

Milestones Area Agency on Aging PSA #5

SFY 2026 - 2029 Area Plan on Aging



Plan Effective Dates: July 1, 2025 – June 30, 2029

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DRAFT

Executive Summary

Area Agencies on Aging (AAAs), established under the Older Americans Act (OAA) of 1965 (amended and reauthorized March 2020), respond to the needs of older adults over age 60, adults 18 - 59 with disabilities, and family caregivers over age 55. Milestones Area Agency on Aging (MAAA) is designated by the State of Iowa Department of Health and Human Services, Division of Aging and Disability Services. It is one of the six area agencies on aging responsible for services across the state. Milestones is also a state-designated Aging and Disability Resource Center (ADRC), branded as LifeLong Links. In accordance with the OAA, and under the direction of the Iowa Health and Human Services Division on Aging and Disability Services, MAAA submits the agency's SFY2026 – 2029 Area Plan on Aging.

The previous four-year plan was written and adopted in 2021, a time in which significant additional emergency funding had been allocated to expand services in response to increased consumer needs during the pandemic. By the end of SFY 2023, MAAA's additional one-time funds were fully expended. In preparation for the diminished budget, Milestones undertook efforts to "right size" service delivery. These efforts included closing Iowa Cafés in counties which also operated congregate meal sites, initiating a wait list for home-delivered meals, and refining the prioritization process to ensure limited funds are used to deliver services to those with the greatest economic or social need, or at risk of institutionalization.

Throughout FY25, Milestones worked to mitigate the impact of necessary reductions on those most at risk. As we enter this plan period, we do so with a leaner workforce, reduced operational capacity, and continued high consumer need. It is a time with great potential for reimagining operations; it is also a time of unusually great changes and transitions taking place throughout the landscape of the aging network.

For all of these reasons, Milestones's SFY2026 – 2029 Area Plan emphasizes activities and services that feature staff knowledge, skills, and partnerships, and can generally be carried out with little expense beyond normally budgeted activities. In order to operate most effectively within budgetary constraints, the agency will focus on the fundamentals, using a strong prioritization process to ensure that limited funds are used to deliver services to older adults in the greatest economic need (poverty), who are socially isolated, frail, and/or are at risk for institutionalization, including those in rural areas and those who live alone.

Plan Objectives, Strategies, and Activities

Goal 1: Maximize Independence –

Objective #1 seeks to increase the number of diverse and underserved older adults receiving care coordination through Options Counseling and Case Management with the goal of promoting independence and individual choice.

Objective #2 will focus on staff knowledge to best assist in providing MAC (Medicaid Administrative Claiming) allowable assistance to persons who are applying for State benefits, specifically individuals 60+ and are at-risk for institutional placement. Objective #3 targets expanding ADRC partnerships to improve coordination of services for those 60+ and people with disabilities. It includes outreach to those of minority status, a demographic that shows low use of these services.

Goal 2 – Improve Health and Wellness

Objective #1 involves a continued review of low-attendance congregate meal sites and expanding access to nutrition services through Iowa Café-style restaurant partnerships. Objective #2 targets those at risk for malnutrition, and places emphasis on identification and intervention, including the development of a screening tool, staff training, and nutrition counseling.

Objective #3 prioritizes reducing the risk of falls through education, awareness, and prevention. Activities include limited small group classes and, in rural areas where classes are not feasible, provide HARP, a personalized in-home falls prevention and home modification evidence-based program.

Goal 3 – Improve Safety and Quality of Life

Objective #1 is to increase awareness, prevention, and reporting of elder abuse and dependent adult abuse, particularly in at risk areas with low reporting history. Increasing partner referrals and educational presentations are among the activities.

Objective #2 targets access to legal assistance, and focuses on increasing referrals through strengthened partnerships – such as that with Iowa Legal Aid and the Rural Justice Project for Older Adults -- and educating staff so they can improve Legal Aid referrals.

Objective #3 strengthens emergency preparedness for care recipients and caregivers through a partnership with the Disaster PrepWise program through the University of Iowa College of Public Health. Disaster PrepWise is a program offered through the University of Iowa College of Public Health to prepare older adults for disasters. It is the first program of its kind to provide a tool and personalized assistance to develop a tailored disaster management plan for individuals and families.

Goal 4 – Stay Engaged and Supported

Objective #1 targets caregivers at risk for stress, depression, and financial troubles due to caregiver role through the development of community-level workgroups.

Objective #2 addresses those at risk of social isolation with the development of a menu of resources for referrals to a wide variety of localized social opportunities for engagement.

Objective #3 focuses on implementing strategies to ensure informal caregivers in underserved areas are aware of, and are receiving as requested, services and supports. This objective also features increasing staff Dementia Friend Champions and working to expand this program's reach in our PSA.

These objectives and activities all share the common goal of reaching those in greatest need, the underserved, and those most at risk, and is consistent with our mission of helping older lowans live safely and independently at home for as long as possible.

Context

The Milestones Area Agency on Aging Planning and Service Area (PSA) is comprised of seventeen counties in Eastern and Southeastern Iowa: Appanoose, Clinton, Davis, Des Moines, Henry, Jefferson, Keokuk, Lee, Louisa, Lucas, Mahaska, Monroe, Muscatine, Scott, Van Buren, Wapello and Wayne. The PSA is primarily rural, with Scott County as the exception qualifying as “urban”. The PSA total 60+, non-institutionalized population is 132,741; 31.7% of this population (42,018) reside in Scott County. Following Scott County in population are Clinton (13,103), Des Moines (10,954), Muscatine (10,571), and Lee (9,731) counties. The remaining twelve counties identify 60+ non-institutionalized populations ranging from 8,943 (Wapello) to 1,945 (Wayne).

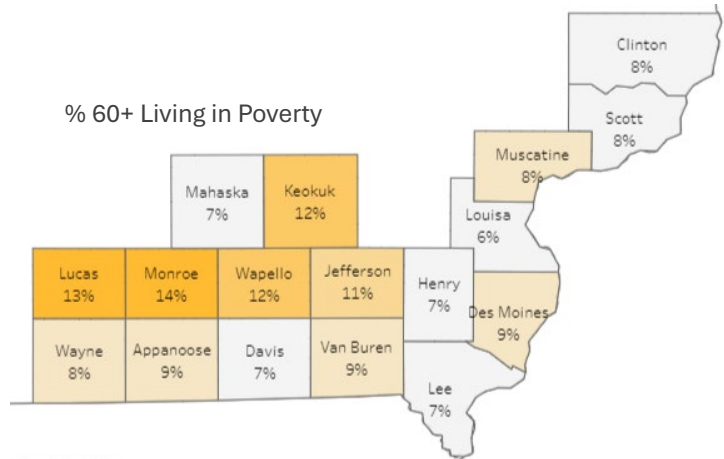
Regarding racial/ethnic composition, the PSA is 95.4% white, with the largest minority 60+ non-institutionalized population residing in Scott County (3,881). This is followed by Muscatine (1,115), Des Moines (611), Wapello (568), Lee (515) and Clinton (485); the remaining twelve counties identify minority 60+ non-institutionalized populations ranging from 275 (Louisa) to 36 (Van Buren).

With the escalating cost of services and limited funding, Milestones SFY 2025 – 2029 plan reflects increased efforts to prioritize limited services to focus on older adults in rural areas, who live alone or are socially isolated, and who are in poverty.

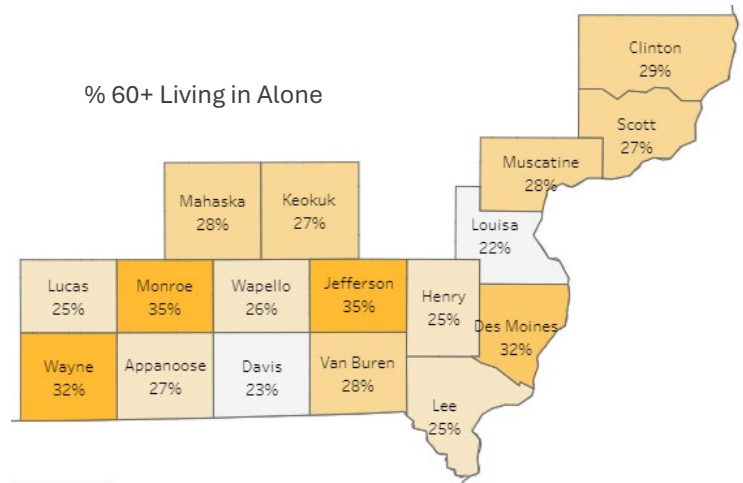
- Rural populations:** As mentioned, sixteen of the counties in the Milestones PSA are identified as “rural”, with Scott County representing the only “urban” exception.

County	% of 60+ population served by county (FY24 Service Delivery)	
Wayne County	2.67%	Rural
Clinton County	2.85%	Rural
Mahaska County	3.45%	Rural
Scott County	3.50%	Urban
Henry County	3.65%	Rural
Muscatine County	4.09%	Rural
Des Moines County	4.27%	Rural
Davis County	4.35%	Rural
Lee County	4.37%	Rural
Jefferson County	4.56%	Rural
Appanoose County	4.65%	Rural
Keokuk County	5.07%	Rural
Monroe County	5.29%	Rural
Louisa County	5.68%	Rural
Van Buren County	5.97%	Rural
Wapello County	6.46%	Rural
Lucas County	6.86%	Rural

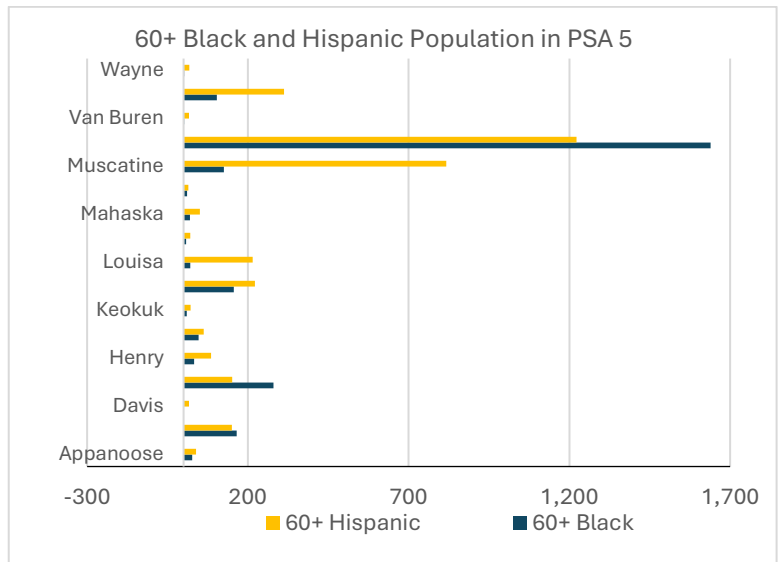
- Economically Disadvantaged 60+ populations:** The 2022 data from the ACL shows that 8.6% of adults aged 60+ live below the poverty line in our service area.



- 60+ Living Alone:** In addition to living in rural areas, often without neighbors nearby, 27.75% of Milestones consumer population live alone in our service area. This puts them at a particular risk if family or community supports are lacking, if the consumer lacks mobility, is frail, or for other reasons has difficulty with necessary activities and meeting basic needs.



- 60+ Minority Populations:** The overall minority population represents 4.6% of the 60+ PSA 5 population. There are 23% more 60+ Hispanic consumers than Black consumers, with notably greater relative numbers in Muscatine, Louisa, and Wapello counties. In these communities, language is often a barrier to knowing about and requesting help for needed services,



especially for older consumers. For this reason, Milestones's partners trusted in the community are invaluable.

Methods used for needs assessment activities-

Milestones staff drew information for the needs assessment from a variety of resources:

- Demographic information for analysis was gathered from census data and Tableau maps and data collected and shared by the Division of Aging and Disabilities resource staff (Tableau is a data visualization tool that helps users connect to various data sources and create interactive dashboards and maps to gain insights for decision-making);
- WellSky data management system – staff ran reports and examined consumer intake information, distribution of services across the PSA, and other factors;
- Consumer satisfaction surveys: In fall of 2024, Milestones AAA sent out a survey to approximately 500 active congregate participants and 600 home delivered meal participants. 269 congregate and 200 HDM participants responded. 96% of congregate responders felt the meal program increased their social connection and 86% found the activities at the site to be good or excellent. 93% of home delivered participants said they ate healthier as a result of receiving Milestone's meals and 95% said they had a greater sense of social connection.
- Direct consumer feedback;
- Information & Assistance staff / field staff reports;
- Service providers and peer agency reports and referrals

The information gained through this needs assessment process informed choices and decisions such as objectives, activities, and geographic targets. To operate within fiscal constraints, this plan focuses on foundational services such as ADRC/Options Counseling, nutrition, falls prevention, elder abuse prevention, and caregiver well-being, for example, and activities that can be accomplished with negligible additional expenditures beyond normally budgeted activities. With severely limited funding, it is of great importance for the agency to focus on fundamental activities and services that best utilize staff knowledge, skills, and partnerships.

Section 1: Goals, Objectives, Strategies & Measures

Goal 1: Maximize Independence

People with disabilities and older adults have access to high quality, equitable, and person-centered services that maximizes their independence, community integration, and self-sufficiency.

Agency Programs, Services, & Initiatives

Data indicate that consumers in some of the most rural and economically disadvantaged communities within our PSA could benefit from increasing knowledge about services available to support them in maximizing independence, self-sufficiency, and quality of life within their communities. Options Counseling and/or Case Management services can be the link to educate and support those who need services of which they are unaware or have been unable to access. By establishing partnerships with other agencies, Milestones' social services programs can connect with new consumers. In SFY24, Milestones served a total of 288 consumers 1,108 units of Options Counseling/Case Management. In 2023, 323 people were served with 1,366 units of service. Some of the most rural counties in our PSA, served relatively few individuals in Options Counseling/Case Management. Please see the table below for information regarding the three counties where efforts will be focused. They are some of the most rural, while the most populated of the three, Wapello County, only has a total population of 35,043. We will engage in partnerships with Samaritan's Feet Seniors, RSVP, local public health departments and Milestones Nutrition programs to expand Options Counseling/Case Management awareness and accessibility to these areas. These three counties are also served by the participating RSVP. By partnering with these agencies/programs, Milestones will be able to reach more of the target populations to assess those in need, make appropriate referrals, coordinate services that include new, well-fitting shoes through Samaritan's Feet Seniors, vaccines from public health departments as well as socialization and nutrition education at our local nutrition sites or other community locations as needed.

Objective 1: 1.4 - Increase the number of diverse and underserved older adults receiving care coordination to maximize independence in their community of choice.

Why it matters...

To better connect with those living counties in where data suggests high priority of meeting criteria for greatest need; increase partnerships with other agencies—particularly Public

Health departments providing services to promote independence—that will improve accessibility to Milestones’ services.

What we are doing...

Strategy: 1.4d - Other (Please explain.)

- Explanation of Other Strategy (if selected):
Provide Options Counseling and Case Management to increase the capacity of individuals to live independently within their community of choice.

Activities:

Milestones will work to partner with other agencies to assist in identifying individuals who may need support or services within their own communities. We will maintain collaboration with public health agencies in prioritized areas and create a process to facilitate direct referrals to the agency care managers for older adults identified in greatest need of support. Previously, Public Health Providers were independently contracted to provide services that support independence but without a high level of connection to Milestones options counseling/case management. A new system of directly managing care coordination for Provider services was designed to improve our ability to assess for greatest need and target limited funding toward a meaningful level of care. The changes we implemented foster increased collaboration with the service Providers for consumers. The benefit to older adults seeking support is a more coordinated network of care including assessment for additional help from other programs like Medicaid, Medicare extra help, etc.

Populations in Greatest Economic Need: Persons ages 60+ who identify as living in poverty (at or below 100% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons ages 60+ living in rural and underserved areas

- Explanation of Other or Sub Population (if selected):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): Caregivers who need additional support in assisting others to live independently

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

For purposes of this program, we will primarily focus on counties where Public Health and other community partners have indicated increased need for care management and services to support independence. This includes, but is not limited to, Monroe, Louisa, and Davis counties. These also make up some of our most rural and under-resourced counties for a wide variety of programs and sources of help for the living conditions that improve health outcomes such as access to transportation, food security, affordable healthcare, and making ends meet.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 1.2 - Total # of consumers receiving Options Counseling. #2: 1.3 - Total # of consumers receiving Case Management. #3: 1.4 - Other (Please explain.)	#1: 1.2 - Total # of consumers who indicate they participated in creating their care plans for Options Counseling. #2: 1.3 - Total # of consumers who indicate they participated in creating their care plans for Case Management. #3: [Choose an item.]	#1: 1.4 - #/% of populations/areas in greatest need who are enrolled in community-based services. #2: 1.4 - #/% of populations/areas in greatest need who are enrolled in community-based services. #3: [Choose an item.]
SFY 2026 Targets	#1: 243 consumers #2: 73 consumers #3: Click or tap here to enter text.	#1: 243 consumers #2: 73 consumers #3: Click or tap here to enter text.	#1: 63 consumers #2: 26 consumers #3: Click or tap here to enter text.

- Explanation of Other Measure(s) (if selected):
Click or tap here to enter text.

- Explanation of logic used to develop SFY 2026 targets:
Service targets are based on data from past performance, feedback from consumers, limited staffing based on funding, restricted funding sources and collaboration commitments, and overall cost-effectiveness of program delivery.

Objective #2: 1.3 - Develop a high quality, equitable, comprehensive, and coordinated system of long-term care that enables people with disabilities and older adults to receive long-term care in community-based settings.

Why it matters...

AARP and others report that while most older adults want to stay in their homes as they age, many are unprepared for the financial, physical, and social challenges involved. This personal preference is reflected in the data: in the past 20 years, the number of community-dwelling adults in traditional housing has increased, while those living in nursing homes has declined according National Library of Medicine research (<https://pmc.ncbi.nlm.nih.gov/articles/PMC9495472/>).

Though future disability needs may be unpredictable, successfully aging in place typically requires adequate social support in addition to having a home that is accessible. (source: University of Michigan Institute for Healthcare Policy & Innovation) While some older adults have strong social connections within their family and community, others are more isolated and do not have people in their life they can rely on for help with personal care, household chores, grocery shopping, or managing finances, particularly those who live alone. According to the study, those who live alone were also more likely to say they do not have someone to help with personal care compared with those who live with someone. Moreover, more than two in five older adults are not confident that they could afford to pay for additional help they might need. Milestones care managers, including Options Counselors, Case Managers, and Family Caregiver Specialists, will help connect older adults with programs and services that best suit their needs and facilitate aging in place to prevent/prolong more expensive long-term care placement.

What we are doing...

Strategy: 1.3f - Other (Please explain.)

- Explanation of Other Strategy (if selected):
Provide MAC (Medicaid Administrative Claiming) allowable assistance to persons who are applying for State benefits, specifically individuals 60+ and are at-risk for institutional placement.

Activities:

Options Counselors, Case Managers, and other program specialists (Family Caregiver, Elder Abuse & Prevention) will increase training to improve knowledge and skills to better learn the benefits available and foster connection to resources for the prioritized populations.

Populations in Greatest Economic Need: Persons applying for State benefits for self or other persons ages 60+ and need assistance during application process

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons ages 60+ living in rural and underserved areas

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): Caregivers who need additional support in assisting others to live independently

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

For this objective, MAAA will focus on Scott, Clinton and Muscatine counties, our three highest populated counties, to reach the greatest number of those in need. Scott County has the largest population with a total of 173,924, while Clinton County has 46,344 and Muscatine County's population is 42,377 as reported in the 2020 census. These three counties make up 53% of the total population living in our 17-county PSA.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 1.3 - #/% of AAA staff who are able to claim MAC allowable activities. #2: [Choose an item.] #3: [Choose an item.]	#1: 1.3 - Agency achieves a MAC rate of at least 25%. #2: [Choose an item.] #3: [Choose an item.]	#1: 1.3 - #/% of populations/areas in greatest need who received application assistance who are now receiving state benefits. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 5 staff #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 2 quarters per fiscal year #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 60% of those who received application assistance #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure(s) (if selected):
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:
Service targets are based on data from past performance, feedback from consumers, limited staffing based on funding, restricted funding sources and collaboration commitments, and overall cost-effectiveness of program delivery.

Objective #3: 1.1 - Expand Aging & Disability Resource Center (ADRC) / No Wrong Door (NWD) partnerships to improve coordination of services for older adults and people with disabilities.

Why it matters...

Milestones will develop and strengthen partnerships within our PSA to make available services better known to older adults of minority status. Though only 10.4% of Iowans are estimated to be minorities (U.S. Census Bureau QuickFacts), and 5.7% of older Iowans identify as minority status (grantsforseniors.org), it is a segment of the population that is

not as easily accessible to information, especially if there are language or other barriers, when support services are publicly promoted. Milestones will get more connected to other agencies that focus services on minority populations. According to the U.S. Census Bureau, 4.5% of the minority population in Iowa is black while those of Hispanic or Latino ethnicity make up 7.4% of the population based on estimates dated July 1, 2024.

What we are doing...

Strategy: 1.1a - Develop and/or strengthen partnerships with other agencies to increase referrals of populations/areas in greatest need to OAA services.

- Explanation of Other Strategy (if selected):
Click or tap here to enter text.

Activities:

The Social Services team at Milestones will reach out to agencies that are identified as working or socializing with those of minority status to offer and present information about services available to them. This will include all team members who will promote their individual services, including Information and Assistance, Options Counseling, Case Management, Family Caregiver, Elder Abuse Prevention and Awareness, and the Social Services Supervisor and Director, as appropriate. We will extend partnership invitations to organizations such as the Diversity Center in Muscatine County, TBMC at the Lincoln Resource Center, the QC Empowerment Network, One Human Family QCA in Scott County and the Community & Economic Development Extension through Iowa State University (Himar Hernandez) in Wapello County. Additionally, we will reach out to various ethnic churches, LULAC (League of United Latin American Citizens) clubs and/or other appropriate settings. Milestones staff will setup and staff booths at various community events to promote accessibility to agency services and supports.

Populations in Greatest Economic Need: Persons ages 60+ who identify as low-income (up to 300% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons ages 60+ who identify as a racial and/or ethnic status

- Explanation of Other or Sub Population (if selected.):

Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): Caregivers who need additional support in assisting others to live independently

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

Though we will maintain or expand No Wrong Door Access in all counties in the PSA, special emphasis will be placed on the counties with the highest percentage of 60+ Minority population according to information from HHS in Tableau. Muscatine County at 10%, Scott County at 9%, Louisa County at 8% and Wapello County at 6% are the four counties within the PSA that will be the areas of focus.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 1.1 - Total # of consumers receiving Information and Assistance. #2: [Choose an item.] #3: [Choose an item.]	#1: 1.1 - #/% of populations/areas in greatest need consumers who indicate they received the information they were seeking. #2: [Choose an item.] #3: [Choose an item.]	#1: 1.1 - #/% of populations/areas in greatest need who received Information and Assistance and are also enrolled in at least one additional OAA service. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 140 minority of projected total consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 130 minority consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 35 minority consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure(s) (if selected):
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:

Service targets are based on data from past performance, feedback from consumers, limited staffing based on funding, restricted funding sources and collaboration commitments, and overall cost-effectiveness of program delivery.

Statewide Performance Measures

Measure	Purpose	SFY 2025 Target	SFY 2025 Results as of 3/31/2025	SFY 2026 Target
#/% of Information and Assistance callers indicating they received the information they were seeking.	To assess and provide information appropriate to the caller's need (from caller's perspective).	Number: n/a Percentage: 95%	Number: 2130 consumers Percentage: 99%	Number: Click or tap here to enter text. Percentage: 95%
#/% of Options Counseling consumers who indicate they were provided information to make an informed decision on goal and service need.	To evaluate the success of the service to assist individuals to make informed choices about long-term services and supports.	Number: n/a Percentage: 90%	Number: 72 consumers Percentage: 100%	Number: Click or tap here to enter text. Percentage: 90%
#/% of Case Management cases closed because Case Management service was no longer needed.	To determine whether Case Management consumers receive supports and services for as long as they need or desire them in order to remain in their residence of choice.	Number: n/a Percentage: 80%	Number: 2 cases Percentage: 100%	Number: Click or tap here to enter text. Percentage: 90%
Average number of months a Case Management consumer experiencing independent living impairments is able to remain safely at home prior to transitioning to facility.	To determine whether Case Management consumers receive supports and services for as long as they need or desire them in order to remain in their residence of choice.	Number of months: 20 months	Number of months: 30 months	Number of months: 17 months

Goal 2: Improve Health and Wellness

Older adults and people with disabilities are empowered to utilize programs that improve their health and wellness.

Agency Programs, Services, & Initiatives

Milestones provides nutrition services throughout the 17-county service area that support health and wellness. Meals are offered both as home delivered for homebound older adults and in congregate settings. In 2021, Milestones piloted the Iowa Café program, a program featuring partnerships to offer congregate meals at restaurants in contrast to the traditional model of meals offered in senior centers and other community buildings. . While most of these partnerships ended due to funding constraints, this service model will be revisited with increased guidelines to ensure that services reach those with the greatest need. In addition to meals, the Milestones nutrition program offers nutrition education and nutrition counseling to provide information services to older adults that support healthy aging.

The future of congregate nutrition must be evaluated to ensure it adapts to the changing needs of older adults. Traditional sites are hosted either through community buildings such as senior centers and churches or through housing units catering to older adults. Each offers a benefit-community buildings tend to offer the most activities, such as crafts, light exercise, bingo, card games, and others, housing units have stronger attendance and reach more individuals with limited travel ability, and Iowa Café offers flexibility in dining time and menu choices which can reach older adults who may still be active in the workforce or in caregiving.

Evidence-Based Programming: Services that include evidence-based health classes are focused on preventing falls, reducing falls hazards, and supporting health management for older Iowans age 60+ delivered directly and in collaboration with community partners in remote areas. Current programs are centered on multi-week series hosted by churches, community centers, congregate meal sites, and periodically at healthcare facilities. Public Health partners offer regular health screenings like blood pressure checks and foot clinics at congregate sites and in the community. In addition, wellness information is disseminated monthly on relevant topics to aging issues. The selected prevention programs and wellness information support older adults to make informed choices about their health, reduce risk factors for injury, and promote well-being in their independence.

Objective #1: 2.2 - Increase older adults' access to high quality and person-centered nutrition services.

Why it matters...

Senior nutrition services are well documented to aid in lowering risk of institutionalization. A 2024 study published by the WellSky Foundation found that receiving home delivered meals reduced hospitalization rates for older adults by 85%. Meals provide 1/3 the daily recommended nutrients established by the FDA for older adults and provide social connection both directly in the case of congregate meals, but also with interactions with the delivery staff for home delivered meals. 93% of home delivered meal participants surveyed in 2024 said that they ate healthier due to receiving the meals. 95% said they felt a greater sense of social connection as a result of volunteers delivering meals.

The Iowa Café model has shown to increase access to these services. Participation in the congregate meal program nearly tripled from 500-600 monthly to over 1,500 for the yearlong pilot. By reaching more older adults, more of those with the greatest social and economic need were served, as well. When comparing the first year the Iowa Cafés were open to the following year, the congregate meal program served 54% more older adults in poverty, 71% more who were living alone, 36% more racial or ethnic minorities, and 94% more living in rural areas by total number served.

What we are doing...

Strategy: 2.2h - Other (Please explain.)

- Explanation of Other Strategy (if selected):
Adjust service offerings to address barriers and/or meet consumer needs, including the use of restaurants as providers.

Activities:

In areas where participation at traditional sites has declined, the Iowa Café model shows promise as an alternative method for providing vital nutrition to older adults. These restaurant partnerships address common barriers to participation including - limited serving times, stigma of participating in perceived charity services, and menu choice/meal acceptance rate. The choice in menu can also allow older adults to choose menu items that meet their dietary needs, for example low-carb, low-fat, or vegetarian. These barriers were identified during the needs assessment completed which was completed in preparation for this Area Plan. During the pilot of the Iowa Café program, mealtimes were recorded as easily as 8:00 am and as late as 6:00 pm, supporting the findings of a workgroup with frontline staff that identified the limited serving times of traditional congregate locations as a barrier. When congregate participants were asked what must

change to attract more seniors to the meal sites, many of the barriers were cited, including meal serving time, meal choice, and the difficulty for new participants to fit in with a preexisting social group. The agency will review the PSA for meal sites with fewer than 10 regular attendees and evaluate for possibility of Iowa Café as an alternative and review the viability of restaurants for partnership.

Populations in Greatest Economic Need: Persons ages 60+ who identify as living in poverty (at or below 100% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons 60+ who screen at higher nutrition risk

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): [Select a population.]

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

Iowa Café as an alternative to lower attended traditional congregate sites will be targeted to the western most counties of the agency’s PSA including Keokuk, Lucas, Wapello, and Monroe with the highest levels of poverty for the 60+ population.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 2.2 - Total # of consumers who received meals through the congregate nutrition program.	#1: 2.2 - #/% of congregate nutrition consumers served who indicate during intake they are at higher nutrition risk.	#1: 2.2 - #/% home delivered nutrition consumers served who indicate during intake they are food insecure.
	#2: [Choose an item.]	#2: [Choose an item.]	#2: [Choose an item.]
	#3: [Choose an item.]	#3: [Choose an item.]	#3: [Choose an item.]

	What We Do	How Well We Do It	Is Anyone Better Off?
SFY 2026 Targets	#1: 1037 consumers	#1: 20%	#1: 20%
	#2: Click or tap here to enter text.	#2: Click or tap here to enter text.	#2: Click or tap here to enter text.
	#3: Click or tap here to enter text.	#3: Click or tap here to enter text.	#3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:
Targets were set utilizing demographic data provided by Iowa HHS through Tableau which show living alone and poverty as widespread concerns in the Milestones PSA and through FY24 and partial FY25 service delivery for feasibility with current resources.

Objective #2: 2.3 - Connect older adults who are at risk for malnutrition and/or have high nutrition risk scores with meaningful interventions.

Why it matters...

Older adults are at higher risk of malnutrition which puts them at higher risk of hospitalization, frailty, and loss of independence. A 2021 study, published by the NIH, shows that older adults are more vulnerable to the negative impacts to recovery from disease, trauma, and surgery due to malnutrition. This study also links malnutrition with lower muscle mass and decreased bone mineral mass, increasing the risk of falls. Identifying those who are at risk of malnutrition is the first step in connecting them with resources that can reduce these risks.

What we are doing...

Strategy: 2.3f - Other (Please explain.)

- Explanation of Other Strategy (if selected):

Implement a workflow process to identify consumers whose intake or assessment responses indicate high nutrition risk and/or risk of malnutrition to refer them to additional service interventions, such as nutrition counseling.

Activities:

Nutrition Counseling, a one-on-one consultation with a registered dietician, can assist older adults in identifying meal choices that support healthy aging. Individuals that participate in Milestones’ meal programs complete an assessment prior to starting services. Milestones will work with a contracted dietician to review the assessment and identify key indicators of nutrition risk that indicate Nutrition Counseling as a potential intervention. Once these key indicators have been identified, they will be provided to Milestones staff for internal referrals. Well Sky, the agency’s internal database, will also be utilized to identify high-risk consumers, who will be provided with information for Nutrition Counseling.

Populations in Greatest Economic Need: Persons ages 60+ who identify as living in poverty (at or below 100% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons 60+ who screen at higher nutrition risk

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): [Select a population.]

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

Malnutrition is a risk for older adults across the PSA, however, fewer alternative resources are available in the most rural counties including Keokuk, Lucas, Monroe, Wayne, Appanoose, Davis, Van Buren, Jefferson, Henry, Lee, and Louisa. Most rural counties identified as those with no population centers of 20,000 or more.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 2.3 - Total # of nutrition consumers who are receiving OAA Nutrition Counseling. #2: [Choose an item.] #3: [Choose an item.]	#1: 2.3 - #/% of consumers who screen "more at-risk" for malnutrition and/or high nutrition risk score within initial intake to enroll within OAA nutrition services. #2: [Choose an item.] #3: [Choose an item.]	#1: 2.3 - #/% home delivered nutrition consumers served who indicate during intake they are at higher nutrition risk of food insecurity or malnutrition. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 12 consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 40% #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 35% #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:
For targets measured in past reporting years, the previous service deliveries were used. For targets not previously measured, a compilation of data from one or more Iowa AAAs was used for a base approximation.

Objective #3: 2.4 - Reduce the risk of falls among older adults through education, awareness, and prevention.

Why it matters...

Falls are the leading cause of injury for adults ages 65 years and older, and a significant concern for Iowans, especially with Iowa's aging population. Falls are the second leading cause of injury deaths in Iowa for all ages.

They're also the leading cause of injury hospitalizations and emergency visits in the State. (source: <https://hhs.iowa.gov/aging-services/nutrition-health/falls-prevention>) One out of 10 falls results in an injury that causes the older adult to restrict their activities for a day or more or to seek attention from the healthcare system. (Older Adult Falls Data, CDC: <https://www.cdc.gov/falls/data-research/index.html>)

Age-related changes like muscle weakness, decreased bone density, and impaired balance make older adults more susceptible to severe injuries from falls, especially hip fractures which can require extensive recovery. (Falls and Fractures in Older Adults, National Institute on Aging: <https://www.nia.nih.gov/health/falls-and-falls-prevention/falls-and-fractures-older-adults-causes-and-prevention>)

And falls are the most common cause of traumatic brain injuries. (About Older Adult Fall Prevention, CDC: <https://www.cdc.gov/falls/about/index.html>)

Falls are a threat to the health of older lowans and can reduce their ability to remain independent. However, many falls can be prevented (A Matter of Balance: Managing Concerns About Falls). Education and prevention efforts can save money and lives. Prevention services help people recognize and manage health problems early, when treatment is most effective. (The Aging Population: The Increasing Effects on Health Care, Pharmacy Times: <https://www.pharmacytimes.com/view/the-aging-population-the-increasing-effects-on-health-care>)

Barriers to utilizing services include lack of awareness about the availability and importance of prevention programs, both by healthcare and older adults; financial constraints, transportation, and required restrictions on how licensed programs are delivered. (Prevention is Still the Best Medicine, HHS: Office of Disease Prevention and Health Promotion: <https://odphp.health.gov/news/202401/prevention-still-best-medicine>)

As an area with both urban and rural/remote communities, the focus for Milestones is on reaching underserved communities where there are fewer resources such as trained facilitators and qualified community partners. Evidence-based falls prevention programs (EBFPPs) are simple, cost-effective interventions that offer treatments that promote behavior change and leverage community networks. The programs help participants improve strength, balance, and mobility, and provide education on how to avoid falls and reduce fall risk factors. Many of these programs also involve medication reviews and modifications and provide home hazard assessments of ways to reduce environmental hazards. They have been rigorously tested, proven to be effective, and translated into practice models available to community-based organizations (source: Evidence-Based Falls Prevention Programs | ACL Administration for

Community Living).

What we are doing...

Strategy: 2.4c - Provide evidence-based falls prevention program to older adults who are at-risk of falls to change knowledge, skills, and/or behaviors.

- Explanation of Other Strategy (if selected):
Click or tap here to enter text.

Activities:

Click or tap here to enter text. Offering a variety of EBP for falls prevention and health promotion was an intentional strategy to increase participation in effective interventions. The Milestones website: <https://www.milestonesaaa.org/wellness-programs/> is a resource for what is currently offered and opportunity to pre-enroll, as well as inquire for person-centered outreach about a program of interest and/or suitability. To address barriers to accessibility for EBP, activities also included identifying and supporting potential community partners in prioritized counties to obtain training to provide EBP in locations underserved by Milestones through voluntary or contracted partnerships with Public Health, Extension Service, qualified Community Volunteers, or Clinicians (where/if required). We contracted with community-based occupational therapy to deliver person-centered multi-disciplinary Home Hazard Removal Program (HARP) for older Iowans in remote and rural communities where class series are not practical or feasible due to enrollment requirements, staffing, and travel requirements. HARP is also provided for referred Iowa Total Care beneficiaries with pilot grant funding from ITC. Due to agency budget restrictions, and limited staff to continue to deliver a variety of falls prevention programs, the focus on accessibility for older adults will be narrowed to three programs: Tai Chi for Arthritis/Falls Prevention, A Matter of Balance, and the Home Hazard Removal Program (contracted). This decision is based on demand for programs and reliable participation/community requests, as well as experience that interest, demand, and commitment is declining for long class series. To ensure quality of all supplemental programs (non-evidence based) to address social isolation, increase physical activity, and improve wellness to reduce negative health outcomes, Milestones seeks and supports partnerships with research-based entities such as (but not limited to) University of Iowa Healthcare, Iowa State University, and St. Ambrose University, to name a few. We connect older adults seeking programs not offered by Milestones to networked providers via Iowa HUB, Iowa State Extension, Public Health, other AAAs, etc.

Populations in Greatest Economic Need: Persons ages 60+ who identify as low-income (up to 300% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons 60+ living in rural and underserved areas

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): [Select a population.]

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

HARP for all counties, with additional priority given to rural older lowans in Lucas, Mahaska, Wayne, Davis, Monroe, Appanoose, Keokuk, Jefferson, and Van Buren since they are geographically remote locations outside the feasible delivery range of the trained staff for small group programs.

Matter of Balance (MOB) program for the following counties: Clinton, Scott, Muscatine, Lucas.

Tai Chi for Arthritis (TCA) for the following counties: Clinton, Scott, Muscatine with possible expansion if additional trainers can be located or trained within the service area using University of Iowa ACL grant funds.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 2.4 - Total # of OAA consumers who are referred to evidence-based falls prevention programming. #2: [Choose an item.]	#1: 2.4 - #/% of populations/areas in greatest need consumers who enroll in evidence-based falls prevention programming. #2: [Choose an item.]	#1: 2.4 - Total # of consumers who complete evidence-based falls prevention programming. #2: [Choose an item.] #3: [Choose an item.]

	What We Do	How Well We Do It	Is Anyone Better Off?
	#3: [Choose an item.]	#3: [Choose an item.]	
SFY 2026 Targets	#1: 47 consumers enrolled #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 29% consumers enrolled #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 70% overall completion rate #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:
Service targets are based on data from past performance, feedback from consumers, limited staffing based on funding, restricted funding sources, and overall cost-effectiveness of program delivery.

Statewide Performance Measures

Measure	Purpose	SFY 2025 Target	SFY 2025 Results as of 3/1/2025	SFY 2026 Target
#/% of nutrition consumers served who indicate during intake they are	To prioritize consumers who are at risk for social isolation.	Number: n/a Percentage: n/a	Number: 58 consumers Percentage: 3%	Number: 100 consumers Percentage: 10%

Measure	Purpose	SFY 2025 Target	SFY 2025 Results as of 3/1/2025	SFY 2026 Target
socially isolated.				
#/% of nutrition consumers served who indicate during intake they are at higher nutrition risk.	To prioritize consumers who have a higher nutrition risk.	Number: n/a Percentage: n/a	Number: 979 consumers Percentage: 56%	Number: 900 consumers Percentage: 60%
#/% nutrition consumers served who indicate during intake they are food insecure.	To prioritize consumers who are at risk for food insecurity.	Number: n/a Percentage: n/a	Number: 491 consumers Percentage: 28%	Number: 450 consumers Percentage: 35%
#/% nutrition consumers served who indicate during intake they are at risk for malnutrition.	To prioritize consumers who are at risk of malnutrition.	Number: n/a Percentage: n/a	Number: 38 consumers Percentage: 2%	Number: 300 consumers Percentage: 20%
#/% nutrition counseling consumers served who indicate during intake they are at risk for malnutrition.	To ensure those at risk for malnutrition receive nutrition counseling so that they have the opportunity to improve their nutrition status.	Number: n/a Percentage: n/a	Number: 0 consumers Percentage: 0%	Number: 3 consumers Percentage: 25%

Goal 3: Improve Safety and Quality of Life

Older adults and people with disabilities are safe from all forms of mistreatment and are empowered to improve their quality of life.

Agency Programs, Services, & Initiatives

Click or tap here to enter text. Milestones' Elder Abuse Prevention and Awareness (EAPA) program educates the public about elder abuse protection and awareness primarily via events, particularly as requested by local community groups, and statewide during Elder Abuse Awareness month in June. Milestones employs 2 full-time EAPA Specialists. EAPA staff continue to participate in monthly MDT (Multi-Disciplinary Team) meetings, which are comprised of representatives from social services and law enforcement agencies to find solutions for difficult cases of alleged abuse, self-neglect and homelessness. In FY24 the EAPA program assisted a total of 86 consumers. More than half of these were cases of self-neglect, primarily in the form of unsuitable housing, loss of utilities, or evictions. Most of these cases were in our most populated area, Scott County.

Objective #1: 3.1 - Increase awareness, prevention, and reporting of elder abuse and dependent adult abuse.

Why it matters...

Studies indicate abuse, including neglect and exploitation, is experienced by about 1 in 10 older adults who live at home. Abuse can have several physical and emotional effects on older adults including physical injuries, premature death, depression, cognitive decline, financial devastation, and increased risk for long-term care placement (sources: World Health Organization and National Institutes of Health). According to Iowa HHS Dependent Adult Abuse data, support services for elder abuse and dependent adult abuse in our area include case management, in-home assistance, and caregiver support services. The EAPA program has served an increasing number of consumers from 2022 to 2024. In SFY24, there were 165 consumers served across the PSA, up from 155 in FY23 and 109 in FY22. With increased awareness, presentations, and promotion of services available, the goal is to reach more individuals experiencing abuse in areas that have not previously reported incidents, despite the likelihood that abuse can be expected to have occurred. According to the National Institute of Justice research, perpetrators of elder abuse and mistreatment often have prior criminal backgrounds, substance abuse issues, or mental health challenges. Many are intimate partners or spouses, and factors like unemployment and social isolation also contribute to risk.

What we are doing...

Strategy: 3.1b - Provide training to increase external referrals from key community partners to Elder Abuse Prevention and Awareness program.

- **Explanation for Other Strategy (if selected):**
Click or tap here to enter text.

Activities:

Milestones will develop partnerships with local community agencies in some of our most rural areas indicating gaps including, but not limited to, Davis, Lucas, and Wayne counties. None of these counties reported any elder abuse cases to Milestones in FY18-24. Additionally, we will target Scott County, which has reported the majority of cases in the PSA. Educational information and presentations will be provided in these counties in coordination with partners, such as local community action agencies, churches, nutrition sites, housing coalitions, law enforcement, EMTs, financial institutions and investment personnel among others.

Populations in Greatest Economic Need: Persons ages 60+ who identify as low-income (up to 300% of the Federal poverty level)

- **Explanation of Other or Sub Population (if selected.):**
Click or tap here to enter text.

Populations in Greatest Social Need: Persons 60+ living with interpersonal safety concerns

- **Explanation of Other or Sub Population (if selected.):**
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): [Select a population.]

- **Explanation of Other or Sub Population (if selected.):**
Click or tap here to enter text.

Area(s) of Focus:

For this strategy, we will focus on Scott County where the majority of cases are reported, and on Davis, Lucas and Wayne counties where data indicates very few reports of elder abuse, possibly due to a lack of awareness of resources. According to the Institute for Community Alliances, Scott County has the second highest number of people experiencing homelessness in the state. Though these numbers are not specific to those age 60+, research shows that “while the population in the United States is aging overall, the population experiencing homelessness is aging at a significantly higher rate than the

population as a whole (“Aging Homeless: Shifting demographics of lowans experiencing homelessness”, Ehren Stover-Wright, PhD, Institute for Community Alliance, 2022). There is no specific statistic for the rate of homelessness resulting directly from elder abuse and neglect because this link is often not recorded. However, research confirms that elder abuse, particularly financial exploitation and neglect, is a significant risk factor for housing instability and homelessness among older adults (source: Journal of Aging & Social Policy). Increased referrals are expected with this targeted effort, most likely from interagency networks, community organizations, faith community leaders, and neighbors/friends/family of suspected victim.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 3.1 - Total # of consumers provided with EAPA Consultation. #2: [Choose an item.] #3: [Choose an item.]	#1: 3.1 - # of and type of public education trainings to identify and prevent abuse of older individuals. #2: [Choose an item.] #3: [Choose an item.]	#1: 3.1 - #/% of EAPA consumers who report their quality of life has improved. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 10 targeted (previously underserved county) consumers of 84 total projected EAPA consultation consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 6 trainings in targeted rural/remote counties #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 85% of EAPA consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):

Click or tap here to enter text.

- **Explanation of logic used to develop SFY 2026 targets:**
Service targets are based on data from past performance, feedback from consumers, limited staffing based on funding, restricted funding sources and collaboration commitments, and increased need in this program.

Objective #2: 3.2 - Provide access to high-quality legal assistance for older adults.

Why it matters...

Legal aid services are important to help older adults navigate unique legal matters and ensure their rights and welfare are protected, especially for those without financial means to afford an attorney when facing eviction and/or landlord issues that increase risk for homelessness (source: Iowa Legal Aid). Legal aid is important to older adults in Iowa for various reasons, including shelter (questions about where to live), food (questions about adequate food), services available to them, public benefits, independence (questions about how to maintain their independence), incapacity (questions about how to exercise legal rights if they become incapacitated), abuse (how to respond to abuse), eligibility (for long term care or Medicare) and property (tax credits or powers of attorney), for example. (State Library of Iowa).

What we are doing...

Strategy: 3.2d - Provide cross training to increase internal referrals to OAA legal assistance.

- **Explanation for Other Strategy (if selected):**
Click or tap here to enter text.

Activities:

A representative from Iowa Legal Aid will be asked to present information and strategies to Milestones Care Managers to assist in their understanding of typical legal issues faced by persons served. Care Managers will review issues with persons served and make appropriate referrals to Iowa Legal Aid or other legal representatives as appropriate. Care Managers will also partner with others in the community to promote awareness to improve knowledge on legal issues such as such as evictions, tenant rights, powers of attorney, guardianships, citizenship and other legal rights. Partnerships with agencies will be

focused on the Diversity Center to reach Spanish-speaking older adults, community action organizations, community health centers, county public health agencies and residence communities. By educating Milestones Care Managers to increase their understanding of common legal issues for older adults, we seek to increase effective referrals to Iowa Legal Aid and other legal representatives, thereby increasing access to representation for older adults seeking assistance with their legal issues.

Populations in Greatest Economic Need: Persons ages 60+ who identify as low-income (up to 300% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons 60+ living in rural and underserved areas

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): [Select a population.]

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

In addition to the general aging population in the Milestones service area, Louisa and Muscatine Counties will be an additional focus area for this objective. Per Tableau, these counties have the highest populations of those 60+ with limited English proficiency. The strategy is focused on strengthening partnership with the Rural Justice Project for Older Adults to increase awareness of resources for assistance and supplement the contract with Iowa Legal Aid to provide direct assistance to those in greatest need of representation.

How we measure impact...

Measures	What We Do	How Well We Do It	Is Anyone Better Off?
	#1: 3.2 - Total # of consumers referred to OAA legal assistance. #2: [Choose an item.]	#1: 3.2 - Total # of consumers who received OAA legal assistance.	#1: 3.2 - Total # of consumers who indicate a change in knowledge, skills, and/or behaviors after

	#3: [Choose an item.]	#2: [Choose an item.] #3: [Choose an item.]	receiving education on legal issues. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 7 consumers from internal referrals #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 300 total consumers with contracted OAA legal assistance #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 80% of total consumers who receive OAA legal assistance #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:
Service targets are based on data from past performance, feedback from consumers, limited funding available for contracting, and overall cost-effectiveness of program delivery. Click or tap here to enter text.

Objective #3: 3.3 - Strengthen emergency preparedness among care recipients, caregivers, and providers.

Why it matters...

Iowa has experienced a notable increase in natural disasters over the last five years, with a significant rise in the frequency and severity of events. (source: NOAA National Centers for Environmental Information and Iowa Homeland Security and Emergency Management). Many individuals we serve may have limited means and supports to adequately prepare for household emergencies. Also, they may live alone, may have cognitive issues, be caregiver for someone who does, or may live with chronic health conditions that complicate preparedness for emergency situations (source: University of Iowa College of Public Health). Furthermore, older adults' increased vulnerability, particularly in response and evacuation scenarios, hinders their ability to react quickly and protect themselves (source: Liao K-M, Hu Y-J (2025) Factors influencing disaster

preparedness behaviors of older adults. PLoS ONE 20(2): e0315617. <https://doi.org/10.1371/journal.pone.0315617>). The study found that most older adults do not invest time or money in disaster preparedness, particularly concerning purchasing disaster insurance, preparing a disaster emergency kit, identifying and planning evacuation locations and routes, and participating in disaster response drills.

What we are doing...

Strategy: 3.3c - Refer Options Counseling consumers to resources where they can create their own individual emergency plan.

- Explanation for Other Strategy (if selected):
Click or tap here to enter text.

Activities:

Milestones will continue in partnership with the Disaster PrepWise program and ensure that Care Managers are trained on the materials and process to make referrals as needed to program representatives. Disaster PrepWise is a program offered through the University of Iowa College of Public Health to prepare older adults for disasters. It is the first program of its kind to provide a tool and personalized assistance to develop a tailored disaster management plan for individuals and families.

We will arrange for training for Milestones Care Managers with Disaster PrepWise representatives to ensure that staff fully understand the program and its components, and that they are supplied with the most up-to-date Disaster PrepWise toolkit. The goal will be for staff to confidently explain the program and its benefits, assist consumers themselves, or make referrals to Disaster PrepWise staff, depending upon the circumstance.

Populations in Greatest Economic Need: Persons ages 60+ who identify as low-income (up to 300% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons 60+ who are living alone

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): [Select a population.]

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

All counties served throughout Milestones' 17-county PSA.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 3.3 - Total # of consumers who were referred to further develop an individual emergency plan. #2: [Choose an item.] #3: [Choose an item.]	#1: 3.3 - Total # of consumers who developed an individual emergency plan. #2: [Choose an item.] #3: [Choose an item.]	#1: 3.3 - Total # of consumers who indicate they feel safe and prepared for times of disaster and emergency situations. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 10 consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 5 consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 5 consumers #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:
Service targets are based on data from past performance, feedback from consumers, limited staffing based on funding, restricted funding sources, and overall cost-effectiveness of program delivery.

Statewide Performance Measures

Measure	Outcome	FY2025 Target	FY2025 Results as of 3/31/2025	FY2026 Target
#/% of EAPA Assessment and Intervention consumer cases closed with services no longer needed.	To evaluate resolution rate for a consumer's abuse, neglect, or exploitation situation.	Number: n/a Percentage: 92%	Number: 25 cases Percentage: 95%	Number: 20 cases Percentage: 92%
#/% of EAPA Consultation consumers whose needs are met through provider referrals for Self-Advocacy.	To evaluate whether consumers are able to use information and referrals for self-advocacy in resolving abuse, neglect, or exploitation situation.	Number: n/a Percentage: 92%	Number: 57 consumers Percentage: 80.7%	Number: 45 consumers Percentage: 90%

Goal 4: Stay Engaged and Supported

People with disabilities and older adults are supported by formal and informal caregivers of their choice and have social connections within their communities.

Agency Programs, Services, & Initiatives

“Limited social connectedness in older adults is a risk factor for poor physical and mental health”, according to the National Library of Medicine. “Older adults who are socially isolated, lonely and disconnected have a higher risk of chronic illness, depression and premature death. Current literature suggests that improved social connectedness reduces these risks.” Mayo Clinic Press reports strong social connections are essential to healthy aging.

Milestones Caregiver Services are provided by regionally located Specialists who connect caregivers to community resources (generalized and for specific diseases), provide assistance in applying for additional supports such as Medicaid waivers and help caregivers navigate complex systems of care and support. Respite services to allow for time away from the individual needing care have proven to be a successful way to give caregivers time to rejuvenate and focus on self-care. Support groups offer a way for caregivers to express get insight from others who share their situation as well as gain social support. Mayo Clinic reports that about 1 in 3 adults in the U.S. is an informal or family caregiver, and that caregivers report a higher level of stress than those who are not responsible for caring for another. Support groups, social support, and getting connected are recommended by numerous research articles.

Objective #1: 4.3: Identify informal caregivers are experiencing or at risk for stress, depression, and financial cost burden due to their caregiver role.

Why it matters...

The long-term stress of caregiving can lead to serious health problems, as outlined by the U.S. Department of Health and Human Services Office on Women’s Health. Some examples are depression and anxiety, a weak immune system, obesity, higher risk of chronic diseases and problems with short-term memory. Caregiver isolation, responsibility, exhaustion, and potential burnout can compromise the health of the caregiver and diminish the quality of care they can provide. Supportive services like respite

and networks like support groups are vital to maintain caregiver well-being (source: National Institutes of Health).

What we are doing...

Strategy: 4.3f - Implement validated screening tools to screen and intervene for caregivers at greatest risk.

- Explanation for Other Strategy (if selected):
Click or tap here to enter text.

Activities:

Click or tap here to enter text. With limited community resources for caregiver support, especially in rural/remote communities, and limited funding to supply respite, Milestones will utilize the Modified Caregiver Strain Index and personal goals to help identify caregivers of greatest need in the service area. To provide a meaningful level of care, it will be necessary to sustain supports in the most practical way possible. Currently, our key community providers of in-home care are County Health Departments and cost-effective home health agencies. Milestones Caregiver Specialists and Care Managers on staff develop individualized plans to provide or refer to supports to help caregivers address the stress and financial burdens of their role. To address isolation, ongoing support groups that focus on information and relevant topics to caregiver strain will be offered in various communities.



Populations in Greatest Economic Need: Persons 60+ who identify as low-income (up to 300% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons 60+ living in rural and underserved areas

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): Caregivers who are experiencing or at-risk for stress, depression, and financial cost burden due to their caregiver role

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

For this strategy, we will focus on utilizing the Modified Caregiver Strain Index from all caregiver assessments in determining eligibility for OAA/Milestones funded supports when requested, such as respite or family caregiver home-delivered nutrition.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 4.3 - #/% of caregivers who completed the caregiver assessment. #2: [Choose an item.] #3: [Choose an item.]	#1: 4.3 - #/% of caregivers who are considered at-risk and are also enrolled in Caregiver/ORC Case Management. #2: [Choose an item.] #3: [Choose an item.]	#1: 4.3 - #/% of caregivers who indicate their stress, depression, and/or financial cost burden due to their caregiver role has been reduced after receiving Caregiver/ORC services. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 90% of caregivers enrolled in Milestones supports (group, respite, HDN, etc.) #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 65 consumers seeking caregiver support #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 90% of caregivers who participated in Milestones caregiver services #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):
of support organizations who agree to partner in workgroup project.

- Explanation of logic used to develop SFY 2026 targets:
Funding limitations for supports have capped the number of consumers projected to receive respite support. Other targets are estimated based on projected number of consumers seeking and receiving options counseling, caregiver counseling, case management, and participating in caregiver support group based on current number of staff positions sustained in the agency budget and estimated funding.

Objective #2: 4.1: Increase social engagement opportunities for persons at risk for social isolation.

Why it matters...

The U.S. Surgeon General report released in 2023 identified loneliness and social isolation as not just emotional issues but also contributes to serious health problems, including increased risk of heart disease, stroke, dementia, and premature death. Researchers compare the physical health impact of isolation to that of smoking 15 cigarettes a day. The impact of isolation and loneliness can increase cognitive impairment as well. Documented benefits experienced by older adults who are more socially engaged are less depression and greater satisfaction with their lives and living situation. Social participation and social supports are both elements of engagement, with social *participation* showing positive outcomes regarding health and mortality.

What we are doing...

Strategy: 4.1g - Develop a menu of interventions for those who screen at risk for social isolation to refer to.

- Explanation for Other Strategy (if selected):
Click or tap here to enter text.

Activities:

Click or tap here to enter text. Discover programs offered by libraries, cultural entities, churches, residence communities, etc. to create resources for referrals to localized social opportunities for engagement. Priority will be given to free/low-cost options so those with limited income have opportunities to participate. For caregivers, encourage participation in caregiver support groups and utilization of community and online

resources including, but not limited to, Alzheimer’s Association, Parkinson’s chapters, the Caregiving.com Foundation.

Populations in Greatest Economic Need: Other (Please explain.)

- Explanation of Other or Sub Population (if selected.):
Older adults age 60+ who experience loneliness and/or social isolation.

Populations in Greatest Social Need: Persons 60+ living in rural and underserved areas

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): Caregivers who need additional support in assisting others to live independently

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

17 counties in PSA 5

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 4.4 - Other (Please explain.) #2: [Choose an item.] #3: [Choose an item.]	#1: 4.1 - # of caregivers who are enrolled to attend a caregiver support group. #2: [Choose an item.] #3: [Choose an item.]	#1: 4.1 - Total # of consumers who completed evidence-based health promotion programming. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 3 regional lists of social activities + 2 evidence-based groups.	#1: 35 caregivers participating in CG support groups #2:	#1: 24 consumers completing small group evidence-based programs

	What We Do	How Well We Do It	Is Anyone Better Off?
	#2: Click or tap here to enter text. #3: Click or tap here to enter text.	Click or tap here to enter text. #3: Click or tap here to enter text.	#2: Click or tap here to enter text. #3: Click or tap here to enter text.

- **Explanation of Other Measure (if selected):**
Click or tap here to enter text. Older adults age 60+ who live in rural remote communities and at risk for social isolation, loneliness based on call-type and assistance requested at point of contact with I&A who are provided with a localized list of social activities and/or inquiries indicating willingness/interest in participating in evidence-based health programs.
- **Explanation of logic used to develop SFY 2026 targets:**
Service targets are based on data from past performance, feedback from consumers, limited staffing based on funding, fidelity requirements for licensed program, restricted funding sources and collaboration commitments, and overall cost-effectiveness of program delivery.

Objective #3: 4.2: Ensure services and supports are available to informal caregivers in underserved areas.

Why it matters...

Supporting caregivers in rural/remote areas is vital because they face unique challenges, such as geographic isolation, limited access to resources and healthcare, and a higher burden of care due to workforce shortages, which negatively impact their physical and mental health. Limited awareness, language barriers, cultural considerations, and financial constraints can also make it difficult for caregivers to find support in underserved communities. While the entire US is aging quickly, rural areas are aging at a faster rate and have greater long-term care needs. Further, rural areas face shortages in the formal long-term care workforce, pushing even more of the burden of care to unpaid caregivers. (source: University of Minnesota Rural Health Research Center) The NIH National Library of Medicine states “The community can [also] play an important role in terms of providing support and services to ‘hard to reach’ caregivers, such as those who live in rural locations, ethnic/racial minorities, or those who have no other source of support for the

care recipient and are often unaware of or have difficulty accessing available resources and sources of caregiver support.” Support is crucial for the caregiver's well-being, ensuring they can continue to provide quality care for their loved one and prevent burnout, thereby maintaining a stable caregiving environment for aging individuals. Support for caregivers enables older adults to remain in their homes and communities for longer. Providing support helps address the inequities faced by rural caregivers, particularly women, who often bear a disproportionate financial burden (source: NIH). In Iowa, more than 70% of persons living with dementia remain in the community. (Iowa HHS) Addressing caregiver needs contributes to the overall health and stability of rural communities, which rely heavily on informal care. (source: NIH, Rural Health Information Hub) Over 66,000 Iowans aged 65 and older have Alzheimer's Disease. It is the sixth-leading cause of death in the US, impacting nearly 6 million Americans. In addition, over 73,000 Iowans provide unpaid care for people with Alzheimer's or dementia (source: Iowa HHS).

What we are doing...

Strategy: 4.4d - Provide training to staff to increase internal referrals of caregivers who are caring for someone with Alzheimer's disease and related disorders with neurological and organic brain dysfunction to Caregiver/ORC services.

- Explanation for Other Strategy (if selected):
Click or tap here to enter text.

Activities:

Click or tap here to enter text. Through its commitment to the Dementia Friendly Iowa network, Milestones has experienced success in reaching community groups to increase understanding of neurodegenerative diseases and cultivate respect for those living with dementia in order to better support older Iowans and their caregivers. Milestones staff in the Family Caregiver program utilize these presentations as an introduction to agency caregiver supports and services. The University of Iowa Geriatric Education Center states “Dementia Friendly Iowa promotes change and education in communities across Iowa to create a more informed, safe, and respectful place for people living with dementia and their caregivers. As the number of people living with dementia in our state increases, so must public awareness and ability to serve this population in the state of Iowa.” Milestones will increase the number of Dementia Friends Champions to at least three- one in each office location who will be expected to provide Dementia Friends training in underserved communities at least quarterly. Presentations will be prioritized for communities where a greater number minority caregivers can be reached, as well as more rural/remote communities. According to Iowa HHS, Black Iowans are twice as likely, and Hispanic Iowans are 1.5 times more likely to get Alzheimer's than White Iowans, but historically these communities have not

been well-served by health care systems and public health messaging. As a result, cases of dementia in these populations are usually caught later in the disease process leading to higher healthcare costs for the persons living with dementia and a heavier toll on care partners (source: State Strategic Plan Alzheimer’s Disease & Related Dementias in Iowa).

Populations in Greatest Economic Need: Persons 60+ who identify as low-income (up to 300% of the Federal poverty level)

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Populations in Greatest Social Need: Persons with a status that: a) limits their ability to perform ADLs/IADLs or b) threatens the capacity of the individual to live independently

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Family Caregivers in Greatest Need (if applicable): Caregivers who need additional support in assisting others to live independently

- Explanation of Other or Sub Population (if selected.):
Click or tap here to enter text.

Area(s) of Focus:

Henry, Louisa, and Des Moines counties will be the focus of the Dementia Friends Champion out of the Burlington office, Muscatine and Clinton counties will be the focus of the Dementia Friends Champion in the Davenport office, and Davis, Jefferson, Keokuk, and Van Buren counties will be the focus of the Dementia Friends Champion in the Ottumwa office. These counties were chosen based on participation in caregiver services in SFY24, evaluation of poverty data, and other indicators of those potentially in greatest need of support.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	#1: 4.4 - Other (Please explain.)	#1: 4.4 - Other (Please explain.)	#1: 4.4 - #/% of caregivers with care recipients who live with

	What We Do	How Well We Do It	Is Anyone Better Off?
	#2: [Choose an item.] #3: [Choose an item.]	#2: [Choose an item.] #3: [Choose an item.]	Alz. Disease and related disorders with neurological and organic brain dysfunction that are enrolled in at least one or more OAA services. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 3 CG Specialists + Social Services Supervisor #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 50 caregivers #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 6 caregivers #2: Click or tap here to enter text. #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):
What We Do: 4.4d - Provide training to staff to increase internal referrals of caregivers who are caring for someone with Alzheimer's disease and related disorders with neurological and organic brain dysfunction to Caregiver/ORC services.
How Well We Do It: 4.4 - #/% of caregivers who are caring for someone with Alzheimer's disease or related disorders with neurological or organic brain dysfunction and referred for Caregiver/ORC services
- Explanation of logic used to develop SFY 2026 targets:
The number of consumers reached by congregate and home delivered services as well as the number of units per consumer served is projected to decrease as limited agency funding is prioritized to those in greatest social and economic need.

Statewide Performance Measures

Measure	Purpose	FY2025 Target	FY2025 Results as of 3/1/2025	FY2026 Target
#/% of congregate meal consumers served who may be socially isolated, percentage eating four meals at a congregate meal site in a month.	To determine whether congregate meal consumers who may be socially isolated have the opportunity to socialize in their community.	Number: Click or tap here to enter text. Percentage: 90%	Number: 324 consumers Percentage: 75%	Number: 300 consumers Percentage: 75%
#/% of home delivered meal consumers served who may be socially isolated, percentage receiving at least eight meals in a month.	To determine whether home delivered meal consumers who may be socially isolated receive regular contact with a meal delivery person.	Number: Click or tap here to enter text. Percentage: 96%	Number: 547 consumers Percentage: 98%	Number: 400 consumers Percentage: 90%
#/% of caregiver consumers indicating caregiver counseling and/or respite care service allowed them to maintain their caregiver role.	To determine whether case management and respite services provide caregivers the supports and services they need to continue to provide informal care to care recipients.	Number: n/a Percentage: 97%	Number: 43 consumers Percentage: 100%	Number: 35 Percentage: 97%

Section 2: Service Projections

SFY 2026 Projected Consumers and Service Units

[Insert a copy of your agency's Form 3A-1]

Service		Service Units Provided	Consumers Served	60+ Rural	60+ Minority	60+ Minority Below Poverty	60+ Below Poverty
1: Personal Care	Gen. Aging	1624	27		1		26
2: Homemaker	Gen. Aging	4122	74		5		69
3: Chore	Gen. Aging	300	10	4	3		3
4: 60+ Home Delivered Nutrition	Gen. Aging	75000	800	550	75	9	166
5: Adult Daycare/Health	Gen. Aging						
6: 60+ Case Management	Gen. Aging	216	59	38	6	1	14
	Senior Living Program	51	14	9	1		4
7: 60+ Congregate Nutrition	Gen. Aging	70000	1037	809	43	31	154
8: Nutrition Counseling	Gen. Aging	6	6	2	2		1
9: Assistive Transportation	Gen. Aging						
10: Transportation	Gen. Aging	15563	457	200	40	20	129
11: Legal Assistance	Gen. Aging	845	510	245	12	8	225
12: Nutrition Ed.	Gen. Aging	12000	1475	1046	65	31	333
13: 60+ Information & Assistance	Gen. Aging	4346	2460	1044	141	28	368
	Senior Living Program	565	236	156	21	4	5
14: Outreach	Gen. Aging	642	517	152	104	38	223
A01: 60+ Material Aid: Home Mod./Repairs	Gen. Aging	25	25	10	1		14
B02: Health Promotion: Non-Evidence	Gen. Aging	3333	507	46	46	1	1
B04: 60+ Emergency Response System	Gen. Aging	312	26	10	1		14
B05: Behavioral Health Supports	Gen. Aging	0	0				
B07: Health Promo: Evidence Based	Gen. Aging	47	47	3	3	1	4
C07: EAPA Consultation	Gen. Aging	79	79	30	10	5	11
	Senior Living Program	5	5	2	1	1	1
C08: EAPA Assess & Intervention	Gen. Aging	413	82	35	12	1	13
	Senior Living Program	27	5	2	1		2
C09: EAPA Training & Education	Gen. Aging	23	2293	289	74	62	662
D01: Training & Education	Gen. Aging	191	43183	598	57	23	459
E05: 60+ Options Counseling	Gen. Aging	668	207	74	53	25	53
	Senior Living Program	118	36	13	10	4	9
F06: 60+ Material Aid: Asst. Tech./Durable Med. Equip.	Gen. Aging	1	1	1			
F07: 60+ Material Aid: Consumable Supplies	Gen. Aging	26	5	2	1		2
F08: 60+ Material Aid: Other	Gen. Aging	16	12	3	3	3	3
CG3: FC Counseling	Caregiving	30	18	6	3	3	3
CG4: FC Information Services	Caregiving	9036	32	6	5	5	5
CG7: FC Home Delivered Nutri.	Caregiving	1600	10	2			6

Service		Service Units Provided	Consumers Served	60+ Rural	60+ Minority	60+ Minority Below Poverty	60+ Below Poverty
CG8: FC Options Counseling	Caregiving	223	117	46	3	2	5
CG9: FC Case Management	Caregiving	112	14		1		
CG10: FC Information & Assistance	Caregiving	445	205	108	9	8	17
CG11: FC Support Groups	Caregiving	184	35	1			2
CG12: FC Training	Caregiving	7	7				
CG13: FC Congregate Nutri.	Caregiving						
CG14: FC Emergency Resp. Sys.	Caregiving						
CG27: FC Supplemental Services: Asst. Tech./Durable Med. Equipment	Caregiving						
CG15: FC Supplemental Services: Consumable Supplies	Caregiving	10	2	1			1
CG22: FC Supplemental Services: Other	Caregiving	10	2	2			
CG23: FC Respite Care: In Home	Caregiving	1188	11	5	1		5
CG24: FC Respite Care: Out-of-Home (Day)	Caregiving	180	5	4			1
CG25: FC Respite Care: Out-of-Home (Overnight)	Caregiving						
CG26: FC Respite: Other	Caregiving	132	1				
GO3: ORC Counseling	Caregiving						
GO4: ORC Information Services	Caregiving						
GO7: ORC Home Delivered Nutrition	Caregiving						
GO8: ORC Options Counseling	Caregiving						
GO9: ORC Case Management	Caregiving						
GO10: ORC Information & Assistance	Caregiving						
GO11: ORC Support Groups	Caregiving						
GO12: ORC Training	Caregiving						
GO13: ORC Congregate Nutrition	Caregiving						
GO14: ORC Emergency Response System	Caregiving						
GO27: ORC Supplemental Services: Asst Tech/Durable Med Equipment	Caregiving						
GO15: ORC Supplemental Services: Consumable Supplies	Caregiving						
GO22: ORC Supplemental Services: Other	Caregiving						
GO23: ORC Respite Care: In-Home	Caregiving						
GO24: ORC Respite Care: Out-of-home (Day)	Caregiving						
GO25: ORC Respite Care: Out-of-home (Overnight)	Caregiving						
GO26: ORC Respite Care: Other	Caregiving						

Authorized Signatures

Area Agency on Aging Name	Primary Street Address	City & Zip Code	Type of Agency	Date of AAA Designation
Milestones Area Agency on Aging	935 E. 53 rd Street	Davenport 52807	AAA	2013

Please **list names and titles** (*signatures are not required*) of all persons authorized to sign and submit documents on behalf of your agency regarding the following areas:

Authorized Signatories for Funding Applications and Contracts

1. Becky J. Passman, CEO
2. Peggy Fisher, Board of Directors Chair

Authorized Signatories for Fiscal Reports

1. Becky J. Passman, CEO
2. Peggy Fisher, Board of Directors Chair
3. Stephanie Newton, Fiscal Director

Authorized Signatories for Program Reports

1. Becky J. Passman, CEO
2. Sonita Oldfield-Carlson, Social Service Director
3. Lisa Harwood, Nutrition Services Director

Note: Should any of your agency's authorized signatories change, please submit an updated list to Eugenia Kendall at eugenia.kendall@hhs.iowa.gov within fifteen (15) business days.