**SAMPLE GOALS FOR 2022-2024 AGING PLANS**

Completed goal worksheets and goal templates for each of the focus areas can be found below. The focus areas are hyperlinked within the document to find the sample goals you are looking for.

* [Title III-B Supportive Services](#IIIB)
  + IIIB (Transportation)/Person-Centered
  + III-B/Equity
* [Title III-C Nutrition Program](#Nutrition)
  + Nutrition/Equity
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* [Title III-D Health Promotion](#HealthPromotion)
* [Title III-E Caregiver Support](#Caregiver)
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Title III-B Supportive Services

**Goal Development Worksheet – IIIB (Transportation)/PERSON-CENTERED**

1. **What are you trying to improve? What problem are you trying to solve?**

* There are some older adults who don’t have access to transportation because of affordability and location.

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* There are some transportation options available, but they are costly for an older adult on a fixed income.
* Older adults living in rural areas do not have access to transportation unless they pay a huge premium for Transportation Network Company (TNC) like Uber and Lyft. Taxi only operates within city limits.
* Current mobility management volunteer driver program is geared towards employment transportation and not older adults.

1. **What factors are hindering your progress? (preventing you from succeeding)**

* No dedicated volunteer driver programs for older adults.
* Taxi and TNC service is too expensive for fixed income older adults.
* TNC is only option in rural areas.

1. **What factors are supporting your efforts?**

* Active mobility manager
* Fixed route transit and paratransit services offered.
* Active senior center shuttle

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* Mobility manager
* Senior center director
* GWAAR
* Other ADRCs

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Work with the mobility manager to expand volunteer driver program to include older adults (apply for 5310 funds to support the expansion).
* Look at possibly starting ADRC operated volunteer driver service. Look at utilizing volunteer drivers from meals on wheels service.
* Look at other ADRC’s to see how they are addressing transportation access issues.
* Look at starting a voucher service to help subsidize fixed income older adult transportation services. Apply for 5310 funding to support voucher program.
* Reach out to neighboring ADRC to learn how they developed their voucher program.

1. **What do you hope to see as an outcome or result?**

* Volunteer driver operation specifically dedicated to older adults, supported by 5310 funding.
* Partnership between mobility manager to operate volunteer driver program for older adults.
* Voucher program to help subsidize transportation cost for those older adults who need financial assistance.

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* Mobility manager partnership formed and successfully obtain 5310 funding to support volunteer driver transportation specifically for older adults.
* Development of voucher program to help fixed income older adults utilize existing transportation services. 5310 funding successfully obtained to support program.
* Compare call-in request for transportation that were unfulfilled before and after implementation of volunteer driver and voucher program.

**GOAL TEMPLATE**

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| **Focus area: Title IIIB Supportive Services/ Person-centered services** | | **Due Date** |
| **Goal statement:** Ensure older adults within our community have the transportation services needed to meet their daily needs. | | 12/1/24 |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*  Compare call-in request for transportation that were unfulfilled before and after implementation of volunteer driver and voucher program. | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Reach out to neighboring ADRCs to learn how they are filling transportation gaps. |  |  |
| Action step: Contact ARCR and set up meeting | Meeting completed | 1/1/22 |
| Action step: Learn about volunteer driver and voucher programs and how they are funded. | Documentation on volunteer driver and voucher program | 6/1/22 |
| Action step: Create an action plan to set up volunteer driver and voucher programs | Action plan completed | 1/1/23 |
| **Strategy 2:** Partner with mobility manager to build and operate volunteer driver and voucher program. |  |  |
| Action step: Set-up meeting with mobility manger to introduce project and get buy-in. | Meeting completed and mobility manger on board | 1/1/22 |
| Action step: Include mobility manager in the development of the action plan. | Action plan completed with mobility manager’s help | 6/1/22 |
| Action step: Work with mobility manager to apply for funding to support program implementation. | Obtain funding to implement volunteer driver and voucher program | 6/1/23 |
| **Strategy 3:** Implement volunteer driver and voucher program |  |  |
| Action step: Work with mobility manager to design operational protocols for programs | Documents completed | 9/1/23 |
| Action step: Review policies and procedures with staff | All staff received two trainings on project operations | 11/1/23 |
| Action step: program implementation | Programs implemented | 1/1/24 |
| **Annual progress notes** | | |

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Title III-C Nutrition Program

**Goal Development Worksheet – NUTRITION/EQUITY**

1. **What are you trying to improve? What problem are you trying to solve?**

* Hispanic/Latin-x older adults are underrepresented participants in nutrition program services in comparison to other populations in the nutrition program’s service area. The nutrition program is aiming to provide equitable access to nutrition program services for Hispanic/Latin-X older adults.

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* Hispanic health is often shaped by factors such as language/cultural barriers, lack of access to preventive care, and the lack of health insurance.
* 41% of older adults 60+ are overweight or obese, but Hispanic/Latin-X older adults are more likely to be overweight or obese. (Dietary Guidelines for Americans)
* Hispanic/Latin-X population is 1.4 times more likely to die from diabetes than the white population when adjusting for age. Mexican American individuals suffer disproportionately from diabetes. (CDC)
* COVID-19 has disproportionately affected the Hispanic/Latin-X community. Compared to White Wisconsin residents, Hispanic or Latinx residents have 1.7 times greater case rates, and because older adults are at a higher risk for complications and death, this poses a concern for Hispanic/Latin-X communities in Wisconsin.

1. **What factors are hindering your progress? (preventing you from succeeding)**

* Challenges in accessing language translation services for program materials.
* Hispanic/Latin-X older adults in our communities have shared that they are often caring for grandchildren, which presents a barrier for accessing existing nutrition services.
* Existing cooking staff and caterers lack familiarity with Hispanic/Latino cultural foods and methods of preparation. Program nutritionists are challenged in creating menus that meet the needs and desires of the Hispanic/Latin-X population.

1. **What factors are supporting your efforts?**

* Access to demographic and program data
* Visibility of the ADRC/Aging Unit in local communities through existing dining centers/home-delivered meals and connections to local media

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* [Hispanic Chamber of Commerce of Wisconsin](https://hccw.org/)
* UW Extension
* Local public health department
* Hispanic/Latin-X communities of faith
* Schools/day care programs
* Local community organizations serving Hispanic/Latin-X communities

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Meet with and explore the ability to contract with Hispanic/Latin-X-owned farms to provide fresh, local foods for nutrition program
* Meet with and explore the ability to contract with Hispanic/Latin-X-owned restaurant to implement a My Meal, My Way restaurant model for congregate dining.
* Explore collaborations with Hispanic/Latin-X community organizations to hire staff or recruit volunteers that can facilitate better connections to the Hispanic/Latin-X older adult population
* Seek out local translating and interpreting resources
* Partner with local organizations who provide health and nutrition services to Hispanic/Latin-X to provide more culturally appropriate nutrition education and nutrition counseling opportunities
* Explore partnerships with trusted organizations to do nutrition screening and program registration/assessments.

1. **What do you hope to see as an outcome or result?**

* provide equitable access to nutrition program services for Hispanic/Latin-X older adults

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* Increased program participation
* Satisfaction surveys

**GOAL TEMPLATE**

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| **Focus area: Nutrition/Racial Equity** | | **Due Date** |
| **Goal Statement:**  To provide equitable access to nutrition program services for Hispanic/Latin-X older adults | | Dec 2024 |
| **Plan for measuring overall goal success** – (H*ow will you know that you have achieved the results you want? Use data.)*  Pre- and post-participation levels measured. Satisfaction surveys provided to new and existing participants to determine whether programming meets their needs/desires. | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Meet with partners to determine the best strategy to implement to meet the needs of the Hispanic/Latin-X older adult population in service area. |  |  |
| **Action step**: Establish partnerships which must include at least one organization that directly serves the Hispanic/Latin-X community | At least 2 community agencies have agreed to participate in the project | Mar 2022 |
| **Action step**: Research existing strategies and brainstorm new ideas that could be implemented. | List of potential strategies is created | May 2022 |
| **Action step:** Partners meet to choose a strategy that is realistic and achievable | Strategy is determined | July 2022 |
| **Strategy 2:** Work with partners to create program materials focused on the Hispanic/Latin-X population, including translated program materials. |  |  |
| **Action step:** Determine the type of nutrition program materials that will be easy and effective to use (flyers, brochures, social media…) | Type of outreach materials have been chosen | Feb 2023 |
| **Action step:** Create program materials focused on the Hispanic/Latin-X population, including translated program materials. | Materials are designed and translated/vetted for use in Hispanic/Latin-X community | May 2023 |
| **Action step**: Create materials and distribute | Materials are being disseminated | June 2023 |
| **Strategy 3:** Implement strategy and provide culturally appropriate services (i.e. dining center opens or culturally appropriate nutrition education/counseling provided, etc.) |  |  |
| **Action step:** Identify specific roles of each partner agency (details will be added after strategy has been chosen - July 2022) | Roles defined and agreed upon by all partners |  |
| **Action step:** Create detailed implementation plan (details will be added after strategy has been chosen - July 2022) | Plan is created and shared with partners |  |
| **Action step:** Create satisfaction survey to be used with new and existing participants. Determine how and when to distribute. | Satisfaction survey created and implementation process determined |  |
| **Annual progress notes** | | |

**GOAL DEVELOPMENT WORKSHEET – Nutrition**

1. **What are you trying to improve? What problem are you trying to solve?**

* Not everyone who wants a home delivered meal is able to get one. There is a shortage of volunteer drivers and an increase in requests for home delivered meals.

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* Loss of volunteer drivers due to Covid
* Increase of home delivered meal participants
* Due to increased number of home delivered meal participants, routes are longer.
* As vaccines are given, the status should start to improve

1. **What factors are hindering your progress? (preventing you from succeeding)**

* Community unaware of volunteer opportunity
* Safety factors due to Covid pandemic
* The need for marketing and outreach within the community

1. **What factors are supporting your efforts?**

* Partnerships with local churches and community centers
* Large corporations located in community that may allow employees to volunteer

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* United Way
* Current home delivered meal volunteers

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Work with local high school to recruit students
* Market “A Call for Action” to local community
* Encourage current home delivered meal driver volunteers to recruit amongst friends and family
* Collaborate with local newspaper for outreach
* Develop plans for a community Volunteer Fair

1. **What do you hope to see as an outcome or result?**

* There will be enough drivers to deliver meals to everyone who wants one

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* By increasing home delivered volunteer driver base by 25%
* Home delivered meal routes have been shortened

**GOAL TEMPLATE**

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| --- | --- | --- |
| **Focus area: III-C Nutrition Program** | | **Due Date** |
| **Goal statement:**  To ensure everyone who wants a home delivered meal will receive one, the ADRC will expand the volunteer driver pool by 25% | | 12-31-24 |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*  By December 31, 2024, the ADRC will see an increase in the number of transports by 10%, the volunteer driver pool will increase by 25%, and the number of turned down requests will be less than 5% of the total rides. Also, when new drivers are recruited, ask them how they heard about the need for drivers. | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Utilize four different community partners to create awareness of the need for drivers in 2022 and 2023. (i.e.: local newspaper, churches, libraries, radio, Board members, food pantries, etc.). | Track the community partners that were contacted and what role they played in this. | Dec 2022-23 |
| **Strategy 2:** During 2022, ask volunteer drivers to “Tell a Friend” about the volunteer driver program and the need for drivers. |  |  |
| Action Step: Create postcards and other materials for drivers to use to give others about the program and need for drivers – a “Tell a Friend” campaign | Materials created - (list what materials were created) | Mar 2022 |
| Action Step: Include information about the “tell a friend” campaign in their paychecks | Information included in with paychecks (list dates) | Dec 2022 |
| Action Step: Discuss “Tell a Friend” campaign at all driver trainings | Campaign discussed at all trainings (list dates) | Dec 2022 |
| **Strategy 3:** In 2024, contact a local TV station about the idea of doing a story/interview about the importance of the transportation program and the need for drivers. |  |  |
| Action Step: Create list of TV Stations and script to use to pitch the idea | List and script created (include list of stations) | May 2024 |
| Action Step: Contact stations and secure at least one interview/story | Stations contacted – interview/story secured (list which station and date) | Dec 2024 |
| **Annual progress notes** | | |

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Title III-D Health Promotion

**Goal Development Worksheet – Health Promotion**

1. **What are you trying to improve? What problem are you trying to solve?**

* Older adults could be healthier if they learned how to better care for themselves and had more access to evidence based health promotion programs.

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* Older adults are disproportionally affected by chronic conditions, such as diabetes, arthritis, and heart disease. Eighty percent have at least one chronic condition, and nearly 70% of Medicare beneficiaries have two or more. (Grantmakers In Aging, <https://www.giaging.org/issues/evidence-based-health-promotion-and-disease-prevention/> 2021 )
* Chronic diseases can limit a person’s ability to perform daily activities, cause them to lose their independence, and result in need for institutional care, in-home caregivers, or other long-terms services and supports. (Grantmakers In Aging, <https://www.giaging.org/issues/evidence-based-health-promotion-and-disease-prevention/> 2021)

1. **What factors are hindering your progress? (preventing you from succeeding)**

* Lack of funding (Title III-D is only 1.4% of overall Title III funding of OAA)
* Recruiting trained facilitators
* Recruitment of participants
* Finding which evidence-based programming will be the best fit for our community
* Lack of health promotion staff at AU/ADRC

1. **What factors are supporting your efforts?**

* Proven positive health outcomes of evidence-based health promotion programs - data
* Participants enjoy the programs and it’s a way to make a meaningful connection in their community

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* Aging Unit Director/Supervisor support
* Evidence-based administrator (i.e. Wisconsin Institute for Healthy Aging, UW-Madison Extension, etc.)
* GWAAR OAA Consultant – Health Promotion Specialist

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Assess what evidence-based health promotion programs are currently being implemented in community either by the Aging Unit or other local providers like hospitals, YMCA’s, recreation centers, faith communities, etc.
* Develop a community coalition on older adults and health promotion programming. This coalition can look at what communities are we not serving? Rural, socio-economic, minority populations, etc. Also, how to reach those populations and what evidence-based programs would best address their needs.
* Develop a plan for addressing health needs with evidence-based programs, which would include partnerships that would allow for the expansion of programming.
* Implement evidence-based programming with a hybrid model, both in-person and virtually.
* Evaluate programming

1. **What do you hope to see as an outcome or result?**

* prevent or delay chronic conditions and promote healthy aging among older adults

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* Quantitative: Number of evidence-based programs implemented, number of completers of evidence-based programs.
* Qualitative: Feedback on satisfaction surveys, as well as other documentation required by the health promotion program.
* Compare health data specific to our county and the outcome of the evidence-based program. For example, if we are implementing the StrongBodies program we could compare county specific data for older adults who are sedentary prior to implementation and after.

**GOAL TEMPLATE**

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| **Focus area: III-D Health Promotion and Disease Prevention** | | **Due Date** |
| **Goal statement:**  To prevent or delay chronic conditions and promote healthy aging among older adults by increasing access to evidence-based health promotion offerings | | Dec 2024 |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data*   * An increase in the number of options for evidence-based health promotion programming from 2022 to 2024 * An increase in the number of completers of evidence-based health promotion programs * An increase in the number of attendees that were underserved in the past - use SAMS client and demographic information | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Assess current health concerns of older adults in the county/tribe. | Data collected through a literature review | March 2022 |
| **Strategy 2:** Create partnerships with community organizations, especially those that provide services to underserved, rural or minority older adult populations, to offer evidence-based health promotion opportunities as determined by a needs assessment. | Partnerships established or a coalition joined or developed | July 2022 |
| **Strategy 3:** Determine which evidence-based health promotion workshops are the most appropriate as a result of the assessment of the health outcomes of older adults in our community. | Facilitators trained in the evidence-based health promotion programs | Sept. 2022 |
| **Strategy 4:** Implement evidence-based health promotion programming | SAMS Data Collected – compared to SAMS data from previous year | April 2023 |
| **Strategy 5:** Evaluate evidence-based programming | Review evaluation data of programming | April 2023 & On-Going |
| **Annual progress notes** | | |

**GOAL DEVELOPMENT WORKSHEET – III-D - Health Promotion - TRIBAL**

1. **What are you trying to improve? What problem are you trying to solve?**

* Tribal Aging Unit Directors are leaving Title III-D dollars unspent
* Not all tribal elders have access to evidence based health promotion programs

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* Due to Covid, Title III-D dollars can and have been moved to fund Title III-C programs
* After the pandemic is over, the problem will possibly continue if there is not a solution TAU Directors accept

1. **What factors are hindering your progress? (preventing you from succeeding)**

* The idea that TAU Directors may HAVE to focus their attention to other programs such as nutrition which is more needed for Elder health
* Need to come up with a solution that AU's have buy in with so they will invest in it

1. **What factors are supporting your efforts?**

* Availability to virtual trainings
* Possibility of coordinating services with other Counties and Tribal Aging Units

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* GWAAR
* WIHA

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Coordinate with other Tribal Aging Unit Directors on trainings they offer (non-virtually) GLITC
* GLITC offers virtual trainings with a set calendar for each year partnering with other Tribal agencies for facilitators
* Other Tribal agencies agreeing to training leaders, GLITC pays for the training

1. **What do you hope to see as an outcome or result?**

* Aging Unit Directors using up more Title III-D dollars
* Elders receiving valuable evidence-based education to better support their overall health

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* There will be participation from multiple Tribal Nation/Band's Elders
* More Elders will be completing EB Classes

**GOAL TEMPLATE – III-D - Tribal**

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| **Focus area: III-D - Health Promotion - TRIBAL** | | **Due Date** |
| **Goal statement:**  Increase Health Promotion for the Elder population within the Tribal Nations/Bands | | Dec 2024 |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*   * There will be participation from the eleven Tribal Nations/Bands * There will be an increased number of Tribal Elders who have completed Evidence Based programs from 2022-2024 | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Coordinate with other Tribal Aging Unit Directors on trainings they offer (non-virtually) and see if they will open to other interested Elders |  | Dec 2022 |
| **Action Step:** Review list of Program Providers and see which each Tribe is trained to facilitate |  |  |
| **Action Step:** Communicate with Tribes about goal and as see if there are trainings planned that others could be included in |  |  |
| **Strategy 2:**  GLITC offers virtual trainings with a set calendar for the year partnering with other Tribal agencies for facilitators |  | Dec 2023 |
| Action Step: Communicate with Tribes on their needs for E-B trainings, work on a schedule to offer virtually |  |  |
| Action Step: Advertise calendar and open trainings to Tribal Elders |  |  |
| **Strategy 3:** GLITC offers to pay for facilitator training to encourage other Tribal agencies to agree to collaborate |  | Dec 2024 |
| Action Step: Communicate with Tribes on their needs for E-B trainings, work on a schedule to offer virtually |  |  |
| Action Step: Continue to add new classes to the calendar for Elders |  |  |
| **Annual progress notes** | | |

**GOAL DEVELOPMENT WORKSHEET – III-D – Fall Prevention**

1. **What are you trying to improve? What problem are you trying to solve?**

* Reduce the number of accidental falls among older adults in our county
* Reduce the physical, emotional and financial impact of falls among older adults in our county

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* Wisconsin has a death rate of 169.9 deadly falls per 100,000 and older in 2019, compared to 66.3 per 100,000 nationwide. (WI State Journal, Jan. 2021) The need is urgent.
* Falling is the leading cause of accidental death among 65 or older in WI.
* In the US, about one in four adults (28%) age 65 and older, report falling each year. This results in about 36 million falls each year. 37% of those who fall reported an injury that required medical treatment or restricted their activity for at least one day, resulting in an estimated 8 million fall injuries.
* In 2008, charges from fall-related hospitalizations and emergency department visits for adults 65 and older in WI totaled $496 million.
* Falls are common, and our population is aging.
* *Insert county data from local hospitals and EMS*

1. **What factors are hindering your progress? (preventing you from succeeding)**

* Lack of awareness of the problem
* Lack of implementation of activities that will reduce falls – exercise, home safety checks, medication review, etc.
* Partners working in silos – not a community-wide cohesive organized approach to implementation of activities and strategies to reduce falls in older adults.
* Prevention requires an individualized approach that addresses multiple risk factors.
* Rural areas and minority populations are underserved.

1. **What factors are supporting your efforts?**

* Evidence-based prevention programs available – Stepping On, Ortego, StrongBodies, Mind Over Matter, etc.
* Older adults are motivated to remain independent; being injured in a fall could result in hospitalization and potentially being placed in a nursing home.

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* Wisconsin Institute for Healthy Aging – evidence based programming
* Local health systems and clinics
* ADRC
* United Way
* EMS
* Recreation and exercise facilities – YMCA’s
* Insurance companies
* Public Health
* Senior Centers
* Pharmacies
* Nursing homes and assisted living centers
* Senior Housing
* Churches
* Caregiver Groups

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Local availability of evidence-Based fall prevention programs – ie. Stepping On, Mind Over Matter, StrongBodies, Otago, etc.
* Home Safety Checks
* Medication Review
* Awareness Campaigns
* System changes that support and align prevention across the continuum of care.

1. **What do you hope to see as an outcome or result?**

* Reduction in the number of falls among older adults in our county.
* Increased awareness around the issue of falls among older adults.

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* Pre and Post data on the number of falls.
* Qualitative data from evidence-based programming

**GOAL TEMPLATE – Fall Prevention**

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| **Focus area: Health Promotion and Disease Prevention (Falls Prevention)** | | **Due Date** |
| **Goal statement: To reduce accidental falls among older adults in our community** | | Dec 2024 |
| **Plan for measuring overall goal success** – Pre and Post Falls data for our community. Evidence based program evaluations. Qualitative feedback from programming. Number of fall prevention programs implemented, number of participants – compare on an annual basis. | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1: Build capacity for local collaboration around fall prevention.** |  |  |
| Action step: Research existing fall prevention coalitions, strategies, programs, and activities as they relate to falls prevention in our community. | List of existing fall prevention coalitions/activities for older adults in our county | Mar 2022 |
| Action step: Gather community partners interested in falls prevention and brainstorm new ideas that could be implemented to reduce falls among older adults in our community. | Development of a coalition if one is not already established | Jan 2023 |
| Action step: Partners will choose evidence-based programs and strategies based on available resources and implement. | List of strategies and/or programs that will be implemented.  Number of new facilitators trained.  Number of programs implemented.  Number of clients impacted in SAMS – can compare to previous years data | Aug 2023 |
| Action step: Evaluate program outcomes on an on-going basis. | Evaluation data from programs and initiatives that were implemented | Dec 2024 |
| **Strategy 2: Increase public and healthcare/aging service providers awareness and skills.** |  |  |
| Action step: Research existing successful marketing campaigns for fall prevention | List of awareness campaign examples | Apr 2022 |
| Action step: Determine messages that resonate with the target group through focus groups and surveys | Focus group or pilot results | Oct 2022 |
| Action step: Implement a Fall Prevention Summit where these materials are distributed to community organizations during Fall Prevention Month in September 20XX. | Campaign materials that were created | Dec 2024 |
| **Annual progress notes** | | |

**GOAL DEVELOPMENT WORKSHEET – III-D-Social Isolation and Loneliness**

1. **What are you trying to improve? What problem are you trying to solve?**

* Reduce the health effects of social isolation and loneliness among older adults

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* Loneliness and social isolation in older adults are serious public health risks affecting a significant number of people in the United States and putting them at risk for serious medical conditions.
* Current research suggests that immigrant, LGBTQ, minorities & victims of elder abuse experience loneliness more often than other groups. (CDC, Loneliness and Social Isolation Linked to Serious Health Conditions (November 4, 2020)
* While isolation and loneliness have negative effects on people of all ages, research shows that those negative impacts, coupled with chronic health conditions, can lead to a high rate of morbidity among older adults, therefore is a serious public health issue (Advancing States, 8/2020)
* Social isolation is an important public health issue that has gained recognition during COVID-19 pandemic because of the risks posed to older adults based on physical distancing (Front. Public Health, 21 July 2020 https://doi.org/10.3389/fpubh.2020.00403 )
* 40% of older adults regularly experience loneliness, according to a University of California, San Francisco (UCSF) Study (Holt-Lunstad et al., 2015)
* Prior to COVID 19, isolation increases Medicare costs by $6.7 billion per/year (Flowers, 2017).
* 40% of older adults experience loneliness, while **7-17% report being socially isolated** (McMaster University Feb. 2019)
* Social Isolation is linked with increased death (1;4), dementia (1;5), depression, and risk of elder abuse; while loneliness is associated with increased blood pressure (3;7), cognitive decline (3;8), and reducing the body’s ability to protect itself from infections (3;9). (McMaster, 2019)
* Lack of knowledge how serious of a public health issue social isolation and loneliness in older adults by community.

1. **What factors are hindering your progress? (preventing you from succeeding)**

* It’s hard to measure social isolation and loneliness
* COVID-19 and social distance protocols: In the time of COVID-19 and physical distancing, traditional practices must be altered and translated to serve and engage older adults, combat social isolation, and facilitate connectivity. Must rethink effective solutions for distanced connectivity.
* Don’t have access to technology or wifi
* COVID-19 may necessitate both the universal access to reliable, broadband internet and ways to improve accessibility, feasibility, and appropriateness of technology for older persons because physically distanced require virtual ways to connect and access resources.

1. **What factors are supporting your efforts?**

* Increased awareness among policy makers
* Health Care Systems are an important, yet underused, partner in identifying loneliness and preventing medical conditions associated with loneliness. Nearly all adults aged 50 and older interact with the health care system in some way. For those without social connections, a doctor’s appointment or visit from a home health nurse may be one of the few face-to-face encounters they have.(CDC, Nov 2020)
* One purpose of the OAA Nutrition Program is promote socialization of older adults.
* Can use Title III-B, Title III-C , Title III-D and Title III-E OAA dollars to implement interventions.
* A review of literature found that programs that were group-based, grounded in theory, and incorporated active input from participants and social support/activity appeared to provide the most benefit. Evidence-based programs succeed in providing all those characteristics.

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* WI State-Wide Coalition to End Social Isolation and Loneliness
* National organizations such as ACL, NCOA, CDC, etc.

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Identifying older adults at risk (health system, ADRC/Aging Units through already established screening tools) and connecting them to resources.
* Possible interventions include: Phone companion programs, robotic companion pets, offering evidence health promotion programs – especially in at-risk communities.
* Program to Encourage Active, Rewarding Lives (PEARLS) addresses late life depression symptoms, which are risk factors and consequences of social isolation and loneliness.
* Focusing on older adults’ lack of social connectedness to more accurately pinpoint the root issues faced by the older adult and more appropriately introduce interventions and solutions to mitigate the program.
* Engage older adults as volunteers
* Facilitate social interaction with peers.
* Utilize resources created by ACL and NCOA to assist in providing services virtually (toolkits, webinars, factsheets, etc.)
* Coordinate efforts with clinical and community-based organizations to unite and form intersectional partnerships to maintain the provision of services and programs for engaging an supporting older adults. (Front. Public Health, 21 July 2020)

1. **What do you hope to see as an outcome or result?**

* Increasing meaningful connections among older adults thus reducing the health effects of loneliness

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* Loneliness scale - baseline in year 1 compared to end of goal period
* number of workshops and participants
* number of partnerships developed

**GOAL TEMPLATE**

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| **Focus area: Health Promotion – Social Isolation and Loneliness** | | **Due Date** |
| **Goal statement: Reduce the health effects of social isolation and loneliness by identifying those older adults most vulnerable, implementing evidence-based interventions and evaluate outcomes.** | | Dec 2024 |
| **Plan for measuring overall goal success** – Implement loneliness scale as a baseline in year 1; partnerships developed, number of evidence-based workshops implemented – number of participants, number of new facilitators trained. | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Raise public awareness of loneliness as a public health issue and share strategies to improve connections and create a feeling of purpose. |  |  |
| Action step: Utilize customizable awareness materials developed by WIHA, ACL, NCOA, etc. and conduct a social isolation and loneliness campaign using social media, as well as print and radio local media. | Number of articles in local newspapers, number of social media posts, etc. | March 2022 |
| Action step: Identify partners who have an interest in working on this public health issue and have them distribute awareness materials as well to their customers/clients/participants. | List of agencies/contacts along with where they sent the awareness materials | March 2022 |
| Action step: Target more vulnerable groups such as, immigrant, LGBTQ, minorities & victims of elder abuse in awareness campaign | List of agencies/organizations within those populations who received awareness campaign materials | March 2022 |
| **Strategy 2:** Identify loneliness in older adults in our community and provide access to meaningful and culturally relevant resources and services. |  |  |
| Action step: Research evidence-based tools that are used to identify older adults who are at-risk to suffer the health effects of social isolation and loneliness. | List of ways to identify at-risk older adults | Dec. 2022 |
| Action step: Create partnerships with key stakeholders to review evidence-based strategies to identify older adults most at-risk, and determine the tool(s) that you will utilize. | Tool(s) identified | March 2023 |
| Action step: Implement strategy to identify at-risk older adults and determine referral process to appropriate interventions. | Process documented and distributed to partners | June 2023 |
| **Strategy 3:** Implement interventions to improve meaningful connections in older adults in our community. |  |  |
| Action step: Implement or expand evidence-based health promotion programs such as StrongBodies, PEARLS, Walk with Ease, Mind Over Matter (<https://www.ncoa.org/professionals/health/center-for-healthy-aging/evidence-based-programs>) | SAMS client data – see an increase over a 3-year period | Dec. 2024 |
| Action step: Implement a phone companion program to older adults identified as at-risk | Number of calls documented | Dec. 2024 |
| Action step: Develop a technology access program (i.e. loan tablets) so older adults can participate in virtual programming. | Tablets purchased and loan program developed. | Dec. 2024 |
| **Annual progress notes** | | |

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Title III-E Caregiver Support

**Goal Development Worksheet –** **CAREGIVER SUPPORT**

**1. Problem Statement: What are trying to improve or achieve? What problem are you trying to solve?**

* Caregivers are not always able to access respite care when they need or want it due to:
  + lack of respite providers
  + high cost of home care
  + fear of allowing others into the home due to Covid
  + not knowing alternative ways to get a break or find some relief from caregiving

**2. What is the current status of your problem statement? Is it getting better or worse?**

* we are unable to provide enough respite options to caregivers – local agencies are short-staffed
* our county won’t let us reimburse non-professionals (family/friends) to provide respite
* COVID has made it even more difficult for caregivers to find respite
* Governor’s budget includes additional support for caregivers
* ARPA includes additional funding for caregiver support

**3. What factors are hindering your progress?**

* lack of home care agencies and staff, COVID restrictions,
* lack of knowledge about importance of respite or how to find respite in non-traditional ways
* people don’t always know all of the options that are available

**4. What factors are supporting your efforts?**

* Statewide registry is available and being improved
* caregiver coalition partners are interested in working on increasing access to respite

**5. Who are your partners in helping you succeed?**

* Respite Care Association, local homecare agencies, adult day program, Caregiver Coalition

**6. What are some strategies or steps that could help?**

* respite care association of Wisconsin (RCAW) mini-grant - recruitment event
* change county policy to include reimbursement of non-professional respite providers
* increase awareness of the importance of respite – use caregiver coalition
* teach caregivers how to find “non-traditional” respite (asking family/friends, adaptive equipment,
* work with assisted living, RCACs and CBRFs to allow short term/overnight respite

**7. What result or outcome are you trying to achieve?**

* Increase the number of respite options available to meet the needs of caregivers
* Reduce caregiver burden

**8. How will you measure your progress? How will you know that you have achieved the results you wanted? How will you know if your work made a difference in people’s lives?**

* Compare the number of available respite options now vs. end of goal period
* Handout with respite options created and widely distributed
* Reduced number of times caregivers report inability to find respite

**GOAL TEMPLATE**

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| **Focus area: CAREGIVER SUPPORT** | | **Due Date** |
| **Goal statement:** Caregivers will have access to the respite they need and desire. | |  |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*   * environmental scan of all available respite options at beginning of 2022 - then repeat at end of 2024 * decrease in reports from caregivers that they are unable to find respite - use I&A/SAMS data (unmet need-respite) and caregiver needs assessments comparing 2021 data to 2024 data. | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Hold recruitment event to help local home care agencies and adult day programs to find more staff |  |  |
| **Action step**: Connect with home care agencies and adult day programs to establish partnership. Utilize Caregiver Coalition. | At least one partner is identified | Mar 2022 |
| **Action step**: In collaboration with above named partners and coalition, apply for a “mini-grant” from Respite Care Association to hold a recruitment event. | Grant applied for and secured | July 2022 |
| **Action step**: Hold recruitment event. | Event held | Sept 2022 |
| **Strategy 2**: Change policy to allow non-professionals to be reimbursed for providing respite |  |  |
| **Action step**: Educate county board members about importance of respite and lack of professional respite providers | Emails and phone calls made, written materials distributed, presentation at meeting | Mar 2023 |
| **Action step:** Request policy change to allow reimbursement for non-professional providers (family, friends) | Policy changed | Mar 2024 |
| **Strategy 3:** Create a list of all available respite options, including non-traditional methods, and make readily available to all who work with caregivers |  |  |
| **Action step:** Work with coalition members to compile list of all respite providers in the county. Include non-traditional methods (adaptive equipment, relaxation techniques, how to ask family and friends to help, etc.) | List created and approved by coalition | July 202 |
| **Action step:** Work with coalition to create a marketing plan for distribution including print, social media, newsletters, and website. | Marketing plan complete |  |
| **Action step:** Distribute according to plan. Keep list updated by reviewing material at coalition meeting at least annually. | Marketing plan enacted – each agency report what was completed. Agenda item added to review list annually. | 2022-24 |
| **Annual progress notes** | | |

**Goal Development Worksheet – CAREGIVER SUPPORT (Technology Loan Program)**

**1. What are you trying to improve or achieve? What problem are you trying to solve?**

* There are a lot of support groups, events and programs for caregivers that are virtual, but not all of the caregivers have access to the technology they need to access them.
* While most seem to be looking forward to in-person events again, many would like to continue to have an option to attend virtually even after Covid.

**2. What is the current status of your problem or situation? Is it getting better or worse?**

* Not everyone has a computer or smart phone or tablet
* Not everyone has access to the internet.
* More people are accessing technology and there are efforts to increase access to the internet.

**3. What factors are hindering your progress?**

* Technology is not cheap so not readily available.
* Some people will have a hard time learning how to use the technology.
* Some people don’t want to use technology or are scared to try.
* Some rural areas don’t have access to the internet.
* It’s hard to teach people how to use technology when you can’t meet with them in person.

**4. What factors are supporting your efforts? What things have worked in the past or are currently helping?**

* There are many virtual offerings now for those who want and can access them
* Caregiver funds can be used to purchase technology and internet access (hotspot) for loan program.
* There are different types of technology (such as the Grandpad) that are available that offer simpler user interface.
* There are many “help guides” for helping people get started with technology.

**5. Who are your partners in helping you succeed?**

* Libraries
* Health system – education department
* University, tech college, or high schools – students help teach how to use technology
* Grandpad or other tech company might give us a deal

**6. What are some strategies or steps that could help?**

* Purchase tablets and Grandpads and set up loan program
* Find partner to help purchase and set up loan program
* Offer training on how to use technology
* Create marketing plan to ensure caregivers are aware of the options for virtual and other support groups and events and availability of technology – ensure equitable
* Partner with students to offer training on using technology

**7. What result or outcome are you trying to achieve?**

* All caregivers will have access to support groups, events, and programs either in person, virtually or a hybrid (such as getting handouts by mail and participating by phone).
* Increase in the number of caregivers access support groups/education/training

**8. How will you measure your progress? How will you know that you have achieved the results you wanted?**

* Loan program set up with goal for number of people using it
* Pre-post survey for user satisfaction
* Use SAMS data to see if there is an increase in number of support groups attended

**GOAL TEMPLATE**

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| **Focus area: Caregiver Support** | | **Due Date** |
| **Goal statement:**  Caregivers will have access to support groups, trainings, presentations, and events as desired, either virtually or in-person, with technology available to those who want to attend virtually | |  |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*   * Technology loan program in place with 75% of tablets being utilized by end of goal period * User satisfaction surveys will indicate 75% of borrowers are satisfied with their use of technology to attend caregiver support events * Increase in number of support groups/trainings attended at end of goal period (2023) compared to 2021 | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** **Create partnership(s) to create a robust technology loan program** |  |  |
| Action step: Find partners to help with program – library, healthcare, senior center, technical college/university/high school | At least one partnership will be established | Mar 2022 |
| Action step: Meet with partners and divide tasks/responsibilities | Partners know their responsibilities and timeline | May 2022 |
| **Strategy 2: Purchase supplies and design loan program** |  |  |
| Action step: Research different types of devices in regards to cost and ease of use | Research completed, list of potential devices | July 2022 |
| Action step: Develop policy/procedure for loan program including materials to train users; ensure equal access to all | Policy/procedures in place | Sept 2022 |
| Action step: Create marketing plan; evaluate for inclusive language/images | Marketing plan in place | Oct 2022 |
| Action step: Purchase supplies – devices, hotspots, training materials | Supplies purchased | Oct 2022 |
| **Strategy 3: Launch program and evaluate** |  |  |
| Action step: Launch program as part of National Caregiver Month – ensure training to use devices is in place | Devices loaned out per policy/procedure, training for using devices completed | Nov 2022 |
| Action step: Create user survey to determine satisfaction | Survey completed and plan for distribution in place | Oct 2022 |
| Action step: Continue in-person support groups/trainings as able – allow caregivers to choose which option works better | Virtual and in-person options are both available | On- going |
| **Annual progress notes** | | |

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Community Engagement

**Goal Development Worksheet** **- Community Engagement**

*Utilize the public input you received to form goals for your plan. The questions below will help you create a well-thought-out goal. Once you complete the questions you will be able to use the answers to write your goal using the template below. Remember to keep the goal SMART – Specific, Measurable, Achievable, Relevant and Time Bound.*

**1. What are you trying to improve or achieve? What problem are you trying to solve?**

* Our public input is usually from our customers. It is not representative of the communities we live in. Current community engagement methods do not ensure that all community members and groups are heard from.

**2. What is the current status of your problem or situation? Is it getting better or worse?**

* Community engagement activities only happen once every three years in preparation for development of the aging plan.
* Input received comes from existing customers, relatively speaking.
* Agency relationships within the community are limited and not inclusive or expansive.

**3. What factors are hindering your progress? (preventing you from succeeding)**

* Staff time/bandwidth.
* Unsure how to reach people who are not familiar with the agency and do not utilize our services/programs.
* Uncertainly of who to contact and how to initiate contact. Lack of established relationships with community entities that interact with diverse populations.

**4. What factors are supporting your efforts?**

* Access to demographic data.
* Input collected from previous aging plan cycles to use as a baseline.
* Buy-in from the agency.
* Vibrant community and potential for engagement.

**5. Who are your partners in helping you succeed? (who could you work with to make this better)**

* Chamber of commerce and/or other association listings.
* Local municipalities – public spaces and places.
* Existing customer base.

**6. What are some strategies or steps that could help? (ideas to fix the problem)**

* Identify community assets and the designated point of contact associated with each asset.
* Take deliberate action to initiate contact.
* Build relationships with local leaders to establish an age-friendly network.
* The established network could improve opportunities for reaching community members who represent diverse backgrounds (age, race, economic, profession, culture, language, educational, and social networks).
* Seek advice, guidance, support and involvement from the network to connect with community members for input on the needs and capacities of program operations and aging plan development.

**7. What result or outcome are you trying to achieve?**

* Ensure community engagement efforts are representative of community members.
* Expand community reach.

**8. How will you measure your progress? How will you know that you have achieved the results you wanted? How will you know if your work made a difference in people’s lives?**

* Uses data (pre and post) and document stories.
* Track communications, developed relationships, and established age-friendly network.

**GOAL TEMPLATE**

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| **Focus area: Community Engagement** | | **Due Date** |
| **Goal statement:** Ensure that community engagement efforts are representative of community members. | | 9/30/2024 |
| **Plan for measuring overall goal success** – (H*ow will you know that you have achieved the results you want? Use data.)*   * Completed action steps associated with each strategy. * Use data available from previous years to track the amount and quality of community input received and establish a baseline for improvement.( Look at how much and how often community input was collected, collection methods used, and community reach.) | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:**  Identify community assets and the designated point of contact associated with each asset. Once complete, take deliberate action to initiate contact. | Community assets identified and associated leaders contacted. | 9/30/2022 |
| Action Step: Utilize the chamber of commerce and/or other associations for a listing of local businesses, organizations and coalitions. | Acquired additional listings of local entities. | 4/30/2022 |
| Action Step: Introduce the aging unit, including its vision, mission, and role within the community to each of the community assets, as deemed appropriate. | Initiated introductions with community assets. Style of introduction varied depending on the entity. Aging unit kept a record of who they contacted and how. | 9/30/2022 |
| **Strategy 2:** Build relationships with local leaders (identified and contacted in strategy 1) to establish an age-friendly network. This network will improve opportunities for reaching community members who represent diverse backgrounds (age, race, economic, profession, culture, language, educational, and social networks). | Relationships built with local leaders and an age-friendly network established. | 9/30/2023 |
| Action Step: Go to the local leaders and the community assets they represent to engage, build trust, and establish a relationship that formulates community awareness and support. | Engaged, built trust, and established relationships with local leaders and the community assets they represent. |  |
| Action Step: Disseminate agency information and maintain an open line of communication. This includes reciprocating community information with current customers. | Disseminated agency information with the age-friendly network and vice versa. |  |
| Action Step: Adjust existing events to allow for collaboration with local leaders and their communities. Step into new spaces and places when planning events, scheduling workshops, and implementing programs. | Adjusted existing events and stepped into new spaces and places for conducting agency activities. |  |
| **Strategy 3:** Seek advice, guidance, support and involvement from the age-friendly network (established in strategy 2) to connect with community members for input on the needs and capacities of program operations and aging plan development. | Age-friendly network provided advice, guidance, support, and involvement in connecting with community members and collecting input. | 9/30/2024 |
| Action Step: Convene the age-friendly network to identify effective strategies for collecting community input. | Identified effective strategies for collecting community input. |  |
| Action Step: Involve age-friendly network members to engage with their communities to collect input. (Collection method = community-driven action) | Age-friendly network members engaged with their communities to collect input. |  |
| Action Step: Evaluate strategies used to determine best practices, lessons learned and helpful resources to ensure community engagement efforts are representative of community members. | Evaluated strategies used to determine best practices, lessons learned and helpful resources. |  |
| **Annual Progress Notes** | | |

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| **Focus area: Caregiver Support – Community Engagement** | | **Due Date** |
| **Goal statement:** Increase the use of programs and services available to family caregivers. | | **Dec 2024** |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*  Use SAMS data to see an increase in caregiver support programs (support groups, respite, supplemental services, caregiver classes) from 1/2022 to 12/2024. | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Gather input from caregivers about their needs to ensure we are providing the programs and services they need. | Surveys created, distributed and collected | July 2023 |
| Action step: Include the questions from the Wisconsin State Dementia Plan – Caregiver Focus Group Team on all program and service evaluations. *(list specific ones such as HDM, support groups, healthy aging classes, transportation, EBS, etc.)* |  | June 2022 |
| Action step: Create a survey, using these questions, and give to all current consumers who identify as a family caregiver, by email, mail and have available in the office. |  | July 2022 |
| Action step: Ask the local Caregiver Coalition to use the questions to gather feedback through events and efforts they coordinate. |  | July 2022 |
| Action step: Complete one effort per year to reach family caregivers who are not currently connected (i.e. identify a new community partner to work with like churches, libraries, or Lions Clubs) and give survey to these caregivers. |  | Aug -each year |
| **Strategy 2:** Use feedback gathered to develop new programs or modify existing programs and services to meet their needs. |  | **Dec 2023** |
| Action step: Identify programs and services currently available that meet the needs of family caregivers and evaluate current promotion efforts |  | July 2023 |
| Action step: Use feedback to identify missing programs and services in the community. |  | July 2023 |
| Action step: Research and develop one new program/service that could be provided by the ADRC or another community agency. Or modify a current program that COULD better meet a need. |  | Dec 2023 |
| **Strategy 3:**  Increase marketing efforts of current and new programs and services to reach family caregivers we aren’t reaching with three new marketing efforts. |  | **Dec 2024** |
| Action step: New marketing effort #1 (i.e. newspaper insert, radio commercial, flyers, etc.). |  | Mar 2024 |
| Action step: New marketing effort #1 (i.e. newspaper insert, radio commercial, flyers, etc.). |  | May 2024 |
| Action step: New marketing effort #1 (i.e. newspaper insert, radio commercial, flyers, etc.). |  | Aug 2024 |
| **Annual progress notes** | | |

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| **Focus area: Caregiver Support – Community Engagement** | | **Due Date** |
| **Goal statement:**  Caregivers of people with dementia will have an opportunity to express their needs in order to improve programs and services available to family caregivers. | | **Dec 2024** |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*  500 surveys will be collected from caregivers of people with memory loss/dementia/Alzheimer’s disease and data given to the Wisconsin State Dementia Plan – Caregiver Focus Group Team | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1: Gather input from caregivers about their needs and experience as a caregiver of someone with memory loss/dementia/Alzheimer’s disease.** | Surveys created, distributed and collected |  |
| Action step: Include the questions from the Wisconsin State Dementia Plan – Caregiver Focus Group Team on program and service evaluations that are geared towards family caregivers. | Questions included on X number of existing evaluations. | June 2022 |
| Action step: Create a stand-alone survey, using these questions, and give to all current consumers who identify as a family caregiver, by email, mail and have available in the office. | X number of surveys were sent | July 2022 |
| Action step: Ask the local Caregiver Coalition to use the questions to gather feedback through events and efforts they coordinate. | Coalition members asked – X number of members agreed to share the survey | July 2022 |
| Action step: Complete one effort per year to reach family caregivers who are not currently connected (i.e. identify a new community partner to work with like churches, libraries, or Lions Clubs) and give survey to these caregivers. | Effort/event held | Nov 22-24 |
| **Strategy 2: Collect and analyze responses.** |  |  |
| Action step: Utilize responses to improve programs at the ADRC/Aging Unit |  | Jan-Dec 2024 |
| Action step: Send responses to the Wisconsin State Dementia Plan – Caregiver Focus Group Team. |  | Dec 2024 |
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PERSON-CENTERED SERVICES

**Goal Development Worksheet – Person-Centered Services/Equity**

**1. What are you trying to improve? What problem are you trying to solve?**

* Very few Black and LatinX community members are utilizing services funded through T-III B Supportive Services. Current SAMS data shows that a small number of people from both of these communities have used any service under T-III B during the past few years. Those services include legal assistance, information and assistance, case management, and in-home services; homemaker, home health aides, visiting and telephone reassurance and chore maintenance, The Aging Unit wants to increase program equity by assuring all people in our community have access to services.

**2. What is the current status of your problem or situation? Is it getting better or worse?**

* Current census data shows there are more than 50 people of the black 72 LatinX communities that may benefit from T-III B services and other OAA programs.

**3. What factors are hindering your progress? (preventing you from succeeding)**

* Black and LatinX community members may not be aware of OAA services including those services offered by T-III B.
* Outreach to both communities has been limited to written material or flyers that appear in newspapers, flyers or our aging newsletter.
* Language barriers limit our ability to communicate with the Latin-X community
* None of our staff or volunteers speak any Spanish
* Limited connections with the both communities
* LatinX communities may be fearful of government programs due fear of deportations for themselves or their family members
* An assumption/bias that if one method of “getting the word out” about services such as transportation works for one community it should work for all.
* An assumption/bias that people from the black and Latin-X communities have their own support networks through faith communities or other family members and they don’t need or will utilize many T-III B services even if they are offered.

**4. What factors are supporting your efforts?**

* Our Aging Unit has a strong desire to reach all people in our community that need our services
* We are willing as a staff to learn more about the culture of both communities
* Our county data shows that many of the people from the black and LatinX communities are within easily accessible service areas.
* We have several local businesses are owned and operated by black and LatinX members that are well established and frequented by all community members and new representation on our city council from both communities. There seems to be a willingness in the community to support both communities.

**5. Who are your partners in helping you succeed? (who could you work with to make this better)**

* LaitinX faith communities especially our local Catholic church
* There are well established communities of faith within the black community
* We have a new council member from the LatinX community that could serve as resource
* There are several local leaders from both communities that may be help us identify how to best reach each community

**6. What are some strategies or steps that could help? (ideas to fix the problem)**

* Meeting with faith based leaders
* Meetings with local leaders from each community
* Assure that outreach materials are written in a language that suits the Latin-X community
* Assure that our outreach materials are culturally informed
* Recruit more staff and volunteers for each community
* See if there are translation services available to help us bridge language barriers
* Work toward hiring more people who are black and brown communities
* Have staff learn basic conversational Spanish
* Identify cultural barriers that might cause people to not use not to use services offered such as rules related to requirements for identification
* Staff education on health equity and racism to better understand the community perspectives

**7. What do you hope to see as an outcome or result?**

* Increased utilization of T-III B services by 50% or greater by each people of each community by the end on 2024.
* Stronger ties with each community

**8. How will you measure your progress? How will you know that you have achieved the results you wanted?**

* We can assess the knowledge of services through surveying the community individually or through community events.
* Identify barriers to using services
* Our SAMS database can be used to develop a baseline measure of participation measure program participation and then we can track our progress toward increased utilization.

**GOAL TEMPLATE**

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| **Focus area: Person-Centered Services/Equity** | | **Due Date** |
| **Goal statement:** A 50% increase in participation/utilization of T-IIIB services by black and Latin-X community members by the Sept. of 2024 | | **Sept 2024** |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*  We will use the SAMS database to gather baseline data and quarterly we will track out progress and share that information will the our advisory council | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** **Meet with community leaders by May 2022 to share the services available to older adults, identify barriers within program delivery, effective ways of communicating, and opportunities to share OAA program information to meet the needs of each community.** |  | May 2023 |
| Action Step: Identify key community leaders and identify strategies to communicate with both communities. | Identify four community leaders and develop communication strategies |  |
| Action Step: Develop outreach tools and materials | Development of three new outreach tools to reach communities |  |
| Action Step: Evaluate impact of tools by asking people who contact the ADRC or Aging office how they heard about aging services | Staff identify the number of contacts for each community quarterly |  |
| **Strategy 2: Increase staff of the Aging Unit or volunteers by 15% each year 2022-2024** |  | **Oct 2024** |
| Action Step: Action Step: Identify hiring and volunteer recruitment strategies that would increase opportunities for black and Latin- X communities to learn about opportunities | Review and develop and implement three strategies that result in participation in interviews/ hiring of staff or volunteer opportunities. |  |
| Action Step: Share information about staff and volunteer opportunities with faith-based communities | Share employment and volunteer opportunities with 10 community organizations serving black and LantinX communities |  |
| Action Step: Ask leaders in target communities to identify people who might be most interested in staff positions or volunteering. | Gather 5 names each year from community leaders of candidates from both communities. And when possible ask community leaders to accompany staff make contact with community members to show support for OAA programs and services. |  |
| **Strategy 3: : Staff will increase their knowledge of each community through participation in language training, cultural sensitivity training, and annual participation in community events** |  | **July 2023** |
| Action Step: Participate in conversational Spanish language | 50% of staff compete a basic conversational Spanish course |  |
| Action Step: Develop a list of community organization serving black and LatinX communities and meet with no less than 2 directors of these agencies to learn about their services | Two lead staff or directors from the community provide cultural sensitivity training |  |
| Action Step: Develop an event or have staff participate in a community event organized by lead agencies serving balk or Latinx communities | 75% of staff participate in at least one community event each year that supports black or LatinX communities. |  |
| **Annual Progress Notes** | | |

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Equity

**Goal Development Worksheet - EQUITY**

**1. What are you trying to improve or achieve? What problem are you trying to solve?**

* There is a disparity in the communities that our programs are serving. We predominantly provide services to White people, and we need to make our spaces safer for people from marginalized communities.

**2. What is the current status of your problem or situation? Is it getting better or worse?**

* We have identified that this is an issue, but haven’t taken many action steps to rectify it.

**3. What factors are hindering your progress? (preventing you from succeeding)**

* This is a relatively unprecedented change in our Department/Bureau. Paving a new path for outreach protocol and establishing safety for our communities.
* Wanting to make sure we do this effectively and have the right tools to proceed has made this move slowly.
* Uncertainty and barriers caused by the pandemic.

**4. What factors are supporting your efforts?**

* Everyone on our team is committed to the work and eager to succeed.
* This is a Department-wide effort to increase health equity, so there are many sources of support.

**5. Who are your partners in helping you succeed? (who could you work with to make this better)**

* *[Insert community partners who are also invested in the effort].*
* Bureau leadership, colleagues, BADR Health Equity Consultant.

**6. What are some strategies or steps that could help? (ideas to fix the problem)**

* We could collect data from a survey sent to program participants to determine their sense of belonging and safety in our spaces.
* Offer training to staff, interns, volunteers, and anyone who has contact with program participants. Aim to reduce implicit biases and offer conflict resolution to situations of injustice and discrimination while working.
* Periodic goal setting and evaluations to determine success.
* Defining what success will look like, how we will know it has been achieved.
* Establish a reporting system/protocol if not already in place.

**7. What result or outcome are you trying to achieve?**

* Reducing instances of injustice and discrimination to increase safety in our programs. Increasing number of participants from marginalized communities.

**8. How will you measure your progress? How will you know that you have achieved the results you wanted? How will you know if your work made a difference in people’s lives?**

* Validating self-reporting will be key to overcome statistical disadvantages, meaning taking people for their word when they disclose their identities and when they disclose instances of discrimination. We will have to make note of the identities currently represented by our participants and then do the same periodically (maybe monthly). *[Insert percentage increase that we would like to see in a time period]*. In this case, presence of reports of injustice will not be a failure, it will actually be a measure of progress because it will indicate that a trustworthy reporting system is in place.

**GOAL TEMPLATE**

|  |  |  |
| --- | --- | --- |
| **Focus Area:** | | **Due Date** |
| **Goal Statement:** By the end of 2024, the Aging Unit will have established an equity framework to foster inclusion and restorative justice for marginalized communities. | | Dec 2024 |
| **Plan for measuring overall goal success** – (*How will you know that you have achieved the results you want? Use data.)*  Participation of members from marginalized communities will increase by 25 percent by the end of the goal period. We will have a reporting system and protocol for instances of injustice. | | |
| **Specific Strategies and Steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Assess demographics of our program participants, specifically identifying marginalized identities. |  |  |
| Action Step: Assign tasks to people who are equipped with the tools to gather this information. | Tasks have been assigned | Apr 1 2022 |
| Action Step: Seek this information from participants by interviews, surveys and other techniques determined appropriate. | Information gathered | Sept 1 2022 |
| Action Step: Clean the data so that it is represented by plain language and distribute to team. | Information sorted and in readable, report form | Dec 2022 |
| **Strategy 2:** Establish reporting system and protocol for instances of injustice. |  |  |
| Action Step: Train staff, interns, and volunteers (where applicable) to mediate instances of injustice. | X number of staff/volunteers are trained | July 2023 |
| Action Step: Create or amend a platform for participants and staff to report instances. | Platform created to report instances of injustice | Aug 2023 |
| Action Step: Notify all partners of the updated/created system and protocol. | All partners are notified | Oct 2023 |
| **Strategy 3:** Conduct outreach to members of marginalized communities. |  |  |
| Action Step: Partner with community organizations or offices that have established trust with these communities. | Partnerships established (list which ones) | May 2024 |
| Action Step: Present information about new developments to partners and members of marginalized communities. | Information presented via monthly email *(or preferred method)* regularly and ongoing | Dec 2024 |
| Action Step: |  |  |

**Goal Development Worksheet – EQUITY (Rural area)**

1. **What are you trying to improve? What problem are you trying to solve?**

* Our communities are not very racially diverse, but we know there are people who qualify for our programs that do not participate or utilize the services that could benefit them
* There is a push for our programs to be equitable and inclusive, but we aren’t sure how to start

1. **What is the current status of your problem or situation? Is it getting better or worse?**

* Our county’s population is 95% White
* 99% of people who use our programs/services are Caucasian
* Lack of awareness of who we are not serving and why

1. **What factors are hindering your progress? (preventing you from succeeding)**

* We don’t know which people are marginalized or how to reach them
* Lack of knowledge/understanding of needs of people from underserved populations
* Difficult to even know what language to use in

1. **What factors are supporting your efforts?**

* AU Staff are interested in ensuring programs and services are inclusive
* Education about equity/inclusivity is readily available

1. **Who are your partners in helping you succeed? (who could you work with to make this better)**

* GWAAR
* DHS (Health Equity Consultant)
* Churches, community organizations who reach marginalized people
* Wisconsin Public Health Association – health equity section

1. **What are some strategies or steps that could help? (ideas to fix the problem)**

* Find education for AU staff about inclusivity/equity
* Evaluate each of our programs/services for inclusivity looking at mobility issues; transportation; acceptance of different cultures, religions, physical and mental abilities, etc. Consider marketing materials, physical location and space, language, “norms”
* Look at population demographics to determine where marginalization might be occurring (race, income, disabilities) and who is not represented as customers of our services
* Connect with agencies/organizations who serve marginalized people in the community – give them program information, community engagement surveys, etc.

1. **What do you hope to see as an outcome or result?**

* AU staff will have an increased understanding of equity/inclusion
* Programs will welcome all people – more diversity in those who access services/programs

1. **How will you measure your progress? How will you know that you have achieved the results you wanted?**

* Increase in the number of non-white people utilizing our services
* Pre- post- test for staff training

**GOAL TEMPLATE**

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| --- | --- | --- |
| **Focus area: EQUITY** | | **Due Date** |
| **Goal statement:**  Aging programs and services will be welcoming to all people | |  |
| **Plan for measuring overall goal success** – H*ow will you know that you have achieved the results you want? Use data.*   * There will be an increase in the number of participants from diverse backgrounds – use SAMS data to track * Connections made with new community organizations who serve people who are marginalized | | |
| **Specific strategies and steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Aging Unit Staff will increase knowledge/awareness of inclusivity/equity issues |  |  |
| Action step: Inclusivity/equity training for staff to occur at least annually | 80% of Aging Unit staff have received training by Aug 2022 | Aug 2022 |
| Action step: Utilize information learned from training to make changes to AU/ADRC to create more inclusive environment | Changes made | On-going |
| Action step: Add “equity/inclusion” topic to staff meeting agendas to | 50% of staff meetings will include topic of equity/inclusion by end of 2022 and ongoing | Each year |
| **Strategy 2:** Connect with community agencies/organizations who serve (or might serve) marginalized people |  |  |
| Action step: Make list of community agencies/organizations who serve marginalized people | List created | Dec 2022 |
| Action step: Connect with each agency via email, phone or in person to introduce Aging Unit/ADRC. Use script created with help from health equity consultant. | Introductions made | Dec 2023 |
| Action step: Continue communication with agencies – newsletter, upcoming programs, community engagement surveys | Communication occurring regularly | Dec 2024+ |
| **Annual progress notes** | | |

**Goal Development Worksheet - Advocacy**

Advocacy

**1. What are you trying to improve or achieve? What problem are you trying to solve?**

* Public policies have a significant impact on the lives of older adults and their communities. Though everyone has a stake in the public policies enacted by federal, state, and local governments, few older adults (or people of any age) understand the legislative process well enough to effectively advocate for the changes they want and need. The aging unit is striving to increase older adults’ access to the training, opportunities, and resources needed to become effective advocates.

**2. What is the current status of your problem or situation? Is it getting better or worse?**

* When local, state, or federal advocacy opportunities arise only a small percentage of older adults actually engage.

**3. What factors are hindering your progress? (preventing you from succeeding)**

* Though the aging units are required to be involved in advocacy with and for older adults, the Older Americans Act doesn’t provide any specific funding to support advocacy activities and program funding is already insufficient to meet the needs. There is no one staff member with responsibilities related to advocacy, instead these responsibilities are spread out among all staff and frequently get pushed aside by other competing responsibilities.
* Some aging unit staff also have limited understanding of the legislative process.
* News deserts – older adults frequently indicate difficulty obtaining information regarding important issues, particularly unbiased information.
* Political polarization and increasing partisan tensions are contributing to a further decline in civic engagement.

**4. What factors are supporting your efforts?**

* The Wisconsin Elders Act (1991 Wisconsin Act 235 - Wisconsin Statutes 46.82) requires aging units to “…assist older individuals in expressing their views to elected officials and providers of services,” and to “advocate on behalf of older adults.” This includes the aging unit as a provider, as aging units are also required to “incorporate and promote older adult participation in the preparation of the county/tribal plan.”
* The current (2021) Scope of Services for Aging and Disability Resource Centers (ADRCs) Grant Agreement requires ADRCs to “advocate on behalf of the individuals and groups who comprise their target populations when needed services are not being adequately provided within the service delivery system,” including “…facilitation of a customer’s self-advocacy…”.
* Voter turnout among older adults remains high (one measure of political engagement).

**5. Who are your partners in helping you succeed? (who could you work with to make this better)**

* County clerk
* Community Action Program
* Independent Living Center
* League of Women Voters – Local Chapter/State Chapter
* Disability Vote Coalition
* ADPAW
* Wisconsin Counties Association/Wisconsin County Human Services Association
* GWAAR
* Wisconsin Aging Advocacy Network
* Survival Coalition of Wisconsin Disability Organizations

**6. What are some strategies or steps that could help? (ideas to fix the problem)**

* Offer training on the legislative process
* Offer education workshops on specific policy issues
* Seek trainers with lived experience in underserved communities
* Conduct outreach to recruit training/workshops participants
* Partner with community leaders and organizations to ensure outreach to underrepresented older adult populations.
* Provide training/meeting space that is accessible and has the technology needed to meet accessibility needs – including translation/interpretation
* Identify opportunities for newly trained advocates to put their skills to work (gain experience) – internal and external
* Provide organizational support (meeting space or platform, photocopies, resources) for advocates interested in forming a local advocacy committee to share ideas, create plans/strategies, and take action.

**7. What result or outcome are you trying to achieve?**

* Older adults will have access to the training, opportunities, and resources needed to become effective advocates; and
* A diverse group of trained older adult advocates will form a local advocacy committee

**8. How will you measure your progress? How will you know that you have achieved the results you wanted? How will you know if your work made a difference in people’s lives?**

* Pre- and post-training evaluations
* Increased number of engaged advocates
* Advocates reflect the diversity of the population served
* Advocacy activities/plans reflect input from all older adult populations served

**GOAL TEMPLATE**

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| --- | --- | --- |
| **Focus Area:** | | **Due Date** |
| **Goal Statement:**  Older adults will have access to annual training and/or issue workshops and will be provided with advocacy opportunities and resources to help them become effective advocates.  By 12/31/24, a diverse group of trained older adult advocates will have formed a local advocacy committee that is meeting at least quarterly. | | 12/31/22  12/31/24 |
| **Plan for measuring overall goal success** – (H*ow will you know that you have achieved the results you want? Use data.)*  The number of trained advocates will be increased by at least 5 people and a local advocacy committee will have been created (if not already in existence). | | |
| **Specific Strategies and Steps to meet your goal:** | **Measure** *(How will you know the strategies and steps have been completed?)* | **Due Date** |
| **Strategy 1:** Offer training on the legislative process or issue education workshops on specific policy issues to increase the effectiveness of advocates at the local level at least annually. |  |  |
| Action Step: Contact GWAAR or community partners to secure a trainer (if not providing an in-house trainer) and schedule an Advocacy 101 training or issue education workshop annually between 1/01/22 – 12/31/24. | Training date on calendar | 2022  2023  2024 |
| Action Step: Meet with community partners to secure assistance with outreach to underrepresented older adult populations. | Meeting conducted and assistance secured. | 6/30/22 |
| Action Step: Register participants and conduct training in an accessible location and providing supports to address any accessibility needs. Seek trainers with lived experience in underserved communities. | Training conducted between desired dates and participants in attendance | 12/31/22  12/31/23  12/31/24 |
| Action Step: Conduct pre- and post-training evaluations to measure participants’ growth in knowledge of the advocacy process. | Participant evaluation will demonstrate an increase in knowledge of the legislative process. | 12/31/22  12/31/23  12/31/24 |
| **Strategy 2:** Identify opportunities for newly trained advocates to put their skills to work (gain experience) – internal and external |  |  |
| Action Step: Include advocacy information and resources in the aging unit newsletter – legislator contact information, tips for meeting with your legislator, issue education | Aging unit newsletters will contain an advocacy section. | 3/31/22 |
| Action Step: Notify advocates of local advocacy opportunities – aging unit service plan, county budget hearing, municipal hearings/listening sessions | A method of sharing local advocacy information with advocates has been established and utilized (email, website posts, social media) and advocates are involved in local opportunities. | 9/30/23 |
| Action Step: State and Federal advocacy alerts from GWAAR, WAAN, and other partners (MOWA, etc.) will be shared with advocates. | Advocates have received alerts and taken action. | 12/31/23 |
| **Strategy 3:** Provide organizational support for advocates interested in forming a local advocacy committee to share ideas, create plans/strategies, and take action. |  |  |
| Action Step: Offer advocates meeting space, clerical support, advocacy resources to assist the work of a local advocacy committee. | A local advocacy committee meeting will be formed and actively meeting. | 3/31/24 |
| Action Step: Assist committee to recruit members who reflect the diversity of the community. | Advocates will reflect the diversity of the population served. | 6/30/24 |
| Action Step: Provide contact names/organizations to assist advocacy committee members to engage a diverse group of community members in advocacy campaigns. | Advocacy activities/plans reflect input from all older adult populations served. | 9/30/24 |
| **Annual Progress Notes** | | |