

# 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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# Executive Summary

[Complete executive summary using the Area Plan Instructions.]

## Context

[Complete context using the Area Plan Instructions.]

# 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 and self-sufficiency within their communities and maximizing quality of life. Options Counseling and/or Case Management services can be the link to educate and support those who are in need of 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.

Year	County	Number of Persons served in OC/CM	Units Provided
SFY24	Jefferson	7	51
	Monroe	0	0
	Wapello	34	103
SFY23	Jefferson	7	38
	Monroe	2	39
	Wapello	27	72
SFY22	Jefferson	11	94
	Monroe	2	9
	Wapello	34	292
SFY21	Jefferson	6	25
	Monroe	3	20

	Wapello	15	65
SFY20	Jefferson	12	102
	Monroe	4	17
	Wapello	22	116

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

As noted in the table above, consumers located in the targeted counties have not accessed services that can support them in maximizing independence in their communities of choice at a suitable level. The targeted counties were identified for this project due to the rural geographic location of the individuals living in these areas, which are also contiguous to our Ottumwa (Wapello County) office. Based on the information provided in the table above, in 2024 only 14% of the persons served and units provided of Options Counseling/Case Management were provided in the identified counties. In 2023, the numbers were even lower. Only 11% of individuals and 8% of units were provided in these locations. Milestones must improve visibility in these areas to make consumers aware of the services available to them and assist with appropriate referrals. Public relations have been limited to traditional sources including requested presentations to community groups and Facebook postings. It is believed that, by partnering with other agencies that can add value to Milestones’ offerings, we can reach the targeted audience of those age 60+ who identify as living in rural and underserved areas, as well as living in poverty. The county seat, Wapello County, is among the highest in our PSA for those 60+ living in poverty at 12%, per Tableau.

Collaboration with Samaritan’s Feet Seniors will offer new, well-fitting shoes to lessen the chances of falls, which can lead to hospitalizations and sometimes long-term care, or even death. According to Samaritan’s Feet, over 80,000 lowans age 65+ experienced a fall in 2021. Deaths increased as age increased. Milestones will work with Samaritan’s Feet to raise funds and get sponsorships from local businesses to purchase the shoes and other items in the Hope Tote (includes socks, hygiene items and health information). Total cost per pair of shoes and tote is \$40 and will be made available to older lowans meeting AAA criteria without cost. As part of this Value-Added project, Milestones will need to partner with local businesses and agencies to request funding to purchase the shoes and other Hope Tote items which are given to prospective consumers at no cost to them. This will heighten awareness in the local and surrounding communities. Additionally, such funding will also be used to increase awareness through local news outlets and sponsorships.

The Mission of Samaritan’s Feet Seniors is “to serve and inspire hope and dignity in our aging population by providing shoes as the foundation to a spiritual and healthy life”. In an extended effort to increase value and collaboration with community partners, Samaritan’s Feet Seniors promotes an initiative titled “Shoes & Shots” which is “designed to provide holistic support for communities in need” by partnering with local

health agencies and organizations to provide essential vaccines at the same time shoes and shoe accessories are provided. Milestones will work in collaboration to secure public health departments or private healthcare agencies to make vaccines available, thereby also expanding our reach to targeted populations. These services can be provided at Milestones' congregate sites where available, making a nutritious meal, nutrition counseling and socialization available, as well. Through these partnerships, we expect to reach those age 60+ who may have not been previously well informed about Milestones or the needed services that are available to them.

What we are doing...

**Strategy: 1.4b - Provide Case Management to provide Options Counseling to increase the capacity of individuals to live independently within their community of choice.**

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

**Activities:**

Milestones will utilize volunteers and will work to partner with other agencies to assist in identifying individuals who may need support or services within their own communities. Milestones will seek partnership with RSVP (Retired and Senior Volunteer Program) and public health agencies in the three-county area with the Samaritan's Feet Seniors program as a way to persuade attendance to learn more about the options available to support them. This program works to provide well-fitting shoes to older adults to support "health and well-being, the ability to live independently, community involvement, and economic stability." In collaboration with RSVP, Public Health, Milestones' Nutrition Program and others as needed, Milestones Social Services will work with Samaritan's Feet to make proper fitting shoes, vaccines and Options Counseling/Case Management available to those in rural areas. We will focus on Wapello, Jefferson, and Monroe counties, which indicated low utilization of these services as related to other counties in our PSA throughout 2020-2024 and where we have an established partnership with RSVP to assist with volunteers and other tasks.

**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): [Select a population.]**

- 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 Wapello, Jefferson, and Monroe counties, which indicate low utilization of Options Counseling/Case Management in SFY23 and SFY24. Support from the Wapello County RSVP is expected after an open conversation with partner staff. These also make up some of our most rural and economically disadvantaged counties.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
<b>Measures</b>	#1: 1.4 - #/% of populations/area in greatest need consumers referred to Case Management.  #2: 1.4 - Total # of consumers referred to Case Management.  #3: 1.4 - Other (Please explain.)	#1: 1.4 - #/% of populations/areas in greatest need enrolled in Case Management services for at least a year or longer.  #2: 1.4 - Total # of consumers enrolled in Case Management services for at least a year or longer.  #3: [Choose an item.]	#1: 1.4 - #/% of populations/areas in greatest need who are enrolled in community-based services.  #2: 1.4 - Total # of consumers who are enrolled in community-based services.  #3: [Choose an item.]
<b>SFY 2026 Targets</b>	#1: 15  #2: 4  #3: Click or tap here to enter text.	#1: 4  #2: 7  #3: Click or tap here to enter text.	#1: 9  #2: 4  #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:  
Click or tap here to enter text.

**Objective #2:** 1.5 - Increase community integration of older adults and people with disabilities through care transition supports from health facilities to community of choice.

Why it matters...

According to an AARP survey, 77% of adults 50 and older want to stay in their homes as they age, for multiple reasons including financial security, attachment to home/neighborhood, having support. Medicare.gov encourages those in long term care who wish to return to their home and community of choice to look into the care and services needed and available resources. Various Care Managers (Options Counseling, Case Management, including Options Counselor, Case Managers, and Family Caregiver Specialists will work together to assist those in long-term care settings as well as hospital stays to return or relocate to their communities.

What we are doing...

**Strategy: 1.5e - Other (Please explain.)**

- Explanation of Other Strategy (if selected):  
Milestones has previously participated in the IRTC program, but this participation is not certain to be continued for the time period in this Area Plan. Therefore, similar care transition services will be provided by Options Counseling and Case Management.

**Activities:**

Though Milestones will not be participating in the IRTC program for at least the first portion of the time period of this area plan, evidence of the need for transition services became clear and can be provided by Options Counseling and Case Management. Milestones saw high utilization of the IRTC program, especially in the largest counties of the PSA, which are Scott, Clinton, and Muscatine counties. Milestones Options Counselors will better learn the benefits and characteristics of each other's roles in order to better provide services and make appropriate referrals in helping people return to their homes and/or communities. In order to deliver person-centered services that are trauma-informed and

culturally sensitive across the social services spectrum, team members will shadow each other and will participate in formal training.

Knowledge about trauma-informed care will be transferred to all MAAA Care Managers through resources offered at “Trauma-Informed Care: Implementation Resource Center” by the Center for Health Care Strategies (<https://www.traumainformedcare.chcs.org/>). Team members will initially learn the principles (safety, trustworthiness + transparency, peer support, collaboration, empowerment and humility + responsiveness) and basics, such as “Understanding the Effects of Trauma on Health”, “10 Key Ingredients for Trauma-Informed Care”, “Laying the Groundwork for Trauma-Informed Care” and “What is Trauma-Informed Care?”.

This information will be provided on a monthly basis at Social Services department team meetings and may be presented through a Zoom or Microsoft Teams link. The team will discuss each topic and examples of how trauma-informed care has been or will be used in past or current cases. New Social Services team members will be provided with information on the principles and basics as part of orientation. Along the same lines, the Social Services Department team will be required to complete the “Improving Cultural Competency for Behavioral Health Professionals” course through HHS.gov (“Think Cultural Health”) and receive a Statement of Participation. The course requires 4-5.5 contact hours. Team members will complete the course electronically and provide the afore-mentioned statement of participation to their supervisor and HR. It is expected that these requirements will be met by all team members within the first fiscal year of the Area Plan, and subsequent refresher courses will be assigned and reviewed by the Social Services Director.

**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 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 objective, MAAA will focus on our largest counties to attempt to reach the highest number of those in need. Scott, Clinton and Muscatine counties will be the areas of focus. In the last fiscal year, 71 individuals were served in PSA 5 through the IRTC program within this three-county area. 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 per the 2020 census. These three counties make up 53% of the total population of all 17 counties served in our PSA.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
<b>Measures</b>	#1: 1.5 - #/% of IRTC program referrals. #2: 1.5 - # of unique facilities making referrals. #3: [Choose an item.]	#1: 1.5 - # of IRTC program referrals who were successfully enrolled into the IRTC program. #2: 1.5 - #/% of IRTC consumers who remain at home for at least 30 days after being discharged and are not readmitted to the hospital. #3: [Choose an item.]	#1: 1.5 - % of IRTC consumers who successfully transitioned from hospital to home for their recovery. #2: 1.5 - # of care transitions completed. #3: [Choose an item.]
<b>SFY 2026 Targets</b>	#1: 25 #2: 3 #3: Click or tap here to enter text.	#1: 20 #2: 18 #3: Click or tap here to enter text.	#1: 18 #2: 16 #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:  
Click or tap here to enter text.

**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, as well as the Iowa Return to Community (IRTC) programs, and the Social Services 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 tailored to

minorities such as Juneteenth, Martin Luther King Day Festival, Mexican Independence Day, Viva Ottumwa International Festival and others

The services and referral sources will be outlined, including but not limited to legal services, homemaker and chore services, personal emergency response systems, caregiver counseling, respite care, behavioral health supports and transportation.

**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): [Select a population.]**

- 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?
<b>Measures</b>	#1: 1.1 - #/% of populations/area(s) in greatest need consumers receiving Information and Assistance.	#1: 1.1 - #/% of populations/areas in greatest need consumers who indicate they received the information they were seeking.	#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: 1.1 - Total # of consumers receiving	#2: 1.1 - Total # of	

	What We Do	How Well We Do It	Is Anyone Better Off?
	Information and Assistance. #3: [Choose an item.]	consumers who indicate they received the information they were seeking. #3: [Choose an item.]	#2: 1.1 - Total # of consumers who received Information and Assistance and are also enrolled in at least one additional OAA service. #3: [Choose an item.]
<b>SFY 2026 Targets</b>	#1: 30  #2: 50  #3: Click or tap here to enter text.	#1: 28  #2: 48  #3: Click or tap here to enter text.	#1: 10  #2: 10  #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:  
Click or tap here to enter text.

### Statewide Performance Measures

Measure	Purpose	SFY 2025 Target	SFY 2025 Results as of [Enter Date]	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: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% of Options Counseling consumers who indicate they were provided information to	To evaluate the success of the service to assist individuals to make informed choices about	Number: Click or tap here to enter text.  Percentage: Click or tap here	Number: Click or tap here to enter text.  Percentage: Click or tap here	Number: Click or tap here to enter text.  Percentage: Click or tap here

Measure	Purpose	SFY 2025 Target	SFY 2025 Results as of [Enter Date]	SFY 2026 Target
make an informed decision on goal and service need.	long-term services and supports.	to enter text.	to enter text.	to enter text.
#/% 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: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
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: Click or tap here to enter text.	Number of months: Click or tap here to enter text.	Number of months: Click or tap here to enter text.

## **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, a new program that partners with restaurants, called Iowa Café, was initiated. While most of these partnerships ended due to funding restraints, 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 lowans 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.

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. 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.  #2: [Choose an item.]  #3: [Choose an item.]	#1: 2.2 - #/% of congregate nutrition consumers served who indicate during intake they are at higher nutrition risk.  #2: [Choose an item.]  #3: [Choose an item.]	#1: 2.2 - #/% home delivered nutrition consumers served who indicate during intake they are food insecure.  #2: [Choose an item.]  #3: [Choose an item.]
SFY 2026 Targets	#1: 1000  #2: Click or tap here to enter text.  #3: Click or tap here to enter text.	#1: 20%  #2: Click or tap here to enter text.  #3: Click or tap here to enter text.	#1: 20%  #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:  
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. 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: 2.3e - 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 or options counseling.**

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

**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 #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 0% #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 0% #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, the target is set at 0 until the baseline is established.

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

Why it matters...

Milestones EBP are in alignment with falls data. Falls are the leading cause of injury for adults ages 65 years and older, and a significant concern for lowans, 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. 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. 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. And falls are the most common cause of traumatic brain injuries. Falls are a threat to the health of older lowans and can reduce their ability to remain independent. However, many falls can be prevented. Education and prevention efforts can save money and lives. Prevention services help people recognize and manage health problems early, when treatment is most effective. 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. 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 programs are a mandated services for their proven effectiveness and documented outcomes for participants.

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:**

Offering a variety of EBP for falls prevention and health promotion is 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 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 include 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 contract with community-based occupational therapy to deliver person-centered multi-disciplinary Home Hazard Removal Program (HARP) for older lowans 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. Increased options for evidence-based programs include focusing on new (not previously offered) shorter interventions to address barrier(s) expressed by participants to enrollment. Interest, demand, and commitment is declining to long class series. Expansion includes identifying and supporting Spanish-speaking Leaders to be trained for Stepping On program (funded by University of Iowa Healthcare grant) to reach OAA prioritized population in Muscatine County. In tandem, supplemental health promotion programs are offered such as health screenings utilizing clinical partners. Health promotion information relevant to OAA prioritized populations is distributed, with priority to those receiving home-delivered nutrition services. 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, St. Ambrose University, Iowa Total Care, Telligen 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:**

Spanish-speaking falls prevention in Muscatine County zip codes 52761, 52776 plus Louisa County zip code 52738. Falls prevention HSOA program for the following counties: Lee, Van Buren, Davis, Appanoose, Mahaska, Keokuk, Jefferson, Louisa, Muscatine. HARP for all counties from Iowa Total Care funded referrals with additional priority given to rural older lowans in Lucas, Mahaska, Wayne, Davis, Monroe, Appanoose, Keokuk, Jefferson, Van Buren. MOB program for the following counties: Clinton, Scott, Muscatine. TCA for the following counties: Clinton, Scott, Muscatine, Des Moines.

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.] #3: [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.] #3: [Choose an item.]	#1: 2.4 - Total # of consumers who complete evidence-based falls prevention programming. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 100 consumers enrolled #2: Click or tap here to enter text. #3: Click or tap here to enter text.	#1: 100 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, fidelity requirements for licensed program, 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 [Enter Date]	SFY 2026 Target
#/% of nutrition consumers served who indicate during intake they are socially isolated.	To prioritize consumers who are at risk for social isolation.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% of nutrition consumers served who indicate during intake they are at higher nutrition risk.	To prioritize consumers who have a higher nutrition risk.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% nutrition consumers served who indicate during intake they are food insecure.	To prioritize consumers who are at risk for food insecurity.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% nutrition consumers served who indicate during intake they are at risk for malnutrition.	To prioritize consumers who are at risk of malnutrition.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% 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: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.

### **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

Milestones' EAPA program takes opportunities to educate the public in elder abuse protection and awareness in events. EAPA staff continue to participate in the monthly MDT (Multi-Disciplinary Team) meetings, which is 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, of which 47 were cases of self-neglect primarily in the form of unsuitable housing, loss of utilities, or evictions. Most of these were in our most populated area, Scott County. We see a need to reach out to the more rural areas to ensure that understanding of issues and options are further wide-spread. The NSA Rural LE Resource Guide ("Elder Abuse: The Rural Response" Law Enforcement Handbook, 2018) reports that the challenges for rural service providers include staff shortages, geographic distances, inability to attract strong talent, professional isolation, terrain and weather conditions, and ethics and confidentiality.

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

#### Why it matters...

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. These numbers are reflective of the utilization of Covid funds in FY21-23, which resulted in serving the need. 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.

#### 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, including Davis, Lucas and Wayne counties, indicating gaps. 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, 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, so efforts will be focused here. 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). Specific to Milestones, we saw 47 such cases just in FY24 reported as self-neglect.

How we measure impact...

Measures	What We Do	How Well We Do It	Is Anyone Better Off?
	#1: 3.1 - Total # of consumers provided with EAPA Consultation.  #2: 3.1 - #/% of populations/areas in greatest need consumers provided with EAPA Consultation.  #3: [Choose an item.]	#1: 3.1 - # of and type of public education trainings to identify and prevent abuse of older individuals.  #2: 3.1 - #/% of referrals made to EAPA program by referral source.  #3: [Choose an item.]	#1: 3.1 - #/% of EAPA consumers report they feel safe from abuse.  #2: 3.1 - #/% of EAPA consumers who report their quality of life has improved.  #3: [Choose an item.]
<b>SFY 2026 Targets</b>	#1: 10  #2: 4  #3: Click or tap here to enter text.	#1: 8  #2: 3  #3: Click or tap here to enter text.	#1: 8  #2: 6  #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:  
Based on previous fiscal year's numbers and expected increase in service due to this initiative, and allowing for additional growth in areas of greatest need.

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

Why it matters...

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: 3.2b - Develop or strengthen partnerships with other agencies to increase referrals of populations/areas in greatest need of 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 legal issues faced by persons served on an annual basis. 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 (POW's), guardianships, citizenship and other legal rights. Partnerships with agencies such as the Diversity Center, community action organizations, community health centers, county public health agencies and retirement homes.

**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+ with language barriers**

- 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 purposes of reaching the target population of those with language barriers, Louisa and Muscatine will be the focus areas for this objective. Per Tableau, these counties have the highest populations of those 60+ with limited English proficiency. Though only estimated at 4% and 2% respectively, it is important that better understanding of legal issues is made available as they work to understand their rights.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	<p>#1: 3.2 - Total # of consumers referred to OAA legal assistance.</p> <p>#2: 3.2 - #/% of populations/areas in greatest need consumers referred to OAA legal assistance.</p> <p>#3: [Choose an item.]</p>	<p>#1: 3.2 - Total # of consumers who received OAA legal assistance.</p> <p>#2: 3.2 - #/% of populations/areas in greatest need consumers who received OAA legal assistance.</p> <p>#3: [Choose an item.]</p>	<p>#1: 3.2 - Total # of consumers who indicate a change in knowledge, skills, and/or behaviors after receiving education on legal issues.</p> <p>#2: 3.2 - #/% of populations/areas in greatest need consumers who indicate a change in knowledge, skills, and/or behaviors after receiving education on legal issues.</p> <p>#3: [Choose an item.]</p>
SFY 2026 Targets	<p>#1: 7</p> <p>#2: 5</p> <p>#3: Click or tap here to enter text.</p>	<p>#1: 5</p> <p>#2: 4</p> <p>#3: Click or tap here to enter text.</p>	<p>#1: 5</p> <p>#2: 4</p> <p>#3: Click or tap here to enter text.</p>

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

- Explanation of logic used to develop SFY 2026 targets:  
Based on review of previous number of consumers served and expecting that projections from How Well We Do It will translate to Is Anyone Better Off.

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

Why it matters...

Many individuals that we serve have limited means, often live alone and may have cognitive issues or be susceptible to anxious concern when confronted with emergency situations. Extended family often does not live close at hand, or they may have no family at all upon whom to call. Some have been reliant on others, especially women of a certain generation, who have taken care of others but have had little experience – or now have reduced capacity - to manage natural disasters or emergency situations alone. Our goal is help give our consumers the tools and confidence to be prepared in case of emergency or natural disaster.

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 Options Counselors are trained on the materials and know how to make referrals as needed to program representatives. We will also arrange for a training for OC/CM staff with the Disaster PrepWise representatives to ensure that they 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?
<b>Measures</b>	#1: 3.3 - Total # of consumers who were referred to futher 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.]
<b>SFY 2026 Targets</b>	#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:

Milestones will consider consumers currently being served, who do not have an emergency plan in place and may be at risk, and who are willing to complete the Disaster PrepWise process.

### Statewide Performance Measures

Measure	Outcome	FY2025 Target	FY2025 Results as of [Enter Date]	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: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% 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: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.

## 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.” SeniorNavigator offers twelve ideas for older adults to stay socially connected,

Milestones served 465 consumers in Caregiver Services in FY2024 and sees a continuing need. 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 them to express their frustrations and get insight from others who share their situation. Mayo Clinic offers information on their website that discusses caregiver stress and ways to take care of oneself. They report 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 some of the suggestions made. Caregivers must take care of themselves in order to be able to take care of their loved one/family member.

**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. Caregivers’ own health notwithstanding it is important for a caregiver to manage their own mental, emotional and physical health so they can provide better care to the recipient for a longer amount of time.

### What we are doing...

**Strategy: 4.3h - Develop community-level workgroups to address stress, depression, and financial cost burden for caregivers.**

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

**Activities:**

Milestones staff will initiate and develop collaboration and partnerships with identified community members and organizations to establish workgroups to specifically address stress, depression and financial cost burden to caregivers. We will establish partnerships with other community resources including churches, retirement homes, employment services, banks and other financial institutions, behavioral health and home health agencies, and/or other providers of aging services. Milestones staff will assemble the workgroups in each area and prepare agendas to keep the groups on task by developing Action Plans. Family caregivers will be included in each workgroup. These groups will be established within the first two fiscal years of the Area Plan and expand as needed thereafter.

**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 with chronic health conditions**

- 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 Scott, Des Moines and Wapello Counties where we already have a greater presence and more networking opportunities. We will seek partnerships with organizations and people within our multi-disciplinary groups, churches and other community-minded businesses.

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: 4.4 - Other (Please explain.) Number of workgroups that establish a plan to address caregiver issues #2: [Choose an item.] #3: [Choose an item.]	#1: 4.4 - Other (Please explain.) Number of initiatives from completed workgroup Action Plans. #2: [Choose an item.] #3: [Choose an item.]
SFY 2026 Targets	#1: 9  #2: Click or tap here to enter text.  #3: Click or tap here to enter text.	#1: 1  #2: Click or tap here to enter text.  #3: Click or tap here to enter text.	#1: 0  #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:  
Initial target of 3 partner organizations per MAAA office area (Burlington, Davenport, Ottumwa).

**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: 4.1e - Pilot a new or emerging program that will address social isolation within evidence-based health programs and/or congregate nutrition services.**

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

**Activities:**

CircleTalk is a research supported, field-tested social engagement program from Telligen that disrupts isolation and loneliness. It is relationship focused and facilitated by trained leaders and structured to be submitted for OAA funded evidence-based approval. An additional activity is in partnership with Iowa State University faculty in music therapy and neuroscience. We have access to a program involving singing to benefit brain health and motor symptoms like tremor and gait for older adults.. The Music activity was developed for persons living with Parkinson’s Disease and is being pilot tested for effectiveness in the general aging population.

**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): [Select a population.]**

- 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 health promotion evidence- based classes delivered.  #2: [Choose an item.]  #3: [Choose an item.]	#1: 4.1 - #/% of populations/areas of greatest need consumers who completed evidence- based health promotion programing.  #2: [Choose an item.]  #3: [Choose an item.]
SFY 2026 Targets	#1: 5 social engagement programs scheduled/offered.  #2: Click or tap here to enter text.  #3: Click or tap here to enter text.	#1: 5 class series delivered  #2: Click or tap here to enter text.  #3: Click or tap here to enter text.	#1: 30 consumers enrolled  #2: Click or tap here to enter text.  #3: Click or tap here to enter text.

- Explanation of Other Measure (if selected):  
Older adults age 60+ who live in rural remote communities and at risk for social isolation, loneliness based on intake data.
- 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...

Limited awareness, geographic barriers, language barriers, cultural considerations and financial constraints can all make it difficult for caregivers to find support in underserved communities. An article from 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.” Milestones has seen some success in improving an understanding of dementia and respect for those with dementia in order to better support older Iowans with dementia and their caregivers.

What we are doing...

**Strategy: 4.2c - Train external key community partners to increase referrals of populations/areas in greatest need to Caregiver/ORC services.**

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

**Activities:**

Milestones has had some involvement with Dementia Friends and values the principles in utilizing this education and information in supporting those with dementia and their caregivers. The Social Services department currently has one Dementia Friends Champion who provides 5-6 presentations per year. Most staff members are trained to be Dementia Friends. The University of Iowa states on their Iowa Geriatric Education Center website that “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.

**Populations in Greatest Economic Need: Persons 60+ who identify as living in poverty (at or below 100% 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 who are living with Alzheimer's disease and related disorders with neurological and organic brain dysfunction**

- 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 County and Louisa County 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 Jefferson and Van Buren Counties will be the focus of the Dementia Friends Champion in the Ottumwa office. These counties all show lower number of consumers and units provided of caregiver services in SFY24.

How we measure impact...

	What We Do	How Well We Do It	Is Anyone Better Off?
Measures	<p>#1: 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.</p> <p>#2: [Choose an item.]</p> <p>#3: [Choose an item.]</p>	<p>#1: 4.4 - #/% of caregivers who have received information on how to care for someone with Alzheimer's disease or related disorders with neurological or organic brain dysfunction.</p> <p>#2: [Choose an item.]</p> <p>#3: [Choose an item.]</p>	<p>#1: 4.4 - #/% of caregivers with care recipients who live with Alz. Disease and related disorders with neurological and organic brain dysfunction that are enrolled in at least one or more OAA services.</p> <p>#2: [Choose an item.]</p> <p>#3: [Choose an item.]</p>
SFY 2026 Targets	<p>#1: 12</p> <p>#2: Click or tap here to enter text.</p> <p>#3: Click or tap here to enter text.</p>	<p>#1: 50</p> <p>#2: Click or tap here to enter text.</p> <p>#3: Click or tap here to enter text.</p>	<p>#1: 6</p> <p>#2: Click or tap here to enter text.</p> <p>#3: Click or tap here to enter text.</p>

- Explanation of Other Measure (if selected):  
Click or tap here to enter text.
- Explanation of logic used to develop SFY 2026 targets:  
Twelve is representative of at least four presentations per office (3). It is reasonable to project that at least five caregivers from each presentation will receive information, which comes to sixty. Project half of the twelve referred (6) will be enrolled in OAA services.

## Statewide Performance Measures

Measure	Purpose	FY2025 Target	FY2025 Results as of [Enter Date]	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: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% 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: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.
#/% 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: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.	Number: Click or tap here to enter text.  Percentage: Click or tap here to enter text.

## 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	1200	35				
2: Homemaker	Gen. Aging	1500	50				
3: Chore	Gen. Aging	30	10				
4: 60+ Home Delivered Nutrition	Gen. Aging	87000	986				
5: Adult Daycare/Health	Gen. Aging	214	9				
6: 60+ Case Management	Gen. Aging	500	55				
7: 60+ Congregate Nutrition	Gen. Aging	46817	1,037				
8: Nutrition Counseling	Gen. Aging	1	1				
9: Assistive Transportation	Gen. Aging						
10: Transportation	Gen. Aging	11500	389				
11: Legal Assistance	Gen. Aging	600	297				
12: Nutrition Ed.	Gen. Aging	9847	1,475				
13: 60+ Information & Assistance	Gen. Aging	2400	1,379				
14: Outreach	Gen. Aging	322	282				
B02: Health Promotion: Non-Evidence	Gen. Aging	1603	282				
B04: 60+ Emergency Response System	Gen. Aging	200	40				
B05: Behavioral Health Supports	Gen. Aging	0	0				
B07: Health Promo: Evidence Based	Gen. Aging	64	64				
C07: EAPA Consultation	Gen. Aging	44	44				
C08: EAPA Assess & Intervention	Gen. Aging	274	63				
C09: EAPA Training & Education	Gen. Aging	14	2000				
D01: Training & Education	Gen. Aging	112	24335				
E05: 60+ Options Counseling	Gen. Aging	458	187				
A01: 60+ Material Aid: Home Mod./Repairs	Gen. Aging	25	25				
F06: 60+ Material Aid: Asst. Tech./Durable Med. Equip.	Gen. Aging	1	1				
F07: 60+ Material Aid: Consumable Supplies	Gen. Aging	5	5				
F08: 60+ Material Aid: Other	Gen. Aging	18	13				
CG3: FC Counseling	Caregiving	25	15				
CG4: FC Information Services	Caregiving	800	12				
CG7: FC Home Delivered Nutri.	Caregiving	200	5				
CG8: FC Options Counseling	Caregiving	85	60				
CG9: FC Case Management	Caregiving	12	3				
CG10: FC Information & Assistance	Caregiving	50	40				
CG11: FC Support Groups	Caregiving	90	35				
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:	Caregiving	5	5				

Service		Service Units Provided	Consumers Served	60+ Rural	60+ Minority	60+ Minority Below Poverty	60+ Below Poverty
Consumable Supplies							
CG22: FC Supplemental Services: Other	Caregiving	0	0				
CG23: FC Respite Care: In Home	Caregiving	210	18				
CG24: FC Respite Care: Out-of-Home (Day)	Caregiving	15	3				
CG25: FC Respite Care: Out-of-Home (Overnight)	Caregiving	8	3				
CG26: FC Respite: Other	Caregiving	0	0				
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	163	20				
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						

## SFY 2026 Service Coverage

### Information & Service Assistance Services

Please indicate with an “X” the services offered within each of your PSA counties.

Services	Appanoose	Clinton	Davis	Des Moines	Henry	Jefferson	Keokuk	Lee	Louisa	Lucas	Mahaska	Monroe	Muscatine	Scott	Van Buren	Wapello	Wayne
60+ Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FC Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ORC Case Management																	
FC Counseling	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ORC Counseling																	
EAPA Assessment & Intervention	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Information & Assistance (general)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FC Information & Assistance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ORC Information & Assistance																	
EAPA Consultation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Legal Assistance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
60+ Options Counseling	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FC Options Counseling	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ORC Options Counseling																	

### Nutrition & Health Promotion Services

Please indicate with an “X” the services offered within each of your PSA counties.

Services	Appanoose	Clinton	Davis	Des Moines	Henry	Jefferson	Keokuk	Lee	Louisa	Lucas	Mahaska	Monroe	Muscatine	Scott	Van Buren	Wapello	Wayne
60+ Congregate Nutrition	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
FC Congregate Nutrition																	
ORC Congregate Nutrition																	
Health Promotion: Evidence-Based	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health Promotion: Non Evidence-Based	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
60+ Home Delivered Nutrition	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FC Home Delivered Nutrition	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition Counseling	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition Education	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

## Services to Promote Independence

Please indicate with an "X" the services offered within each of your PSA counties.

Services	Appanoose	Clinton	Davis	Des Moines	Henry	Jefferson	Keokuk	Lee	Louisa	Lucas	Mahaska	Monroe	Muscatine	Scott	Van Buren	Wapello	Wayne
Adult Day Care / Health													X	X			
Assisted Transportation																	
Behavioral Health Supports																	
Chore	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
60+ Emergency Response System	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FC Emergency Response System																	
ORC Emergency Response System																	
Homemaker	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FC Information Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ORC Information Services																	
60+ Material Aid – Types:																	
• Assistive Tech/Durable Medical Equipment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• Consumable Supplies	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• Home Modification/Repairs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FC Supplemental Services – Types:																	
• Assistive Tech/Durable Medical Equipment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• Consumable Supplies	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ORC Supplemental Services Types:																	
• Assistive Tech/Durable Medical Equipment																	
• Consumable Supplies																	
• Other																	
Outreach	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Personal Care	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Caregiver Respite																	
• FC Respite Care: In-Home	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• ORC Respite Care: In-Home																	
• FC Respite Care: Out-of-Home (Day)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• ORC Respite Care: Out-of-Home (Day)																	
• FC Respite Care: Out-of-Home (Overnight)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• ORC Respite Care: Out-of-Home (Overnight)																	
• FC Respite: Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• ORC Respite: Other																	
CG Support Group				X										X		X	
ORC Support Group													X				
Training & Education	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Services	Appanoose	Clinton	Davis	Des Moines	Henry	Jefferson	Keokuk	Lee	Louisa	Lucas	Mahaska	Monroe	Muscatine	Scott	Van Buren	Wapello	Wayne
FC Training	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ORC Training																	
EAPA Training & Education	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Transportation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X