grant Writer, Transportation Manager, VP	Research grant opportunities using existing grant writing tools, create relationships with agencies serving like populations in Clermont County and explore partnering with them to serve their members.	Apply for a minimum of two grants annually to support this initiative. Complete five outreach activities to create &/or maintain relationships with Hamilton and Clermont County organizations.
2 - Rider survey satisfaction related to timely, reliable and easy scheduling is 92% or higher.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Hamilton County Levy, Medicaid NEMT, Grants	Specialist	Random riders will be selected to complete a phone survey within 3 days of ride completion.	Rider survey satisfaction related to timely, reliable and easy scheduling is 95% or higher.
3 - Explore opportunites to enhance transporation servicesby including transporation coordination services for individuals with mobility limitations	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	County Levy Funding, Title III-B, Medicaid NEMT, Grants	home52 Transportation Manager, VP	Review Community Needs Assessments to determine where transportation is identified as a gap	Community Needs Assessments for counties in COA's service area are reviewed and gaps identified.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Expanding home52 Transportation Coordination Services to other counties requires relationship building and collaborations with local organizations and public transit that currently provide transportation. Planning and collaboration highlights what is working well and how transportation coordination can fill the gaps and enhance current service levels for vulnerable populations.
Expected outcome(s) of this goal:	Collaboration with local transit and organizations providing transportation to improve and enhance existing transportation services and options for aging and disabled individuals.

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Priority Area (Please choose from drop down)	Reliable transportation
Goal #2	Care Management staff are educated on all available transportation options so that clients are fully informed of and able to access appropriate transportation resources within their communities.
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).	Access to reliable transportation is essential for older adults to maintain independence in the community. Ensuring clients are knowledgeable about transportation options helps reduce barriers, improve access to services, and supports overall client well-being.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Create Resource Accessibility Tool	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	Levy - all counties	Supervisors	Create resource for staff to reference when sharing transportation options with clients Include resource, eligibility guidelines, and referral process	Completed resource tool stored in shared location
2 - Transportation resource education will be provided	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Levy - all counties	Supervisors, Training	Create training covering all community transportation options and review for updates annually. Share training at department meetings and through email communications	Track how and when education and training is provided. Staff receive training on transportation options at least yearly

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Transportation resources change frequently and vary by location.
Expected outcome(s) of this goal:	Clients will be informed about resources available to meet their transportation needs

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #1	Expand Fast Track Home in all counties with a particular focus on Butler County.
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).	Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 -Program Awareness	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Provide care transitions education to hospitals, SNF /rehabilitation facilities in our service area recognized for specializing in older adult care	Fast Track Home Team	Track outreach activities for each hospital	25 educational outreach activities her year

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	High staff turnover rates with discharge planners and social work staff employed with hospitals, SNF, rehabilitation facilities. Educational outreach activities often times have to be repeated 2 - 3 times annually.
Expected outcome(s) of this goal:	Regular referrals from hospitals, SNF /rehabilitation facilities in our service area.

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #2	Ensure PACE is provided as an option for clients. Staff will have educational materials to support options available

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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).	PACE is a new option for individuals in Hamilton County and the community and individuals need to be aware of the type of in home options that are available.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Create tools that provide staff with the necessary resources to inform of options available. Train staff on these tools	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	Front Door/ADRC	Director - Community and Business Services Operations	Develop training materials and educate staff. Create mechanism for new hires coming in to ensure training is received.	COA will have option tools in place and training will be conducted in Year 1

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	New program and learning the nuances between community based programs can be difficult. Ensuring that options provided are consistent with staff can be difficult
Expected outcome(s) of this goal:	Community and individuals inquiring about services and supports will have access to understanding all options and the newer program PACE.

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #3	Provide Care Transitions services through MedMutual
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).	Medical Mututal of Ohio Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Timely client engagement to explain program advantages	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Engage referrals received by Medical Mutual of Ohio to provide care tranisitons services	Engagement Specialist	Timely engage referrals	Engagement will be successful for 70% of the MMO referrals received.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Ensuring automated referrals/alerts are received timely and patient contact informtion has been updated and accurate.
Expected outcome(s) of this goal:	More MMO members are offered and accept care transitions services which is intended to reduce readmissions.

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #4	Continue collaboration with the Veterans Administration and grow the Veterans Directed Care Program
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 Veteran Directed Care Program is a collaborative self directed program with Veteran Adminsitration focused on keeping veterans who are at a high risk of being placed in instintutional care due to a variety of co- occuring health conditions. Move to community supports and services section only

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Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Support the indivdiual at home with self directed personal care services	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Continue to collaborate with the VA and referrals for the VDC program	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
2 - Supports the caregiver - either to be paid to provide the service or additonal assistance to the caregiver for respite and to assist with daily caregiving related to personal care needs	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Meet with the VA on an as needed basis.	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
3 - Remain at home in the community and aging in place	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Enrolled veterans on the program will be able to remain at home in the community	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	This program is small currenlty and serves all ages so need to ensure only capturing 60+ population				
Expected outcome(s) of this goal:	Continue to keep veterans in their own home in the community as well as provide additional support to the caregiver				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #5	Monitor data to improve access of services through collaborative networking and training.
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 community we serve is increasingly diverse, with varying cultural, linguistic, socioeconomic, and accessibility needs. Ensuring equal access requires a data-informed approach that identifies disparities and guides targeted interventions. By leveraging comprehensive data analysis and cross-functional collaboration, the Community Access Workgroup can proactively address barriers, improve service delivery, and strengthen trust and participation within all segments of the community as well as appropriatley training staff on importance of identifying diversity

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Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Data Monitoring & Analysis Continuously collect, monitor, and analyze quantitative data to identify trends, disparities which allows us to brainstorm barriers impacting community access in Hamilton County	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Levy - Hamilton County	Transitional Care Supervisor Care Manager Staff	Monthly meetings to discuss and review data, trends findings and next steps for community outreach and collaborate on training.	COA will conitnue to gather collect and analzyze data that is gathered quartetly. The group will utilize the date to drive changes that reduces disparities and barriers.
2 - Cross-Sector Collaboration Partner with internal teams, external agencies, and community stakeholders to ensure solutions are culturally relevant and aligned with community needs- partner with external agencies at events and spread the word of COA at culturally appropriate events.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Levy - All counties	Transitional Care Supervisor Care Manager Staff	Group will collaborate and stratagize with applicable departments internally for community outreach events	continue to locate applicable events to we can attend and collaborate with.
3 - Capacity Building Promote organizational awareness and competency around appropriatley asking about race and ethnicity. We will create a training on the importance of it but also how to approratley ask and share with departments. We will have all applicable staff trained by the end of 2027 and thereafter annually at applicable department meetings. New staff will also be onboarded with the created training.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Levy - All counties	Transitional Care Supervisor Care Manager Staff	attend department meetings, create a training that can be given to new hires.	We will have all applicable staff trained by the end of 2027 and therafter annually as well as train new hires.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Outside community factors with reaching additional populations. We may also see challenges with the populations we try and reach through events as we are not able to control turn out etc.
Expected outcome(s) of this goal:	Continue to attempt to access all populations that is represented in Hamilton County through community events, outreach training and collaboration

Priority Area (Please choose from drop down)	Community supports and services
Goal #1	Increase individuals awareness of services and supports that are available 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).	Individuals in the community aren't always aware to call their local AAA. Bringing the front door services out the community will increase awareness and connect more individuals to needed services to remain independent.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures

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1 - Partner with the Hamilton County 513 Relief Bus to go out in the community and provide front door services	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Screening-PSP	Kim Clark Director - Community and Business Services Operations	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.
2 - Distribute informational materials at events	Year 1 (of a Year 1-2 Goal) 10/1/2026 - 9/30/2027	Screening-PSP	Kim Clark	In collaboration with the Benefits Enrollment Center for financial assistance individuals will also be provided with additional resources and information	Schedule 22 events in community through the 5 county region
3 - Connect olders adults to services and supports that will allow them to remain as independent as possible	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Screening-PSP	Kim Clark	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	County controls calendar for bus events. Events may be mixes of ages and not just older adults. Only Hamilton Count has bus.				
Expected outcome(s) of this goal:	Older adults will have increased awareness of resources available.				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #2	Expand the UPLIFT program in Butler County				
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).	Mental Health Services for older adults has been identified as a need. Expansion of mental health services and supports will help meet this need.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Increased awareness of service and supports provided by UPLIFT	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	COA, Mental Health Board, Best Point	Shelby Stout Director - Business Operations	Increase awareness through outreach and distribution of informational materials to referral sources and clients	Collaborate with stakeholders to determine outreach opportunites and strategies
2 - Service offerings will be expanded to meet client needs	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	COA, Mental Health Board, Best Point	Shelby Stout	Determine gaps in service and implement new programs and services to address unmet needs	Implementation of new programs to close gaps
3 - Staff will be informed about mental health services and programming offered through UPLIFT and referral process	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	COA, Best Point	Shelby Stout	Provide education and training to staff on UPLIFT, services available and referral process	Education will be provided at least annually during department meetings.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients are hesitant to particiapte in mental health services due to stigma and perception of need				

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Expected outcome(s) of this goal:	Clients, staff and other stakeholders will be informed of available mental health services and identified gaps in UPLIFT services will be addressed

Priority Area (Please choose from drop down)	Community supports and services
Goal #3	Expand and strengthen the partnership with Senior Connections through collaborative efforts
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).	Mental health services that include transportation was identified as a gap within our community. Partnerships with local community organization were created to attempt and bridge the gap of the accesability of services.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Refer applicable clients to the Senior connections program.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	COA, Mental Health Board	Judy And Alyssia VP - Community & New Business Operations Transitional Care Supervisor	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Monitor the referal number's
2 - Create Visability and Awarness for Senior connections liason to attend and collaborate at 2 events annually.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	COA, Mental Health Board	Judy And Alyssia	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Track the events attended
3- Work with the senior connections liason to pinpoint specific areas where we can collabriativley and collectivley work to coordinate a referal stream.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	COA, Mental Health Board	Judy And Alyssia	attend quartlerly board meetings with senior connections and mental health board to continue to maintain referal stream	Monitor the referal number's
4 - Educate staff at applicable department meetings regarding the partnership with senior connections	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	COA, Mental Health Board	Judy And Alyssia	have senior connections contact come to applicable department meetings	Track meetings attended

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients in general are hesitient to access and seek access to mental health services, even if the referal is made we have no control of follow through or partcipation
Expected outcome(s) of this goal:	Continue a sustaining relationship with senior connections which generates referals to them

Priority Area (Please choose from drop down)	Community supports and services
Goal #4	Address a gap in available Guardianship services in Hamilton County by collaborating with local partners.
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).	Individuals in need of a professional guardian, and a lack of resources and available guadians.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures

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1 - Establish a written agreement and establish process for the work with collaborating organizations, select a provider thru a competative process and execute an agreement.	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	Hamilton County Levy	Guardianship Collaborative	Coordinate with local entities such as Developmental Disabiity Services, Adult Protective Services, Probate Court, Mental Health Board, and Hamilton County Administration.	Fully executed agreement with collaborative, and provider.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Available funding from levies that are stretched thin with inflation and property tax pushback. This project relies on cooperation from 6 different entities which is very challenging.				
Expected outcome(s) of this goal:	Decrease the gap of individuals who present to probate court with a need for a professional guardian, and no local resource being available.				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #5	Expand and diversify evidenc-based programming in our service area				
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).	Older adults are more likely to participate in evidence-based health education programs when they are available in their neighborhoods where they frequent often. Diversifying program options attracts more older adult and caregiver participants.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Expand relationships with community organizations to host evidence-based health education programs.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Title III D	Health and Wellness Team	Leverage COA's relationships with non-profits, faith based organizations and senior housing facilities in our service area	Provide workshops for five (5) new host site sponsors annually
3 - Explore opportunities to diversify programs that fit into COA's hybrid community model for evidence-based programs.	Year 1 (of a Year 1 only goal/obj) 10/1/2026 - 9/30/2027	Title III D	Health and Wellness Team	Review evidence-based programs approved on the NCOA website to identify which programs fit COA's hybrid community model.	NCOA website review completed and programs identified that fit COA's hybrid community model.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	The challenges are typical for any new Host Site Sponsors who have not offered programming to older adults in their communities. They include recruting, enaging,and supporting new participants to meet the fidelity requirements of evidence-based programs. COA's network of Community Leaders and Master Trainers support new Host Site Sponsors through this process. Another anticipated challenge may be found in the number of NCOA approved evidence-based programs that fit our hybrid community model. We will engage AGE and NCOA in addressing any concerns that may arise.				
Expected outcome(s) of this goal:	We expect to increase our geopgraphic foot print for evidence-based programs by adding a minimum of five new neighborhood host site sponsor locations which will engage more older adults in program participation. We also expect to diversify our current programs by adding at least one more aapproved program in our service area before year 4 of this Area plan.				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #6	Address unmet needs identified in our Needs Assessment under independent living and community supports.				
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).	Explore and apply for grant funding opportunities for community supports and services such as lawn care, snow removal, and furniture need to remain independent in community and at home				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**

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1- Explore and apply for any grant oppoturnity	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Grant Funding and potential Title III	Stephanie VP Managed Care & Aging Programs	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.
2 - Explore other avenues to pay for service need- donations, foundation opportunities.	Year 1 (of a Year 1-4 Goal) 10/1/2026 - 9/30/2027	Grant Funding and potential Title III	Stephanie	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.
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- no grant dollars available to meet the identified need				
Expected outcome(s) of this goal:	We expect to apply for some grant opportunities and explore other options such as foundations and private donations.				

Priority Area (Please choose from drop down)	Caregiver supports				
Goal #1	Expand overnight respite options to include facility and/or an in-home respite option.				
how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and	Caregiver Supports and Services was an identified high need as part of the needs assessment findings.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Supports the caregiver with respite options	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Expand facility options - 51 respite stay completed in 2025	1. Increase respite stays to average of 56/year
2 - Provides needed self care for the caregiver	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Pilot in-home respite options in year 2 with home care agencies.	1. Engage interest with home care providers providing in home respite options 2. Implement in October 2028
3 - Reduce caregiver stress and burnout	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Provide overnight respite options that support caregiver relief and time away from caregiving responsibilities.	Track overnight respite utilization and caregiver access to time away for rest and self-care.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	N/A for #1 inpatient respite. In home respite- capacity issue may be a barrier. Explore short term respite 3-4 days respite options.				
Expected outcome(s) of this goal:	Provide resources and support to the caregiver to decrease burnout and CG stress.				

Priority Area (Please choose from drop down)	Caregiver supports				
Goal #2	Increase use, increase sustainability, identify barriers and provide education on Adult Day.				
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).	Adult Day Services may be underutilized due to limited awareness and barriers to access. Education and collaboration across counties can support increased use and service sustainability.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Increase Care Coordinator knowledge of Adult Day services	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Title 3/OAAA/ESP	ESP Supervisor	Create and provide education to Care Coordinators on Adult Day Services and referral considerations.	Adult Day education will be distributed or presented across all 4 counties.
2 - Increase appropriate Adult Day Referrals	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Title 3/OAAA/ESP	ESP Supervisor	Coordinate Adult Day Provider Tours for staff.	Staff will be provided the opportunity to participate in tours/site visits with at least 2 Adult Day Providers.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Limited awareness of Adult Day Services. Client/caregiver hesitation or misconceptions about Adult Day. Transportation barriers and provider availaiblity and program capacity.				
Expected outcome(s) of this goal:	Increased staff understanding of Adult Day services and improve appropriate utilization.				

Priority Area (Please choose from drop down)	Caregiver supports
Goal #3	Increase awareness of the Caregiver Support Program to help reduce stress and CG burnout
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).	Caregivers reported strong need for support as they navigate caring for their loved one. Increased awareness and education for caregivers will help decrease their stress.

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Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Increase awareness of CG Support program in our area through community events	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Title 3/OAAA/ESP	Care Managers	Attend community events and promoting CG Support program.	Track outreach efforts and caregiver enrollments connected to program promotion.
2 - Reduce stress and burnout through access to supports and resources.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Title 3/OAAA/ESP	Care Managers	Provide caregivers with education, resources, and referrals through the CG Support Program.	Track how and when education, resources, and referrals through the CG Support Program.
3 - Strengthen unpaid caregiver's ability to provide care.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Title 3/OAAA/ESP	Care Managers	Provide education and support to unpaid caregivers to build caregiving skills and confidence.	Track how and when education and support is provided to unpaid caregivers through the program.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Workload management for care managers.				
Expected outcome(s) of this goal:	Increased CG enrollments and awareness of community supports and services for caregivers in our area				

Priority Area (Please choose from drop down)	Financial well-being				
Goal #1	Provide utility assistance and resources to older adults				
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).	Costs of utilities has continued to rise and has caused increased financial strain				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Assist eligible Hamiton County Older Adults with a one-time credit towards their utility bill	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
2 - Reduce some financial burden of utility expenses for older adults through outreach.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Funding each year is not necessarily guaranteed. Funding is available at the beginning of each calendar year and not availabe throughout the year due to high demand. Funding is also limited to Hamilton County.				
Expected outcome(s) of this goal:	Older adults will have awareness of utility credits and understand how to apply. Older adults that are eligible and receive the one time credit will have reduced financial burden.				

Priority Area (Please choose from drop down)	Financial well-being				
Goal #2	Assist individuals with understanding benefit programs and assist with the application process				
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).	Older adults often times are not aware of the financial benefits that they are eligible for. The benefits enrollment center can help individuals determine if they appear eligible for savings programs and assist with the application process.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Conduct outreach events for awareness of the support this program can provide	Year 2 (of a Year 1-2 Goal) 10/1/2027 - 7/31/2028	NCOA grant	ADRC Manager Benefits Enrollment Specialist	Engage with community partners to provide education to send referrals	Conduct 1 event per month
2 - Assist eligible individuals with applying for financial benefits to help reduce some financial burden	Year 2 (of a Year 1-2 Goal) 10/1/2027 - 7/31/2028	NCOA grant	ADRC Manager Benefits Enrollment Specialist	Work with local programs that serve older adults and provide education and opportunities to send referrals	900 applications submitted by 7/31/2028

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3 -Educate individuals on benefits and continuation of those benefits	Year 2 (of a Year 1-2 Goal) 10/1/2027 - 7/31/2028	NCOA grant	ADRC Manager Benefits Enrollment Specialist	When providing assistance to individuals on applications, education will be provided of what to expect and how to ensure benefits continue	Talking points to be developed that will be incoporated into steps when assisting indivduals.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	In order to meet the 900 applications, a large number of individuals will have to be screened as not all referrals will be financially eliglble for benefit programs.				
Expected outcome(s) of this goal:	Individuals age 65 and over will understand benefits programs, the application process and maintaining eligibility.				

Priority Area (Please choose from drop down)	Financial well-being				
Goal #3	Connect inviduals with available resources through their Medicare Advantage plan				
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 is a great need for older adults. Many individuals with medicaid advantage plans are unaware of how to access the transportation benefit along with other available benefits that can help them maintain support and independence.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Provide assistance to individuals with medicare advantage plans and connect them with benefits	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide internal resource to assist individuals with understanding and connecting with their Medicare benefits.	Assist 1500 individuals through 9/30/30
2 - Educate individuals on the benefits that their advantage plan may provide	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide education, awareness and referral process	Assist 1500 individuals through 9/30/30
3 - Connect individuals to transportation benefit that will provide individual ability to routinely attend necessary appointments	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide connection to health plan to get needed services set up. Call health plan with client if assistance is needed.	Assist 1500 individuals through 9/30/30
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Navigation of medicare advantage plans can be diffucult. Individuals often don't know which exact advantage plan they are enrolled with. Coordination on some may take longer.				
Expected outcome(s) of this goal:	Individuals with medicare advantage plan will be connected to available resources				

Priority Area (Please choose from drop down)	Healthy food access				
Goal #1	Enhance congregate meal options in restaurant setting (Swipe N' Dine program) by establishing additional restaurant-based partnerships in Hamilton County and expand into Butler, Clermont, Clinton and Warren Counties				
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 Swipe N' Dine program promotes health, enhances nutritional intake, and supports social engagement in community-based settings beyond traditional senior centers. Program can be beneficial to a larger audience with focus on greatest social and economic needs.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Competitive Bid Process with the release of a Title III RFP in 2027	Year 2 (of a Year 2-4 Goal) 10/1/2027 - 9/30/2028	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Incorporate clear program details and requirements into the Title III Request for Proposals (RFP) to support and achieve the intended goals of program expansion.	Procure Provider(s) with capacity to operate and manage program in all 5 counties in our region. List of procured providers and counties served

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2 - Community Promotion of program to areas with greatest social and economic needs	Year 2 (of a Year 2-4 Goal) 10/1/2027 - 9/30/2028	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Prioritize targeted communication and outreach efforts to promote program awareness among individuals in communities with the greatest social and economic need.	approval of participants in areas of identified communities of greatest social and economic needs. # of new participants in areas of greatest need.
3 - Education to Restaurants- program details, responsibilities and partnership benefits in community with greatest social and economic needs.	Year 2 (of a Year 2-4 Goal) 10/1/2027 - 9/30/2028	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Develop program education materials, provide clear and user-friendly demonstrations for participating restaurants, and facilitate peer-to-peer support by connecting prospective restaurant partners with currently participating restaurants within or outside the region.	Restaurant participation- addition of 2 restaurants in Hamilton County. 1 participating restaurant in Butler, Clermont, Clinton and Warren Counties. # of new partnerships/collaborations
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Lack of qualifying restaurants in communities with greatest need. Lack of interest from Restaurants Flat funding which hinders growth				
Expected outcome(s) of this goal:	Expansion of Swipe N' Dine program to all 5 counties in our region.				

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Priority Area (Please choose from drop down)	Healthy food access				
Goal #2	Increase in redemption rate in the 5 counties in our region for the Senior Farmers Market Nutrition Program (SFMNP)				
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).	Insert needs assessment language- Redemption rates for the 2025 SFMNP did not meet expectations, indicating that program participants were not fully utilizing their allotted benefits.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Use Ohio Farmers Market Network (OFMN) map of approved markets to identify gaps in communities of greatest need. Partner with OFMN to identify markets and promote application and approval of new markets	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Use Policy Map platform/website to map out farmers markets and roadside stands. Use Policy Map platform/website to map out residents age 60+ in low economic areas.	Increase in number of farmers markets/roadside stands that are in close proximity to those in greatest need. # of new markets in communities of greatest need
2 - Survey 2025 participants who did not use the benefits on barriers	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, social media platforms and during community outreach to identify barriers to program participation.	Conduct data analysis to identify barriers and develop strategies to address them.
3 - Investigate alternative methods of redemption- such as produce delivery, transportation to market	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, and social media platforms to gather input from the following stakeholders: •Farmers and markets to assess interest and capacity to deliver produce •Community senior housing managers to evaluate the ability to accept and distribute produce •Contracted providers to support produce distribution efforts	Conduct data analysis to identify interest and capacity to provide/promote alternative methods of benefit redemption
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Lack of approved markets in areas of great need Lack of available resources to transport participants to market Limited alternative methods such as produce delivery Delay in distribution of physical cards				
Expected outcome(s) of this goal:	Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region				

Priority Area (Please choose from drop down)	Safe and accessible housing

Goal #1	Provide individuals with a resource to search available housing options in their 5 county region.				
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 is a need that has been continuously identified as limited. While housing options are limited, individuals need information to search all housing options that are in the community				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Individuals will be able to search COA housing database to assist with the exploration of housing	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	ADRC/PSP	Director - Community and Business Services Operations	Add new housing options as we are made aware.	10,000 inviduals accessing the database
2 - ADRC specialist will have the resource to navigate and provide information to callers	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	ADRC/PSP	Director - Community and Business Services Operations	Ensure database is always accessible	Database is active
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Affordable and quality housing availablity is limited. Buildings have waitlists and tracking of that can be difficult				
Expected outcome(s) of this goal:	Individuals will be able to access database with list of housing resources and have needed information to contact buildings to ascertain what is available.				

Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #2	Provide options and explore all grant opportunities that support home modifications and repairs and provide those oportunities to enable older adults to remain safe, independent and at				
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).	Based on the community needs assessments, older adults expressed a desire to age in place and to remain in their homes but face housing challenges. Home modifications are allowing older adults to remain in their home.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Focus on home modificiations that address barriers to aging in place.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
2 - Maximize independence for older adults in day-to-day activities	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
3 - Explore other funding opportunities to expand accessibility to home modifications and repairs for older adults to age in place.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Explore all potential grant and funding opportunities to support home modifications	We will explore funding opportunities for a minumum of 3-5 different areas
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	1.) Funding availability and priority shifts 2.) Needs of community exceeds available funding resources				
Expected outcome(s) of this goal:	Our expected outcome is we are able to meet our targets and measures so that older adults can remain in their homes and age succesfully in place.				

Priority Area (Please choose from drop down)	Reliable transportation				
Goal #1	Expansion of home52 Transportation Coordination Services to other counties in our service area				
how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and	Transportation is identified and recogized as a social determinant of health in our service area. home52 Transportation Coordination Center's model has been successful in Hamilton County based on rider feedback. We want to maintain this service in Hamilton County and expand the model in our service area.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**

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Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Explore funding opportunities, with grants and traditional program funding, to provide free transportation services to older and disabled adults residing in Hamilton and Clermont County. This goal also extends to any other county expansion during this period.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Hamilton County Levy, Medicaid NEMT, Grants	Grant Writer, Transportation Manager, VP	Research grant opportunities using existing grant writing tools, create relationships with agencies serving like populations in Clermont County and explore partnering with them to serve their members.	Apply for a minimum of two grants annually to support this initiative. Complete five outreach activities to create &/or maintain relationships with Hamilton and Clermont County organizations.
2 - Rider survey satisfaction related to timely, reliable and easy scheduling is 92% or higher.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Hamilton County Levy, Medicaid NEMT, Grants	Specialist	Random riders will be selected to complete a phone survey within 3 days of ride completion.	Rider survey satisfaction related to timely, reliable and easy scheduling is 95% or higher.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Expanding home52 Transportation Coordination Services to other counties requires relationship building and collaborations with local organizations and public transit that currently provide transportation. Planning and collaboration highlights what is working well and how transportation coordination can fill the gaps and enhance current service levels for vulnerable populations
Expected outcome(s) of this goal:	Collaboration with local transit and organizations providing transportation to improve and enhance existing transportation services and options for aging and disabled individuals.

Priority Area (Please choose from drop down)	Reliable transportation
Goal #2	Care Management staff are educated on all available transportation options so that clients are fully informed of and able to access appropriate transportation resources within their
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).	Access to reliable transportation is essential for older adults to maintain independence in the community. Ensuring clients are knowledgeable about transportation options helps reduce barriers, improve access to services, and supports overall client well-being.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
2 - Transportation resource education will be provided	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Levy - all counties	Supervisors, Training	Create training covering all community transportation options and review for updates annually. Share training at department meetings and through email communications	Track how and when education and training is provided. Staff receive training on transportation options at least yearly
3 - Staff will document that they provided education on transportation resources to clients with transportation needs	Year 2 (of a Year 2-4 Goal) 10/1/2027 - 9/30/2028	Levy - all counties	Staff, Supervisors	Audit a sample of clients annually	90% of clients who reported transportation needs were educated on transportation resources based on documentation in the client record

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Transportation resources change frequently and vary by location.
Expected outcome(s) of this goal:	Clients will be informed about resources available to meet their transportation needs

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #1	Expand Fast Track Home in all counties with a particular focus on Butler County.
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).	Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 -Program Awareness	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Provide care transitions education to hospitals, SNF /rehabilitation facilities in our service area recognized for specializing in older adult care	Fast Track Home Team	Track outreach activities for each hospital	25 educational outreach activities her year

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What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	High staff turnover rates with discharge planners and social work staff employed with hospitals, SNF, rehabilitation facilities. Educational outreach activities often times have to be repeated 2 - 3 times annually.
Expected outcome(s) of this goal:	Regular referrals from hospitals, SNF /rehabilitation facilities in our service area.

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #2	Provide Care Transitions services through MedMutual
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).	Medical Mututal of Ohio Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Timely client engagement to explain program advantages	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Engage referrals received by Medical Mutual of Ohio to provide care tranisitons services	Engagement Specialist	Timely engage referrals	Engagement will be successful for 70% of the MMO referrals received.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Ensuring automated referrals/alerts are received timely and patient contact informtion has been updated and accurate.
Expected outcome(s) of this goal:	More MMO members are offered and accept care transitions services which is intended to reduce readmissions.

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #3	Continue collaboration with the Veterans Administration and grow the Veterans Directed Care Program
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 Veteran Directed Care Program is a collaborative self directed program with Veteran Adminsitration focused on keeping veterans who are at a high risk of being placed in instintutional care due to a variety of co- occuring health conditions. Move to community supports and services section only

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Support the indivdiual at home with self directed personal care services	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Continue to collaborate with the VA and referrals for the VDC program	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
2 - Supports the caregiver - either to be paid to provide the service or additonal assistance to the caregiver for respite and to assist with daily caregiving related to personal care needs	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Meet with the VA on an as needed basis.	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.

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3 - Remain at home in the community and aging in place	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Enrolled veterans on the program will be able to remain at home in the community	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	This program is small currenlty and serves all ages so need to ensure only capturing 60+ population				
this goal:	Continue to keep veterans in their own home in the community as well as provide additional support to the caregiver				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #4	Monitor data to improve access of services through collaborative networking and training.				
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 community we serve is increasingly diverse, with varying cultural, linguistic, socioeconomic, and accessibility needs. Ensuring equal access requires a data-informed approach that identifies disparities and guides targeted interventions. By leveraging comprehensive data analysis and cross-functional collaboration, the Community Access Workgroup can proactively address barriers, improve service delivery, and strengthen trust and participation within all segments of the community as well as appropriatley training staff on importance of identifying diversity				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Data Monitoring & Analysis Continuously collect, monitor, and analyze quantitative data to identify trends, disparities which allows us to brainstorm barriers impacting community access in Hamilton County	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Levy - Hamilton County	Transitional Care Supervisor Care Manager Staff	Monthly meetings to discuss and review data, trends findings and next steps for community outreach and collaborate on training.	COA will conitnue to gather collect and analzyze data that is gathered quartetly. The group will utilize the date to drive changes that reduces disparities and barriers.
2 - Cross-Sector Collaboration Partner with internal teams, external agencies, and community stakeholders to ensure solutions are culturally relevant and aligned with community needs- partner with external agencies at events and spread the word of COA at culturally appropriate events.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Levy - All counties	Transitional Care Supervisor Care Manager Staff	Group will collaborate and stratagize with applicable departments internally for community outreach events	continue to locate applicable events to we can attend and collaborate with.
3 - Capacity Building Promote organizational awareness and competency around appropriatley asking about race and ethnicity. We will create a training on the importance of it but also how to approratley ask and share with departments. We will have all applicable staff trained by the end of 2027 and thereafter annually at applicable department meetings. New staff will also be onboarded with the created training.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Levy - All counties	Transitional Care Supervisor Care Manager Staff	attend department meetings, create a training that can be given to new hires.	We will have all applicable staff trained by the end of 2027 and therafter annually as well as train new hires.

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What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Outside community factors with reaching additional populations. We may also see challenges with the populations we try and reach through events as we are not able to control turn out etc.
Expected outcome(s) of this goal:	Continue to attempt to access all populations that is represented in Hamilton County through community events, outreach training and collaboration

Priority Area (Please choose from drop down)	Community supports and services
Goal #1	Increase individuals awareness of services and supports that are available 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).	Individuals in the community aren't always aware to call their local AAA. Bringing the front door services out the community will increase awareness and connect more individuals to needed services to remain independent.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Partner with the Hamilton County 513 Relief Bus to go out in the community and provide front door services	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Screening-PSP	Kim Clark Director - Community and Business Services Operations	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.
2 - Distribute informational materials at events	Year 2 (of a Year 1-2 Goal) 10/1/2027 - 7/31/2028	Screening-PSP	Kim Clark	In collaboration with the Benefits Enrollment Center for financial assistance individuals will also be provided with additional resources and information	Schedule 22 events in community through the 5 county region
3 - Connect olders adults to services and supports that will allow them to remain as independent as possible	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Screening-PSP	Kim Clark	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	County controls calendar for bus events. Events may be mixes of ages and not just older adults. Only Hamilton Count has bus.
Expected outcome(s) of this goal:	Older adults will have increased awareness of resources available.

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Priority Area (Please choose from drop down)	Community supports and services
Goal #2	Expand the UPLIFT program in Butler County
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).	Mental Health Services for older adults has been identified as a need. Expansion of mental health services and supports will help meet this need.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
3 - Staff will be informed about mental health services and programming offered through UPLIFT and referral process	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	COA, Best Point	Shelby Stout	Provide education and training to staff on UPLIFT, services available and referral process	Education will be provided at least annually during department meetings.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients are hesitant to particiapte in mental health services due to stigma and perception of need
Expected outcome(s) of this goal:	Clients, staff and other stakeholders will be informed of available mental health services and identified gaps in UPLIFT services will be addressed

Priority Area (Please choose from drop down)	Community supports and services
Goal #3	Expand and strengthen the partnership with Senior Connections through collaborative efforts
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).	Mental health services that include transportation was identified as a gap within our community. Partnerships with local community organization were created to attempt and bridge the gap of the accesability of services.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Refer applicable clients to the Senior connections program.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	COA, Mental Health Board	Judy And Alyssia VP - Community & New Business Operations Transitional Care Supervisor	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Monitor the referal number's
2 - Create Visability and Awarness for Senior connections liason to attend and collaborate at 2 events annually.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	COA, Mental Health Board	Judy And Alyssia	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Track the events attended
3- Work with the senior connections liason to pinpoint specific areas where we can collabriativley and collectivley work to coordinate a referal stream.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	COA, Mental Health Board	Judy And Alyssia	attend quartlerly board meetings with senior connections and mental health board to continue to maintain referal stream	Monitor the referal number's
4 - Educate staff at applicable department meetings regarding the partnership with senior connections	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	COA, Mental Health Board	Judy And Alyssia	have senior connections contact come to applicable department meetings	Track meetings attended

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients in general are hesitient to access and seek access to mental health services, even if the referal is made we have no control of follow through or partcipation
Expected outcome(s) of this goal:	Continue a sustaining relationship with senior connections which generates referals to them

Priority Area (Please choose from drop down)	Community supports and services
Goal #4	Address a gap in available Guardianship services in Hamilton County by collaborating with local partners.
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).	Individuals in need of a professional guardian, and a lack of resources and available guadians.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
2 - Develop and execute referral and payment procedures for individuals in need of a professional guardian.	Year 2 (of a Year 2-4 Goal) 10/1/2027 - 9/30/2028	Hamilton County Levy	Guardianship Collaborative	Develop a written procedure, test and refine it with feedback on its effectiveness with the 6 partering entities.	# of older adults served with guardianship services

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Available funding from levies that are stretched thin with inflation and property tax pushback. This project relies on cooperation from 6 different entities which is very challenging.

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Expected outcome(s) of this goal:	Decrease the gap of individuals who present to probate court with a need for a professional guardian, and no local resource being available.

Priority Area (Please choose from drop down)	Community supports and services
Goal #5	Expand and diversify evidenc-based programming in our service area
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).	Older adults are more likely to participate in evidence-based health education programs when they are available in their neighborhoods where they frequent often. Diversifying program options attracts more older adult and caregiver participants.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
Expand relationships with community organizations to host evidence-based health education programs.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Title III D	Health and Wellness Team	Leverage COA's relationships with non-profits, faith based organizations and senior housing facilities in our service area	Provide workshops for five (5) new host site sponsors annually

barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these	The challenges are typical for any new Host Site Sponsors who have not offered programming to older adults in their communities. They include recruting, enaging,and supporting new participants to meet the fidelity requirements of evidence-based programs. COA's network of Community Leaders and Master Trainers support new Host Site Sponsors through this process. Another anticipated challenge may be found in the number of NCOA approved evidence-based programs that fit our hybrid community model. We will engage AGE and NCOA in addressing any concerns that may arise.
Expected outcome(s) of this goal:	We expect to increase our geopgraphic foot print for evidence-based programs by adding a minimum of five new neighborhood host site sponsor locations which will engage more older adults in program participation. We also expect to diversify our current programs by adding at least one more aapproved program in our service area before year 4 of this Area plan.

Priority Area (Please choose from drop down)	Community supports and services
Goal #6	Address unmet needs identified in our Needs Assessment under independent living and community supports.
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).	Explore and apply for grant funding opportunities for community supports and services such as lawn care, snow removal, and furniture need to remain independent in community and at home

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1- Explore and apply for any grant oppoturnity	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Grant Funding and potential Title III	Stephanie VP Managed Care & Aging Programs	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.
2 - Explore other avenues to pay for service need- donations, foundation opportunities.	Year 2 (of a Year 1-4 Goal) 10/1/2027 - 9/30/2028	Grant Funding and potential Title III	Stephanie	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.

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- no grant dollars available to meet the identified need
Expected outcome(s) of this goal:	We expect to apply for some grant opportunities and explore other options such as foundations and private donations.

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Priority Area (Please choose from drop down)	Caregiver supports
Goal #1	Expand overnight respite options to include facility and/or an in-home respite option.
how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and	Caregiver Supports and Services was an identified high need as part of the needs assessment findings.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Supports the caregiver with respite options	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Expand facility options - 51 respite stay completed in 2025	1. Increase respite stays to average of 56/year
2 - Provides needed self care for the caregiver	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Pilot in-home respite options in year 2 with home care agencies.	1. Engage interest with home care providers providing in home respite options 2. Implement in October 2028
3 - Reduce caregiver stress and burnout	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Provide overnight respite options that support caregiver relief and time away from caregiving responsibilities.	Track overnight respite utilization and caregiver access to time away for rest and self-care.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	N/A for #1 inpatient respite. In home respite- capacity issue may be a barrier. Explore short term respite 3-4 days respite options.
Expected outcome(s) of this goal:	Provide resources and support to the caregiver to decrease burnout and CG stress.

Priority Area (Please choose from drop down)	Caregiver supports
Goal #2	Increase use, increase sustainability, identify barriers and provide education on Adult Day.
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).	Adult Day Services may be underutilized due to limited awareness and barriers to access. Education and collaboration across counties can support increased use and service sustainability.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Increase Care Coordinator knowledge of Adult Day services	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Title 3/OAAA/ESP	ESP Supervisor	Create and provide education to Care Coordinators on Adult Day Services and referral considerations.	Adult Day education will be distributed or presented across all 4 counties.
2 - Increase appropriate Adult Day Referrals	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Title 3/OAAA/ESP	ESP Supervisor	Coordinate Adult Day Provider Tours for staff.	Staff will be provided the opportunity to participate in tours/site visits with at least 2 Adult Day Providers.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Limited awareness of Adult Day Services. Client/caregiver hesitation or misconceptions about Adult Day. Transportation barriers and provider availaiblity and program capacity.
Expected outcome(s) of this goal:	Increased staff understanding of Adult Day services and improve appropriate utilization.

Priority Area (Please choose from drop down)	Caregiver supports
Goal #3	Increase awareness of the Caregiver Support Program to help reduce stress and CG burnout
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).	Caregivers reported strong need for support as they navigate caring for their loved one. Increased awareness and education for caregivers will help decrease their stress.

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Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Increase awareness of CG Support program in our area through community events	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Title 3/OAAA/ESP	Care Managers	Attend community events and promoting CG Support program.	Track outreach efforts and caregiver enrollments connected to program promotion.
2 - Reduce stress and burnout through access to supports and resources.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Title 3/OAAA/ESP	Care Managers	Provide caregivers with education, resources, and referrals through the CG Support Program.	Track how and when education, resources, and referrals through the CG Support Program.
3 - Strengthen unpaid caregiver's ability to provide care.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Title 3/OAAA/ESP	Care Managers	Provide education and support to unpaid caregivers to build caregiving skills and confidence.	Track how and when education and support is provided to unpaid caregivers through the program.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Workload management for care managers.				
Expected outcome(s) of this goal:	Increased CG enrollments and awareness of community supports and services for caregivers in our area				

Priority Area (Please choose from drop down)	Financial well-being
Goal #1	Provide utility assistance and resources to older adults
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).	Costs of utilities has continued to rise and has caused increased financial strain

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Assist eligible Hamiton County Older Adults with a one-time credit towards their utility bill	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
2 - Reduce some financial burden of utility expenses for older adults through outreach.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Funding each year is not necessarily guaranteed. Funding is available at the beginning of each calendar year and not availabe throughout the year due to high demand. Funding is also limited to Hamilton County.				
Expected outcome(s) of this goal:	Older adults will have awareness of utility credits and understand how to apply. Older adults that are eligible and receive the one time credit will have reduced financial burden.				

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Priority Area (Please choose from drop down)	Financial well-being
Goal #2	Connect inviduals with available resources through their Medicare Advantage plan
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 is a great need for older adults. Many individuals with medicaid advantage plans are unaware of how to access the transportation benefit along with other available benefits that can help them maintain support and independence.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Provide assistance to individuals with medicare advantage plans and connect them with benefits	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide internal resource to assist individuals with understanding and connecting with their Medicare benefits.	Assist 1500 individuals through 9/30/30

2 - Educate individuals on the benefits that their advantage plan may provide	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide education, awareness and referral process	Assist 1500 individuals through 9/30/30
3 - Connect individuals to transportation benefit that will provide individual ability to routinely attend necessary appointments	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide connection to health plan to get needed services set up. Call health plan with client if assistance is needed.	Assist 1500 individuals through 9/30/30
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Navigation of medicare advantage plans can be diffucult. Individuals often don't know which exact advantage plan they are enrolled with. Coordination on some may take longer.				
Expected outcome(s) of this goal:	Individuals with medicare advantage plan will be connected to available resources				

Priority Area (Please choose from drop down)	Healthy food access				
Goal #1	Enhance congregate meal options in restaurant setting (Swipe N' Dine program) by establishing additional restaurant-based partnerships in Hamilton County and expand into Butler, Clermont, Clinton and Warren Counties				
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 Swipe N' Dine program promotes health, enhances nutritional intake, and supports social engagement in community-based settings beyond traditional senior centers. Program can be beneficial to a larger audience with focus on greatest social and economic needs.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Competitive Bid Process with the release of a Title III RFP in 2027	Year 3 (of a Year 2-4 Goal) 10/1/2028 - 9/30/2029	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Incorporate clear program details and requirements into the Title III Request for Proposals (RFP) to support and achieve the intended goals of program expansion.	Procure Provider(s) with capacity to operate and manage program in all 5 counties in our region. List of procured providers and counties served
2 - Community Promotion of program to areas with greatest social and economic needs	Year 3 (of a Year 2-4 Goal) 10/1/2028 - 9/30/2029	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Prioritize targeted communication and outreach efforts to promote program awareness among individuals in communities with the greatest social and economic need.	approval of participants in areas of identified communities of greatest social and economic needs. # of new participants in areas of greatest need.
3 - Education to Restaurants- program details, responsibilities and partnership benefits in community with greatest social and economic needs.	Year 3 (of a Year 2-4 Goal) 10/1/2028 - 9/30/2029	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Develop program education materials, provide clear and user-friendly demonstrations for participating restaurants, and facilitate peer-to-peer support by connecting prospective restaurant partners with currently participating restaurants within or outside the region.	Restaurant participation- addition of 2 restaurants in Hamilton County. 1 participating restaurant in Butler, Clermont, Clinton and Warren Counties. # of new partnerships/collaberations
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Lack of qualifying restaurants in communities with greatest need. Lack of interest from Restaurants Flat funding which hinders growth				
Expected outcome(s) of this goal:	Expansion of Swipe N' Dine program to all 5 counties in our region.				

Priority Area (Please choose from drop down)	Healthy food access
Goal #2	Increase in redemption rate in the 5 counties in our region for the Senior Farmers Market Nutrition Program (SFMNP)

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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).	Insert needs assessment language- Redemption rates for the 2025 SFMNP did not meet expectations, indicating that program participants were not fully utilizing their allotted benefits.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Use Ohio Farmers Market Network (OFMN) map of approved markets to identify gaps in communities of greatest need. Partner with OFMN to identify markets and promote application and approval of new markets	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Use Policy Map platform/website to map out farmers markets and roadside stands. Use Policy Map platform/website to map out residents age 60+ in low economic areas.	Increase in number of farmers markets/roadside stands that are in close proximity to those in greatest need. # of new markets in communities of greatest need
2 - Survey 2025 participants who did not use the benefits on barriers	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, social media platforms and during community outreach to identify barriers to program participation.	Conduct data analysis to identify barriers and develop strategies to address them.
3 - Investigate alternative methods of redemption- such as produce delivery, transportation to market	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, and social media platforms to gather input from the following stakeholders: •Farmers and markets to assess interest and capacity to deliver produce •Community senior housing managers to evaluate the ability to accept and distribute produce •Contracted providers to support produce distribution efforts	Conduct data analysis to identify interest and capacity to provide/promote alternative methods of benefit redemption
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Lack of approved markets in areas of great need Lack of available resources to transport participants to market Limited alternative methods such as produce delivery Delay in distribution of physical cards				
Expected outcome(s) of this goal:	Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region				

Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #1	Provide individuals with a resource to search available housing options in their 5 county region.				
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 is a need that has been continuously identified as limited. While housing options are limited, individuals need information to search all housing options that are in the community				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Individuals will be able to search COA housing database to assist with the exploration of housing	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	ADRC/PSP	Director - Community and Business Services Operations	Add new housing options as we are made aware.	10,000 invividals accessing the database
2 - ADRC specialist will have the resource to navigate and provide information to callers	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	ADRC/PSP	Director - Community and Business Services Operations	Ensure database is always accessible	Database is active
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Affordable and quality housing availablity is limited. Buildings have waitlists and tracking of that can be difficult				
Expected outcome(s) of this goal:	Individuals will be able to access database with list of housing resources and have needed information to contact buildings to ascertain what is available.				

Priority Area (Please choose from drop down)	Safe and accessible housing

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Goal #2	Provide options and explore all grant opportunities that support home modifications and repairs and provide those oportunities to enable older adults to remain safe, independent and at				
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).	Based on the community needs assessments, older adults expressed a desire to age in place and to remain in their homes but face housing challenges. Home modifications are allowing older adults to remain in their home.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Focus on home modificiations that address barriers to aging in place.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
2 - Maximize independence for older adults in day-to-day activities	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
3 - Explore other funding opportunities to expand accessibility to home modifications and repairs for older adults to age in place.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Explore all potential grant and funding opportunities to support home modifications	We will explore funding opportunities for a minumum of 3-5 different areas
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	1.) Funding availability and priority shifts 2.) Needs of community exceeds available funding resources				
Expected outcome(s) of this goal:	Our expected outcome is we are able to meet our targets and measures so that older adults can remain in their homes and age succesfully in place.				

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Priority Area (Please choose from drop down)	Reliable transportation				
Goal #1	Expansion of home52 Transportation Coordination Services to other counties in our service area				
how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and	Transportation is identified and recogized as a social determinant of health in our service area. home52 Transportation Coordination Center's model has been successful in Hamilton County based on rider feedback. We want to maintain this service in Hamilton County and expand the model in our service area.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Explore funding opportunities, with grants and traditional program funding, to provide free transportation services to older and disabled adults residing in Hamilton and Clermont County. This goal also extends to any other county expansion during this period.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Hamilton County Levy, Medicaid NEMT, Grants	Grant Writer, Transportation Manager, VP	Research grant opportunities using existing grant writing tools, create relationships with agencies serving like populations in Clermont County and explore partnering with them to serve their members.	Apply for a minimum of two grants annually to support this initiative. Complete five outreach activities to create &/or maintain relationships with Hamilton and Clermont County organizations.
2 - Rider survey satisfaction related to timely, reliable and easy scheduling is 92% or higher.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Hamilton County Levy, Medicaid NEMT, Grants	Specialist	Random riders will be selected to complete a phone survey within 3 days of ride completion.	Rider survey satisfaction related to timely, reliable and easy scheduling is 95% or higher.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Expanding home52 Transportation Coordination Services to other counties requires relationship building and collaborations with local organizations and public transit that currently provide transportation. Planning and collaboration highlights what is working well and how transportation coordination can fill the gaps and enhance current service levels for vulnerable populations				
Expected outcome(s) of this goal:	Collaboration with local transit and organizations providing transportation to improve and enhance existing transportation services and options for aging and disabled individuals.				

Priority Area (Please choose from drop down)	Reliable transportation
Goal #2	Care Management staff are educated on all available transportation options so that clients are fully informed of and able to access appropriate transportation resources within their

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).	Access to reliable transportation is essential for older adults to maintain independence in the community. Ensuring clients are knowledgeable about transportation options helps reduce barriers, improve access to services, and supports overall client well-being.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
2 - Transportation resource education will be provided	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Levy - all counties	Supervisors, Training	Create training covering all community transportation options and review for updates annually. Share training at department meetings and through email communications	Track how and when education and training is provided. Staff receive training on transportation options at least yearly
3 - Staff will document that they provided education on transportation resources to clients with transportation needs	Year 3 (of a Year 2-4 Goal) 10/1/2028 - 9/30/2029	Levy - all counties	Staff, Supervisors	Audit a sample of clients annually	90% of clients who reported transportation needs were educated on transportation resources based on documentation in the client record
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Transportation resources change frequently and vary by location.				
Expected outcome(s) of this goal:	Clients will be informed about resources available to meet their transportation needs				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #1	Expand Fast Track Home in all counties with a particular focus on Butler County.				
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).	Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 -Program Awareness	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Provide care transitions education to hospitals, SNF /rehabilitation facilities in our service area recognized for specializing in older adult care	Fast Track Home Team	Track outreach activities for each hospital	25 educational outreach activities her year
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	High staff turnover rates with discharge planners and social work staff employed with hospitals, SNF, rehabilitation facilities. Educational outreach activities often times have to be repeated 2 - 3 times annually.				
Expected outcome(s) of this goal:	Regular referrals from hospitals, SNF /rehabilitation facilities in our service area.				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #2	Provide Care Transitions services through MedMutual				
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).	Medical Mututal of Ohio Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Timely client engagement to explain program advantages	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Engage referrals received by Medical Mutual of Ohio to provide care tranisitons services	Engagement Specialist	Timely engage referrals	Engagement will be successful for 70% of the MMO referrals received.

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What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Ensuring automated referrals/alerts are received timely and patient contact informtion has been updated and accurate.
Expected outcome(s) of this goal:	More MMO members are offered and accept care transitions services which is intended to reduce readmissions.

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #3	Continue collaboration with the Veterans Administration and grow the Veterans Directed Care Program
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 Veteran Directed Care Program is a collaborative self directed program with Veteran Adminsitration focused on keeping veterans who are at a high risk of being placed in instintutional care due to a variety of co- occuring health conditions. Move to community supports and services section only

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Support the indivdiual at home with self directed personal care services	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Continue to collaborate with the VA and referrals for the VDC program	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
2 - Supports the caregiver - either to be paid to provide the service or additonal assistance to the caregiver for respite and to assist with daily caregiving related to personal care needs	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Meet with the VA on an as needed basis.	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
3 - Remain at home in the community and aging in place	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Enrolled veterans on the program will be able to remain at home in the community	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	This program is small currenlty and serves all ages so need to ensure only capturing 60+ population
this goal:	Continue to keep veterans in their own home in the community as well as provide additional support to the caregiver

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #4	Monitor data to improve access of services through collaborative networking and training.

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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 community we serve is increasingly diverse, with varying cultural, linguistic, socioeconomic, and accessibility needs. Ensuring equal access requires a data-informed approach that identifies disparities and guides targeted interventions. By leveraging comprehensive data analysis and cross-functional collaboration, the Community Access Workgroup can proactively address barriers, improve service delivery, and strengthen trust and participation within all segments of the community as well as appropriatley training staff on importance of identifying diversity

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
1 - Data Monitoring & Analysis Continuously collect, monitor, and analyze quantitative data to identify trends, disparities which allows us to brainstorm barriers impacting community access in Hamilton County	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Levy - Hamilton County	Transitional Care Supervisor Care Manager Staff	Monthly meetings to discuss and review data, trends findings and next steps for community outreach and collaborate on training.	COA will conitnue to gather collect and analzyze data that is gathered quartetly. The group will utilize the date to drive changes that reduces disparities and barriers.
2 - Cross-Sector Collaboration Partner with internal teams, external agencies, and community stakeholders to ensure solutions are culturally relevant and aligned with community needs- partner with external agencies at events and spread the word of COA at culturally appropriate events.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Levy - All counties	Transitional Care Supervisor Care Manager Staff	Group will collaborate and stratagize with applicable departments internally for community outreach events	continue to locate applicable events to we can attend and collaborate with.
3 - Capacity Building Promote organizational awareness and competency around appropriatley asking about race and ethnicity. We will create a training on the importance of it but also how to approratley ask and share with departments. We will have all applicable staff trained by the end of 2027 and thereafter annually at applicable department meetings. New staff will also be onboarded with the created training.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Levy - All counties	Transitional Care Supervisor Care Manager Staff	attend department meetings, create a training that can be given to new hires.	We will have all applicable staff trained by the end of 2027 and therafter annually as well as train new hires.

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What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Outside community factors with reaching additional populations. We may also see challenges with the populations we try and reach through events as we are not able to control turn out etc.
Expected outcome(s) of this goal:	Continue to attempt to access all populations that is represented in Hamilton County through community events, outreach training and collaboration

Priority Area (Please choose from drop down)	Community supports and services
Goal #1	Increase individuals awareness of services and supports that are available 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).	Individuals in the community aren't always aware to call their local AAA. Bringing the front door services out the community will increase awareness and connect more individuals to needed services to remain independent.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures

1 - Partner with the Hamilton County 513 Relief Bus to go out in the community and provide front door services	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Screening-PSP	Kim Clark Director - Community and Business Services Operations	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.
3 - Connect olders adults to services and supports that will allow them to remain as independent as possible	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Screening-PSP	Kim Clark	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	County controls calendar for bus events. Events may be mixes of ages and not just older adults. Only Hamilton Count has bus.				
Expected outcome(s) of this goal:	Older adults will have increased awareness of resources available.				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #2	Expand the UPLIFT program in Butler County				
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).	Mental Health Services for older adults has been identified as a need. Expansion of mental health services and supports will help meet this need.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
3 - Staff will be informed about mental health services and programming offered through UPLIFT and referral process	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	COA, Best Point	Shelby Stout	Provide education and training to staff on UPLIFT, services available and referral process	Education will be provided at least annually during department meetings.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients are hesitant to particiapte in mental health services due to stigma and perception of need				
Expected outcome(s) of this goal:	Clients, staff and other stakeholders will be informed of available mental health services and identified gaps in UPLIFT services will be addressed				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #3	Expand and strengthen the partnership with Senior Connections through collaborative efforts				
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).	Mental health services that include transportation was identified as a gap within our community. Partnerships with local community organization were created to attempt and bridge the gap of the accesability of services.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Refer applicable clients to the Senior connections program.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	COA, Mental Health Board	Judy And Alyssia VP - Community & New Business Operations Transitional Care Supervisor	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Monitor the referal number's
2 - Create Visability and Awarness for Senior connections liason to attend and collaborate at 2 events annually.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	COA, Mental Health Board	Judy And Alyssia	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Track the events attended

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3- Work with the senior connections liason to pinpoint specific areas where we can collabriativley and collectivley work to coordinate a referal stream.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	COA, Mental Health Board	Judy And Alyssia	attend quartlerly board meetings with senior connections and mental health board to continue to maintain referal stream	Monitor the referal number's
4 - Educate staff at applicable department meetings regarding the partnership with senior connections	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	COA, Mental Health Board	Judy And Alyssia	have senior connections contact come to applicable department meetings	Track meetings attended
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients in general are hesitient to access and seek access to mental health services, even if the referal is made we have no control of follow through or partcipation				
Expected outcome(s) of this goal:	Continue a sustaining relationship with senior connections which generates referals to them				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #4	Address a gap in available Guardianship services in Hamilton County by collaborating with local partners.				
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).	Individuals in need of a professional guardian, and a lack of resources and available guadians.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
2 - Develop and execute referral and payment procedures for individuals in need of a professional guardian.	Year 3 (of a Year 2-4 Goal) 10/1/2028 - 9/30/2029	Hamilton County Levy	Guardianship Collaborative	Develop a written procedure, test and refine it with feedback on its effectiveness with the 6 partering entities.	# of older adults served with guardianship services
3 - Evaluate the effectiveness of the new program.	Year 3 (of a Year 3-4 Goal) 10/1/2028 - 9/30/2029	Hamilton County Levy	Guardianship Collaborative	Leverage the expertise and resources of the collabortive.	Cost effectiveness, impact on the addressing the needs, and satisfaction.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Available funding from levies that are stretched thin with inflation and property tax pushback. This project relies on cooperation from 6 different entities which is very challenging.				
Expected outcome(s) of this goal:	Decrease the gap of individuals who present to probate court with a need for a professional guardian, and no local resource being available.				

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Priority Area (Please choose from drop down)	Community supports and services				
Goal #5	Expand and diversify evidenc-based programming in our service area				
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).	Older adults are more likely to participate in evidence-based health education programs when they are available in their neighborhoods where they frequent often. Diversifying program options attracts more older adult and caregiver participants.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Expand relationships with community organizations to host evidence-based health education programs.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Title III D	Health and Wellness Team	Leverage COA's relationships with non-profits, faith based organizations and senior housing facilities in our service area	Provide workshops for five (5) new host site sponsors annually
2 - Evaluate if additonal funding is needed to support program growth and expansion and explore grant funding to supplement when needed.	Year 3 (of a Year 3-4 Goal) 10/1/2028 - 9/30/2029	Title III D and possible grant funding	Health and Wellness Team	Leverage grant writer's expertise of foundation's priorities and mission	Apply for one grant to support evidence-basd programs in each of year 3 and 4.

barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these	The challenges are typical for any new Host Site Sponsors who have not offered programming to older adults in their communities. They include recruting, enaging,and supporting new participants to meet the fidelity requirements of evidence-based programs. COA's network of Community Leaders and Master Trainers support new Host Site Sponsors through this process. Another anticipated challenge may be found in the number of NCOA approved evidence-based programs that fit our hybrid community model. We will engage AGE and NCOA in addressing any concerns that may arise.
Expected outcome(s) of this goal:	We expect to increase our geopgraphic foot print for evidence-based programs by adding a minimum of five new neighborhood host site sponsor locations which will engage more older adults in program participation. We also expect to diversify our current programs by adding at least one more aapproved program in our service area before year 4 of this Area plan.

Priority Area (Please choose from drop down)	Community supports and services				
Goal #6	Address unmet needs identified in our Needs Assessment under independent living and community supports.				
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).	Explore and apply for grant funding opportunities for community supports and services such as lawn care, snow removal, and furniture need to remain independent in community and at home				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1- Explore and apply for any grant oppoturnity	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Grant Funding and potential Title III	Stephanie VP Managed Care & Aging Programs	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.
2 - Explore other avenues to pay for service need-donations, foundation opportunities.	Year 3 (of a Year 1-4 Goal) 10/1/2028 - 9/30/2029	Grant Funding and potential Title III	Stephanie	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.
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- no grant dollars available to meet the identified need				
this goal:	We expect to apply for some grant opportunities and explore other options such as foundations and private donations.				

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Priority Area (Please choose from drop down)	Caregiver supports				
Goal #1	Expand overnight respite options to include facility and/or an in-home respite option.				
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 Supports and Services was an identified high need as part of the needs assessment findings.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Supports the caregiver with respite options	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Expand facility options - 51 respite stay completed in 2025	1. Increase respite stays to average of 56/year
2 - Provides needed self care for the caregiver	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Pilot in-home respite options in year 2 with home care agencies.	1. Engage interest with home care providers providing in home respite options 2. Implement in October 2028
3 - Reduce caregiver stress and burnout	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	OAA, ESP levy, Alzheimers Respite Funds	Caregiver Support Team Lead & ESP Supervisor	Provide overnight respite options that support caregiver relief and time away from caregiving responsibilities.	Track overnight respite utilization and caregiver access to time away for rest and self-care.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	N/A for #1 inpatient respite. In home respite- capacity issue may be a barrier. Explore short term respite 3-4 days respite options.				
Expected outcome(s) of this goal:	Provide resources and support to the caregiver to decrease burnout and CG stress.				

Priority Area (Please choose from drop down)	Caregiver supports				
Goal #2	Increase use, increase sustainability, identify barriers and provide education on Adult Day.				
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).	Adult Day Services may be underutilized due to limited awareness and barriers to access. Education and collaboration across counties can support increased use and service sustainability.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Increase Care Coordinator knowledge of Adult Day services	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Title 3/OAAA/ESP	ESP Supervisor	Create and provide education to Care Coordinators on Adult Day Services and referral considerations.	Adult Day education will be distributed or presented across all 4 counties.
2 - Increase appropriate Adult Day Referrals	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Title 3/OAAA/ESP	ESP Supervisor	Coordinate Adult Day Provider Tours for staff.	Staff will be provided the opportunity to participate in tours/site visits with at least 2 Adult Day Providers.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Limited awareness of Adult Day Services. Client/caregiver hesitation or misconceptions about Adult Day. Transportation barriers and provider availaiblity and program capacity.				
Expected outcome(s) of this goal:	Increased staff understanding of Adult Day services and improve appropriate utilization.				

Priority Area (Please choose from drop down)	Caregiver supports				
Goal #3	Increase awareness of the Caregiver Support Program to help reduce stress and CG burnout				
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).	Caregivers reported strong need for support as they navigate caring for their loved one. Increased awareness and education for caregivers will help decrease their stress.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Increase awareness of CG Support program in our area through community events	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Title 3/OAAA/ESP	Care Managers	Attend community events and promoting CG Support program.	Track outreach efforts and caregiver enrollments connected to program promotion.
2 - Reduce stress and burnout through access to supports and resources.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Title 3/OAAA/ESP	Care Managers	Provide caregivers with education, resources, and referrals through the CG Support Program.	Track how and when education, resources, and referrals through the CG Support Program.
3 - Strengthen unpaid caregiver's ability to provide care.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Title 3/OAAA/ESP	Care Managers	Provide education and support to unpaid caregivers to build caregiving skills and confidence.	Track how and when education and support is provided to unpaid caregivers through the program.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Workload management for care managers.				

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Expected outcome(s) of this goal:	Increased CG enrollments and awareness of community supports and services for caregivers in our area				

Priority Area (Please choose from drop down)	Financial well-being				
Goal #1	Provide utility assistance and resources to older adults				
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).	Costs of utilities has continued to rise and has caused increased financial strain				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Assist eligible Hamiton County Older Adults with a one-time credit towards their utility bill	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
2 - Reduce some financial burden of utility expenses for older adults through outreach.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Hamilton County Levy Funding	Director - Community and Business Services Operations	Work with local county commissioners and outreach to maximize reach and ensure all areas of county are represented	600 individuals served per calendar year
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Funding each year is not necessarily guaranteed. Funding is available at the beginning of each calendar year and not availabe throughout the year due to high demand. Funding is also limited to Hamilton County.				
Expected outcome(s) of this goal:	Older adults will have awareness of utility credits and understand how to apply. Older adults that are eligible and receive the one time credit will have reduced financial burden.				

Priority Area (Please choose from drop down)	Financial well-being				
Goal #2	Connect inviduals with available resources through their Medicare Advantage plan				
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 is a great need for older adults. Many individuals with medicaid advantage plans are unaware of how to access the transportation benefit along with other available benefits that can help them maintain support and independence.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Provide assistance to individuals with medicare advantage plans and connect them with benefits	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide internal resource to assist individuals with understanding and connecting with their Medicare benefits.	Assist 1500 individuals through 9/30/30
2 - Educate individuals on the benefits that their advantage plan may provide	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide education, awareness and referral process	Assist 1500 individuals through 9/30/30
3 - Connect individuals to transportation benefit that will provide individual ability to routinely attend necessary appointments	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Levy funding and PSP	Benefits Specialists Director - Community and Business Services Operations	Provide connection to health plan to get needed services set up. Call health plan with client if assistance is needed.	Assist 1500 individuals through 9/30/30
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Navigation of medicare advantage plans can be diffucult. Individuals often don't know which exact advantage plan they are enrolled with. Coordination on some may take longer.				
Expected outcome(s) of this goal:	Individuals with medicare advantage plan will be connected to available resources				

Priority Area (Please choose from drop down)	Healthy food access				
Goal #1	Enhance congregate meal options in restaurant setting (Swipe N' Dine program) by establishing additional restaurant-based partnerships in Hamilton County and expand into Butler, Clermont, Clinton and Warren Counties				
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 Swipe N' Dine program promotes health, enhances nutritional intake, and supports social engagement in community-based settings beyond traditional senior centers. Program can be beneficial to a larger audience with focus on greatest social and economic needs.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Competitive Bid Process with the release of a Title III RFP in 2027	Year 4 (of a Year 2-4 Goal) 10/1/2029 - 9/30/2030	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Incorporate clear program details and requirements into the Title III Request for Proposals (RFP) to support and achieve the intended goals of program expansion.	Procure Provider(s) with capacity to operate and manage program in all 5 counties in our region. List of procured providers and counties served

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2 - Community Promotion of program to areas with greatest social and economic needs	Year 4 (of a Year 2-4 Goal) 10/1/2029 - 9/30/2030	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Prioritize targeted communication and outreach efforts to promote program awareness among individuals in communities with the greatest social and economic need.	approval of participants in areas of identified communities of greatest social and economic needs. # of new participants in areas of greatest need.
3 - Education to Restaurants- program details, responsibilities and partnership benefits in community with greatest social and economic needs.	Year 4 (of a Year 2-4 Goal) 10/1/2029 - 9/30/2030	OAA funds	Nutrition Business Relations Partner Procurement and Provider Services Manager	Develop program education materials, provide clear and user-friendly demonstrations for participating restaurants, and facilitate peer-to-peer support by connecting prospective restaurant partners with currently participating restaurants within or outside the region.	Restaurant participation- addition of 2 restaurants in Hamilton County. 1 participating restaurant in Butler, Clermont, Clinton and Warren Counties. # of new partnerships/collaberations
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Lack of qualifying restaurants in communities with greatest need. Lack of interest from Restaurants Flat funding which hinders growth				
Expected outcome(s) of this goal:	Expansion of Swipe N' Dine program to all 5 counties in our region.				

Priority Area (Please choose from drop down)	Healthy food access				
Goal #2	Increase in redemption rate in the 5 counties in our region for the Senior Farmers Market Nutrition Program (SFMNP)				
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).	Insert needs assessment language- Redemption rates for the 2025 SFMNP did not meet expectations, indicating that program participants were not fully utilizing their allotted benefits.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Use Ohio Farmers Market Network (OFMN) map of approved markets to identify gaps in communities of greatest need. Partner with OFMN to identify markets and promote application and approval of new markets	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Use Policy Map platform/website to map out farmers markets and roadside stands. Use Policy Map platform/website to map out residents age 60+ in low economic areas.	Increase in number of farmers markets/roadside stands that are in close proximity to those in greatest need. # of new markets in communities of greatest need
2 - Survey 2025 participants who did not use the benefits on barriers	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, social media platforms and during community outreach to identify barriers to program participation.	Conduct data analysis to identify barriers and develop strategies to address them.
3 - Investigate alternative methods of redemption- such as produce delivery, transportation to market	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	USDA/Ohio GRF	Nutrition Business Relations Partner Procurement and Provider Services Manager	Distribute a survey through email, text messaging, and social media platforms to gather input from the following stakeholders: •Farmers and markets to assess interest and capacity to deliver produce •Community senior housing managers to evaluate the ability to accept and distribute produce •Contracted providers to support produce distribution efforts	Conduct data analysis to identify interest and capacity to provide/promote alternative methods of benefit redemption
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Lack of approved markets in areas of great need Lack of available resources to transport participants to market Limited alternative methods such as produce delivery Delay in distribution of physical cards				
Expected outcome(s) of this goal:	Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region Increased redemption rate in the 5 counties in our region				

Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #1	Provide individuals with a resource to search available housing options in their 5 county region.				
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 is a need that has been continuously identified as limited. While housing options are limited, individuals need information to search all housing options that are in the community				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Individuals will be able to search COA housing database to assist with the exploration of housing	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	ADRC/PSP	Director - Community and Business Services Operations	Add new housing options as we are made aware.	10,000 inviduals accessing the database
2 - ADRC specialist will have the resource to navigate and provide information to callers	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	ADRC/PSP	Director - Community and Business Services Operations	Ensure database is always accessible	Database is active

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What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Affordable and quality housing availablity is limited. Buildings have waitlists and tracking of that can be difficult
Expected outcome(s) of this goal:	Individuals will be able to access database with list of housing resources and have needed information to contact buildings to ascertain what is available.

Priority Area (Please choose from drop down)	Safe and accessible housing				
Goal #2	Provide options and explore all grant opportunities that support home modifications and repairs and provide those oportunities to enable older adults to remain safe, independent and at				
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).	Based on the community needs assessments, older adults expressed a desire to age in place and to remain in their homes but face housing challenges. Home modifications are allowing older adults to remain in their home.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Focus on home modificiations that address barriers to aging in place.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
2 - Maximize independence for older adults in day-to-day activities	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Follow COA's outreach plan and initiatives	We will serve 150 older adults.
3 - Explore other funding opportunities to expand accessibility to home modifications and repairs for older adults to age in place.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Grant/levy funds	ESP Supervisors ESP Program Coordinator	Explore all potential grant and funding opportunities to support home modifications	We will explore funding opportunities for a minumum of 3-5 different areas
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	1.) Funding availability and priority shifts 2.) Needs of community exceeds available funding resources				
Expected outcome(s) of this goal:	Our expected outcome is we are able to meet our targets and measures so that older adults can remain in their homes and age succesfully in place.				

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Priority Area (Please choose from drop down)	Reliable transportation				
Goal #1	Expansion of home52 Transportation Coordination Services to other counties in our service area				
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 is identified and recogized as a social determinant of health in our service area. home52 Transportation Coordination Center's model has been successful in Hamilton County based on rider feedback. We want to maintain this service in Hamilton County and expand the model in our service area.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Explore funding opportunities, with grants and traditional program funding, to provide free transportation services to older and disabled adults residing in Hamilton and Clermont County. This goal also extends to any other county expansion during this period.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Hamilton County Levy, Medicaid NEMT, Grants	Grant Writer, Transportation Manager, VP	Research grant opportunities using existing grant writing tools, create relationships with agencies serving like populations in Clermont County and explore partnering with them to serve their members.	Apply for a minimum of two grants annually to support this initiative. Complete five outreach activities to create &/or maintain relationships with Hamilton and Clermont County organizations.
2 - Rider survey satisfaction related to timely, reliable and easy scheduling is 92% or higher.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Hamilton County Levy, Medicaid NEMT, Grants	Specialist	Random riders will be selected to complete a phone survey within 3 days of ride completion.	Rider survey satisfaction related to timely, reliable and easy scheduling is 95% or higher.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Expanding home52 Transportation Coordination Services to other counties requires relationship building and collaborations with local organizations and public transit that currently provide transportation. Planning and collaboration highlights what is working well and how transportation coordination can fill the gaps and enhance current service levels for vulnerable populations				
Expected outcome(s) of this goal:	Collaboration with local transit and organizations providing transportation to improve and enhance existing transportation services and options for aging and disabled individuals.				

Priority Area (Please choose from drop down)	Reliable transportation				
Goal #2	Care Management staff are educated on all available transportation options so that clients are fully informed of and able to access appropriate transportation resources within their				
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).	Access to reliable transportation is essential for older adults to maintain independence in the community. Ensuring clients are knowledgeable about transportation options helps reduce barriers, improve access to services, and supports overall client well-being.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
2 - Transportation resource education will be provided	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Levy - all counties	Supervisors, Training	Create training covering all community transportation options and review for updates annually. Share training at department meetings and through email communications	Track how and when education and training is provided. Staff receive training on transportation options at least yearly

3 - Staff will document that they provided education on transportation resources to clients with transportation needs	Year 4 (of a Year 2-4 Goal) 10/1/2029 - 9/30/2030	Levy - all counties	Staff, Supervisors	Audit a sample of clients annually	90% of clients who reported transportation needs were educated on transportation resources based on documentation in the client record
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Transportation resources change frequently and vary by location.				
Expected outcome(s) of this goal:	Clients will be informed about resources available to meet their transportation needs				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #1	Expand Fast Track Home in all counties with a particular focus on Butler County.				
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).	Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 -Program Awareness	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Provide care transitions education to hospitals, SNF /rehabilitation facilities in our service area recognized for specializing in older adult care	Fast Track Home Team	Track outreach activities for each hospital	25 educational outreach activities her year
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	High staff turnover rates with discharge planners and social work staff employed with hospitals, SNF, rehabilitation facilities. Educational outreach activities often times have to be repeated 2 - 3 times annually.				
Expected outcome(s) of this goal:	Regular referrals from hospitals, SNF /rehabilitation facilities in our service area.				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #2	Provide Care Transitions services through MedMutual				
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).	Medical Mututal of Ohio Care Transitions is an evidence-based program approach to reduce hospital re-admissions for older adults.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Timely client engagement to explain program advantages	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Engage referrals received by Medical Mutual of Ohio to provide care tranisitons services	Engagement Specialist	Timely engage referrals	Engagement will be successful for 70% of the MMO referrals received.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Ensuring automated referrals/alerts are received timely and patient contact informtion has been updated and accurate.				
Expected outcome(s) of this goal:	More MMO members are offered and accept care transitions services which is intended to reduce readmissions.				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #3	Continue collaboration with the Veterans Administration and grow the Veterans Directed Care Program				
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 Veteran Directed Care Program is a collaborative self directed program with Veteran Adminsitration focused on keeping veterans who are at a high risk of being placed in instintutional care due to a variety of co- occuring health conditions. Move to community supports and services section only				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Support the indivdiual at home with self directed personal care services	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Continue to collaborate with the VA and referrals for the VDC program	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.

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2 - Supports the caregiver - either to be paid to provide the service or additonal assistance to the caregiver for respite and to assist with daily caregiving related to personal care needs	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Meet with the VA on an as needed basis.	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
3 - Remain at home in the community and aging in place	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Self Directed Care Model and VA funds the program	VP Managed Care & Aging Programs Transitional Care Supervisor	Enrolled veterans on the program will be able to remain at home in the community	1. COA collaborates with the Veteran Administration to offer another option for home and community based programs for eligible veterans 2. Measurement to show the number of veterans aged 60 and over that were able to remain at home in the community instead of going into long term placement.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	This program is small currenlty and serves all ages so need to ensure only capturing 60+ population				
Expected outcome(s) of this goal:	Continue to keep veterans in their own home in the community as well as provide additional support to the caregiver				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare				
Goal #4	Monitor data to improve access of services through collaborative networking and training.				
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 community we serve is increasingly diverse, with varying cultural, linguistic, socioeconomic, and accessibility needs. Ensuring equal access requires a data-informed approach that identifies disparities and guides targeted interventions. By leveraging comprehensive data analysis and cross-functional collaboration, the Community Access Workgroup can proactively address barriers, improve service delivery, and strengthen trust and participation within all segments of the community as well as appropriatley training staff on importance of identifying diversity				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Data Monitoring & Analysis Continuously collect, monitor, and analyze quantitative data to identify trends, disparities which allows us to brainstorm barriers impacting community access in Hamilton County	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Levy - Hamilton County	Transitional Care Supervisor Care Manager Staff	Monthly meetings to discuss and review data, trends findings and next steps for community outreach and collaborate on training.	COA will conitnue to gather collect and analzyze data that is gathered quartetly. The group will utilize the date to drive changes that reduces disparities and barriers.
2 - Cross-Sector Collaboration Partner with internal teams, external agencies, and community stakeholders to ensure solutions are culturally relevant and aligned with community needs- partner with external agencies at events and spread the word of COA at culturally appropriate events.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Levy - All counties	Transitional Care Supervisor Care Manager Staff	Group will collaborate and stratagize with applicable departments internally for community outreach events	continue to locate applicable events to we can attend and collaborate with.
3 - Capacity Building Promote organizational awareness and competency around appropriatley asking about race and ethnicity. We will create a training on the importance of it but also how to approratley ask and share with departments. We will have all applicable staff trained by the end of 2027 and thereafter annually at applicable department meetings. New staff will also be onboarded with the created training.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Levy - All counties	Transitional Care Supervisor Care Manager Staff	attend department meetings, create a training that can be given to new hires.	We will have all applicable staff trained by the end of 2027 and therafter annually as well as train new hires.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Outside community factors with reaching additional populations. We may also see challenges with the populations we try and reach through events as we are not able to control turn out etc.				
Expected outcome(s) of this goal:	Continue to attempt to access all populations that is represented in Hamilton County through community events, outreach training and collaboration				

Priority Area (Please choose from drop down)	Community supports and services
Goal #1	Increase individuals awareness of services and supports that are available in the community

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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).	Individuals in the community aren't always aware to call their local AAA. Bringing the front door services out the community will increase awareness and connect more individuals to needed services to remain independent.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Partner with the Hamilton County 513 Relief Bus to go out in the community and provide front door services	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Screening-PSP	Kim Clark Director - Community and Business Services Operations	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.
3 - Connect olders adults to services and supports that will allow them to remain as independent as possible	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Screening-PSP	Kim Clark	Collaborate with 513 Reilef Bus for COA to provide screening services at events	Attend 513 relief bus events in each calendar year as long as bus is in operation Bus usually operates March through Sept/Oct. Attend 12 events in each calendar year.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	County controls calendar for bus events. Events may be mixes of ages and not just older adults. Only Hamilton Count has bus.				
Expected outcome(s) of this goal:	Older adults will have increased awareness of resources available.				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #2	Expand the UPLIFT program in Butler County				
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).	Mental Health Services for older adults has been identified as a need. Expansion of mental health services and supports will help meet this need.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
3 - Staff will be informed about mental health services and programming offered through UPLIFT and referral process	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	COA, Best Point	Shelby Stout	Provide education and training to staff on UPLIFT, services available and referral process	Education will be provided at least annually during department meetings.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients are hesitant to particiapte in mental health services due to stigma and perception of need				
Expected outcome(s) of this goal:	Clients, staff and other stakeholders will be informed of available mental health services and identified gaps in UPLIFT services will be addressed				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #3	Expand and strengthen the partnership with Senior Connections through collaborative efforts				
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).	Mental health services that include transportation was identified as a gap within our community. Partnerships with local community organization were created to attempt and bridge the gap of the accesability of services.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1 - Refer applicable clients to the Senior connections program.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	COA, Mental Health Board	Judy And Alyssia VP - Community & New Business Operations Transitional Care Supervisor	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Monitor the referal number's
2 - Create Visability and Awarness for Senior connections liason to attend and collaborate at 2 events annually.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	COA, Mental Health Board	Judy And Alyssia	Collaborate with senior connection liason, and identify 2 events annually for them to attend to provide information on the program and refeal process.	Track the events attended
3- Work with the senior connections liason to pinpoint specific areas where we can collabriativley and collectivley work to coordinate a referal stream.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	COA, Mental Health Board	Judy And Alyssia	attend quartlerly board meetings with senior connections and mental health board to continue to maintain referal stream	Monitor the referal number's
4 - Educate staff at applicable department meetings regarding the partnership with senior connections	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	COA, Mental Health Board	Judy And Alyssia	have senior connections contact come to applicable department meetings	Track meetings attended
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Clients in general are hesitient to access and seek access to mental health services, even if the referal is made we have no control of follow through or partcipation				
Expected outcome(s) of this goal:	Continue a sustaining relationship with senior connections which generates referals to them				

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Priority Area (Please choose from drop down)	Community supports and services				
Goal #4	Address a gap in available Guardianship services in Hamilton County by collaborating with local partners.				
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).	Individuals in need of a professional guardian, and a lack of resources and available guadians.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
2 - Develop and execute referral and payment procedures for individuals in need of a professional guardian.	Year 4 (of a Year 2-4 Goal) 10/1/2029 - 9/30/2030	Hamilton County Levy	Guardianship Collaborative	Develop a written procedure, test and refine it with feedback on its effectiveness with the 6 partering entities.	# of older adults served with guardianship services
3 - Evaluate the effectiveness of the new program.	Year 4 (of a Year 3-4 Goal) 10/1/2029 - 9/30/2030	Hamilton County Levy	Guardianship Collaborative	Leverage the expertise and resources of the collabortive.	Cost effectiveness, impact on the addressing the needs, and satisfaction.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Available funding from levies that are stretched thin with inflation and property tax pushback. This project relies on cooperation from 6 different entities which is very challenging.				
Expected outcome(s) of this goal:	Decrease the gap of individuals who present to probate court with a need for a professional guardian, and no local resource being available.				

Priority Area (Please choose from drop down)	Community supports and services				
Goal #5	Expand and diversify evidenc-based programming in our service area				
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).	Older adults are more likely to participate in evidence-based health education programs when they are available in their neighborhoods where they frequent often. Diversifying program options attracts more older adult and caregiver participants.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
Expand relationships with community organizations to host evidence-based health education programs.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Title III D	Health and Wellness Team	Leverage COA's relationships with non-profits, faith based organizations and senior housing facilities in our service area	Provide workshops for five (5) new host site sponsors annually
2 - Evaluate if additonal funding is needed to support program growth and expansion and explore grant funding to supplement when needed.	Year 4 (of a Year 3-4 Goal) 10/1/2029 - 9/30/2030	Title III D and possible grant funding	Health and Wellness Team	Leverage grant writer's expertise of foundation's priorities and mission	Apply for one grant to support evidence-basd programs in each of year 3 and 4.
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	The challenges are typical for any new Host Site Sponsors who have not offered programming to older adults in their communities. They include recruting, enaging,and supporting new participants to meet the fidelity requirements of evidence-based programs. COA's network of Community Leaders and Master Trainers support new Host Site Sponsors through this process. Another anticipated challenge may be found in the number of NCOA approved evidence-based programs that fit our hybrid community model. We will engage AGE and NCOA in addressing any concerns that may arise.				
Expected outcome(s) of this goal:	We expect to increase our geopgraphic foot print for evidence-based programs by adding a minimum of five new neighborhood host site sponsor locations which will engage more older adults in program participation. We also expect to diversify our current programs by adding at least one more aapproved program in our service area before year 4 of this Area plan.				

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Priority Area (Please choose from drop down)	Community supports and services				
Goal #6	Address unmet needs identified in our Needs Assessment under independent living and community supports.				
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).	Explore and apply for grant funding opportunities for community supports and services such as lawn care, snow removal, and furniture need to remain independent in community and at home				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1- Explore and apply for any grant opporturnity	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Grant Funding and potential Title III	Stephanie VP Managed Care & Aging Programs	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.
2 - Explore other avenues to pay for service need- donations, foundation opportunities.	Year 4 (of a Year 1-4 Goal) 10/1/2029 - 9/30/2030	Grant Funding and potential Title III	Stephanie	Will work with grant team to explore, idenfity and apply for any grant and or funding opportunity available.	Report on the number of grant applications that are applied for.
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- no grant dollars available to meet the identified need				
Expected outcome(s) of this goal:	We expect to apply for some grant opportunities and explore other options such as foundations and private donations.				

2025 & 2026 Southwestern Ohio Community Needs Assessment Survey

May 30, 2025 & April 2, 2026

Introduction and Background

Southwestern Ohio, encompassing the five counties of Butler, Clermont, Clinton, Hamilton, and Warren, is experiencing a significant demographic shift as the population ages. The southwestern region includes urban areas like Cincinnati as well as suburban and rural communities, each with distinct aging-related needs and resources. As a result, tailored strategies are necessary to ensure aging services are responsive to each community's unique characteristics and challenges.

Council on Aging of Southwestern Ohio (COA) is the Area Agency on Aging serving this region. In this role, COA administers programs designed to support the mission of keeping older adults and those with disabilities living independently in the community, as opposed to residing in long-term care facilities. Programs administered include Medicaid Waiver programs such as PASSPORT and the assisted living waiver, MyCare Ohio, and Elderly Services Program, which is funded by county property tax levies in COA's service area. Services include home-delivered meals, personal care, caregiver support, transportation, home modifications, and case management, among others.

Community Needs Assessment Survey

From February 13 through April 30, 2025, COA conducted a 2025 Southwestern Ohio Community Needs Assessment Survey of its region. COA reopened the needs assessment survey between February and March 2026 to Older adults, caregivers, and professionals in the aging services network. The survey had thirty-four questions and included open-ended responses, multiple-choice responses, Likert scales, and a numeric rating scale. The survey was intended to be completed online, but paper versions were available for older adults by request. COA promoted the survey in local news outlets, at community outreach events, on social media, and through its e-newsletter. COA staff conducted outreach at its health and wellness sites and in area senior apartment buildings. In total, the survey was completed by 1,311 respondents.

The survey used for the needs assessment focused primarily on questions about the respondents' desires to age in the community and knowledge about the availability of resources to support older people. Specific questions included a rating of the importance of staying in one's current home, typical ways to transport oneself, and whether the respondent had difficulty having their needs met. Demographic characteristics of respondents were also collected.

Demographics

The Southwestern Ohio Community Needs Assessment gathered input from a total of 1,311 participants (Table 1).

Older Adults	Aging Services Professionals	Caregivers
871	169	271 190 were also older adults

Table 1: Breakdown of Survey Participants, by Stakeholder Group

As expected, based on its population size, Hamilton County contributed the most responses, representing 51.72% of all survey participants. Butler County followed with 14.57%, while Clermont (10.68%), Clinton (9.15%), and Warren (9.61%) counties also had notable participation (Figure 1).

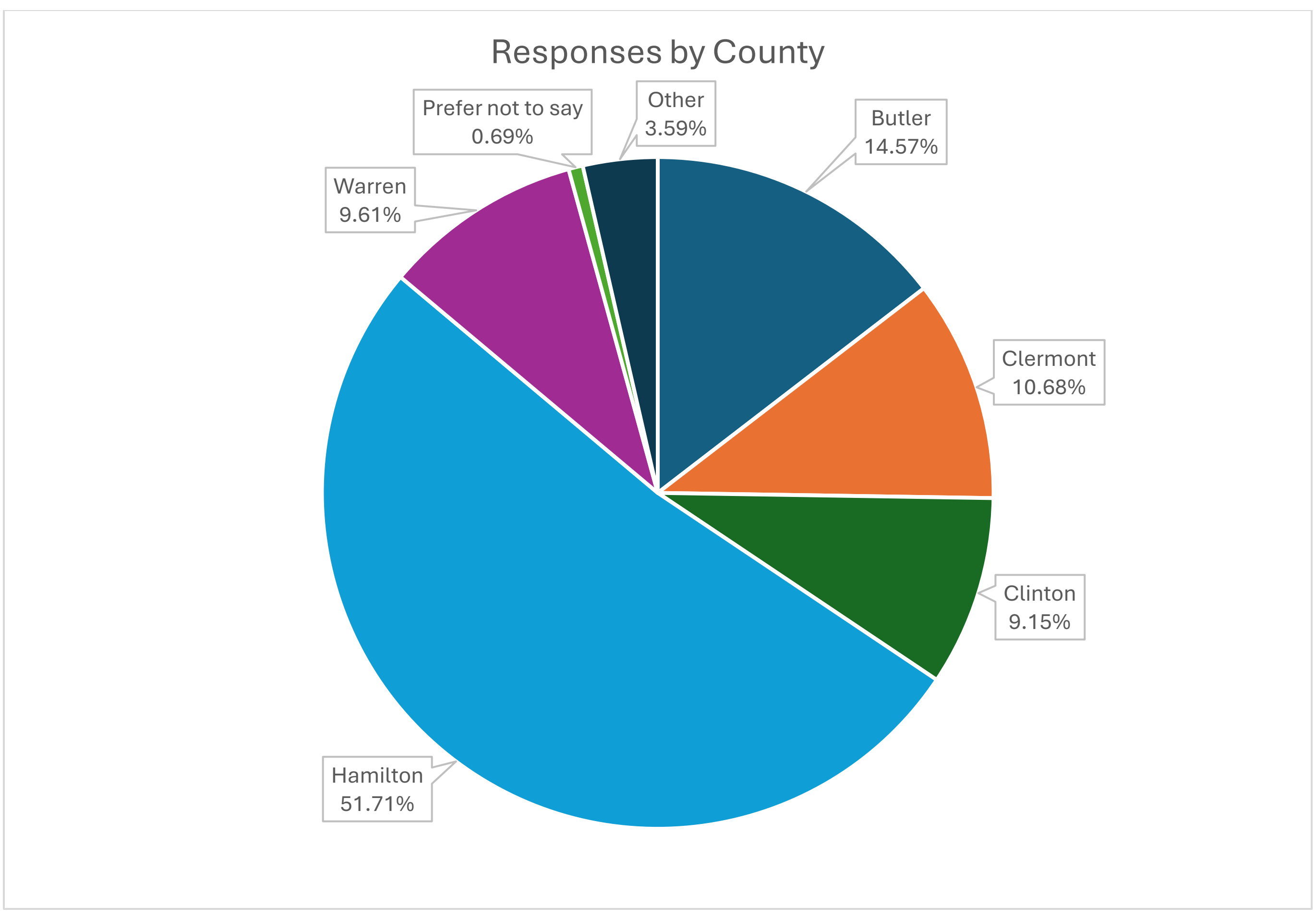

Figure 1: Survey Responses by County

Age Distribution and Gender

The age distribution confirms that the survey primarily engaged older adults. The largest age group was 65–74 years, accounting for 45.10% of respondents. This was followed by individuals aged 75–84 (23.82%) and those aged 60–64 (10.77%). A small percentage (1.75%) of participants were under age 40, and 1.49% did not report their age.

Among the 1,142 respondents who shared their gender, 81.79% identified as female, 15.76% as male, and 2.45% chose not to disclose their gender.

Health Status Ranking

Respondents rated their health on a scale from 1 (poor) to 10 (excellent). Both the average and median ratings were seven, suggesting positive health perceptions. The most common ratings were 8 (27.32%), 7 (21.98%), and 9 (12.78%), indicating most participants viewed their health as above average. Very few rated their health at the lowest levels, with only 0.09% selecting 1, and 0.70% selecting 2.

Living Arrangements

When asked about living situations, responses indicated a potential risk for social isolation. A significant portion of respondents, 40.81%, reported living alone. Another 38.88% lived with a spouse or significant other. Multi-generational households accounted for 6.57% of responses. Smaller

proportions reported living with an adult child (4.20%) or another family member (2.89%). Additionally, 3.68% selected “other,” citing arrangements such as living in a nursing home or with a sibling, or previous options already listed, such as living with a spouse, living with an adult child, or living alone.

Key Findings

The survey revealed clear themes related to caregiving strain, housing instability, barriers to aging in place, and difficulties managing daily tasks. Respondents also highlighted transportation limitations and social isolation as pressing concerns. These findings underscore the urgent need for targeted strategies and resources to support the well-being and independence of the aging population in Southwestern Ohio.

Caregiving Strain

The data illustrate that caregiving has profound and multifaceted impacts on respondents' lives. Among the 271 individuals who answered the caregiving section, a vast majority reported significant personal, professional, emotional, and financial consequences stemming from their caregiving responsibilities (Table 2).

Nearly three-quarters (74.17%) said they have cut back or postponed personal activities they enjoy due to caregiving, highlighting the strain on personal time and self-care, and 42.44% reported taking time off work for caregiving responsibilities. Emotional tolls were also prevalent, as 64.94% of respondents reported feeling fatigued, stressed, or unhappy, and an equal percentage said caregiving had negatively affected their mental or emotional health.

Life Impacts/Changes	Percent Responding Yes
Cut Back on Personal & Enjoyable Activities	74.17%
Impacted Mental/Emotional Health	65.31%
Felt Fatigued, Stressed, and/or Unhappy	64.94%
Impacted Personal Relationships	52.03%
Impacted Physical Health	44.65%
Time Off Work	42.44%
Financial Impact	40.59%
Decreased Work Hours	20.30%

Table 2: Reported Impact of Caregiving

Several respondents offered qualitative responses under “Other,” describing caregiving as “overwhelming,” affecting “all aspects of life,” or leading to other issues such as job loss, lack of help, and inability to manage household tasks. Moreover, 48.71% of the caregiver respondents reported they need time away from caregiving, or respite care, and 65.68% reported they needed a caregiver support program. These responses reflect the complex and often burdensome realities caregivers face, reinforcing the need for comprehensive caregiver support services in the region.

Housing Instability and Financial Burden

Nearly two-thirds (64.18%) of participants described the affordability of their current housing as completely unaffordable (33.65%) or slightly unaffordable (30.54%). When asked whether affordable and appropriate housing options are available in their area, most respondents (60.51%) answered "no."

Another 31.10% said they were "not sure," indicating uncertainty or lack of visibility around viable housing options. Only 7.45% of respondents believed affordable and appropriate housing is currently available in their community.

Regarding specific housing-related financial concerns, 89.07% reported they were concerned with paying utilities, rent/mortgage, and/or property taxes (Figure 2). More than half of the participants (68.52%) felt that rising economic costs would have an impact on their quality of life.

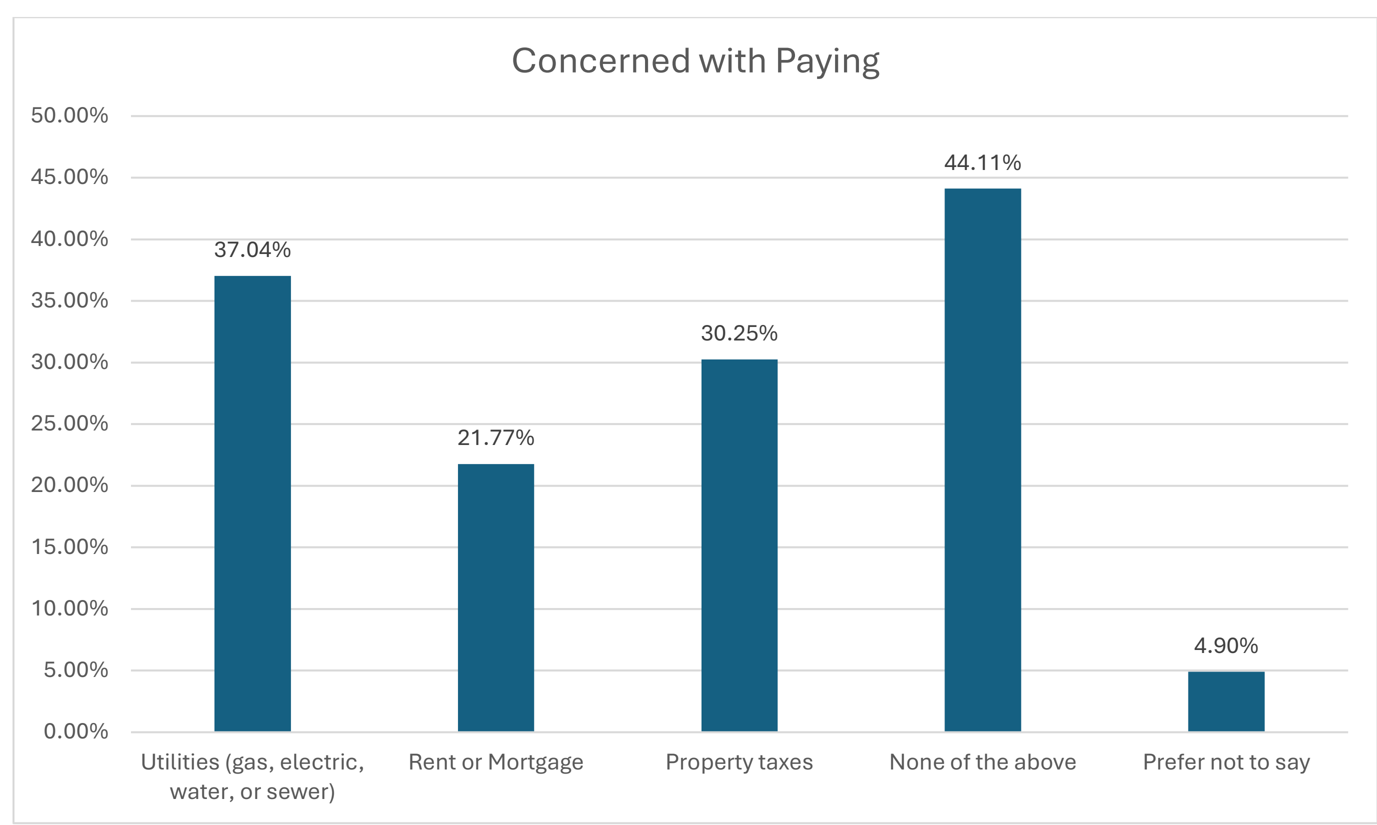

Figure 2: Concerns with Housing-Related Expenses

Despite these challenges and the prior housing affordability responses noted above, 44.11% of respondents reported no concerns about paying for utilities, rent/mortgage, or property taxes, suggesting some variation in financial stability across the population. A small portion (4.90%) chose not to disclose their concerns.

Aging-in-Place Barriers

Survey respondents overwhelmingly expressed a desire to age in place, with 79.36% stating that it is either “very important” (46.94%) or “absolutely essential” (32.42%) to remain in their homes as they grow older. However, many respondents face housing challenges that could undermine their desire. Only 37.32% reported that their current home fully meets their needs as they age. Whereas 58.44% reported that their current housing situation needed minor adjustments, will need adjustments, or cannot meet needs (Figure 3).

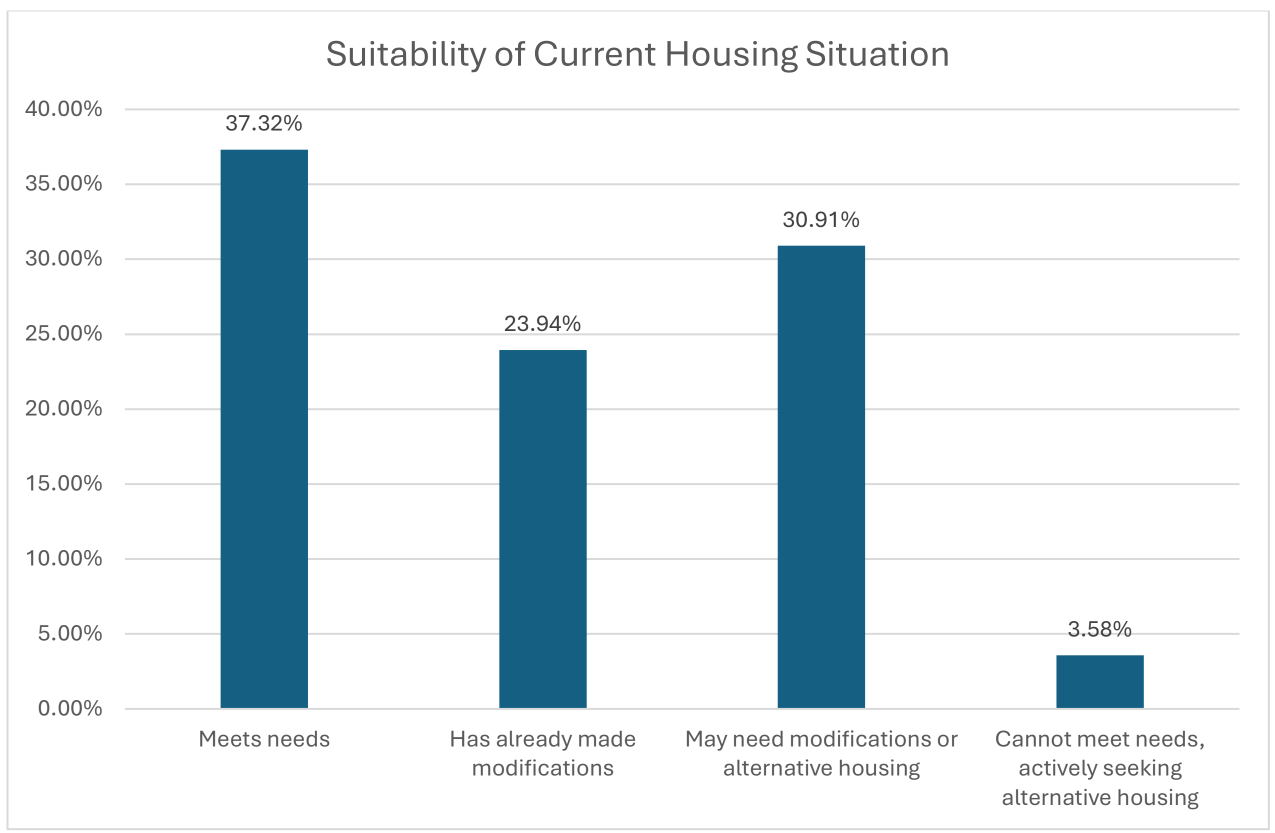

Figure 3: Suitability of Current Housing to Meet Needs During Aging Process

Responses to the open-ended “Other” category further illustrate the complexity of housing-related challenges. Participants cited issues such as the inability to afford their current home, difficulties maintaining the property, unsafe or deteriorating neighborhoods (including those in subsidized housing), and an urgent need for home modifications.

Challenges Managing Daily Activities

Respondents reported difficulty managing daily tasks essential to maintaining independence and home safety, again threatening the ability to age-in-place. The most cited challenges were home repairs (58.91%) and yard work or tree care (52.21%), both of which often require physical labor, tools, or hired assistance, which may be difficult for older adults to access or afford.

General cleaning and household management were also significant barriers, with 40.72% of respondents identifying them as a challenge. Smaller, but still notable, percentages reported difficulty with managing household paperwork (9.33%) and personal care tasks, such as bathing and grooming (6.50%).

While 19.98% of respondents indicated they did not have trouble with any of the listed tasks, the majority expressed some level of need for support in maintaining their homes and personal routines. The findings suggest that older adults could benefit from expanded access to in-home services, home modifications, and routine maintenance assistance to remain safe and comfortable in their homes.

Transportation Challenges

The transportation questions of the survey were created to be “select all which apply,” meaning respondents could select more than one option. Of the respondents, 84% reported they can drive themselves, indicating that many currently maintain independence in meeting their transportation needs. Additionally, 23.09% rely on family or friends, and smaller portions use private ride services like Uber or Lyft (6.03%), public transportation or community shuttles (4.71%), or walk to get where they need to go (1.60%).

While three-quarters (77.38%) indicated transportation is not a barrier in their lives, a closer look reveals transportation is still a critical issue for a segment of the population (Figure 4). These limitations contribute to social isolation, missed medical care, and reduced quality of life.

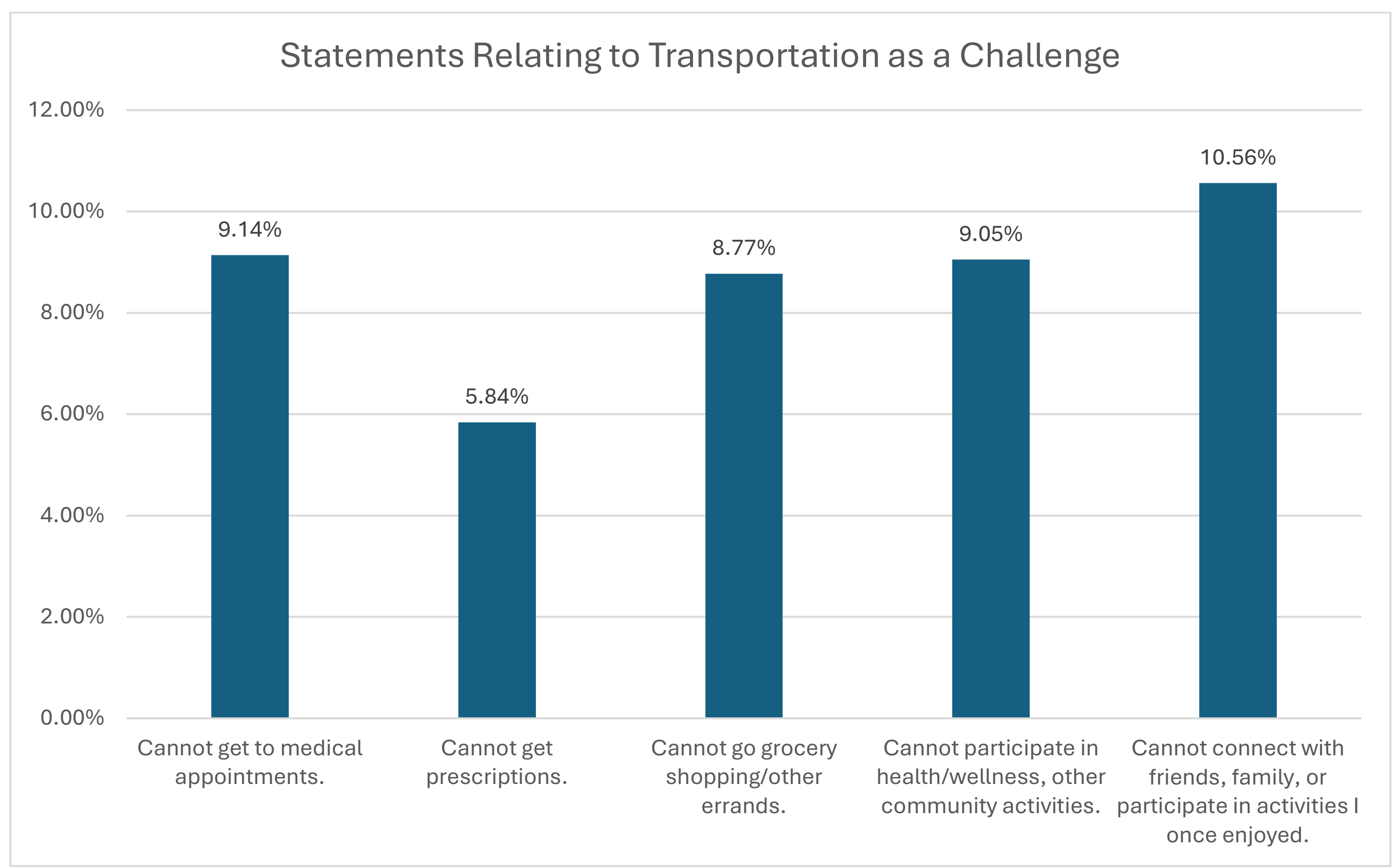

Figure 4: Impact of Transportation Challenges

Respondents also identified specific challenges with public transportation. The most frequently cited issue was a lack of available options nearby (27.14%), followed by accessibility concerns related to physical ability or proximity to services (22.34%). Other concerns included inconsistent schedules or delays (15.55%) and cost (10.27%). Open-ended responses added further context, with comments noting unfamiliarity with routes, long ride times, limited out-of-town services, and issues with safety, cleanliness, or inconvenient hours. Additionally, 63.43% of respondents rated the quality of public transportation as “poor” or “fair” (Figure 5).

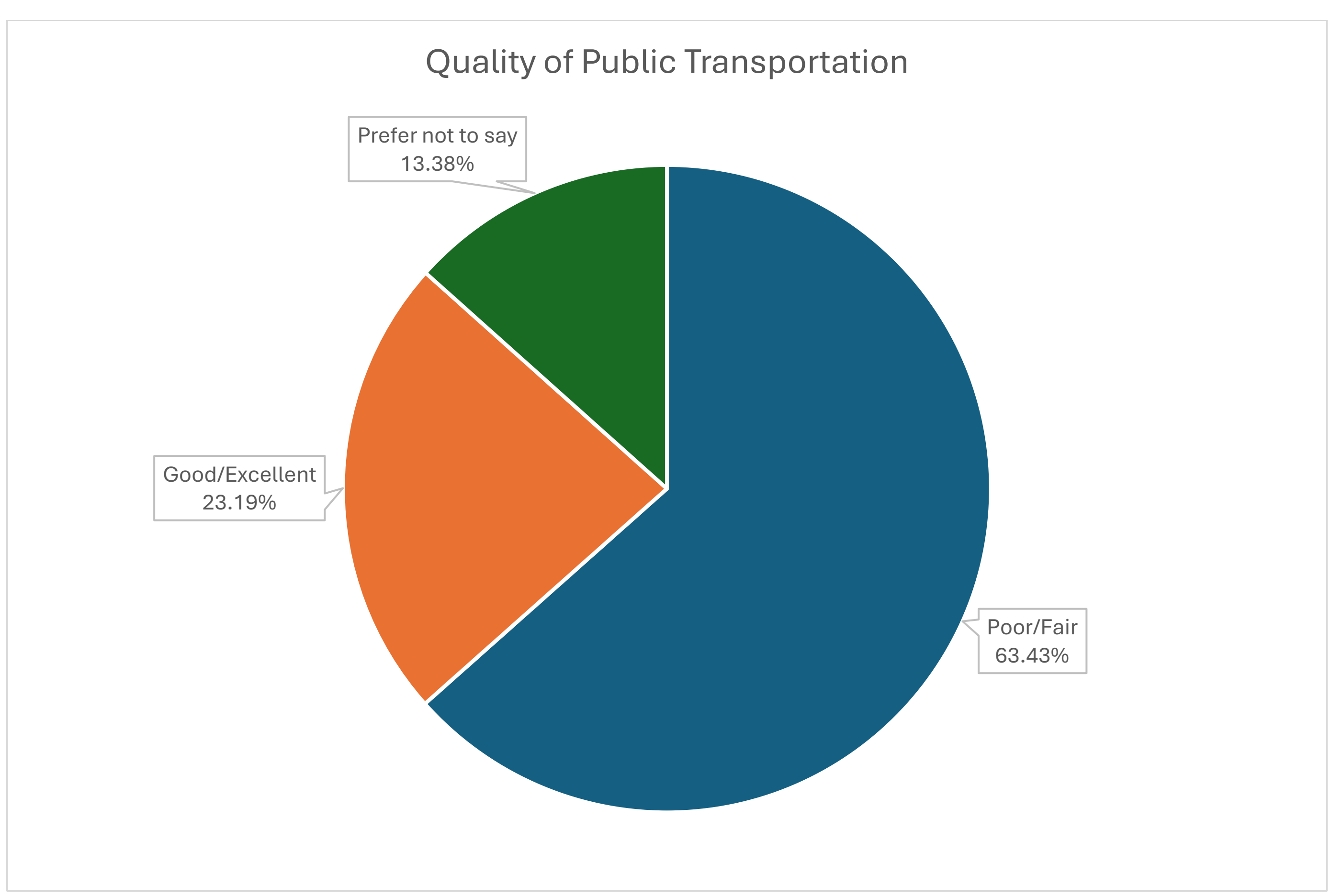

Figure 5: Rating of Available Public Transportation Options

Top Five Unmet Needs

COA utilized an Artificial Intelligence (AI) tool to analyze and identify themes from within the open-ended responses for both Community Needs Assessments. Microsoft Co-Pilot uses AI and natural language processing to analyze open-ended survey responses. It analyzes the text to detect patterns, frequently mentioned topics, and conceptually related ideas. Co-Pilot then groups similar responses and suggests common themes. The five most cited priorities were:

> Transportation (480 mentions): Respondents emphasized general transportation challenges, especially for medical appointments. Important subthemes included social/non-medical transportation, accessibility issues, reliability, affordability, and difficulties specific to rural areas.
>
> Housing (313 mentions): Concerns centered around housing affordability, safety, accessibility, and the need for repairs or modifications. Other issues included the desire to age in place, risks of homelessness or eviction, long waiting lists for senior housing, and property tax burdens.

Access to Care (260mentions): Comments related to care broadly, including access to health care, insurance coverage, affordability of services, availability of respite and supportive care, care coordination, mental health resources, and challenges related to accessibility.

Cost of Living (249 mentions): Respondents frequently mentioned financial strain related to medications, food, utilities, in-home care, assisted living, transportation costs, taxes, and rent, highlighting the challenge of living on fixed incomes.

Independent Living (246 mentions): This theme focused on in-home services like caregiving, homemaking, housekeeping, home modifications, lawn care, snow removal, and safety improvements, all essential for living independently and maintaining daily living support.

Perception Gaps Between Older Adults and Aging Services Professionals

A key component of the Southwestern Ohio Community Needs Assessment was comparing responses from older adults with those from aging services professionals regarding anticipated challenges, shown in Table 3. The findings reveal significant perception gaps, with professionals consistently anticipating a greater need for assistance across nearly all areas than older adults themselves reported.

The largest gaps emerged in areas tied to mobility, independence, and personal care. While 82.84% of professionals believed transportation would be a challenge, only 22.16% of older adults identified it as likely—a gap of 60.68 percentage points. Similarly, 73.96% of professionals foresaw a need for in-home care (e.g., housekeeping or personal care tasks), compared to only 23.65% of older adults, a difference of 50.31 percentage points.

The gaps reflect differing perspectives shaped by experience and role. On one hand, professionals work with older adults in crisis or periods of decline, and they may anticipate future needs that older adults do not yet recognize. Additionally, older adults may be hesitant to report their needs due to a variety of reasons such as stigma, pride, or embarrassment some older adults may struggle to recognize the need for help or may underestimate the impact of their health conditions on their daily life (Table 3).

Activities Needing Help	Professionals	Older Adults	Difference
Transportation	82.84%	22.16%	60.68%
In-home care (help with housekeeping or personal care tasks)	73.96%	23.65%	50.31%
Alzheimer's disease or other dementia	51.48%	5.28%	46.20%
Finding a new place to live	58.58%	14.24%	44.34%
Cooking meals or obtaining groceries	60.36%	19.17%	41.18%
Mental Health	53.25%	13.32%	39.94%
Caregiving	43.79%	9.64%	34.14%
Paying mortgage or rent	47.34%	16.19%	31.15%
Leaving the hospital or nursing home	40.24%	9.18%	31.05%
Making modifications to current residence	62.72%	34.33%	28.39%
Technology	48.52%	20.32%	28.20%
Paying household bills (gas, electric, water, sewer)	47.93%	21.70%	26.23%
Making repairs to current residence	69.82%	44.20%	25.62%
Pet care	31.95%	10.10%	21.85%
Finding and participating in social activities	42.60%	21.35%	21.25%
Legal Matters	39.64%	26.18%	13.47%
Yard/Lawn Care	54.44%	41.33%	13.11%
Paying property taxes	28.99%	17.57%	11.43%
Snow Removal	52.23%	41.24%	10.99%
Staying physically fit	31.36%	34.79%	-3.43%

Table 3: Comparative Rates for Anticipated Needs, Older Adults vs. Professionals

Differences Across the Southwestern Counties

Council on Aging's Southwestern Ohio Community Needs Assessment survey was developed for individuals in Hamilton, Butler, Clermont, Clinton, and Warren counties. A general "Other" category includes those taking the survey but not residing in Southwestern Ohio. These "Other" respondents were included in the final analyses, when appropriate.

Age Distribution

The age group distribution of survey respondents across the five counties reveals strong participation from older adults, particularly those aged 65 to 74. This age group made up the largest proportion of respondents in every county. Adults aged 75 to 84 represented the second largest group in most counties (Table 4).

County	65-74 Age Group
Butler	36.65%
Clermont	38.57%
Clinton	45.00%
Hamilton	40.41%
Warren	36.51%

Table 4: Specific Age Group Response Rate, by County

Participation among adults under fifty was minimal across all counties. Responses from individuals aged thirty-nine or younger never exceeded 2.06% in any county. A small number of respondents chose not to disclose their age or left the age question blank.

Gender

In every county, women made up between approximately two-thirds and three-quarters of those who responded, with the highest percentage in Warren County (75.40%) and Clinton County (73.33%). Male respondents were notably fewer, ranging from 11.43% in Clermont to 19.17% in Clinton. A small percentage of respondents in each county preferred not to disclose their gender, with the highest percentage in Clermont County (2.86%).

Health Status Ranking

Older adults across the counties rated their health positively, with an average self-reported health rating of 7 out of 10 in every county. The full range of ratings, from a low of 1 in Hamilton County to a high of 10, indicates a broad spectrum of perceived health. Most individuals rated their health in the mid-to-high range (Figure 6).

Lower health ratings were less frequently reported. Only one respondent in the entire sample rated their health as 1, and just a few across all counties selected 2 or 3. Meanwhile, higher-end ratings (9 or 10) were less common than 7 or 8 but still present: 15.87% of Warren respondents rated their health as a 9, and 7.50% in Clinton gave themselves a 10.

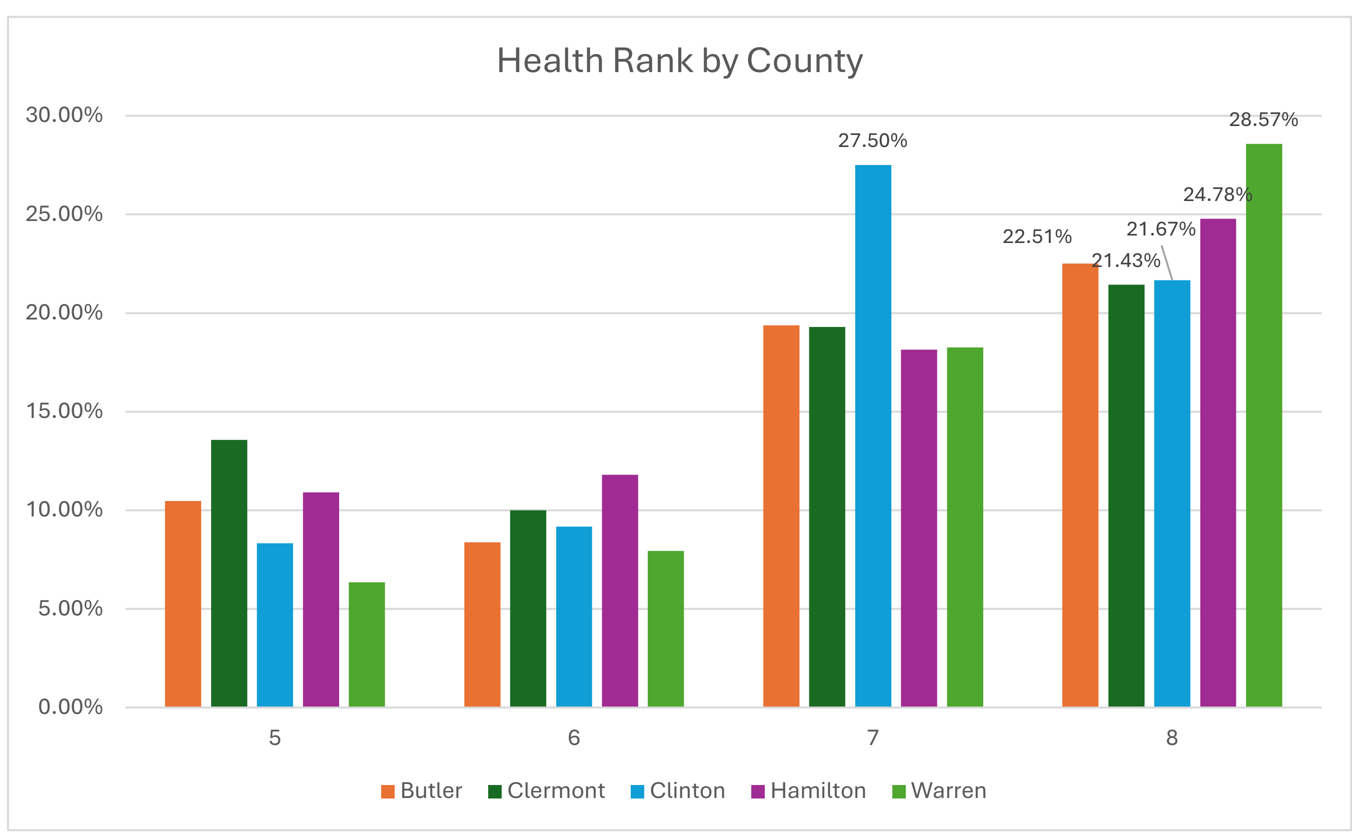

Figure 6: Reported Health Status, by County

Caregiving Strain

The data on caregiving responsibilities across the counties highlights the varied, yet impactful, toll caregiving takes on individuals' lives, particularly among older adults. One of the most frequently reported impacts was emotional distress: respondents across all counties indicated that caregiving responsibilities left them feeling fatigued, stressed, or unhappy. It was especially prominent in Butler (16.75%) and Warren (15.87%) counties. A substantial portion also reported mental or emotional health impacts due to caregiving, with Butler and Clermont leading (16.23% and 15.71%, respectively).

Respondents also acknowledged that caregiving interfered with their personal lives. Many said they had to cut back or postpone activities they enjoyed (more than 14% in all counties), and caregiving affected their relationships, with up to 13.09% in Butler County noting such an impact. Participants in Hamilton and Warren counties also reported the highest amount of financial impact and strain from caregiving.

Housing Instability and Financial Burden

As seen in Figure 7, "completely unaffordable" was among the most frequently selected responses, particularly in Clinton (34.17%) and Warren (28.57%) counties. Hamilton (27.88%) and Butler (26.70%) had similar responses, with Clermont reporting at 17.86%. Few respondents reported housing as "slightly affordable" or "very affordable," with the categories comprising less than 21% of responses per county.

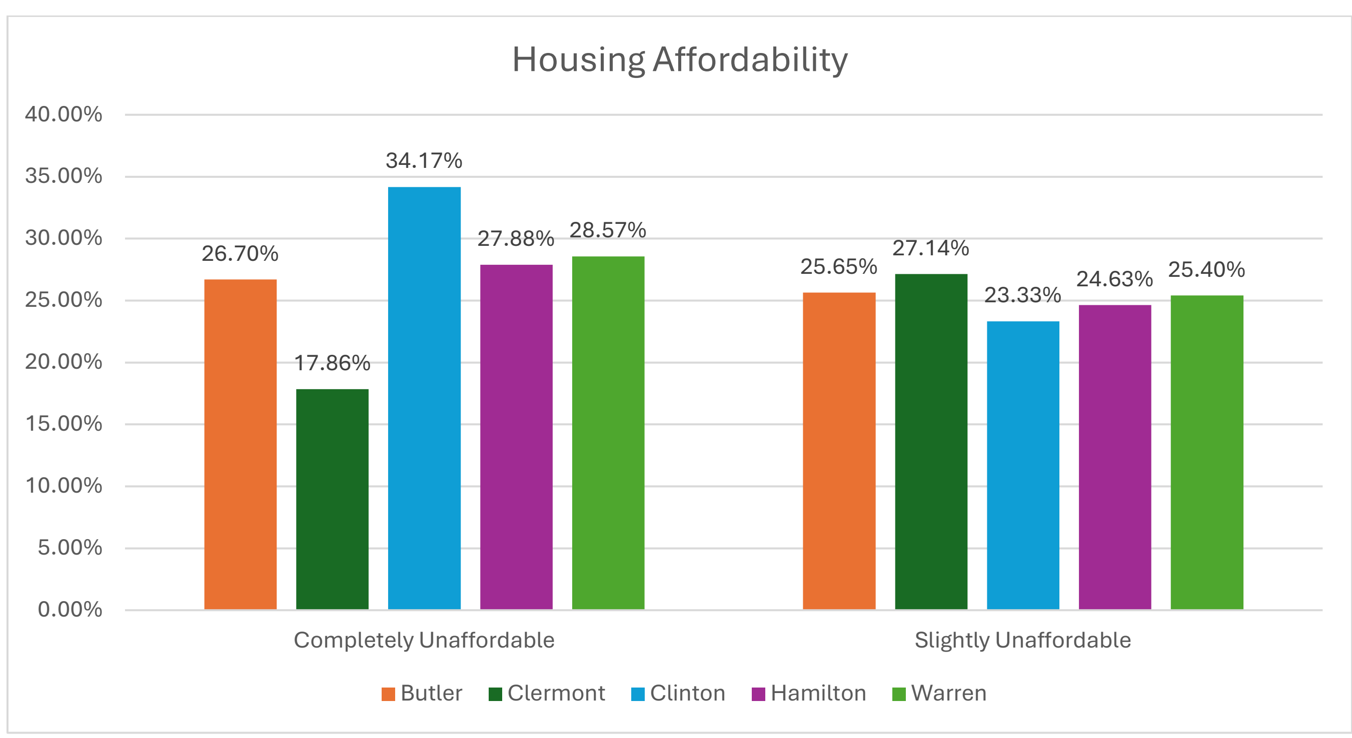

Figure 7: Housing Affordability, by County

When asked directly whether there are affordable and appropriate housing options in their area, a considerable number of respondents said "no," ranging from 45.00% in Clermont County to a substantial 64.17% in Clinton County. Only a small percentage in each county responded "yes," with no county surpassing 9% on the measure. Additionally, a notable share of participants indicated they were

“not sure,” especially in Clermont (27.86%) and Hamilton (27.58%) counties, which suggests a lack of visibility or clarity about available housing resources.

Necessities were a prominent theme, as shown in Figure 8. In each region, utilities, such as gas, electricity, water, and sewer bills, were the most reported source of financial concern.

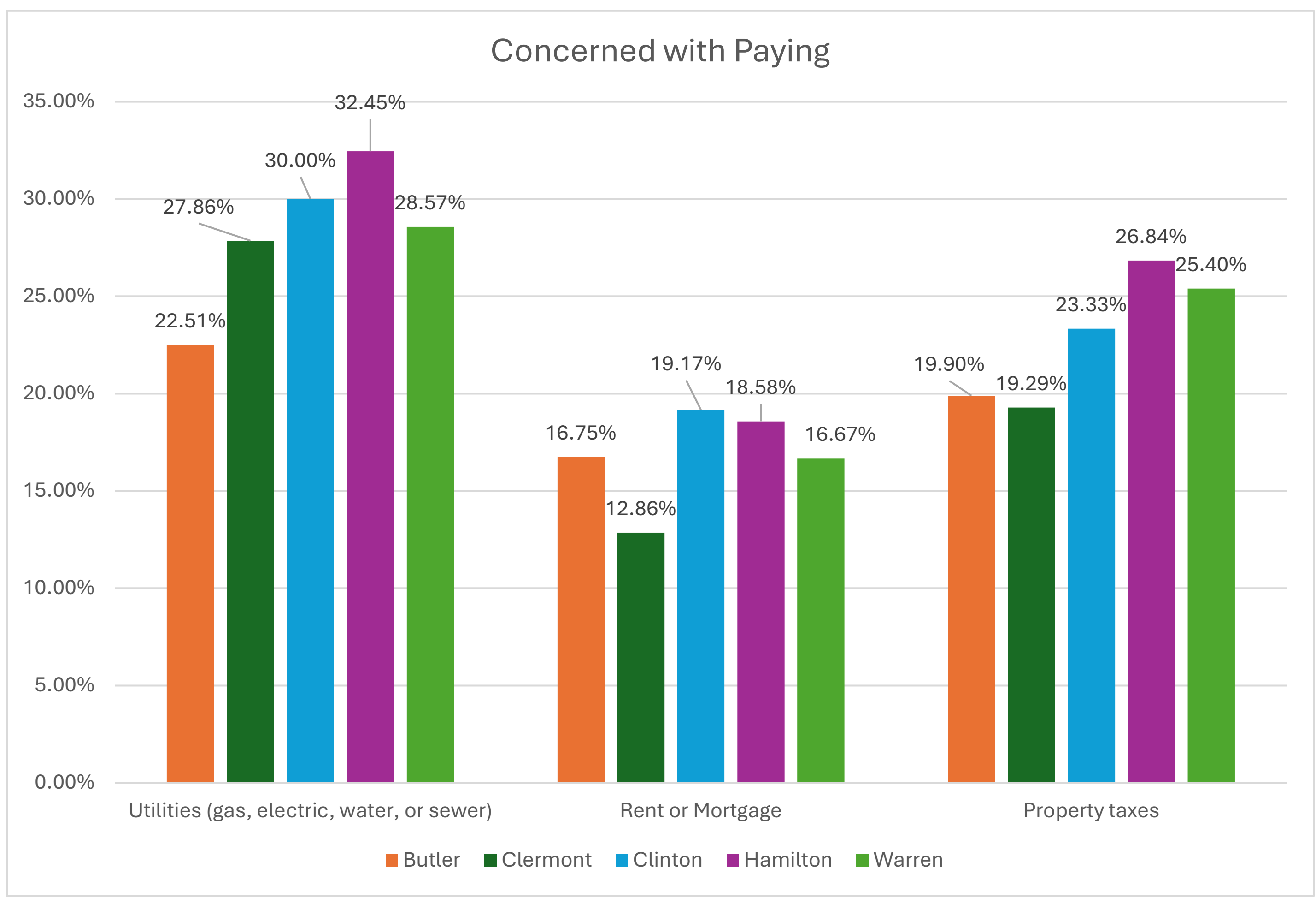

Figure 8: Concerns with Paying Household Expenses, by County

Property taxes emerged as a significant concern across the board, with about one-fifth to one-quarter of respondents in most counties identifying this as a financial stressor. In Hamilton County, 26.84% of respondents expressed worry over property taxes, the highest among the six groups. Meanwhile, rent or mortgage concerns were less common but still notable, with 19.17% reporting concerns in Clinton. Interestingly, a considerable portion of respondents in every county selected "none of the above," suggesting a segment of the population is not currently struggling with these specific financial issues. The group ranged from 32.45% in Hamilton to over 40% in the other four counties.

When asked about the impact of rising costs on their overall quality of life, most respondents reported either “a moderate or significant impact,” indicated in Figure 9. In Clinton County, 35.83% reported a moderate impact, and 29.17% a significant one. Warren County followed closely with 30.95% reporting moderate impact and 19.84% significant. Across all counties, only a small number (5–10%) reported no impact.

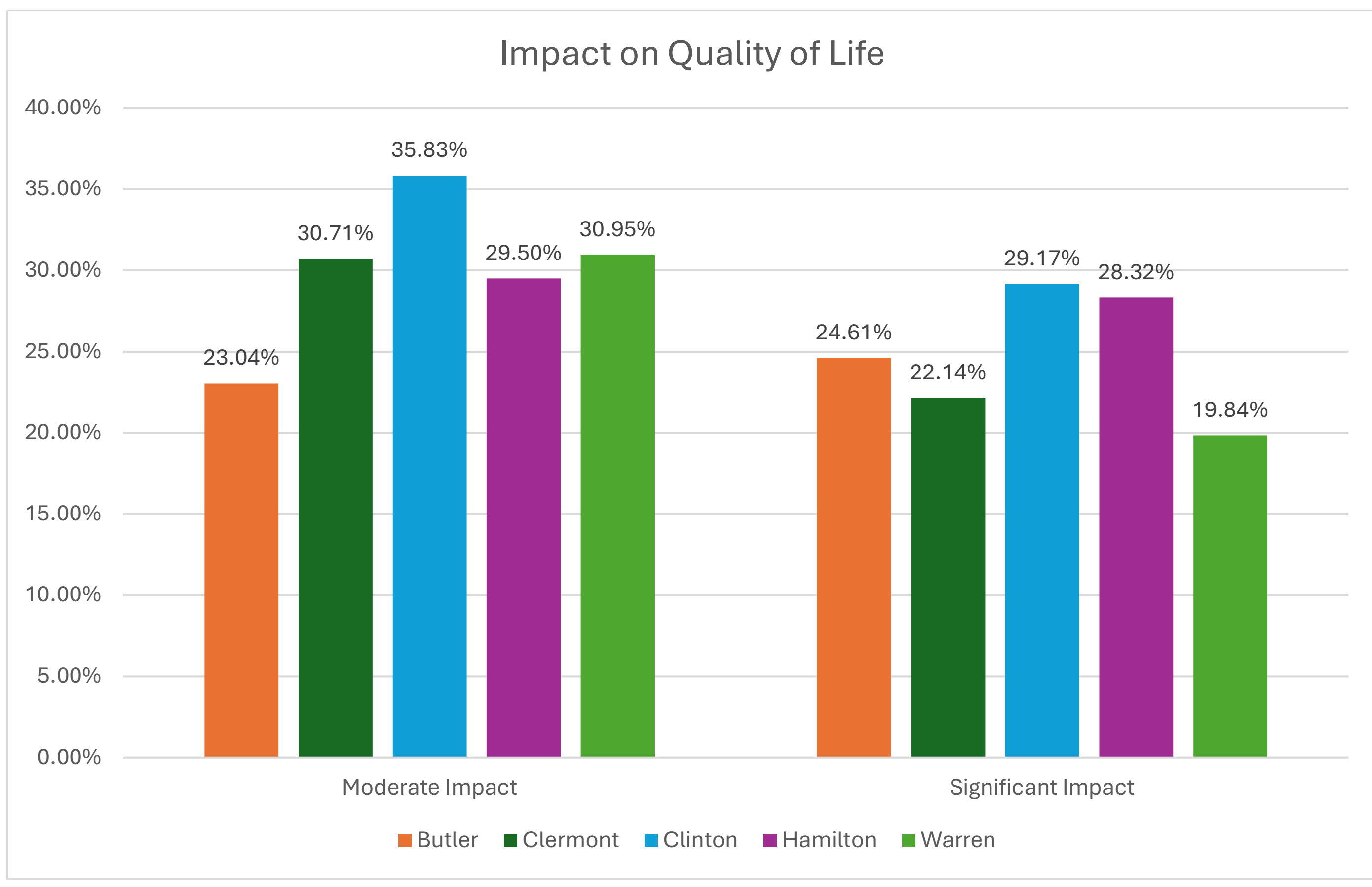

Figure 9: Impact of Inflation on Quality of Life, by County

Challenges Managing Daily Activities

The survey data highlights that older adults across the region face significant challenges with physically demanding home maintenance tasks, with home repairs and yard work emerging as the most cited difficulties (Table 5). In every county, home repairs topped the list, with rates ranging from 46.43% in Clermont County to 54.76% in Warren County. Yard work and tree care followed closely behind, particularly in Warren (48.41%), Clinton (46.67%), and Hamilton County (42.63%). These results suggest that older adults struggle with physically demanding home maintenance tasks.

General cleaning and daily household management were also reported as challenging by approximately 25% to 36% of respondents across counties, with the highest rate in Hamilton County (35.84%). It indicates a broad need for support with routine upkeep. In contrast, tasks like personal care (bathing and grooming) and managing household paperwork (such as paying bills or making phone calls) were cited far less frequently. Personal care was mentioned by no more than 6.35% of respondents in any county, while paperwork challenges peaked at 8.85% in Hamilton. These lower rates may suggest respondents remain independent in core activities of daily living and cognitive tasks, even as they need more help with physical chores.

A smaller segment of respondents indicated no challenges managing these tasks, with "none of the above" responses ranging from 12.70% in Warren to 22.86% in Clermont County. However, it still indicates most older adults surveyed experience at least one area of difficulty in daily functioning. The

findings underscore a strong regional need for services which assist with home maintenance, cleaning, and yard care to help older adults continue living safely and comfortably in their homes.

Tasks	Butler	Clermont	Clinton	Hamilton	Warren
Cleaning/Household Management	32.98%	27.86%	25.83%	35.84%	34.92%
Personal Care	4.19%	2.86%	1.67%	6.34%	6.35%
Managing Household Paperwork	6.81%	7.86%	3.33%	8.85%	5.56%
Yard Work/Tree Care	40.31%	39.29%	46.67%	42.63%	48.41%
Home Repairs	47.12%	46.43%	47.50%	47.94%	54.76%

Table 5: Challenges Managing Daily Activities, by County

Transportation Barriers

Transportation access among older adults in the region varies, but most respondents across counties reported they are still able to drive themselves. It was especially true in Clinton (76.67%) and Warren (73.02%), though still the majority in every region. Family and friends also play a key role in meeting transportation needs, particularly in Hamilton, where 21.83% rely on informal networks. Use of public transit or private transportation options like Uber or Lyft remains low, though slightly more common in more urban Hamilton County (8.11%) than elsewhere. Walking as a primary method of getting around was rare across all areas, and a small percentage of respondents in each county indicated difficulty finding transportation that meets their needs, with rates of 6.05% in Hamilton and 4.76% in Warren.

When asked about specific challenges, transportation issues were shown to have a tangible impact on older adults' ability to manage essential errands and maintain social and community involvement. Some respondents, up to 8.73% in Warren, said they cannot get to medical appointments, and up to 7.96% (Hamilton) said they cannot go grocery shopping or complete errands. Between 5%-10% in all four counties said they are unable to connect with family and friends or participate in activities they once enjoyed.

Older adults rated the quality of public transportation as “poor” or “fair” more than “good” or “excellent” in all counties (Figure 10). However, all counties had respondents who chose not to answer or selected "prefer not to say," potentially signaling limited personal experience with public transportation.

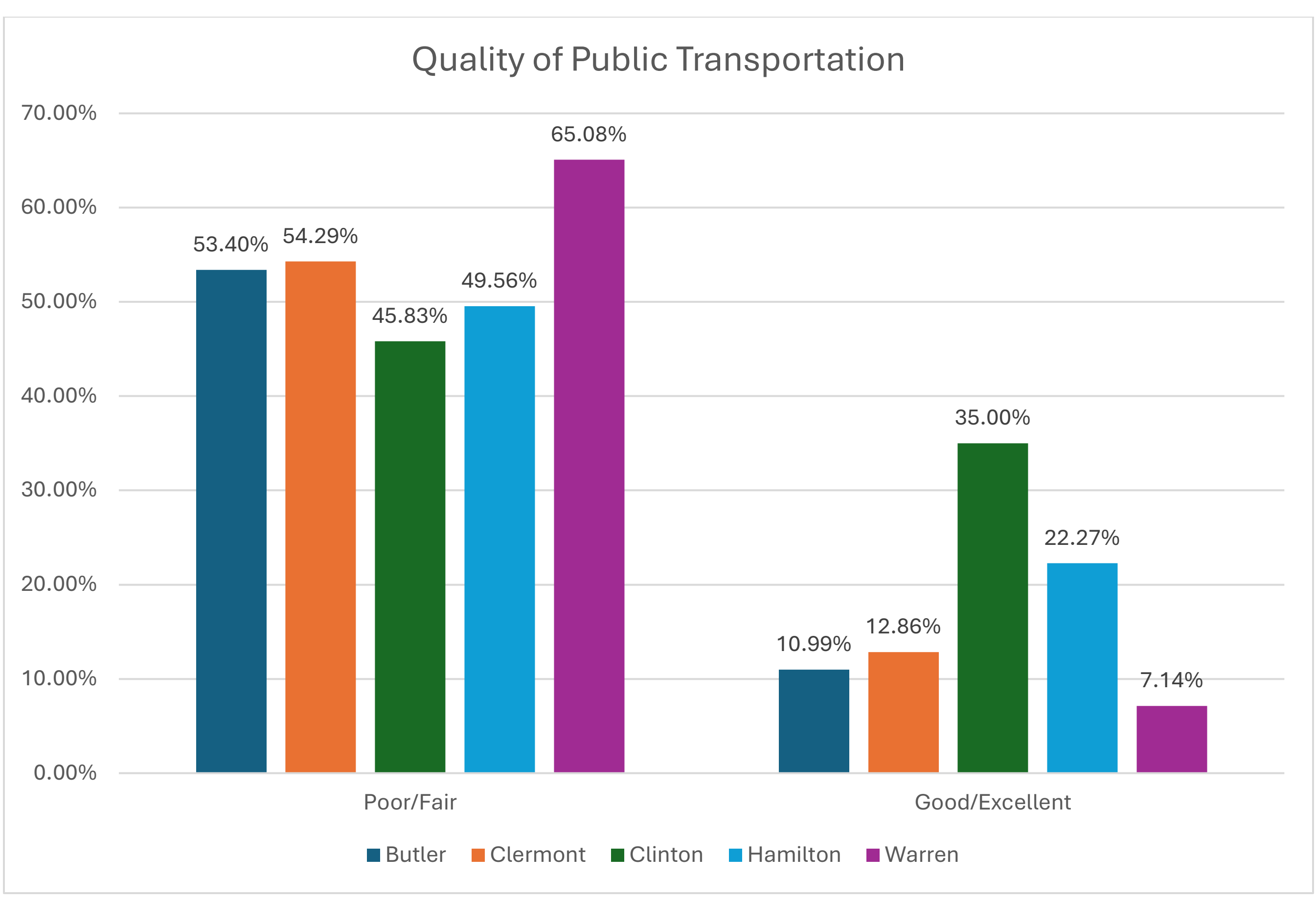

Figure 10: Quality Rating of Public Transportation, by County

Reported barriers to using public transportation reinforce these ratings. The most common challenge was the absence of service: 41.27% of Warren County respondents and over 18% in Clinton and 27% in Butler and Clermont said there were no public transportation options near them. However, the most common challenge in Hamilton was transportation accessibility at 21.98% where the physical design or availability of service could not meet respondents' needs. Concerns around inconsistent schedules and delays were mentioned to a lesser extent, ranging from 9.42% in Butler to 15.04% in Hamilton. Fewer respondents identified cost as a significant concern, with about 5% to 10% citing it across counties.

Six Activities the Counties May Need Help with Next Year

Across the counties, older adults reported a range of challenges related to aging in place, with the most prominent shown in Table 6. The most frequently reported need was making repairs to the current residence and yard/lawn care, selected by 44.58% of respondents overall. These issues were across all counties, with making repairs as the top need in Clermont and Hamilton, 33.57% and 38.50% respectively and yard/lawn care in Butler, Clinton, and Warren, 35.08%, 40.00%, and 35.71% respectively. Related to this was snow removal (41.75%). These outdoor maintenance tasks had over 26% reporting difficulty across the five counties.

Another major concern was staying physically fit, 36.38% of respondents reported. This need was consistent across the region, indicating a broad interest in maintaining mobility and independence. In addition, modifications to the current residence (34.50%), such as installing grab bars or ramps, were cited frequently, suggesting that older adults are attempting to adapt their homes to meet changing physical needs rather than relocating.

Activity	Butler	Clermont	Clinton	Hamilton	Warren
Making repairs to current residence	34.03%	33.57%	37.50%	38.50%	32.54%
Making modifications to current residence	23.56%	25.00%	25.00%	31.27%	24.60%
Legal matters	22.51%	17.86%	10.00%	26.11%	19.84%
Staying physically fit	28.27%	25.00%	28.33%	32.74%	20.63%
Yard/Lawn Care	35.08%	26.43%	40.00%	34.51%	35.71%
Snow Removal	34.55%	29.29%	40.00%	38.05%	35.71%

Table 6: Six Common Unmet Needs, by County

Other common challenges reflect a need for support with day-to-day living. Paying household bills was reported by 20.64% of respondents, followed closely by transportation (20.55%) and technology use (20.64%). These issues point to the financial strain and access barriers many older adults face, which may be particularly difficult for those with limited income or rural access to services. Additionally, in-home care, such as help with housekeeping or personal care, was reported by 25.07%, and legal matters were a concern for 27.14%.

While reported less frequently overall, mental health challenges (15.83%) and caregiving responsibilities (13.57%) still affect a significant number of respondents. Notably, Butler County (14.14%) and Hamilton County (14.60%) showed slightly higher concern in these caregiving and mental health, respectively. Conversely, pet care (10.46%), leaving the hospital or nursing home (8.67%), and Alzheimer's disease or other dementia (7.07%) were among the least commonly selected issues.

Highest Priority Services Identified as part of the 2025 & 2026 Needs Assessment

1. Transportation
    - Reliable Medical and Non-Medical
    - Affordability
    - Accessibility
    - Rural Barries
2. Cost of living / financial assistance
    - Affording medications
    - Food, utilities, rent/taxes

- In-home care
- Transportation costs

3. In-home supportive services for independent living
    - homemaking/housekeeping
    - Help with daily tasks
4. Coordinated health care / access to care
    - Insurance/affordability
    - Care coordination
    - Access to services
5. Home modifications & safety supports
    - Ramps/grab bars
    - Safety improvements to remain at home)
6. Home repair/maintenance supports
    - Repairs
    - Routine maintenance help
    - Snow removal
7. Healthy food access/Nutrition
    - Home-delivered meals
    - Congregate meals
    - Help obtaining groceries/cooking meals
8. Caregiver supports
    - Caregiver support programs
    - Navigation
    - Respite/time away
9. Supportive service- connection to community
    - Reducing social isolation
    - Help finding/participating in social activities
10. Technology supports accessing resources and care
    - Help using technology to connect to services/health care and community resources
11. Legal/Ombudsman Services

Next Steps and Conclusion

The Southwestern Ohio Community Needs Assessment revealed that older adults across the region face a broad and varied set of challenges related to aging in place, health, housing, daily living, and access to services. Many needs, such as home repairs, modifications, and mobility, are widely shared, and the data revealed perception gaps between older adults and aging services professionals, with professionals anticipating greater future need in key areas such as transportation, in-home care, and care coordination. Many older adults also report only moderate health, with few ranking themselves in excellent condition. It reflects the broader reality of aging, where it often comes with compounding physical, mental, and financial stressors.

The consistency of these themes across different types of respondents and locations underscores the importance of broad, accessible, and responsive systems of support. Aging in place is not simply a matter of remaining at home. It requires a network of practical resources, personal support, and community infrastructure that adapts as needs evolve. The data presented should serve as both a mirror and a guide: a mirror reflecting the lived experiences of older adults, and a guide for shaping policies and programs that truly meet them where they are.

To deepen understanding and ensure programs are responsive to real needs, COA held a series of focus groups with stakeholders across the region. These sessions provided space for participants to share perspectives and explore topics which may not have emerged in the survey alone.

2027-2030 Strategic Area Plan – Establishment and Maintenance of Information and Referral (I&R) Providers

Ask…

Provide a compilation of results of the required I&R survey conducted by your AAA.

COA's Response

An Information & Referral (I&R) survey was conducted in March 2026. The survey was emailed to all businesses listed in COA's resource directory. A total of 43 responses were collected. Of the total respondents, just over half (53.5%) indicated that their organization provided information and referral (I&R), or similar services, within Butler, Clermont, Clinton, Hamilton or Warren counties of COA's service area. The information provided below is based on the responses of the 53.5% (n=23) organizations providing I&R in the service area.

- 43.5% served all 5 counties in COA's service area with organizations providing services in an average of 3.5 counties (median: 4).
- Respondents were asked to identify the scope of I&R services they offer (could select more than one response):
    - 39.1% - Elderly specific
    - 30.4% - Generic
    - 8.7% - 24-hour crisis line
    - 56.5% - checked indicated an 'other' type of scope which included offering services for Alzheimer's and other dementia specific needs, automobility, children, counseling, disability needs, food and personal care needs, private duty, and utility related)
- Respondents were asked to list the types of I&R services their organization offers. On average, organizations offered 4.7 services (median: 3). The most common types of services provided include:

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45.5% (10) - Personal care 39.1% (9) - Homemaker services 39.1% (9) - Medicaid 26.1% (6) - Respite care 26.1% (6) - Transportation 17.4% (4) - Education 17.4% (4) - Family caregiver support 17.4% (4) - Food assistance 17.4% (4) - Medicare 17.4% (4) - Veterans assistance 13.0% (3) - Assistive technology 13.0% (3) - Housing assistance 13.0% (3) - Independent living skills 13.0% (3) - Peer support/counseling 8.7% (2) - Adult protective services 8.7% (2) - Benefits analysis/assistance	8.7% (2) - Care transitions 8.7% (2) - Case management 8.7% (2) - Comm aid/assistance 8.7% (2) - Home modifications 8.7% (2) - Legal services 8.7% (2) - Mental health services 8.7% (2) - SSDI benefits apps/claims 8.7% (2) - Utility assistance 8.7% (2) - Vehicle adaptations/mods 8.7% (2) - Youth transition prog/svcs 4.3% (1) - Adult day services 4.3% (1) - Congregate meals 4.3% (1) - Employment 4.3% (1) - Financial assistance 4.3% (1) - Health insurance counseling 4.3% (1) - Home delivered meals 4.3% (1) - Recreation

- 47.8% indicated that the I&R services provided by their organization are conveniently accessible by toll-free or collect call to older individuals.

Attach documentation that satisfies the requirements (this document)

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Ask...

Describe your AAA's plan of action to resolve unmet I&R needs. Include, at a minimum, the following:

- Identify the unmet I&R needs of the PSA;
- Specify if the unmet needs will be resolved by either:
    - A) coordinating with local providers to establish and maintain an I&R service or similar provider; or,
    - B) providing Title III funding for the establishment and maintenance of an I&R provider;
- Provide the planned completion date; and
- Specify the amount of Title III funds involved.

COA's Response

Although the response rate was not high, the results indicate some areas where support and resources may be lacking. The benefits of analysis/assistance seem to be areas

without readily available support. Our area plan goals show that financial assistance is crucial in helping individuals stay in their home of choice. However, people are often unaware of what assistance exists or how to access it. With our Benefits Enrollment Center NCOA grant, COA can help bridge this gap across our five-county region. This will offer an extra resource for the community, helping individuals apply for financial assistance. Referrals can be made both by the community and internally at COA. This grant goes through July of 2028, and no additional Title III funds will be needed to support this work.

Attach documentation that satisfies the requirements (this document)

2027-2030 Strategic Area Plan – Targeted Outreach Plan

Explain your AAA's planned outreach activities to address the identified service needs of targeted populations. At a minimum, include how your agency will:

- Identify individuals eligible for assistance, with special emphasis on:
  - Older individuals residing in rural areas;
  - Older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
  - Older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
  - Older individuals with severe disabilities;
  - Older individuals with limited English proficiency;
  - Older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
  - Older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and
- Inform those individuals and their caregivers of the availability of assistance.

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COA's response

COA will administer a robust outreach plan using a combination of digital, print and grassroots tactics – both paid and earned – that will inform eligible individuals and their caregivers about the availability of assistance.

In efforts to provide education to the community about available resources for older adults, those with disabilities and their caregivers, COA's Communications Team works with program staff to identify outreach needs and determine the most appropriate and effective strategies for each identified service need. The team places particular emphasis on reaching hard-to-serve populations in COA's service area (for example, rural areas.) A large part of COA's service area is considered rural and COA has been effective at deploying grassroots outreach in these communities to raise awareness and build confidence in available programs and services.

In the most rural part of COA's service area, Clinton County, communications staff work closely with the care management team to identify outreach opportunities. Additionally, COA operates a satellite office in the county to provide easy access to programs and

services for community members. Appointments with COA's Aging Disability Resource Center are available at the Clinton County office.

COA's Communications Team includes an outreach coordinator who works to identify channels through which COA can better reach priority populations. Through continuous community outreach, including virtual and in-person speaking engagements and information tables, COA is already connecting with audiences including veterans, professionals in aging, low-income older adults, caregivers, caregivers of individuals with Alzheimer's and other brain disorders, and members of the Jewish community. We continually evaluate the effectiveness of these efforts and seek to identify new channels through which targeted populations may be reached.

An area of particular interest with regard to outreach is the development of relationships with organizations that directly serve the target populations. By developing these relationships and creating clear pathways of communication and referral, we can improve awareness of and access to available programs and services.

COA's community outreach coordinator works with Front Door staff to identify opportunities to bring the Front Door to the people vs having people come to the Front Door. For example, COA communications staff frequently collaborates with Front Door staff to present COA information to possible referral sources such as first responders and social service agencies. Council on Aging Front Door representatives are regularly available in the community as part of the 513Relief Bus program activities (reaching underserved populations in Hamilton County).

Finally, COA is aware of the increasing demands being placed on family caregivers. Many of these caregivers juggle multiple responsibilities, including working and raising young families. In recent years, COA has received requests from area businesses to provide education and information to employees who are also serving as family caregivers. COA's outreach efforts will support family caregivers by spreading awareness and creating connections with area businesses where they are employed.

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APPLICATION FOR DIRECT SERVICE WAIVER

*Please submit **one** application form for **each** service (III-B, C, D, or E) that your agency requests to provide directly.*

Title of requested service: ______________________

Type of requested service: ☐ Title III-B ☐ Title III-C ☐ Title III-D ☐ Title III-E

1. Please select the basis for which the waiver is requested (more than one may be selected) and provide detailed justification for direct provision of services and the date that this service was last competitively bid.

☐ Provision of such services by the AAA is necessary to assure an **adequate supply** of such services.

☐ Such services are directly related to the AAA's **administrative functions.**

☐ Such services can be provided more **economically**, and with **comparable quality**, by the AAA.

2. Identify the projected dollar amount requested and the applicable funding source for the service to be provided:

☐ Fund: ______________ Amount: **$** ______________

☐ Fund: ______________ Amount: **$** ______________

☐ Fund: ______________ Amount: **$** ______________

Note: Approved amounts are valid for a 12-month period. **Total Request: $** ______________

3. Provide a copy of the request for proposal along with the list of prospective and current providers notified of the opportunity, the names of those that submitted a proposal and reasons why the proposal(s) were not acceptable. Also explain the methods used for notification.

4. Describe how the AAA will develop capacity for local service providers to provide this service in the future.

______________________ ______________________

AAA Director's Signature **Date**

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