**EXAMPLES: IDEAS FOR REQUIRED FOCUS AREAS - 2022-2024 AGING PLANS**

**EXAMPLES OF IDEAS TO ENHANCE PROGRAMS**

**Title III-B Supportive Services**

* Increase transportation options for people needing to get to congregate meal sites in rural communities
* Decrease social isolation by developing a telephone reassurance service in partnership with community volunteers/organization
* Regional transportation coordination
* Transportation emergency planning
* Public/private transportation partnerships
* Embrace new transportation technologies
* Increase marketing and education efforts on available transportation services
* Partner with other local agencies (ILC, Veterans, pharmacy/home medical supply, etc.) to build an assistive technology or mobility support loan closet
* Create a volunteer program to provide home repair, small home modifications, and chore services
* Develop a tablet loan program to use for telehealth, support groups, socialization, etc.
* Purchase a virtual community engagement platform and develop a plan for continuous community engagement – milestones over 3 years and include intentional outreach to underserved populations
* Support non evidence-based health promotion efforts like the Aging Mastery Program
* Develop a virtual meeting space for LGBTQ caregivers and family members.
* Develop ongoing virtual community connections meeting space for older adults with disabilities/ chronic conditions/ deaf and hearing communities
* Develop a phone support program to address solation and loneliness

**Title III-C Nutrition Program**

* Utilizing a Malnutrition Screening Tool and enhancing DETERMINE checklist
* Getting leaders trained in Stepping Up Your Nutrition Class and/or Eat Better, Move More, Weigh Less High-Level EB Class
* Develop a 3 year plan to utilize Nutrition Education Initiative Materials (Eat Well and Beneficial Bites)
* Increase the amount and type of Nutrition Counseling offered
* Work with local and statewide partners to address Hunger, Food Insecurity, and Increased Access
* Incorporate Cooking Classes (virtual or in-person)
* Incorporate Nutrient-Dense Meals by utilizing Menu Development and Culinary Support from GWAAR and Sustainable Kitchens
* Expand Socialization opportunities
* Consider Medically Tailored Meals
* Work with healthcare entities on Care Transitions
* Expand under serviced participants in our County
* Record  programs  and air throughout the year on local cable community channel or Facebook featuring  recipe sharing
* Explore breakfast option or Dining at 5 with the goal of increasing participation by at least 25 new, unduplicated individuals participating.
* Emergency planning for participants, meals , drivers and other staff for multiple emergency scenarios.

**Title III-D Health Promotion**

* Reduce the health effects of loneliness in older adults
  1. Identify lonely older adults (possibly through HDM)
  2. Implement proven strategies to reduce loneliness
     1. Phone Companion Program
     2. Implement high-level evidence based programming
     3. Create partnerships with local organization for a collective impact approach (i.e. healthcare, UW-Extension, WIHA)
  3. Evaluate effectiveness of intervention
* Expand high-level evidence based health promotion opportunities for older adults in your community.
  1. Assess current evidence based health promotion programming for older adults in your community (Aging Unit, ADRC, Senior Ctr, hospitals, clinics, Athletic Clubs, public health)
  2. Establish partnerships to increase evidence based health promotion programming – identify which programs you would like to expand, new programs to address a health need in the community.  Possibly create an evidence based coalition for older adults in your community.
  3. Plan and implement new programming based on need (train facilitators, etc.)
  4. Evaluate programming – is it fitting the need identified

**Title III-E Caregiver Support**

* Increase access to and availability of respite care services
* Apply for a [CORE Respite Grant](https://secure-web.cisco.com/1apGyqGUuV4hsNK1C7cCOGAM9BLexzO350JEAF4mZwvN-VCQ8ruvyRRXd3BWiESSpLOfU2eTti8VqxO0kDzjirzc1LRjLFbippj5e7DaWrbQ-FxGhnmuZ4RahBBqczrzDN7hgQqZHIGhVO4Q1J0vZ04Kj-n48xWwpKyflGufVcHovW-QkXtpsJdzA7Z5KCsV3MnvLlx3tLQyFB0zRDkW9PW_gEjD-6VKk0HavK9RVrHBCv9q2SYWTY0JgKCI8IGFq1tfudobRp4Nhbs3-cqRhA0uYefYI8nr7V6BSFMjcRpam4WfHfBT_eRA8SxKOSFZojzl8wp2ooGVUqcdWNOAfCiLS2h3BWtxRpYeFBoWpKUs/https%3A%2F%2Frespitecarewi.org%2Fgrants%2Fcore-grant-program%2F) from RCAW  *(The purpose of the****CORE Grant Program****is to expand the pool of trained respite care providers by hosting recruitment and outreach events, educate family caregivers about long-term care resources, including respite care, and collaborate with agencies that support family caregivers, including but not limited to ADRC’s, County CLTS, and CCOP staff, and Tribes.)*
* Environmental scan of respite support services in county/tribe
* Educate/outreach/marketing on availability of respite services
* Increase support for grandparents and relative caregivers caring for relatives’ children
* Participate in RAPP workgroup through WFACSA
* Create a vehicle for regular communication with Kinship Care staff, WI Adoption & Permanency Support, local Family Resource Center, and the Coalition for Children, Youth and Families
* Survey grandparents/relative caregivers in the county/tribe to find greatest need
* Work with above partners to initiate one support discovered from survey
* Increase the number of caregivers who access virtual caregiver training, support groups and events
* Create a system of referral and engagement of caregivers to the Trualta program
* Start a tablet loan program which includes internet access
* Hold regular education opportunities to teach how to use technology and virtual platforms such as Zoom (Senior Planet and Generations Online have programs to access)
* Utilize Virtual Events page
* Ensure underserved populations have access to (are comfortable accessing) caregiver supports
  + Connect with trusted leaders of underserved communities.
* Review resources and materials with these groups to assess for relevance/cultural appropriateness
* Create/revise/extend services to meet specific needs of the groups as identified by above activities

**EXAMPLES OF IDEAS TO ADVANCE VALUES**

At least one goal is required to ***enhance ongoing community engagement*** with aging plans and program operations so that they build a sense of ownership and commitment by the community.

* Successfully engage individuals who are not program participants in the community engagement/needs assessment process
* Hold three community engagement events, two virtual, and get input from people who can’t attend in-person
* Hold a community engagement event in partnership with a community organization from the Black, Latinx or Hmong community to discuss ways to better serve.
* Form a community engagement committee to create and manage ongoing community engagement
* Purchase and utilize a virtual engagement platform

At least one goal is required to address progress within one or more program area toward ***person-centered services, maximizing consumer control and choice***. This may include efforts to expand choice and participant direction in specific Title III programs. One example might be a goal to introduce a choice-based restaurant model as part of the congregate meal program. The person centered services goal can be a stand-alone goal or met in one or more of the goals for Title IIIB, Title IIIC, Title IIID or Title IIIE.

* Increase choice in congregate dining participation by opening a restaurant model in cooperation with a local restaurant (this is also a nutrition program goal).
* Expanding congregate and home delivered menu options to include meals that appeal to members of underserved communities, such as the Hispanic, Hmong, Black or Indigenous community (this is also a health equity and nutrition goal).
* Expand respite and in-home services to include non-professional/agency providers
  + Create a list of non-agency providers of respite, personal care and homemaker services
  + Seek out providers of underserved populations to find resources that caregivers of less visible communities (LGBTQ+, minorities, low income) are comfortable, willing and able to access. May need to start by forming relationships with the leaders of these communities.

At least one goal is required to ***address a barrier to racial equity*** within one or more program area. This may include efforts to expand the racial equity or inclusiveness of specific Title III programs. One example might be a goal to move closer to equitable distribution of aging services to reflect county demographics. The racial equity goal can be a stand-alone goal or met in one or more of the goals for Title IIIB, Title IIIC, Title IIID or Title IIIE.

* Modify program outreach and operations to increase the number of people participating from the underserved communities, such as the Hispanic, Hmong, Black or Indigenous community in home delivered and congregate meal program. (This also a nutrition program goal).
* Offer Spanish language versions of Stepping On and Living Well with Diabetes to increase participation of people from underserved communities.
* Expand offering and outreach for Grandparent Caregiver supports or kinship care services to underserved populations in your community.
* Provide Spanish and Hmong language supports to facilitate participation in caregiver services by underserved communities in your area.
* Provide in-depth training to agency staff about inclusiveness and equity with the goal of identifying groups in your communities who are not being served because programs offered do not take into account the specific needs of these groups.

At least one goal is required to increase local aging and disability network participants’ ***knowledge and skills related to advocacy***. This may include efforts to educate older adults about policy making or legislative processes, sometimes known as “Senior Statesman” training. The advocacy goal can be a stand-alone goal or met in one or more of the goals for Title IIIB, Title IIIC, Title IIID or Title IIIE.

1. **Increase the effective advocacy skills of X # of people by offering training and resources – Increase Knowledge**
   1. Who are your legislators? What role do they play?
   2. Legislative process
   3. How to tell your story
   4. Issues impacting older adults/people with disabilities – local, state, federal or budget or non-budget policy
2. **Identify opportunities for (newly trained) advocates to put their skills to work**
   1. County/tribal budget process
   2. Municipal issue
   3. State budget process
   4. State legislative process
   5. Federal budget process
   6. Federal legislative process
3. **Provide organizational supports to advocates/members willing to form a local Advocacy Committee**

* Meeting space
* Photo copies and supplies
* Access to resources
* Share advocacy updates
* Agenda items

**Advocacy goals could also advance racial equity by incorporating the following:**

* When recruiting for advocacy training, specifically reach out to parts of the community that have not been represented before.
  + Ensure the accessibility of advocacy events with attention to the physical space, the technology used, and the need for interpretation, closed captioning, and translation.
  + Make sure outreach materials are accessible and available in translation.
  + Seek trainers with lived experience in underserved communities.
  + Connect with trusted leaders of underserved communities.
* Make sure topics you address in the three steps above reflect the needs of underserved communities.
* Support partners from underserved communities by allying with their advocacy efforts.
* Test your results – do the advocacy activities or plans reflect input from all populations in the community?