2027-2030

Area Agency on Aging 3

Strategic Area Needs Assessment

AGE WITH DISTINCTION

2027 2030

Area Agency on Aging 3

STRATEGIC AREA PLAN

Area Agency on Aging 3

Integrity. Independence. Quality of Life.

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I. Introduction & Overview

The 2027–2030 Strategic Area Plan developed by Area Agency on Aging 3 serves as a comprehensive framework to guide the organization's efforts in addressing the evolving needs of older adults, caregivers, and individuals with disabilities throughout the Planning and Service Area (PSA). This plan reflects the agency's commitment to promoting independence, dignity, health, safety, and quality of life for the populations served across the region.

The needs assessment process was conducted to identify existing strengths, emerging trends, service gaps, barriers to access, and priority needs impacting older adults and caregivers within the PSA. Consistent with the requirements of the Older Americans Act and guidance provided by the Ohio Department of Aging, the assessment incorporated both quantitative and qualitative data collection methods designed to ensure broad community representation and meaningful stakeholder engagement.

The development of this assessment included review and analysis of demographic and socioeconomic data, consumer and stakeholder survey results, focus groups, public input opportunities, community partner feedback, program utilization trends, and other reputable local, state, and national data sources. Special emphasis was placed on identifying the needs of populations identified within 42 U.S. Code § 3026(a)(4)(B), including older adults residing in rural areas, individuals with greatest economic and social need, minority older adults, individuals with limited English proficiency, older adults with severe disabilities, individuals living with Alzheimer's disease and related disorders, caregivers, and individuals at risk for institutional placement.

Findings gathered through the needs assessment process directly informed the development of the agency's strategic priorities, goals, objectives, and proposed strategies for the 2027–2030 planning cycle. The resulting Area Plan is intended to serve as a responsive, data-informed roadmap that strengthens community-based supports, enhances service coordination, promotes equitable access to resources, and positions the agency and its network to effectively respond to both current and future aging-related needs within the region.

This section of the Strategic Area Plan summarizes the methodology utilized, key findings identified, targeted outreach efforts, Information and Referral (I&R) activities, and the manner in which collected data and community input were incorporated into the planning and decision-making process.

II. Needs Assessment Methodology

Area Agency on Aging 3 conducted a comprehensive needs assessment utilizing both surveys and community-based focus groups to gather quantitative and qualitative data related to the needs, priorities, barriers, and emerging trends impacting older adults, caregivers, and communities throughout the Planning and Service Area (PSA).

To ensure broad community representation and meaningful stakeholder input, two separate but similarly structured surveys were developed. One survey targeted community members residing within the PSA, while the second survey targeted individuals currently enrolled in or receiving services through AAA3 programs. Both surveys were designed to collect demographic information, identify service needs and gaps, assess barriers to accessing services, and evaluate priorities aligned with guidance provided by the Administration for Community Living (ACL) and the Ohio Department of Aging (AGE).

Survey content incorporated key priority areas identified by ACL, including caregiving, connecting individuals to services and supports, whole-person health, employment, and protecting rights while preventing abuse, neglect, and exploitation. In addition, the surveys addressed the identified 2027–2030 focus areas established by AGE, including financial well-being, healthy food access, quality and coordinated healthcare, community supports and services, safe and accessible housing, reliable transportation, and caregiver supports.

Surveys were made available in both electronic and paper formats to maximize accessibility and participation across the region. A regional outreach and engagement campaign was launched in June 2025, with survey collection continuing throughout the remainder of the calendar year. Distribution efforts were intentionally broad and multifaceted to encourage participation from diverse populations and included promotion through social media platforms, television outreach, the agency website, electronic newsletters, direct program mailings, and dissemination through agency staff, including care coordinators and case managers.

Additional outreach and survey distribution efforts were conducted in partnership with local Councils on Aging, senior centers, libraries, independent living communities, contracted service providers, the agency's Advisory Council, Board of Trustees, and other collaborating community organizations throughout the PSA.

As a result of these efforts, the agency received a total of 1,019 completed survey responses, including 343 responses from community members and 676 responses from individuals currently receiving services through AAA3 programs. Full survey instruments,

detailed survey findings, and supplemental response data are included within the appendices for additional reference and review.

To supplement survey findings and provide additional qualitative insight, nine regional focus groups were conducted across the PSA at identified Councils on Aging, senior centers, libraries, and independent living senior apartment complexes. A total of 174 older adults participated in the focus group process. At least one focus group session was conducted within each of the seven counties served by AAA3 to help ensure geographic representation and capture localized perspectives regarding service needs, barriers, and opportunities for future planning and system improvement. Full focus group questions, participant summaries, and compiled focus group findings are included within the appendices for additional reference and review.

III. Regional Profile

Area Agency on Aging 3 serves a seven-county Planning and Service Area (PSA) located in west central Ohio and bordering the state of Indiana. The PSA includes Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, and Van Wert counties and reflects a diverse mix of metropolitan, micropolitan, rural, and noncore communities.

The classifications referenced throughout the Regional Profile section are based on population and commuting patterns established by the United States Office of Management and Budget and commonly utilized by the U.S. Census Bureau and federal agencies for planning and demographic purposes.

- **Metropolitan:** Counties tied to urbanized areas with populations of 50,000 or more residents, typically with greater access to healthcare, transportation, employment, and community resources.
- **Micropolitan:** Counties centered around urban clusters with populations between 10,000 and 49,999 residents that often serve as regional hubs for surrounding rural communities.
- **Rural:** Areas outside of major urban centers that may experience lower population density, greater travel distances, reduced transportation options, and limited access to services.
- **Noncore:** The most rural classification, referring to counties that are not part of either a metropolitan or micropolitan area and may face increased challenges related to healthcare access, transportation, broadband connectivity, and service delivery.

These classifications help describe the geographic diversity of the AAA3 Planning and Service Area and provide context regarding service accessibility, transportation barriers, healthcare availability, and outreach needs throughout the region.

The region is characterized by strong community networks, locally supported aging services infrastructure, and a growing older adult population with varying economic, healthcare, transportation, and social support needs. Demographic and socioeconomic trends throughout the PSA continue to shape service demand and influence strategic planning priorities related to aging, caregiving, healthcare access, nutrition, housing, transportation, and community-based supports.

The following regional profile provides an overview of key demographic, geographic, social, and economic characteristics impacting older adults and caregivers within the PSA.

The map below represents the 7-county region served by the Area Agency on Aging 3.

Population & Aging Trends:

According to U.S. Census and American Community Survey data, population distribution across the AAA3 region varies significantly by county, with Allen and Hancock counties representing the largest population centers within the PSA. At the same time, several counties within the region are classified as rural or noncore communities, creating unique challenges related to transportation access, healthcare availability, broadband connectivity, workforce shortages, and access to aging services.

Like many areas throughout Ohio and the nation, the AAA3 region continues to experience growth in its older adult population, including increases in adults age 60 and older and

adults age 85 and older. These demographic shifts are expected to place increasing demand on long-term services and supports, caregiver resources, healthcare coordination, home and community-based services, transportation, and dementia-related supports over the coming decade.

Identification of Largest Cities Served by County in AAA3:

	Total Pop, 2020
Ohio	**11,799,448**
Allen	102,206
Auglaize	46,422
Hancock	74,920
Hardin	30,696
Mercer	42,528
Putnam	34,451
Van Wert	28,931

Source: Ohio Department of Development, Office of Research
Ohio-population.org

County Name: Allen	Allen
Total Population	101,115
Total Population 60+	25,983
Total Population 65+	19,202
Percent of Population Age 65+	19.0
Population Age 85+ as a % of 65+	11.8
Percent 65+ Female	55.3
Percent 65+ Married	49.9
Percent 65+ Living Alone	32.0
Median 65+ Household Income ($)	43,164
Percent 65+ Population Below Poverty	8.5
Percent 65+ who are Veterans	16.1
Percent 65+ with High School Diploma or Higher	89.9
Percent 65+ having Internet Access	78.9
Population 65+ having High Need for LTSS*	2,445
Population 65+ having Moderate Need for LTSS**	1,712
Population 65+ having Moderate or High Need	4,157
Life Expectancy at Birth	76.2
Life Expectancy at Age 65	18.2

County Name: Auglaize	Auglaize
Total Population	45,948
Total Population 60+	12,286
Total Population 65+	9,027
Percent of Population Age 65+	19.6
Population Age 85+ as a % of 65+	11.9
Percent 65+ Female	53.9
Percent 65+ Married	57.7
Percent 65+ Living Alone	32.0
Median 65+ Household Income ($)	47,583
Percent 65+ Population Below Poverty	6.1
Percent 65+ who are Veterans	15.5
Percent 65+ with High School Diploma or Higher	87.8
Percent 65+ having Internet Access	77.4
Population 65+ having High Need for LTSS*	1,161
Population 65+ having Moderate Need for LTSS**	809
Population 65+ having Moderate or High Need	1,970
Life Expectancy at Birth	78.1
Life Expectancy at Age 65	18.3

County Name: Hancock	Hancock
Total Population	74,861
Total Population 60+	18,970
Total Population 65+	13,870
Percent of Population Age 65+	18.5
Population Age 85+ as a % of 65+	11.5
Percent 65+ Female	55.3
Percent 65+ Married	54.7
Percent 65+ Living Alone	32.0
Median 65+ Household Income ($)	46,405
Percent 65+ Population Below Poverty	6.0
Percent 65+ who are Veterans	18.7
Percent 65+ with High School Diploma or Higher	91.2
Percent 65+ having Internet Access	81.3
Population 65+ having High Need for LTSS*	1,726
Population 65+ having Moderate Need for LTSS**	1,232
Population 65+ having Moderate or High Need	2,958
Life Expectancy at Birth	77.4
Life Expectancy at Age 65	18.4

County Name: Hardin	Hardin
Total Population	30,416
Total Population 60+	6,809
Total Population 65+	4,977
Percent of Population Age 65+	16.4
Population Age 85+ as a % of 65+	9.6
Percent 65+ Female	54.1
Percent 65+ Married	57.7
Percent 65+ Living Alone	32.0
Median 65+ Household Income ($)	43,215
Percent 65+ Population Below Poverty	9.0
Percent 65+ who are Veterans	16.0
Percent 65+ with High School Diploma or Higher	91.8
Percent 65+ having Internet Access	73.7
Population 65+ having High Need for LTSS*	620
Population 65+ having Moderate Need for LTSS**	460
Population 65+ having Moderate or High Need	1,080
Life Expectancy at Birth	75.7
Life Expectancy at Age 65	17.5

County Name: Mercer	Mercer
Total Population	42,348
Total Population 60+	11,226
Total Population 65+	8,238
Percent of Population Age 65+	19.5
Population Age 85+ as a % of 65+	12.1
Percent 65+ Female	53.3
Percent 65+ Married	58.8
Percent 65+ Living Alone	32.0
Median 65+ Household Income ($)	47,108
Percent 65+ Population Below Poverty	4.8
Percent 65+ who are Veterans	16.0
Percent 65+ with High School Diploma or Higher	88.6
Percent 65+ having Internet Access	75.9
Population 65+ having High Need for LTSS*	1,051
Population 65+ having Moderate Need for LTSS**	726
Population 65+ having Moderate or High Need	1,777
Life Expectancy at Birth	78.8
Life Expectancy at Age 65	18.9

County Name: Putnam	Putnam
Total Population	34,334
Total Population 60+	9,011
Total Population 65+	6,466
Percent of Population Age 65+	18.8
Population Age 85+ as a % of 65+	11.9
Percent 65+ Female	53.0
Percent 65+ Married	61.2
Percent 65+ Living Alone	32.0
Median 65+ Household Income ($)	49,156
Percent 65+ Population Below Poverty	10.4
Percent 65+ who are Veterans	14.2
Percent 65+ with High School Diploma or Higher	91.2
Percent 65+ having Internet Access	77.0
Population 65+ having High Need for LTSS*	827
Population 65+ having Moderate Need for LTSS**	570
Population 65+ having Moderate or High Need	1,397
Life Expectancy at Birth	79.8
Life Expectancy at Age 65	19.0

County Name: Van Wert	Van Wert
Total Population	28,769
Total Population 60+	7,814
Total Population 65+	5,793
Percent of Population Age 65+	20.1
Population Age 85+ as a % of 65+	11.6
Percent 65+ Female	54.9
Percent 65+ Married	55.9
Percent 65+ Living Alone	32.0
Median 65+ Household Income ($)	50,039
Percent 65+ Population Below Poverty	6.8
Percent 65+ who are Veterans	15.6
Percent 65+ with High School Diploma or Higher	89.2
Percent 65+ having Internet Access	74.9
Population 65+ having High Need for LTSS*	753
Population 65+ having Moderate Need for LTSS**	523
Population 65+ having Moderate or High Need	1,276
Life Expectancy at Birth	77.1
Life Expectancy at Age 65	18.4

Source:

- Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023. CC-EST2023-ALLDATA-[ST-FIPS].
- U.S. Census Bureau. (2022). American Community Survey 5-Year Estimates, 2018-2022. Retrieved from IPUMS NHGIS, University of Minnesota, www.nhgis.org.
- National Health and Aging Trends Study. Produced and distributed by www.nhats.org with funding from the National Institute on Aging (grant number NIA U01AG32947). Calculated using data from the Ohio Department of Development (ODD), Office of Research, "County Population Projections: 2020-2050"
- Mortality data used in the life expectancy calculations were provided by the Ohio Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Councils on Aging:

There are seven Councils on Aging throughout the AAA3 region. Hancock County is identified by 50 North. The COA's are funded in part by local levies at the administrative county level.

Allen County
2423 Allentown Road
Lima, Ohio 45805

Auglaize County
610 Indiana Ave
Saint Mary's, Ohio 45885

Hancock County (50 North)
339 E Melrose Ave
Findlay, Ohio 45840

Hardin County
100 Memorial Ave
Kenton, Ohio 43326

Mercer County
217 Riley Street
Celina, Ohio 45822

Putnam County
1425 E. 4th Street
Ottawa, Ohio 45875

Van Wert County
220 Fox Road
Van Wert, Ohio 45891

Senior Centers:

Senior Centers throughout the AAA3 region serve as important community-based gathering locations that provide opportunities for socialization, nutrition services, wellness activities, recreation, education, volunteer engagement, and access to supportive services for older adults. Senior centers additionally serve as key community partners in outreach, service coordination, and dissemination of information regarding available aging programs and resources throughout the PSA.

Senior Centers available within Allen County:

- Senior Citizens Services
  3400 West Elm St.
  Lima, Ohio 45805
- Delphos Senior Citizens' Center
  301 E Suthoff Street
  Delphos, Ohio 45833
- Bluffton Senior Citizens' Center
  132 N Main Street
  Bluffton, Ohio 45817

Senior Centers available within Auglaize County:

- New Bremen Senior Center
  700 E. Monroe St.
  New Bremen, Ohio 45869

IV. Target Populations & Priority Focus Areas

Required OAA Priority Populations

Older Adults Residing in Rural Areas

The AAA3 Planning and Service Area (PSA) is predominantly rural in nature, with several counties classified as micropolitan or noncore communities. Rural older adults throughout the PSA may experience increased barriers related to transportation access, healthcare availability, broadband connectivity, workforce shortages, social isolation, and access to supportive services.

Needs Assessment findings reinforced the impact of these barriers, particularly among individuals residing farther from population centers and healthcare providers. These findings continue to guide AAA3's focus on outreach, transportation coordination, home and community-based services, and strengthening access to care and supports within rural communities throughout the region.

Older Adults with Greatest Economic & Social Need

Needs Assessment findings and regional demographic data demonstrate that many older adults throughout the PSA experience financial strain associated with fixed incomes, rising housing costs, healthcare expenses, food insecurity, and utility burdens. Survey findings identified affordability of housing, medications, groceries, transportation, and healthcare services as significant concerns impacting long-term stability and independence.

Older adults residing in rural communities, individuals living alone, and underserved populations may face increased economic and social vulnerability due to limited access to transportation, healthcare services, employment opportunities, and affordable housing resources. These factors continue to contribute to increased need for benefits enrollment assistance, nutrition supports, transportation services, social engagement opportunities, and home and community-based supports throughout the PSA.

Older Adults with Severe Disabilities

A significant number of older adults throughout the AAA3 region are living with physical, cognitive, sensory, developmental, and chronic health-related disabilities that may impact their ability to safely and independently remain in the community.

American Community Survey estimates indicate that thousands of adults throughout the PSA report living with one or more disabilities, with the highest concentrations located in Allen and Hancock counties due to overall population size. Older adults with disabilities may experience increased barriers related to transportation, housing accessibility, healthcare access, digital connectivity, caregiving support, and activities of daily living.

Needs Assessment findings highlighted continued demand for home and community-based services, home modifications, transportation assistance, caregiver supports, benefits enrollment assistance, and coordinated care planning designed to promote independence and reduce risk of institutional placement.

Geography	Total #	Total ME#	Disability #	Disability ME#	Disability %	Disability ME%	No Disability #	No Disability ME#	No Disability %	No Disability ME%
United States	329,981,000	12,000	43,870,000	82,000†	13.29	0.02†	286,111,000	87,000†	86.71	0.02†
Ohio	11,643,000	1,000	1,678,000	12,000†	14.42	0.10†	9,964,000	12,000†	85.58	0.10†
Allen County	99,000	100	16,000	1,000†	16.21	0.97†	83,000	1,000†	83.79	0.97†
Auglaize County	46,000	20	6,000	600†	13.93	1.31†	39,000	600†	86.07	1.31†
Hancock County	74,000	30	9,000	800†	12.51	1.13†	65,000	1,000†	87.49	1.13†
Hardin County	30,000	0	4,000	400†	12.35	1.30†	27,000	400†	87.65	1.30†
Mercer County	42,000	40	5,000	500†	10.91	1.24†	37,000	600†	89.09	1.24†
Putnam County	34,000	20	4,000	400†	10.49	1.11†	30,000	400†	89.51	1.11†
Van Wert County	29,000	50	4,000	400†	14.33	1.34†	24,000	400†	85.67	1.34†

Margins of error (ME) are based on 95% confidence intervals.
† the margin of error is estimated assuming independence due to the necessity of combining error estimates when reporting aggregated measures.

Source: Center for Research on Disability
https://www.researchondisability.org/annual-disability-statistics-collection/build-your-own-statistics/build-your-own-statistics-county-level-statistics

✖ Projections of Ohioans with a High level of disability, statewide and by county from 2020 to 2050

High Need* for Long-Term Services

AGE GROUP	2020 %	2020 #	2030 #	2040 #	2050 #
65-69	7.3	49,933	50,235	41,225	42,012
70-74	8.1	44,158	51,033	41,344	37,138
75-79	10.1	35,473	47,081	47,025	38,178
80-84	14.7	34,372	40,791	46,770	37,991
85+	43.9	102,290	94,657	114,885	126,379
Total 65+ High Need	13.0	266,226	283,797	291,249	281,698

** High Need is defined as having 2 impairments with Activities of Daily Living (ADL) tasks (mobility, eating, bathing, dressing, grooming, toileting) that require hands on assistance or a doctor's diagnosis of Alzheimer's Disease or Related Dementia or 1 impairment with ADL tasks and medication management assistance.*

Moderate Need** for Long-Term Services

AGE GROUP	MODERATE NEED	2020 #	2030 #	2040 #	2050 #
65-69	9.7	66,731	67,037	54,792	55,771
70-74	8.5	46,356	53,517	43,078	38,561
75-79	9.7	34,109	45,315	45,303	36,868
80-84	8.2	19,166	22,692	26,004	21,080
85+	10.8	25,160	23,404	28,265	31,015
Total 65+ Moderate Need	9.4	191,522	211,965	197,442	183,295

*** Moderate Need is defined as having 1 impairment with an Activity of Daily Living (ADL) task (mobility, eating, bathing, dressing, grooming, toileting) that requires hands on assistance or 2 or more impairments in Instrumental Activity of Daily Living (IADL) tasks (Shopping, meal preparation, light housework) that require hands on assistance.*

Total of all Disability for Long-Term Services

NEED FOR LONG-TERM SERVICES	%	2020	2030	2040	2050
Total of all Disability	22.4	457,748	495,762	488,691	464,993

Calculated using data from the Ohio Department of Development (ODD), Office of Research, "County Population Projections: 2020-2050"

Ohio Department of Development (ODD), Office of Research, "County Population Projections: 2020-2050"; National Health and Aging Trends Study (NHATS8). Produced and distributed by www.nhats.org with funding from the National Institute on Aging (grant number NIA U01AG32947)."

Older Adults with Limited English Proficiency

Older adults with limited English proficiency (LEP) represent a relatively small but important population within the AAA3 region. Based on American Community Survey estimates and demographic modeling, approximately 700 adults age 65 and older across Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, and Van Wert counties may experience limited English proficiency.

Although this population represents a smaller percentage of the overall regional population, individuals with limited English proficiency may face barriers in accessing healthcare, transportation, nutrition programs, benefits enrollment assistance, caregiving supports, and other aging services. These challenges may be amplified within rural communities where interpreter services and culturally responsive supports may be more limited.

Needs assessment findings reinforced the importance of maintaining accessible outreach materials, strengthening community partnerships, and ensuring older adults with limited English proficiency are aware of and able to access available programs and services.

Estimated Adults Age 65+ with Limited English Proficiency (LEP)

Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, and Van Wert Counties, Ohio

County	Estimated Total LEP Population (Age 5+)	Estimated % Age 65+	Estimated Adults 65+ with LEP
Allen County	1,057	~18%	~190
Auglaize County	255	~18%	~47
Hancock County	1,328	~19%	~247
Hardin County	439	~18%	~78
Mercer County	287	~18%	~53
Putnam County	378	~17%	~66
Van Wert County	138	~19%	~26
Total (7-County Region)	**3,882**	—	**~707**

Source: American Community Survey S0102 ACS 5-Year Estimates Subject Tables

Older Adults Living with Alzheimer's Disease & Related Dementias

Alzheimer's disease and related dementias continue to present significant and growing challenges for older adults, caregivers, healthcare systems, and community-based service providers throughout Ohio and the AAA3 region.

According to estimates from the Alzheimer's Association, approximately 236,200 Ohio adults age 65 and older are currently living with Alzheimer's disease. As the population ages, the prevalence of dementia-related conditions is expected to continue increasing, resulting in greater need for caregiver supports, respite services, home and community-

based services, dementia-capable programming, healthcare coordination, and long-term care resources.

Needs assessment findings throughout the AAA3 region identified caregiver support, respite, dementia education, social isolation, and access to coordinated in-home supports as ongoing and emerging areas of concern that will require continued planning and resource development throughout the 2027–2030 planning cycle.

County	Share of 65+ population with Alzheimer's	Number of 65+ population with Alzheimer's
Allen	11.4%	2,200
Auglaize	10.8%	900
Hancock	10.6%	1,500
Hardin	NA	NA
Mercer	10.7%	800
Putnam	10.9%	700
Van Wert	10.8%	600

Source: Alzheimer's Association
https://stacker.com/stories/ohio/seniors-these-ohio-counties-have-highest-alzheimers-rates

Caregivers

Caregivers represent a growing and increasingly important population throughout the AAA3 region. Needs Assessment findings identified many individuals currently providing unpaid care and support to spouses, parents, adult children, relatives, neighbors, or friends with chronic health conditions, disabilities, or dementia-related illnesses.

Within the Consumer Needs Assessment Survey, approximately 51% of respondents reported currently providing care or assistance on a regular basis to a family member, friend, or neighbor due to age, disability, or chronic illness. Similarly, approximately 65% of respondents to the Community Needs Assessment Survey identified as currently providing some form of caregiving support.

Caregivers frequently reported challenges associated with emotional stress, burnout, financial strain, respite availability, transportation coordination, and navigating healthcare and long-term care systems. Findings reinforced the need for flexible caregiver supports, respite services, dementia education, peer support, and caregiver resource navigation throughout the PSA.

Older Adults at Risk for Institutional Placement

Several factors identified through the Needs Assessment process may increase risk for institutional placement among older adults throughout the PSA. These factors include chronic health conditions, dementia-related illnesses, caregiver burnout, transportation barriers, housing accessibility concerns, social isolation, limited informal supports, and financial instability.

AAA3 continues identifying individuals at risk for institutional placement through waiver programs, care coordination services, Adult Protective Services, hospital and nursing facility partnerships, transitions of care initiatives, and community referrals. Strategic planning efforts continue emphasizing home and community-based services designed to support independence and reduce unnecessary institutionalization.

Holocaust Survivors

While the identified population of Holocaust survivors within the PSA remains limited, AAA3 recognizes the importance of ensuring individuals are connected to appropriate services and supports. The agency will continue collaborating with community organizations, healthcare providers, and local partners to identify and support individuals who may require specialized outreach, assistance, or referral services.

Additional Priority & Emerging Population Trends

Older Adult Veterans

The AAA3 region is home to a significant veteran population, many of whom are older adults with unique healthcare, behavioral health, mobility, and social support needs. Based on American Community Survey estimates, Allen and Hancock counties report the largest concentrations of veterans age 60 and older within the PSA.

Needs Assessment survey findings additionally demonstrated notable veteran representation throughout the region. Within the Consumer Needs Assessment Survey, approximately 6% of respondents identified themselves as veterans. Similarly, approximately 9% of respondents to the Community Needs Assessment Survey identified as veterans, reinforcing the importance of continued coordination and outreach to veteran populations throughout the PSA.

As veterans age, many experience increased need for supportive services, transportation, chronic disease management, behavioral health supports, caregiver assistance, and access to coordinated long-term services and supports. Understanding the geographic

distribution of veterans across the PSA remains important in planning and coordinating aging and veteran-related services throughout the region.

	Allen	Auglaize	Hancock	Hardin	Mercer	Putnam	Van Wert
60+ Veterans	3,401	1,450	2,805	NA	1,249	853	925

Source: American Community Survey S0102 ACS 5-year Estimates Subject
Data unavailable for Hardin County

Minority Older Adult Populations

While the PSA population remains predominantly White/Caucasian, minority older adult populations continue to grow throughout portions of the region, particularly within larger population centers. Needs Assessment survey findings demonstrated increasing diversity among respondents throughout the PSA. Within the Community Needs Assessment Survey, approximately 9% of respondents identified as a racial or ethnic minority population, including individuals identifying as Black/African American (3%), Hispanic or Latino (1%), Native American or Pacific Islander (1%), or Other (3%). Similarly, approximately 22% of respondents to the Community Needs Assessment Survey identified as belonging to a minority racial or ethnic population – Black/African American (16%), Hispanic or Latino (2%), Native American or Pacific Islander (1%), or Other (3%).

These findings reinforce the importance of ensuring equitable outreach, culturally responsive services, and accessible supports for underserved populations throughout the region. Minority older adults may experience increased barriers related to healthcare access, transportation, economic stability, social support systems, and awareness of available aging services and community resources.

AAA3 will continue focusing outreach and service coordination efforts on reducing barriers to access, strengthening community partnerships, and improving awareness of available programs and supports among minority and underserved older adult populations throughout the PSA.

Older Adults Living Alone

Older adults living alone represent an important population within the AAA3 region due to increased risk for social isolation, food insecurity, healthcare access barriers, falls, and unmet support needs. Individuals living alone may also experience greater difficulty managing chronic health conditions, transportation needs, home maintenance, and activities of daily living without informal support systems.

Needs Assessment findings demonstrated a significant percentage of respondents throughout the PSA currently live alone. Within the Consumer Needs Assessment Survey, approximately 53% of respondents reported living alone, while approximately 49% of respondents to the Community Needs Assessment Survey also identified as living alone. These findings highlight the substantial number of older adults throughout the region who may be at increased risk for isolation, limited support networks, unmet daily living needs, and challenges safely aging in place.

Survey respondents and focus group participants frequently identified concerns related to social isolation, transportation access, maintaining independence within the home, and access to community-based supports. Participants additionally expressed strong interest in increased opportunities for socialization, congregate programming, wellness activities, transportation services, home-delivered meals, and in-home supports designed to help older adults safely and independently remain within their homes and communities.

These findings reinforced the importance of expanding outreach, social engagement opportunities, nutrition services, transportation coordination, wellness programming, and home and community-based supports throughout the region.

Transportation Barriers

Transportation barriers remain one of the most frequently identified service concerns throughout the PSA, particularly within rural communities and among individuals with disabilities or chronic health conditions. Needs Assessment findings identified challenges related to limited provider availability, scheduling restrictions, non-medical transportation access, travel distances, and affordability.

Survey findings further reinforced the significance of transportation-related concerns throughout the region. Within the Community Needs Assessment Survey, approximately 41% of respondents reported that transportation options within their community were either limited, difficult to access, or not adequate to meet the needs of older adults. Similarly, approximately 30% of respondents to the Consumer Needs Assessment Survey reported concerns related to limited or inadequate transportation options available within their communities.

Transportation limitations may contribute to missed medical appointments, reduced social engagement, food insecurity, and increased risk for isolation and institutionalization. These findings continue to guide regional priorities related to mobility management, transportation coordination, volunteer transportation models, and access to community-based supports throughout the PSA.

Social Isolation Indicators

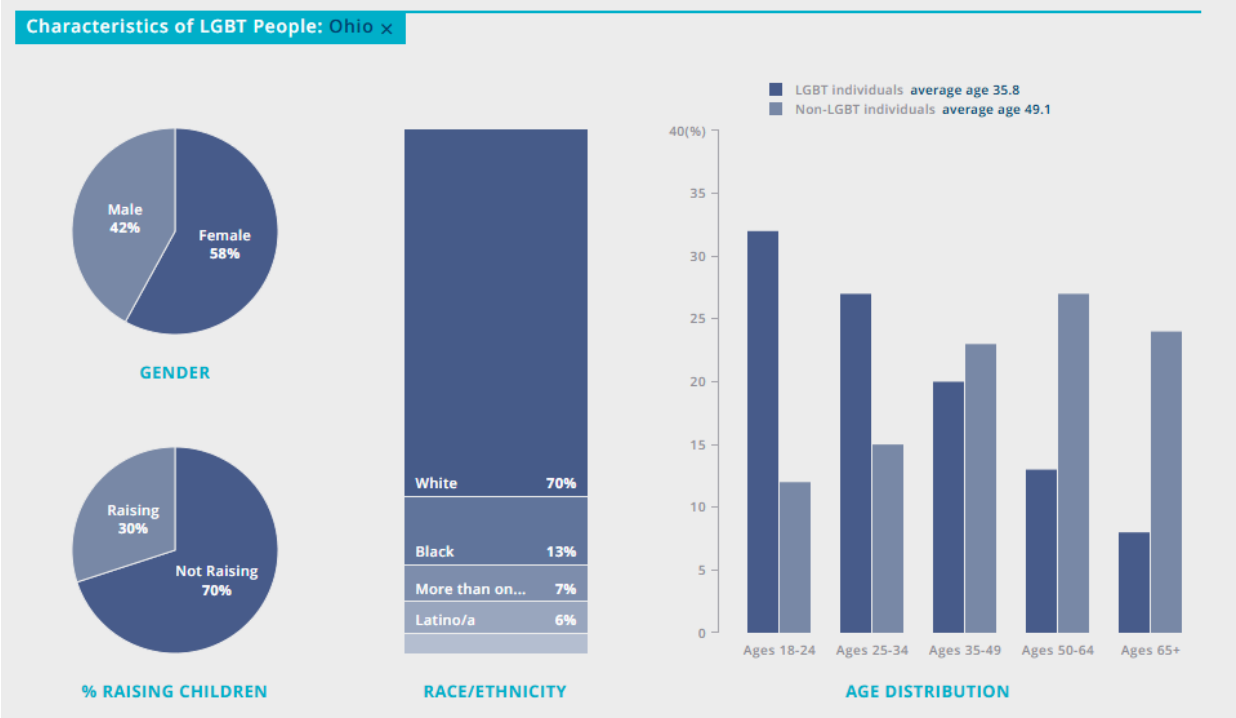
Social isolation and loneliness were identified as significant concerns throughout the Needs Assessment process. Older adults experiencing transportation barriers, chronic health conditions, caregiver responsibilities, limited family support, or residence within rural communities may face increased risk for isolation and reduced community engagement.

Participants expressed strong interest in socialization opportunities, wellness activities, volunteerism, technology assistance, lifelong learning, and congregate programming. These findings reinforced the importance of expanding community-based engagement opportunities and strengthening outreach efforts designed to improve social connection and overall well-being among older adults throughout the PSA.

LGBTQ+ Older Adults

Although comprehensive county-level data related to sexual orientation and gender identity remain limited, national estimates suggest that approximately 1.5–2.5% of adults age 65 and older identify as LGBTQ+. Applying these estimates to the AAA3 region suggests that approximately 1,300–1,400 LGBTQ+ older adults may reside within the PSA.

LGBTQ+ older adults may face unique challenges related to social isolation, discrimination, reduced family caregiving support, healthcare access, and concerns regarding inclusivity within healthcare and long-term care environments. Recognizing the experiences and needs of this population remains important in supporting equitable, person-centered, and inclusive aging services throughout the region.



Source: UCLA School of Law: Williams Institute https://williamsinstitute.law.ucla.edu/wp-content/uploads/OHIO-one-sheet.pdf?file_page=1&hlsentence=White%2071%%20LGBT%20SNAPSHOT%20OHIO%20RACE/ETHNICITY%20AGE%20DISTRIBUTION%20EDUCATION%20GENDER%20Male%20Female%20Raising%20Not%20Raising%2058%%2030%%2042%%2070%%20RAISING%20CHILDREN&hlword=ohio

V. Findings: Identified Service Needs & Gaps

AAA3's Needs Assessment process incorporated consumer surveys, community stakeholder surveys, and regional focus groups conducted throughout the seven-county planning and service area. Findings from these engagement activities revealed several consistent themes related to the needs, concerns, and priorities of older adults, caregivers, and community stakeholders across the region. Collectively, the data highlighted increasing concerns related to affordability, transportation access, caregiver burden, housing stability, chronic health conditions, social isolation, and difficulty navigating available services and supports.

The findings outlined below directly informed the development of the agency's 2027–2030 Strategic Area Plan goals, objectives, and priority strategies.

Financial Stability, Housing, & Basic Needs

Financial strain emerged as one of the most significant themes throughout the Needs Assessment process. Participants consistently described challenges associated with rising costs for housing, utilities, groceries, transportation, medications, insurance

premiums, and healthcare services. Focus group participants specifically identified affordable housing, inflation, and financial stability as major concerns impacting older adults' ability to remain independent within the community.

Survey findings reinforced these concerns. Within the Consumer Needs Assessment Survey, approximately 46% of respondents reported that housing costs created at least some level of financial strain, including 5% who indicated their housing costs exceeded what they could afford. Similarly, approximately 28% of respondents to the Community Needs Assessment Survey reported housing-related financial strain or inability to afford housing costs without sacrificing other basic needs.

Respondents additionally identified prescription costs, insurance limitations, and lack of dental and vision coverage as barriers to receiving needed care. Food affordability and nutrition access also emerged as ongoing concerns throughout both surveys and focus groups. Participants discussed increasing grocery costs, limited access to healthy foods in some communities, and the importance of reliable nutrition supports for older adults experiencing mobility or financial limitations. Respondents expressed strong interest in home-delivered meals, congregate dining opportunities, and programs that support both nutrition and social connection.

Housing-related concerns were also frequently identified throughout the assessment process. While many respondents indicated their housing generally met their needs, others identified concerns related to affordability, accessibility, safety, and home maintenance. Participants specifically identified the need for ramps, railings, bathroom modifications, lighting improvements, structural repairs, and accessibility modifications that support aging in place.

Collectively, these findings highlighted the continued need for:

- Benefits enrollment and financial wellness supports
- Affordable and accessible housing options
- Home repair and modification assistance
- Nutrition and food access programs
- Services that support aging in place and long-term independence

Transportation, Healthcare Access, & Wellness

Transportation access remained a significant concern, particularly within rural communities and among individuals with disabilities or chronic health conditions. While

many respondents reported transportation options were available, others described services as limited, difficult to coordinate, or unavailable when needed.

Participants identified barriers including advance scheduling requirements, limited provider availability, lack of non-medical transportation, and difficulty accessing transportation for errands, grocery shopping, and social activities. Focus group participants emphasized the importance of transportation in maintaining healthcare access, independence, and social connection.

The assessment findings also reflected the significant impact of chronic health conditions on older adults throughout the region. Respondents frequently identified arthritis, hypertension, heart disease, diabetes, COPD, dementia-related conditions, hearing loss, and physical disabilities. Participants additionally identified concerns related to falls, healthcare affordability, access to specialists, dental and vision services, and management of chronic conditions.

Survey respondents demonstrated strong interest in exercise programs, wellness activities, falls prevention, health screenings, home modifications, and chronic disease management supports.

These findings demonstrated continued need for:

- Expanded transportation coordination and mobility supports
- Flexible transportation models, including non-medical transportation
- Preventative health and wellness programming
- Chronic disease management and falls prevention initiatives
- Coordinated healthcare navigation and support services

Social Connection, Mental Well-Being, & Community Engagement

Social isolation and loneliness emerged as important concerns across multiple engagement methods. Participants expressed interest in additional opportunities for socialization, lifelong learning, volunteerism, exercise, arts and crafts, group outings, and community engagement activities.

Survey findings additionally highlighted the importance of mental well-being and social connection among older adults throughout the PSA. Within the Community Needs Assessment Survey, only 26% of respondents rated their overall mental health as “Excellent,” while 16% rated their mental health as either “Fair” or “Poor.” Similarly, among respondents currently receiving AAA3 services through the Consumer Needs Assessment Survey, only 23% rated their mental health as “Excellent,” while approximately 23% rated their mental health as “Fair” or “Poor.” These findings reinforce the importance of

continued focus on social connection, wellness programming, behavioral health awareness, and community engagement opportunities throughout the region.

Focus group participants emphasized the importance of accessible and affordable social programming, particularly in rural communities where opportunities may be more limited. Respondents additionally identified transportation limitations, health conditions, and financial barriers as factors impacting their ability to participate in community activities. Participants further identified interest in technology assistance and digital literacy supports to help maintain communication, access information, and reduce social isolation.

Collectively, these findings highlighted the need for:

- Expanded community-based social and recreational opportunities
- Programs that promote mental well-being and social connection
- Technology assistance and digital literacy supports
- Volunteer and intergenerational engagement opportunities
- Outreach to isolated and vulnerable older adults

Caregiver Supports & Dementia-Related Needs

Caregiver burden was consistently identified throughout the Needs Assessment process. Many respondents reported providing care to spouses, parents, adult children, neighbors, or friends with chronic health conditions, disabilities, or dementia-related illnesses.

Caregivers identified respite care, in-home support, transportation assistance, dementia education, financial assistance, and help navigating available services as major areas of need. Focus group discussions reinforced the growing demand for flexible and accessible caregiver supports throughout the region.

Participants additionally expressed concerns related to Alzheimer's disease, dementia, memory loss, caregiver stress, and the increasing difficulty associated with supporting loved ones with complex medical and cognitive conditions.

Findings demonstrated continued need for:

- Respite and caregiver relief services
- Dementia education and caregiver training
- In-home support and caregiver assistance programs
- Caregiver peer support and counseling resources
- Improved navigation and coordination of caregiver services

Service Awareness, Outreach, & Navigation

Participants across all engagement methods identified ongoing confusion regarding available programs, eligibility requirements, and where to seek assistance. Respondents expressed a desire for clearer communication, centralized information resources, printed materials, and in-person assistance navigating available services and benefits.

The findings reinforced the importance of strengthening outreach efforts, enhancing service coordination, and maintaining the Aging and Disability Resource Center (ADRC) "No Wrong Door" approach to improve access to information and supports.

These findings highlighted the need for:

- Increased outreach and public awareness efforts
- Simplified access to information and services
- Expanded benefits enrollment and navigation assistance
- Improved coordination among aging, healthcare, and community providers
- Continued development of person-centered, community-based resource systems

Overall Findings & Strategic Planning Implications

Overall, the Needs Assessment findings demonstrated that older adults and caregivers within the AAA3 region desire to remain healthy, safe, connected, and independent within their homes and communities for as long as possible. However, growing financial pressures, healthcare challenges, transportation barriers, housing limitations, caregiver strain, and social isolation continue to impact quality of life and long-term independence for many residents.

These findings directly informed the development of AAA3's 2027–2030 Strategic Area Plan priorities, goals, objectives, and strategies by identifying the most significant service gaps, emerging trends, and areas of unmet need across the region. The resulting plan prioritizes coordinated, community-based, person-centered approaches that strengthen independence, improve access to essential services, support caregivers, and enhance overall quality of life for older adults throughout the planning and service area.

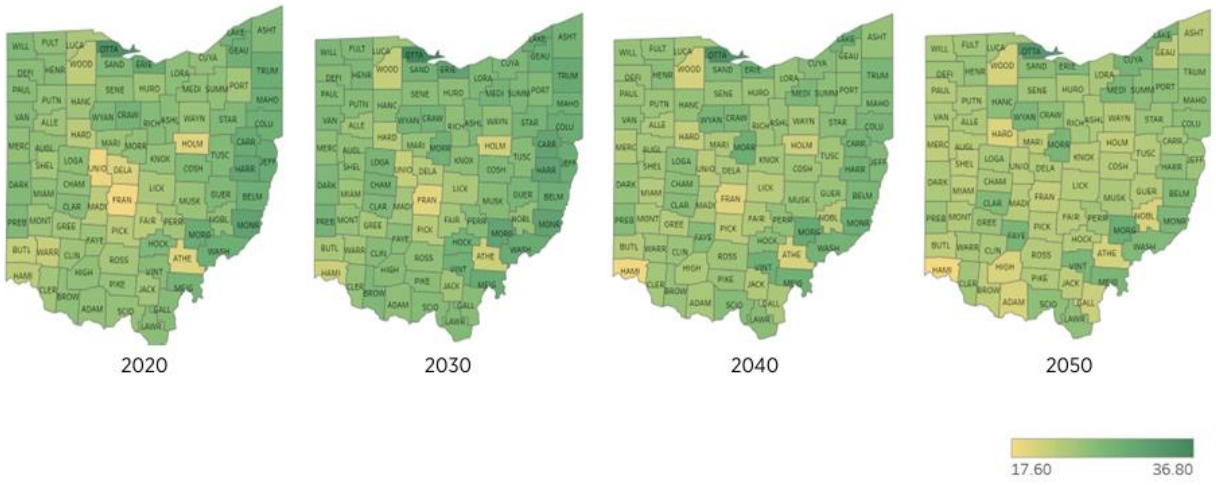
VI. Analysis of Future Population Trends & System Readiness

Demographic projections indicate that the Area Agency on Aging 3 Planning and Service Area (PSA) will continue to experience significant aging-related population shifts over the coming decades. The AAA3 region, consisting of Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, and Van Wert counties, reflects broader statewide trends associated with

population aging, increasing longevity, and growing demand for long-term services and supports.

Data from the Scripps Gerontology Center at Miami University and the Ohio Department of Development indicate that Ohio's population age 60 and older will continue to grow substantially through 2050, while many counties throughout the state — particularly rural and noncore counties — are projected to experience overall population decline or stagnant growth. By 2030, more than one in four Ohioans is projected to be age 60 or older.

The Percentage Ohio's Population that is 60 or Older: 2020-2050



Ohio-Population.org

MIAMI UNIVERSITY | SCRIPPS GERONTOLOGY CENTER

Ohio's Total Population			
2020	2030	2040	2050
11,799,448	11,694,767	11,425,531	11,123,896

Data Source: Ohio Department of Development, Office of Research

Several counties within the AAA3 region already reflect disproportionately older population trends compared to statewide averages. Scripps population profiles and county-level projections demonstrate continued growth in the proportion of adults age 65 and older throughout northwest and west central Ohio, particularly within rural communities where aging populations, shrinking household sizes, and caregiver shortages are expected to intensify over time.

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Ohio-Population.org
Data Source: Ohio Department of Development, Office of Research

2020	Total Pop, 2020	60+ Pop, 2020	60+ Pop %, 2020	65+ Pop, 2020	65+ Pop %, 2020	65+ Pop % Rank, 2020	85+ Pop, 2020	85+ Pop %, 2020	85+ Pop % Rank, 2020	85+ % of 65+, 2020	Rank of 85+/65+ %, 2020
Allen	102,206	25,251	24.7	18,290	17.9	61	2,232	2.2	33	12.2	14
Auglaize	46,422	11,929	25.7	8,632	18.6	40	1,070	2.3	26	12.4	11
Hancock	74,920	18,302	24.4	13,186	17.6	64	1,501	2.0	49	11.4	34
Hardin	30,696	6,845	22.3	4,929	16.1	76	499	1.6	75	10.1	64
Mercer	42,528	10,834	25.5	7,765	18.3	51	1,005	2.4	20	12.9	5
Putnam	34,451	8,692	25.2	6,122	17.8	63	785	2.3	27	12.8	7
Van Wert	28,931	7,628	26.4	5,568	19.2	30	693	2.4	18	12.4	8

2030	Total Pop, 2030	60+ Pop, 2030	60+ Pop %, 2030	65+ Pop, 2030	65+ Pop %, 2030	65+ Pop % Rank, 2030	85+ Pop, 2030	85+ Pop %, 2030	85+ Pop Rank, 2030	85+ % of 65+, 2030	Rank of 85+/65+ %, 2030
Allen	96,098	23,548	24.5	18,512	19.3	69	1,656	1.7	62	8.9	63
Auglaize	44,956	11,579	25.8	9,038	20.1	62	714	1.6	71	7.9	79
Hancock	72,393	18,824	26.0	14,671	20.3	58	1,452	2.0	50	9.9	42
Hardin	28,887	6,575	22.8	5,003	17.3	80	427	1.5	77	8.5	71
Mercer	42,871	11,055	25.8	8,772	20.5	52	876	2.0	47	10.0	40
Putnam	33,175	8,859	26.7	6,995	21.1	40	624	1.9	57	8.9	64
Van Wert	27,773	7,564	27.2	6,014	21.7	30	705	2.5	12	11.7	6

2040	Total Pop, 2040	60+ Pop, 2040	60+ Pop %, 2040	65+ Pop, 2040	65+ Pop %, 2040	65+ Pop Rank, 2040	85+ Pop, 2040	85+ Pop %, 2040	85+ Pop Rank, 2040	85+/65+%, 2040	Rank of 85+/65+ %, 2040
Allen	88,791	20,633	23.2	15,779	17.8	75	1,848	2.1	67	11.7	65
Auglaize	43,154	10,331	23.9	8,067	18.7	63	835	1.9	73	10.4	73
Hancock	67,936	17,223	25.4	13,566	20.0	42	1,701	2.5	49	12.5	54
Hardin	27,115	5,865	21.6	4,482	16.5	82	455	1.7	80	10.2	76
Mercer	42,214	9,763	23.1	7,807	18.5	69	1,078	2.6	45	13.8	28
Putnam	31,341	7,773	24.8	6,146	19.6	49	733	2.3	56	11.9	63
Van Wert	26,562	6,777	25.5	5,308	20.0	41	791	3.0	19	14.9	11

2050	Total Pop, 2050	60+ Pop, 2050	60+ Pop %, 2050	65+ Pop, 2050	65+ Pop %, 2050	65+ Pop Rank, 2050	85+ Pop, 2050	85+ Pop %, 2050	85+ Pop Rank, 2050	85+ % of 65+, 2050	Rank of 85+/65+ %, 2050
Allen	81,503	18,911	23.2	14,127	17.3	63	1,864	2.3	72	13.2	69
Auglaize	41,386	9,302	22.5	7,088	17.1	66	895	2.2	74	12.6	74
Hancock	63,066	16,414	26.0	12,265	19.4	26	1,866	3.0	38	15.2	50
Hardin	25,409	4,993	19.7	3,887	15.3	84	466	1.8	82	12.0	76
Mercer	41,766	9,093	21.8	6,957	16.7	73	1,185	2.8	44	17.0	25
Putnam	29,668	6,948	23.4	5,356	18.1	46	838	2.8	46	15.6	41
Van Wert	25,440	5,893	23.2	4,678	18.4	38	829	3.3	23	17.7	19

In addition to overall aging trends, the region is expected to experience continued growth in the number of adults age 85 and older — a population group more likely to require assistance with activities of daily living, chronic disease management, dementia-related supports, transportation, caregiving assistance, and long-term services and supports. Scripps research further indicates that increasing rates of disability and chronic health conditions among older adults will place additional strain on healthcare systems, caregivers, housing resources, and community-based aging services throughout Ohio over the coming decades.

These projected demographic shifts are particularly significant for the AAA3 region given the findings identified through the agency's Needs Assessment process, including:

- Increasing caregiver burden
- Transportation and mobility barriers
- Growing demand for home and community-based services
- Concerns related to housing affordability and accessibility

- Rising rates of chronic disease and fall risk
- Social isolation and limited access to services in rural communities
- Difficulty navigating healthcare, benefits, and long-term care systems

Rural communities throughout the PSA may experience disproportionate impacts due to limited provider networks, healthcare workforce shortages, transportation challenges, reduced broadband access, and fewer available supportive services. These factors may increase risk for institutionalization, caregiver burnout, unmet health needs, and social isolation among older adults residing in underserved areas.

The aging of the region's population is expected to increase demand for:

- Home and community-based services
- Dementia-capable systems and caregiver supports
- Transportation and mobility assistance
- Home modification and accessibility programs
- Chronic disease management and falls prevention services
- Nutrition and wellness programming
- Benefits enrollment and care navigation assistance
- Social engagement and behavioral health supports

At the same time, projected workforce limitations and declining availability of both formal and informal caregivers may create additional strain on aging and healthcare systems throughout the region. These trends reinforce the importance of strategic planning, regional collaboration, volunteer engagement, and innovative service delivery models designed to support aging in place and reduce unnecessary institutionalization.

Needs Assessment findings further demonstrated that older adults throughout the AAA3 region overwhelmingly desire to remain healthy, independent, and connected within their homes and communities for as long as possible. As a result, the 2027–2030 Strategic Area Plan prioritizes strengthening person-centered, community-based supports that promote independence, improve service coordination, expand caregiver capacity, and enhance access to essential services across the region.

To address anticipated future demands, AAA3 will continue focusing on system readiness efforts that include strengthening community partnerships, enhancing outreach and navigation services, leveraging technology and innovative service models, expanding caregiver and volunteer supports, promoting age-friendly and dementia-capable communities, and improving access to services within rural and underserved areas. These efforts are intended to better position the regional aging network to respond to changing

demographics and the increasing complexity of older adult needs throughout the coming decade.

VII. Information & Referral (I&R) Survey Results

As part of the 2027–2030 Strategic Area Plan development process, Area Agency on Aging 3 conducted an Information and Referral (I&R) provider survey to assess the availability, accessibility, and scope of I&R and navigation services throughout the Planning and Service Area (PSA).

Survey findings demonstrated that participating organizations provide a wide variety of information, referral, navigation, and supportive services throughout the region, including benefits assistance, transportation, housing assistance, caregiver support, food assistance, mental health services, home modifications, financial assistance, respite care, and Adult Protective Services supports. Most respondents identified their services as elderly-specific in scope.

Survey respondents additionally reported that services are generally accessible through local and toll-free phone numbers, websites, electronic communication, and in-person assistance. It is important to note that survey participation represented only a limited sample of organizations within the PSA and does not fully represent the total availability of I&R-related services throughout the region.

AAA3 primarily functions as the region's Aging and Disability Resource Center (ADRC) and centralized "No Wrong Door" access point, connecting individuals with appropriate local providers, community resources, benefits programs, and supportive services rather than maintaining a standalone I&R provider database or utilizing Title III funding to establish separate I&R provider entities. The agency has additionally received funding through the National Council on Aging to serve as the region's Benefits Enrollment Center (BEC), further strengthening the agency's ADRC infrastructure and navigation services throughout the PSA.

While the survey did not identify unmet needs requiring establishment of additional standalone I&R providers within the PSA, findings from the broader Needs Assessment process reinforced ongoing needs related to service awareness, outreach, navigation of complex healthcare and benefits systems, rural access barriers, and coordination among providers.

AAA3 will continue addressing these needs through coordination with local providers and continued operation of the regional ADRC utilizing a "No Wrong Door" approach. Planned activities include strengthening provider partnerships, enhancing outreach and public

awareness efforts, expanding benefits enrollment and navigation assistance, and continuing advocacy efforts supporting ADRC and aging network front door infrastructure.

AAA3 will continue serving as the region's centralized ADRC and primary navigation hub while collaborating with local providers and community organizations to strengthen and maintain access to information and referral services throughout the PSA.

At this time, AAA3 does not utilize Older Americans Act Title III funding for the establishment of standalone I&R provider entities. Available Title III funding is primarily utilized to support the provision of direct services to older adults throughout the PSA.

VIII. Targeted Outreach Plan

Area Agency on Aging 3 will continue utilizing a comprehensive and community-based outreach strategy designed to identify and inform eligible individuals and caregivers of available programs, services, and supports throughout the seven-county Planning and Service Area (PSA). Outreach activities are guided by findings from the agency's Needs Assessment process and place special emphasis on older adults residing in rural areas, individuals with greatest economic and social need, individuals with disabilities, caregivers, and other priority populations identified under the Older Americans Act.

AAA3 primarily operates as the region's Aging and Disability Resource Center (ADRC) and centralized access point providing information, referral, benefits enrollment assistance, options counseling, and linkage to supportive services through phone, in-person, electronic, and community-based outreach methods. The agency additionally serves as the region's Benefits Enrollment Center (BEC) through funding received from the National Council on Aging, strengthening the agency's ability to assist older adults with benefits access and navigation of complex healthcare and public benefit systems.

Outreach efforts will continue through:

- Community presentations, health fairs, resource fairs, and outreach events
- Partnerships with Councils on Aging, senior centers, healthcare providers, libraries, housing complexes, and community organizations
- Social media, electronic newsletters, television, radio, newspapers, and printed outreach materials
- Collaboration with hospitals, nursing facilities, behavioral health providers, and local social service agencies
- Participation in community coalitions and partnership meetings throughout the PSA

- Direct outreach conducted by ADRC staff, care coordinators, case managers, and program staff

AAA3 will utilize the following strategies to identify eligible individuals and inform targeted populations and caregivers of available services and supports:

Older adults residing in rural areas:
Outreach will continue through partnerships with rural senior centers, Councils on Aging, libraries, healthcare providers, food distribution sites, housing complexes, and community organizations. Outreach efforts will include in-person events, printed materials, local media, social media, and ADRC navigation assistance designed to address transportation, healthcare access, and social isolation barriers common within rural communities.

Older adults with greatest economic and social need:
AAA3 will continue targeting outreach efforts toward low-income older adults, individuals residing in subsidized housing, individuals experiencing food insecurity, and underserved populations through benefits enrollment assistance, nutrition programs, outreach events, and collaboration with housing, behavioral health, and social service providers.

Older adults with severe disabilities:
Individuals with severe disabilities will continue to be identified through waiver programs, HOME Choice, care coordination services, healthcare partnerships, and referrals from community providers. Outreach efforts will focus on increasing awareness of home and community-based services designed to support independence and reduce institutionalization risk.

Older adults with limited English proficiency:
AAA3 will continue providing access to interpreter and translation services and will make outreach materials available in alternative languages and formats as feasible and appropriate.

Older adults with Alzheimer's disease and related dementias and their caregivers:
Outreach and education efforts will continue through partnerships with the Alzheimer's Association, memory care providers, dementia coalitions, healthcare providers, and caregiver support programs. Efforts will focus on dementia education, respite awareness, caregiver supports, and dementia-capable community resources.

AAA3 will additionally continue leveraging Trualta, an online caregiver education and support platform designed to provide caregivers with on-demand training, coaching, support groups, educational resources, and skill-building tools related to caregiving, dementia care, behavioral health, safety, and activities of daily living. The platform provides caregivers with flexible and accessible support opportunities intended to reduce caregiver stress, increase confidence and preparedness, and improve overall caregiver and care recipient outcomes.

Utilization and outcome data associated with Trualta have demonstrated strong engagement and quantifiable health-related outcomes among caregivers served within the region, including increased caregiver knowledge, reduced stress and burnout, and improved ability to safely support individuals living with Alzheimer's disease and related dementias within the community. AAA3 will continue utilizing Trualta as a key component of its caregiver support and dementia-capable outreach strategy throughout the 2027–2030 planning cycle.

Older adults at risk for institutional placement, including Holocaust survivors: Individuals at risk for institutional placement will continue to be identified through care coordination activities, waiver programs, hospital and nursing facility partnerships, Adult Protective Services referrals, and transitions of care initiatives. While the identified Holocaust survivor population within the PSA remains limited, AAA3 will continue collaborating with community partners to ensure individuals are connected to available services and supports as needed.

Informing individuals and caregivers of available assistance:
AAA3 will continue informing individuals and caregivers of available services through ADRC navigation, benefits enrollment assistance, outreach events, social media, traditional media outlets, community presentations, provider partnerships, printed materials, and direct person-centered assistance provided by agency staff.

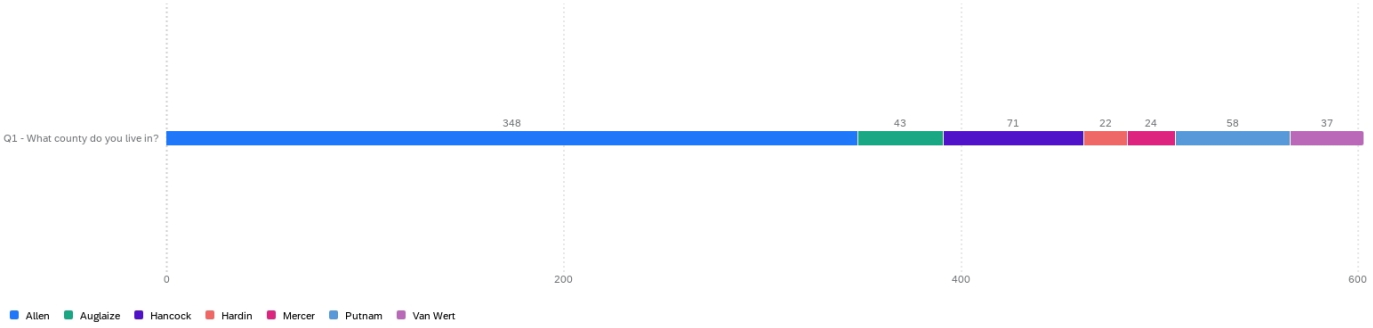
Through these ongoing outreach and engagement efforts, AAA3 will continue working to improve awareness of available services, strengthen access to community-based supports, and ensure priority populations throughout the PSA are informed of and connected to available resources and assistance.

IX. Appendices

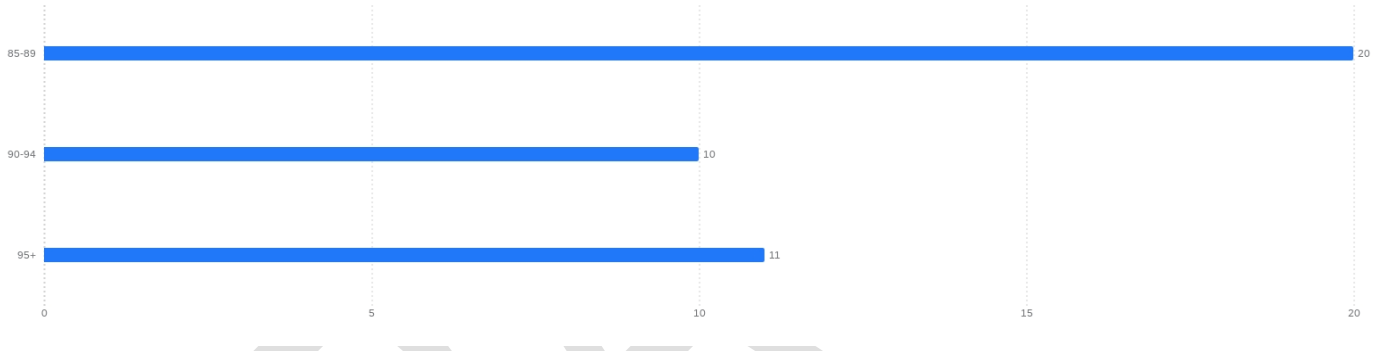
F. Consumer Needs Assessment Survey Results
G. Community Needs Assessment Survey Results
H. Summary of Focus Group Sessions
I. Information and Referral Survey Results

Consumer Needs Assessment Survey Results

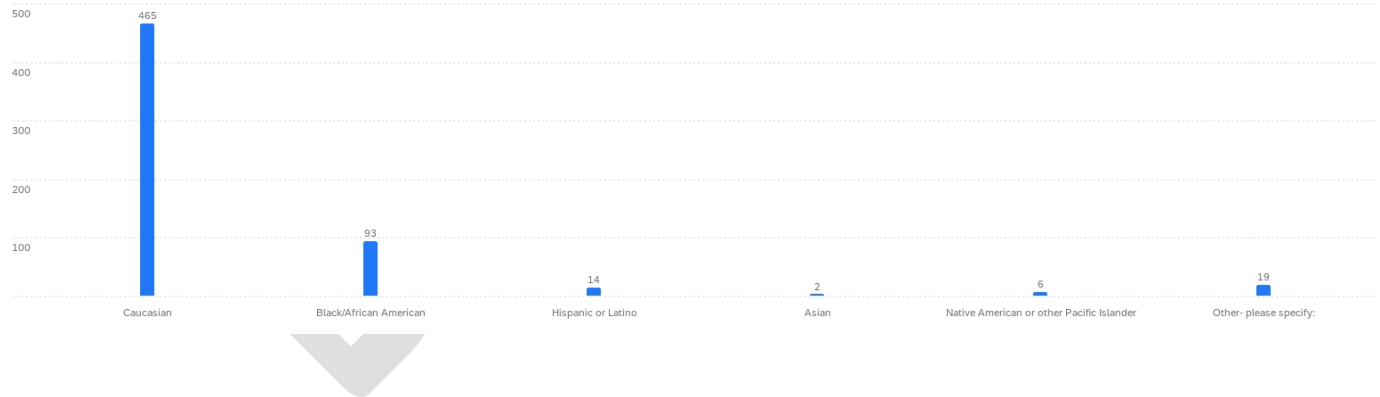
What county do you live in? 603



What age range do you fall in? 41



Which of the following would you say is your race? 599



Which of the following would you say is your race? 599

Q3 - Which of the following would you say is your race? - Selected Choice	Count	Count
Caucasian	78%	465
Black/African American	16%	93
Hispanic or Latino	2%	14
Asian	0%	2
Native American or other Pacific Islander	1%	6
Other- please specify:	3%	19

Which of the following would you say is your race?: Other- please specify: - Text 14

Other- please specify:

Caucasian and American Indian

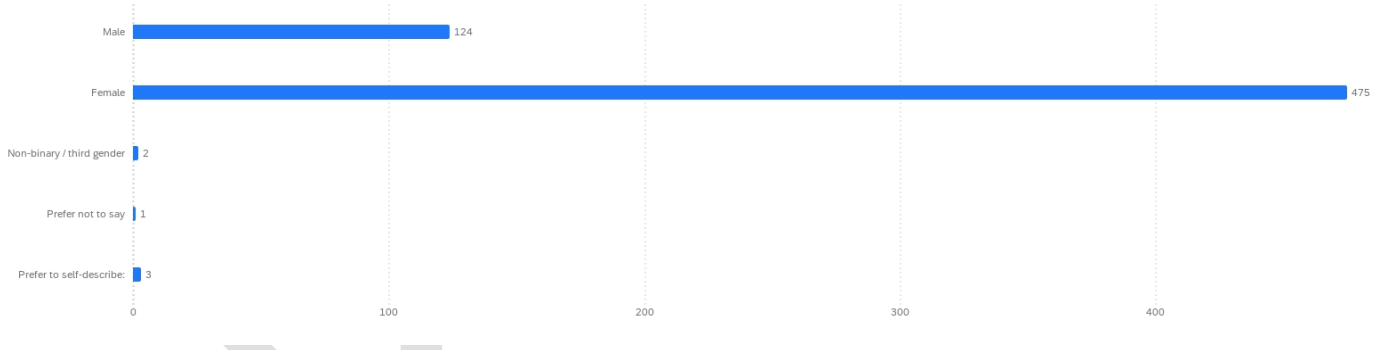
White

White/ Mexican

TEST

Human race

What is your gender? 605



What is your gender? 605

Q4 - What is your gender? - Selected Choice	Count	Count
Male	20%	124
Female	79%	475
Non-binary / third gender	0%	2
Prefer not to say	0%	1
Prefer to self-describe:	0%	3

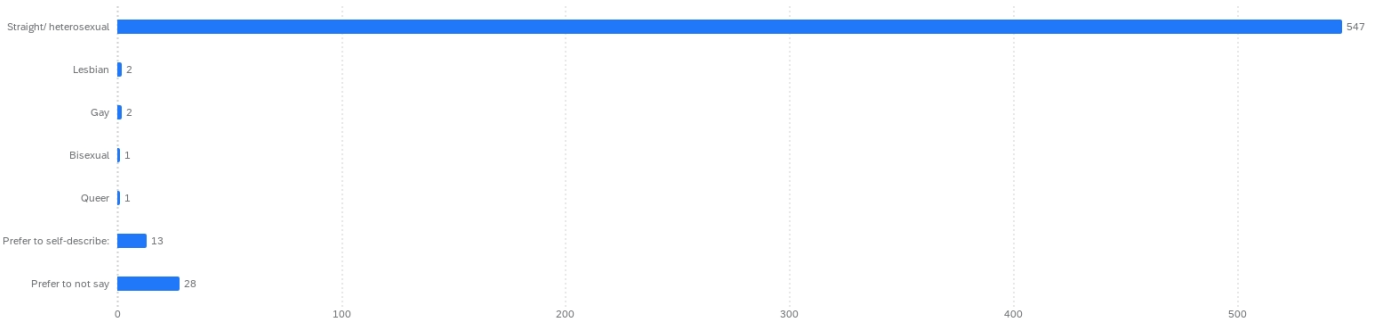
What is your gender?: Prefer to self-describe: - Text 2

Prefer to self-describe:

TEST

My SEX is male

Do you identify as: 594



Do you identify as: 594

Q5 - Do you identify as: - Selected Choice	Count	Count
Straight/ heterosexual	92%	547
Lesbian	0%	2
Gay	0%	2
Bisexual	0%	1
Queer	0%	1
Prefer to self-describe:	2%	13
Prefer to not say	5%	28

Do you identify as:: Prefer to self-describe: - Text 9

Prefer to self-describe:

Normal

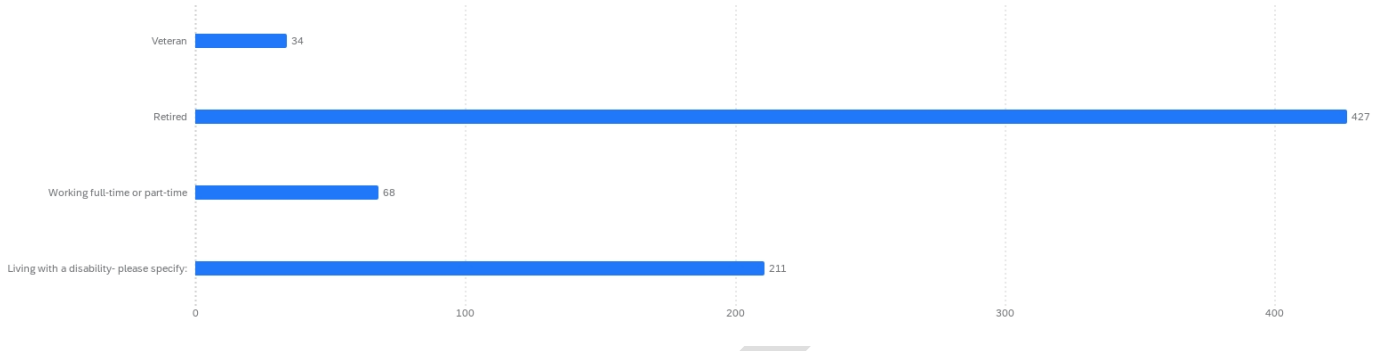
TEST

I see that DEI is alive and well in this organization

Myself

Play and sex with females, play with males.

Which of the following applies to you? (Check all that apply) 595



Which of the following applies to you? (Check all that apply) 595

Q6 - Which of the following applies to you? (Check all that apply) - Selected Choice	Count	Count
Veteran	6%	34
Retired	72%	427
Working full-time or part-time	11%	68
Living with a disability- please specify:	35%	211

Which of the following applies to you? (Check all that apply): Living with a disability- please specify: - Text 175

Living with a disability- please specify:

Degenerative disk, heart condition, PA and RA

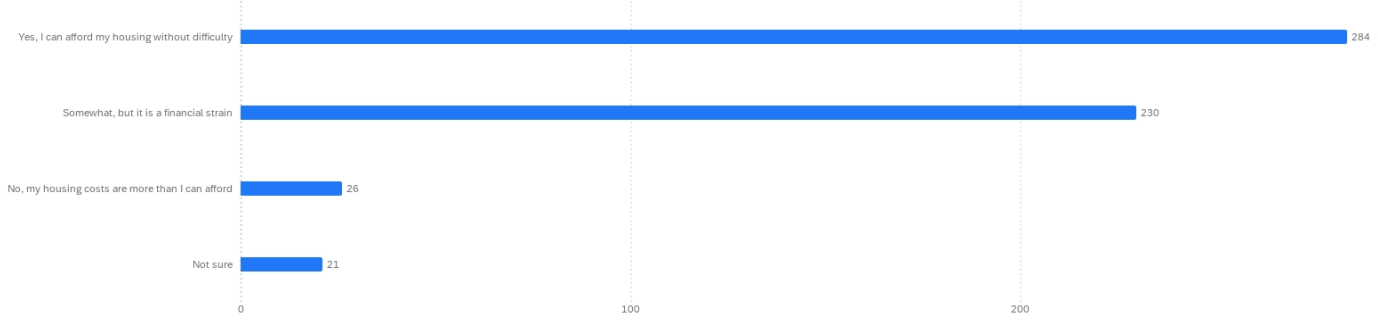
Parkinson

99% immobile, in great need of aid/help/assistance of any kind.

Heart, Kidney and Acute Intermittent porphyria

Bad knees

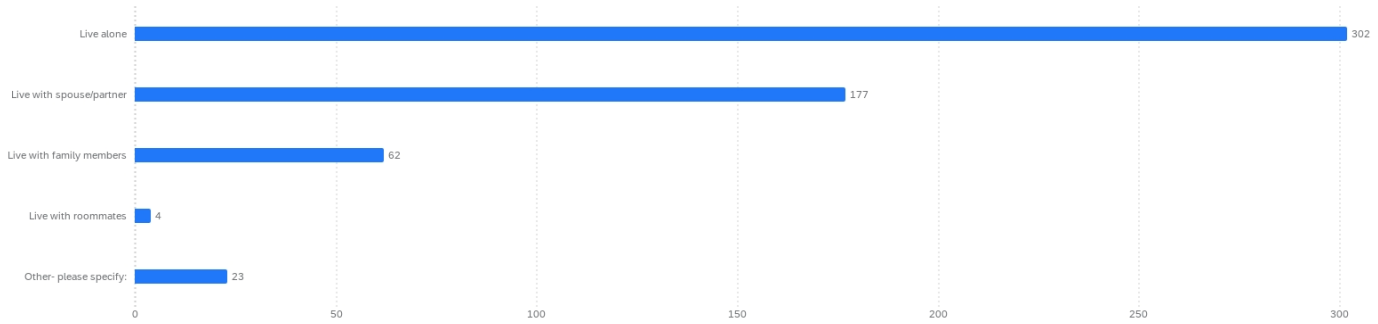
Are you able to afford your current housing (including rent or mortgage, utilities, and maintenance) without having to sacrifice other basic needs (such as food, medication, or transportation)? 561



Are you able to afford your current housing (including rent or mortgage, utilities, and maintenance) without having to sacrifice other basic needs (such as food, medication, or transportation)? 561

Q7 - Are you able to afford your current housing (including rent or mortgage, utilities, and maintenance) without having to sacrifice other basic needs (such as food, medication, or transportation)?	Count	Count
Yes, I can afford my housing without difficulty	51%	284
Somewhat, but it is a financial strain	41%	230
No, my housing costs are more than I can afford	5%	26
Not sure	4%	21

Which best describes your current living arrangements? 568



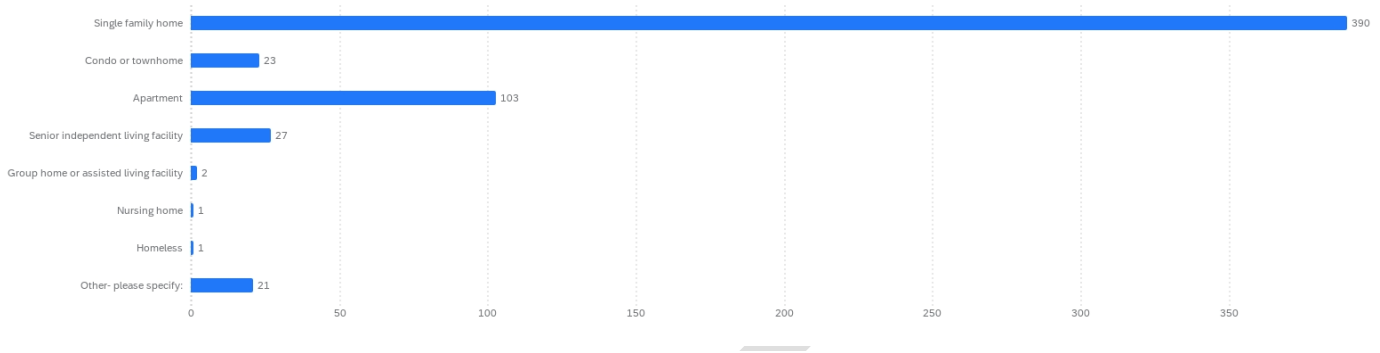
Which best describes your current living arrangements? 568

Q8 - Which best describes your current living arrangements? - Selected Choice	Count	Count
Live alone	53%	302
Live with spouse/partner	31%	177
Live with family members	11%	62
Live with roommates	1%	4
Other- please specify:	4%	23

Which best describes your current living arrangements?: Other- please specify: - Text 20

Other- please specify:
Son and daughter in law
Have dog
Son stays some time
Taking care of my handicapped grandson
Live and caretaker of my 42 yr old paraplegic son and raising his 4 kids

Which best describes your residence? 568



Which best describes your residence? 568

Q9 - Which best describes your residence? - Selected Choice	Count	Count
Single family home	69%	390
Condo or townhome	4%	23
Apartment	18%	103
Senior independent living facility	5%	27
Group home or assisted living facility	0%	2
Nursing home	0%	1
Homeless	0%	1

Which best describes your residence?: Other- please specify: - Text 21

Other- please specify:

Duplex

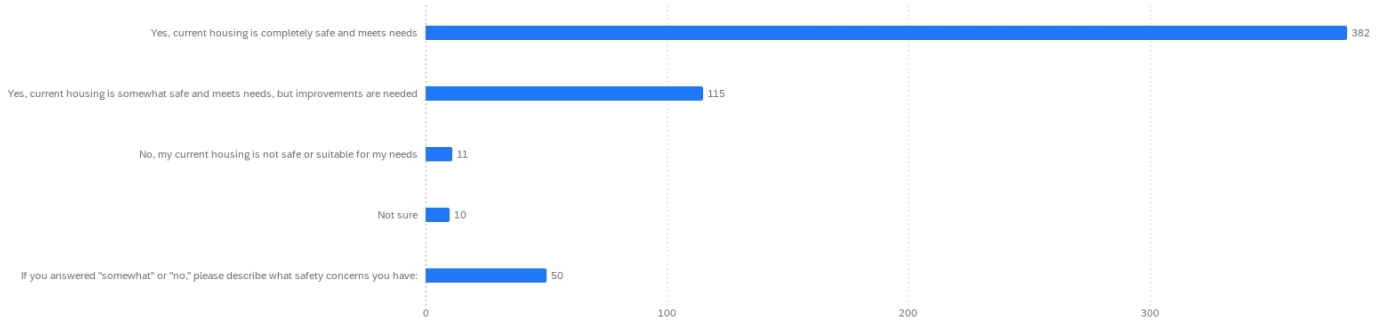
Trailer

House Trailer

Mobile Home

Hud Housing

Do you feel that your current housing is safe and meets your physical needs... 568



Do you feel that your current housing is safe and meets your physical needs... 568

Q10 - Do you feel that your current housing is safe and meets your physical needs (accessibility, easy to navigate, lighting, absence of hazards such as loose rugs or stairs without railings)? - Selected Choice	Count	Count
Yes, current housing is completely safe and meets needs	67%	382
Yes, current housing is somewhat safe and meets needs, but improvements are needed	20%	115
No, my current housing is not safe or suitable for my needs	2%	11
Not sure	2%	10
If you answered "somewhat" or "no," please describe what safety concerns you have:	9%	50

Do you feel that your current housing is safe and meets your physical needs...: If you answered "somewhat" or "no," please describe what safety concerns you have: - Text 50

If you answered "somewhat" or "no," please describe what safety concerns yo...

When I had windows installed in 2011 the contractor never put insulation around the frames. Therefore my home is very cold in the winter and does not hold air conditioning well.

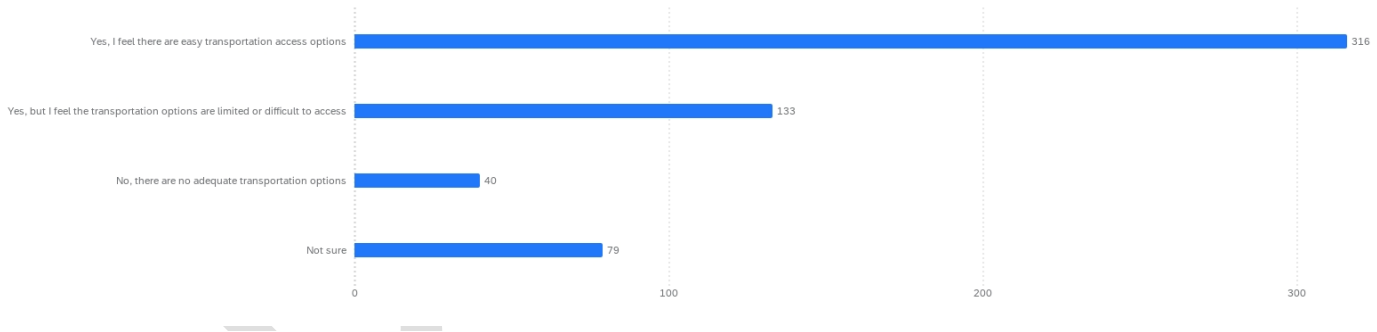
Doorways too small, too many stairs. Not wheelchair accessible.

Too many steps. Just not proper due care and caution.

I need central air, my refrigerator isn't working properly and I have to pay someone to mow my grass

Front steps have no hand rails and bottom step is falling apart

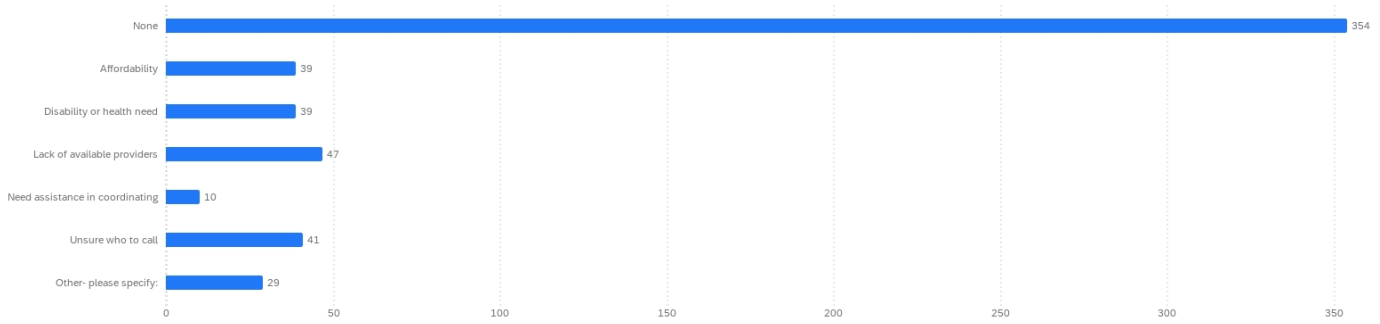
Are there adequate transportation options available in your community (buses, shuttles, taxis, or rideshare services) for older adults to access essential services in your community? (grocery stores, restaurants, pharmacies, banks)? 568



Are there adequate transportation options available in your community (buses, shuttles, taxis, or rideshare services) for older adults to access essential services in your community? (grocery stores, restaurants, pharmacies, banks)? 568

Q11 - Are there adequate transportation options available in your community (buses, shuttles, taxis, or rideshare services) for older adults to access essential services in your community? (grocery stores, restaurants, pharmacies, banks)?	Count	Count
Yes, I feel there are easy transportation access options	56%	316
Yes, but I feel the transportation options are limited or difficult to access	23%	133
No, there are no adequate transportation options	7%	40
Not sure	14%	79

What barriers do you experience to secure the transportation you need? 559



What barriers do you experience to secure the transportation you need? 559

Q12 - What barriers do you experience to secure the transportation you need? - Selected Choice	Count	Count
None	63%	354
Affordability	7%	39
Disability or health need	7%	39
Lack of available providers	8%	47
Need assistance in coordinating	2%	10
Unsure who to call	7%	41
Other- please specify:	5%	29

What barriers do you experience to secure the transportation you need?: Other- please specify: - Text 28

Other- please specify:

Payment for, and whom do I call/trust?

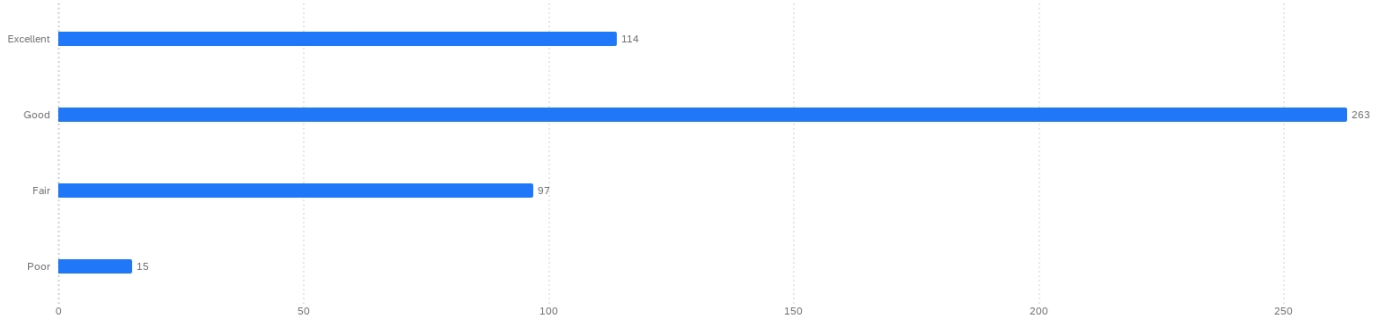
Taxis/Lyft costs too much for a senior to do all that is needed.

I own a car

I have a old car. But it runs.

when call sometimes not available to ride, if done in advance they do not show up

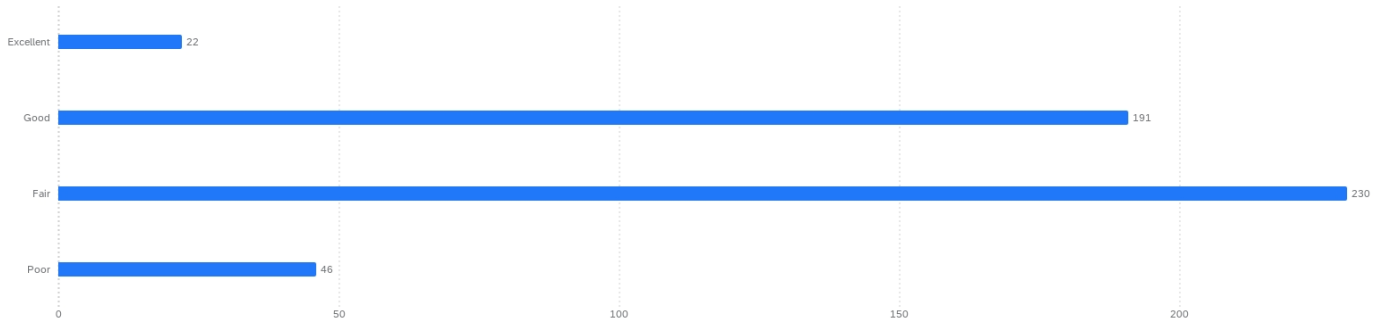
How would you rate your overall mental health? 489



How would you rate your overall mental health? 489

Q13 - How would you rate your overall mental health?	Count	Count
Excellent	23%	114
Good	54%	263
Fair	20%	97
Poor	3%	15

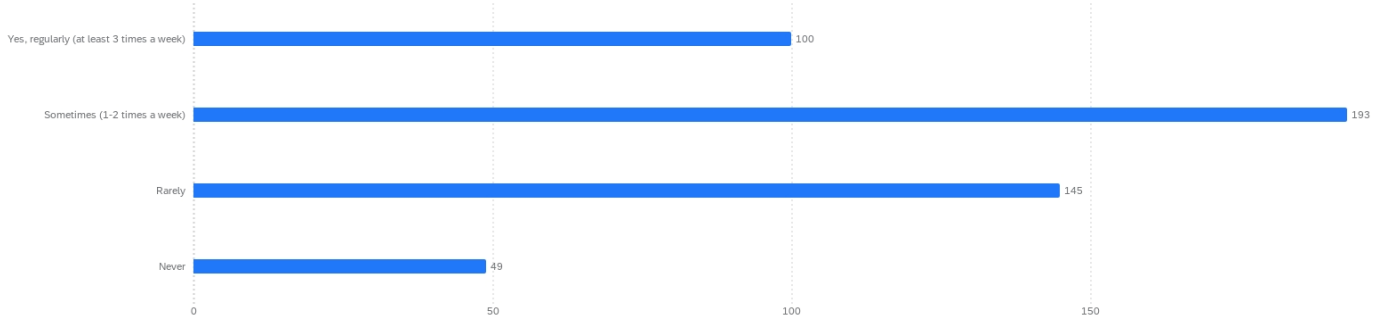
How would you rate your overall physical health? 489



How would you rate your overall physical health? 489

Q14 - How would you rate your overall physical health?	Count	Count
Excellent	4%	22
Good	39%	191
Fair	47%	230
Poor	9%	46

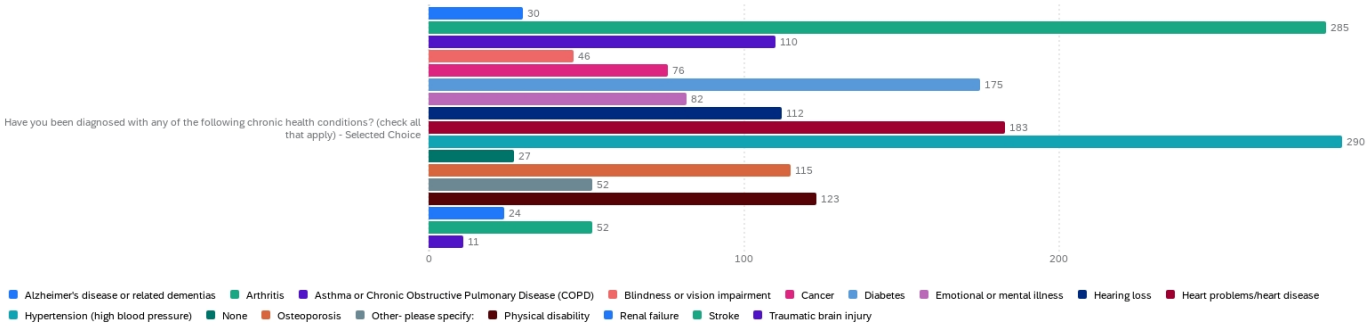
Do you engage in regular physical activity (walking, exercise, yoga, etc.)? 487



Do you engage in regular physical activity (walking, exercise, yoga, etc.)? 487

Q15 - Do you engage in regular physical activity (walking, exercise, yoga, etc.)?	Count	Count
Yes, regularly (at least 3 times a week)	21%	100
Sometimes (1-2 times a week)	40%	193
Rarely	30%	145
Never	10%	49

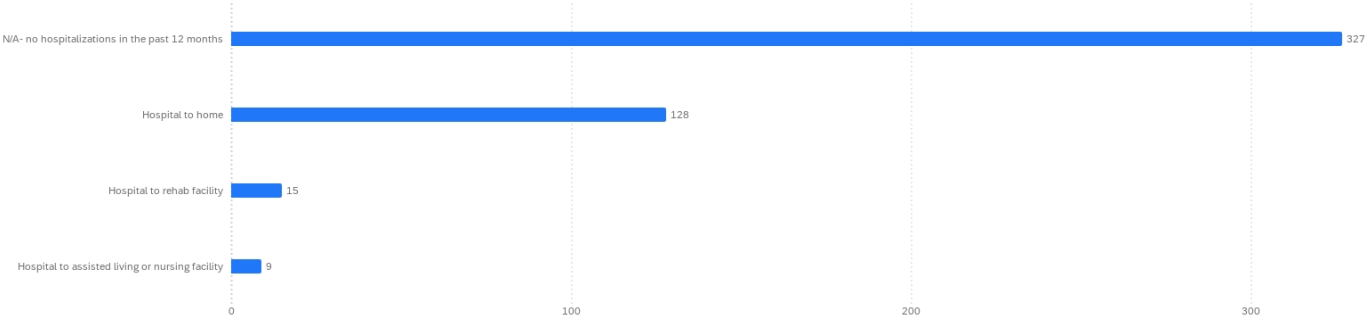
Rank your interest in the health and wellness subjects below. Drag each ite... 489



Rank your interest in the health and wellness subjects below. Drag each ite... 489

Have you been diagnosed with any of the following chronic health conditions...	Alzheimer's disease or related dementias	Arthritis	Asthma or Chronic Obstructive Pulmonary Disease (COPD)	Blindness or vision impairment	Cancer	Diabetes	Emotional or mental illness	Hearing loss	Heart problems /heart disease	Hypertension (high blood pressure)	None	Osteoporosis	Other- please specify:	Physical disability	Renal failure	Stroke	Traumatic brain injury
Have you been diagnosed with any of the following chronic health conditions? (check all that apply) - Selected Choice	30	285	110	46	76	175	82	112	183	290	27	115	52	123	24	52	11

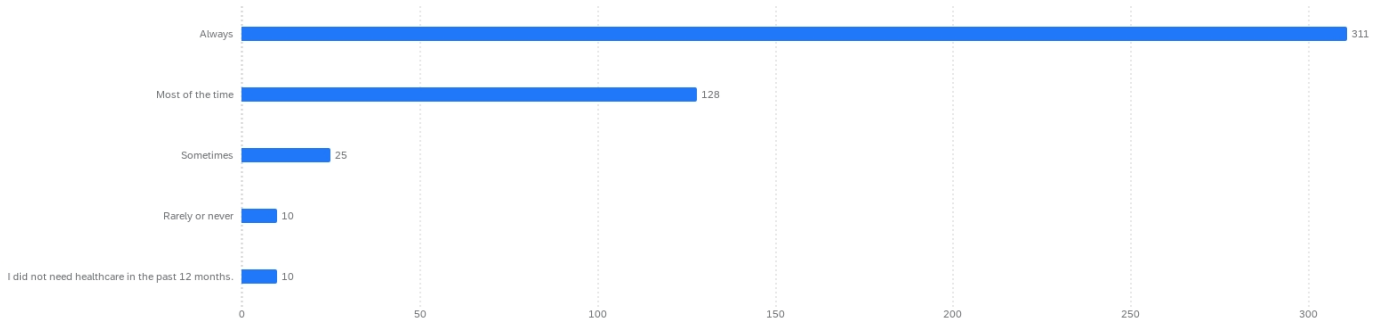
If you have been hospitalized in the past 12 months, where were you discharged to? 479



If you have been hospitalized in the past 12 months, where were you discharged to? 479

Q17 - If you have been hospitalized in the past 12 months, where were you discharged to?	Count	Count
N/A- no hospitalizations in the past 12 months	68%	327
Hospital to home	27%	128
Hospital to rehab facility	3%	15
Hospital to assisted living or nursing facility	2%	9

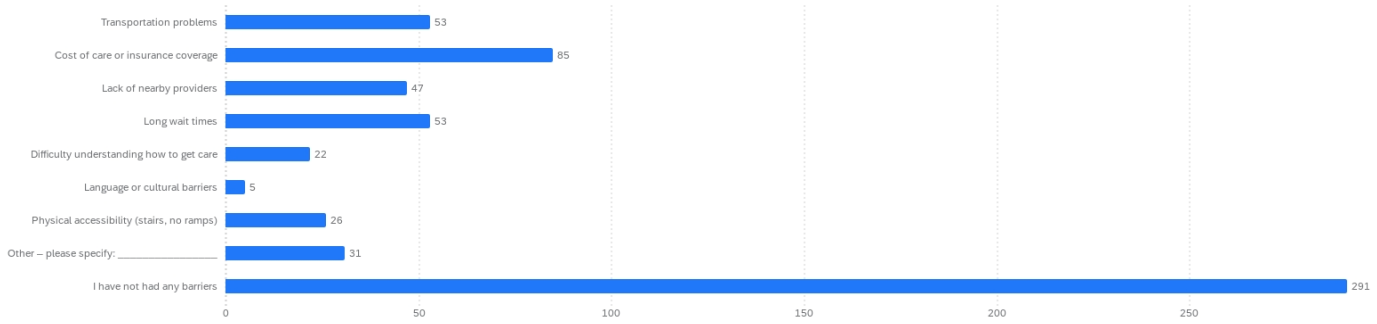
In the past 12 months, how often have you been able to get the healthcare you needed (including primary care, specialist care, mental health, or dental services)? 484



In the past 12 months, how often have you been able to get the healthcare you needed (including primary care, specialist care, mental health, or dental services)? 484

Q19 - In the past 12 months, how often have you been able to get the healthcare you needed (including primary care, specialist care, mental health, or dental services)?	Count	Count
Always	64%	311
Most of the time	26%	128
Sometimes	5%	25
Rarely or never	2%	10
I did not need healthcare in the past 12 months.	2%	10

What barriers, if any, have prevented you from getting the care you need? (... 482



What barriers, if any, have prevented you from getting the care you need? (... 482

Q20 - What barriers, if any, have prevented you from getting the care you need? (check all that apply) - Selected Choice	Count	Count
Transportation problems	11%	53
Cost of care or insurance coverage	18%	85
Lack of nearby providers	10%	47
Long wait times	11%	53
Difficulty understanding how to get care	5%	22
Language or cultural barriers	1%	5
Physical accessibility (stairs, no ramps)	5%	26

What barriers, if any, have prevented you from getting the care you need? (...: Other – please specify: _____ - Text 29

Other – please specify: _____

It's extremely difficult to pay each month for plan g and it doesn't even include dental or vision. I am blessed I was able to go out of county to get dental help. But how sad is that

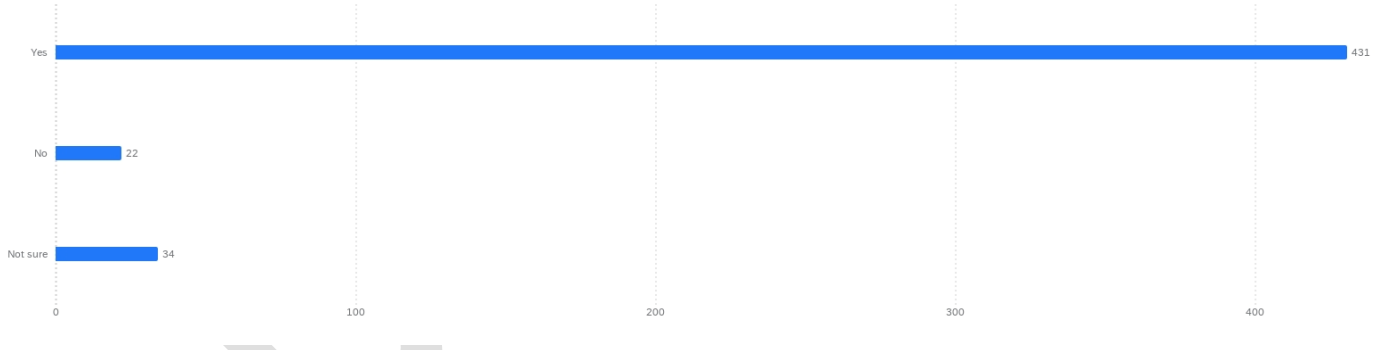
Not needed at this time

Don't have an in network dentist yet this year

Too unwell to go

no family members

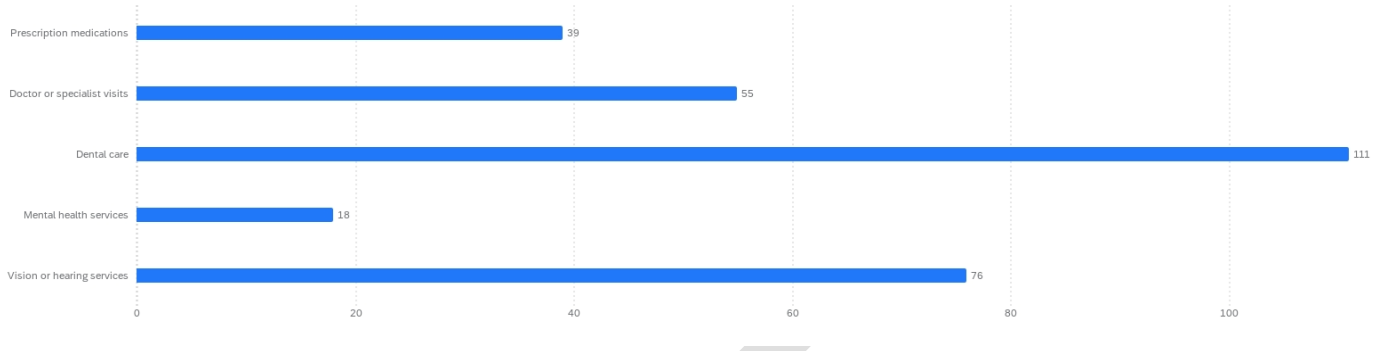
Do you have at least one person you can rely on for help when you have a health issue or emergency? 487



Do you have at least one person you can rely on for help when you have a health issue or emergency? 487

Q21 - Do you have at least one person you can rely on for help when you have a health issue or emergency?	Count	Count
Yes	89%	431
No	5%	22
Not sure	7%	34

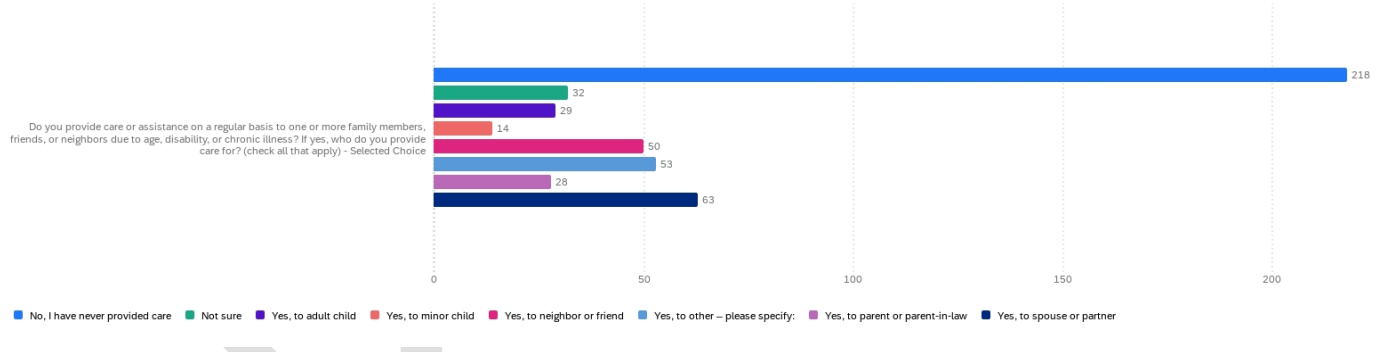
Have you delayed or gone without any of the following in the past 12 months due to issues with health coverage access or costs? (check all that apply) 166



Have you delayed or gone without any of the following in the past 12 months due to issues with health coverage access or costs? (check all that apply) 166

Q22 - Have you delayed or gone without any of the following in the past 12 months due to issues with health coverage access or costs? (check all that apply)	Count	Count
Prescription medications	23%	39
Doctor or specialist visits	33%	55
Dental care	67%	111
Mental health services	11%	18
Vision or hearing services	46%	76

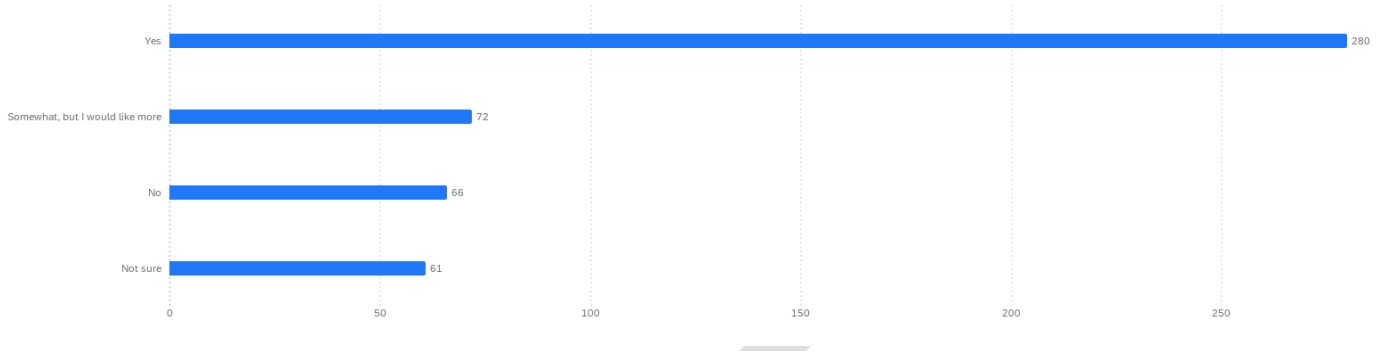
How often do you: 448



How often do you: ⚠

An unexpected error has occurred.

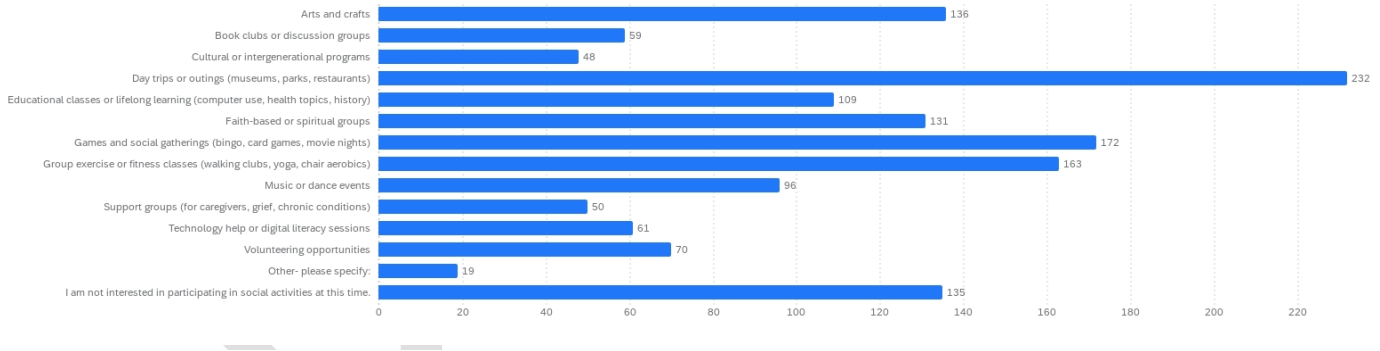
Do you feel you have enough opportunities to participate in social or community activities (events, clubs, educational programs, group outings)? 479



Do you feel you have enough opportunities to participate in social or community activities (events, clubs, educational programs, group outings)? 479

Q24 - Do you feel you have enough opportunities to participate in social or community activities (events, clubs, educational programs, group outings)?	Count	Count
Yes	58%	280
Somewhat, but I would like more	15%	72
No	14%	66
Not sure	13%	61

What types of social activities or opportunities would you be most interest... 470



What types of social activities or opportunities would you be most interest... 470

Q25 - What types of social activities or opportunities would you be most interested in participating in, if available in your community? (check all that apply) - Selected Choice	Count	Count
Arts and crafts	29%	136
Book clubs or discussion groups	13%	59
Cultural or intergenerational programs	10%	48
Day trips or outings (museums, parks, restaurants)	49%	232
Educational classes or lifelong learning (computer use, health topics, history)	23%	109
Faith-based or spiritual groups	28%	131
Games and social gatherings (bingo, card games, movie nights)	37%	172

What types of social activities or opportunities would you be most interest...: Other- please specify: - Text 17

Other- please specify:

If I am having a good day, I might be able to attend.

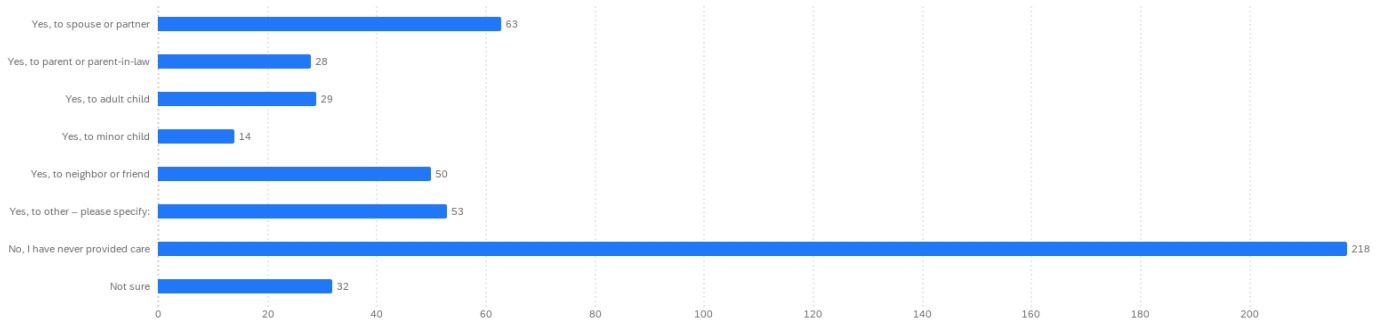
Most are offered in Hancock Cty but I am limited by health issues.

Nothing cause have bladder issues

My bad knees prevents me to do most things

Going to basketball games

Do you provide care or assistance on a regular basis to one or more family... 448



Do you provide care or assistance on a regular basis to one or more family... 448

Q26 - Do you provide care or assistance on a regular basis to one or more family members, friends, or neighbors due to age, disability, or chronic illness? If yes, who do you provide care for? (check all that apply) - Selected Choice	Count	Count
Yes, to spouse or partner	14%	63
Yes, to parent or parent-in-law	6%	28
Yes, to adult child	6%	29
Yes, to minor child	3%	14
Yes, to neighbor or friend	11%	50
Yes, to other – please specify:	12%	53
No, I have never provided care	49%	218

Do you provide care or assistance on a regular basis to one or more family...: Yes, to other – please specify: - Text 52

Yes, to other – please specify:

Other relatives

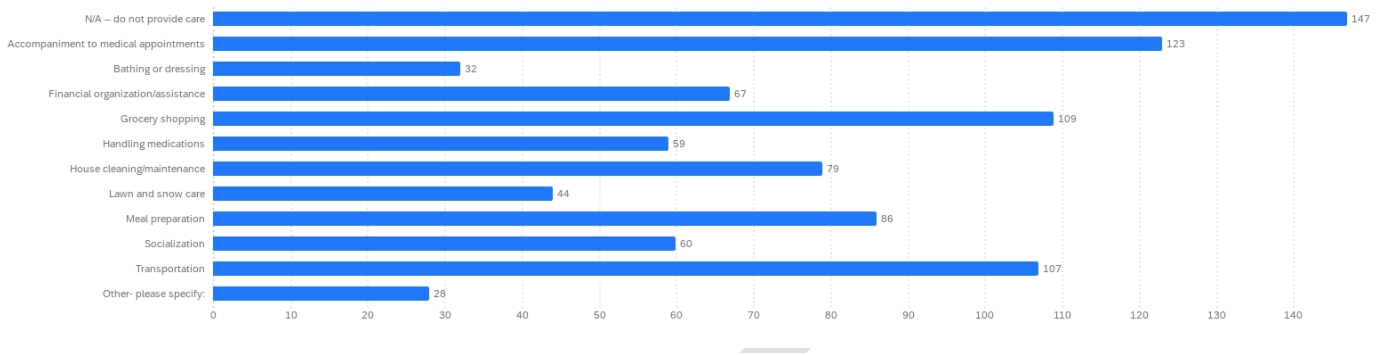
Brother and sister

Sister & nephew

I have provided care in the past, but not currently

I'm a former caregiver if needed I help.

If yes, what types of care do you provide? 342



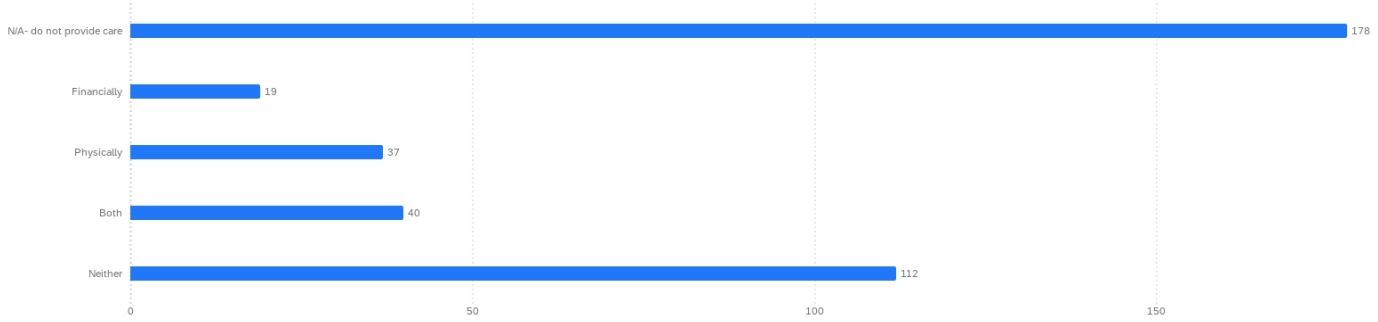
If yes, what types of care do you provide? 342

Q27 - If yes, what types of care do you provide? - Selected Choice	Count	Count
N/A – do not provide care	43%	147
Accompaniment to medical appointments	36%	123
Bathing or dressing	9%	32
Financial organization/assistance	20%	67
Grocery shopping	32%	109
Handling medications	17%	59
House cleaning/maintenance	23%	79

If yes, what types of care do you provide?: Other- please specify: - Text 27

Other- please specify:
In the past, but not currently.
Blindness
19 months old
Help put away his groceries. Large once a month.
help keep bills in order and help find health connection

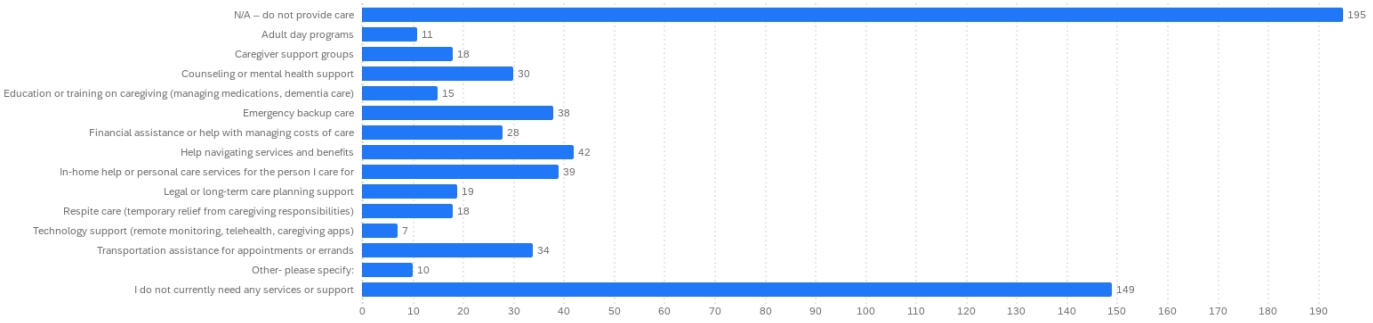
If yes, have you ever felt financially or physically burdened by your caregiving? 386



If yes, have you ever felt financially or physically burdened by your caregiving? 386

Q28 - If yes, have you ever felt financially or physically burdened by your caregiving?	Count	Count
N/A- do not provide care	46%	178
Financially	5%	19
Physically	10%	37
Both	10%	40
Neither	29%	112

As a caregiver, what services or supports do you feel would be most helpful... 404



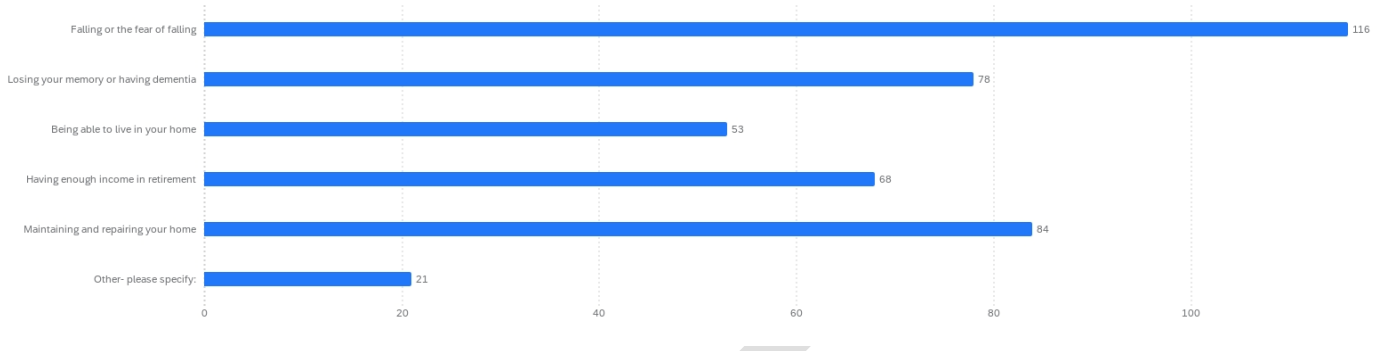
As a caregiver, what services or supports do you feel would be most helpful... 404

Q29 - As a caregiver, what services or supports do you feel would be most helpful for your care situatio - Selected Choice	Count	Count
N/A – do not provide care	48%	195
Adult day programs	3%	11
Caregiver support groups	4%	18
Counseling or mental health support	7%	30
Education or training on caregiving (managing medications, dementia care)	4%	15
Emergency backup care	9%	38
Financial assistance or help with managing costs of care	7%	28

As a caregiver, what services or supports do you feel would be most helpful...: Other- please specify: - Text 676

Other- please specify:

Of the situations below, which concerns you the most? 420



Of the situations below, which concerns you the most? 420

Q30 - Of the situations below, which concerns you the most? - Selected Choice	Count	Count
Falling or the fear of falling	28%	116
Losing your memory or having dementia	19%	78
Being able to live in your home	13%	53
Having enough income in retirement	16%	68
Maintaining and repairing your home	20%	84
Other- please specify:	5%	21

Of the situations below, which concerns you the most?: Other- please specify: - Text 17

Other- please specify:

ALL ITEMS.

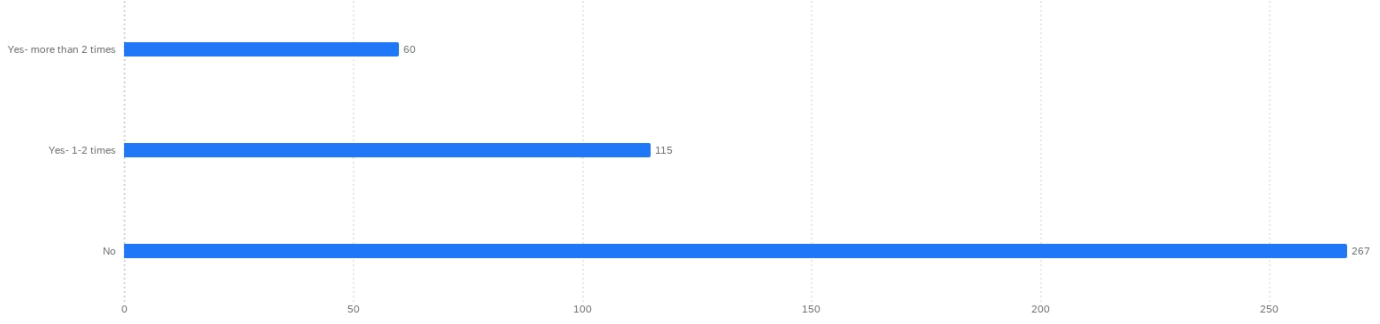
All of the above!

Being able to spray for bugs I can't keep paying and my complex won't pay the bugs are extreme amounts of roly poly bugs spiders and centipedes. Also afraid of falling.

None of the above

ending up in a nursing home and them taking all I worked for

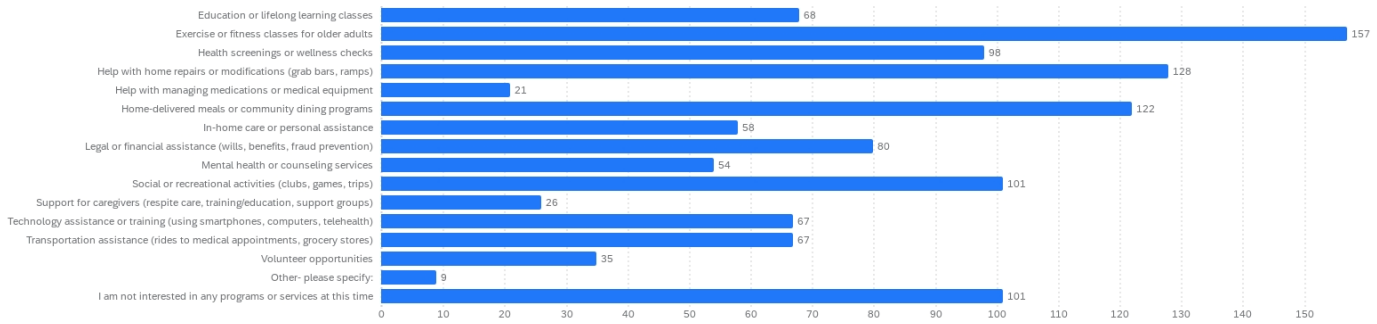
Have you experienced a fall within the past year? 442



Have you experienced a fall within the past year? 442

Q31 - Have you experienced a fall within the past year?	Count	Count
Yes- more than 2 times	14%	60
Yes- 1-2 times	26%	115
No	60%	267

What programs and services are you most interested in? (check all that appl... 432



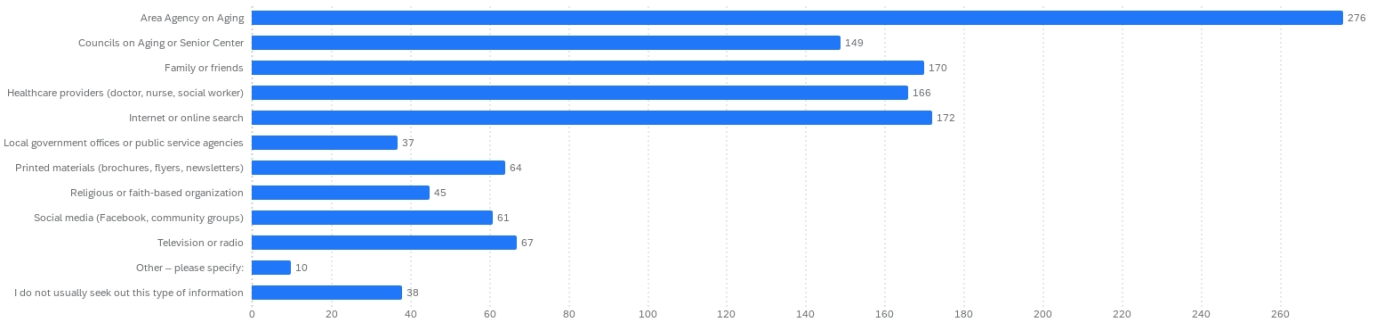
What programs and services are you most interested in? (check all that appl... 432

Q32 - What programs and services are you most interested in? (check all that apply) - Selected Choice	Count	Count
Education or lifelong learning classes	16%	68
Exercise or fitness classes for older adults	36%	157
Health screenings or wellness checks	23%	98
Help with home repairs or modifications (grab bars, ramps)	30%	128
Help with managing medications or medical equipment	5%	21
Home-delivered meals or community dining programs	28%	122
In-home care or personal assistance	13%	58

What programs and services are you most interested in? (check all that appl...: Other- please specify: - Text 676

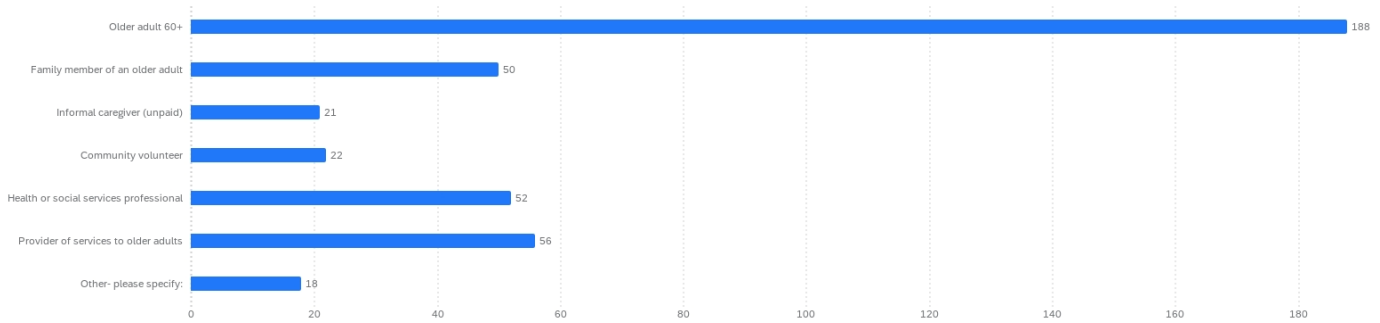
Other- please specify:

Where do you usually go to get information about aging or disability-relate... 440



Community Needs Assessment Survey Results

What best describes your role in the community? (Check all that apply) 299



What best describes your role in the community? (Check all that apply) 299

Q1 - What best describes your role in the community? (Check all that apply) - Selected Choice	Count	Count
Older adult 60+	63%	188
Family member of an older adult	17%	50
Informal caregiver (unpaid)	7%	21
Community volunteer	7%	22
Health or social services professional	17%	52
Provider of services to older adults	19%	56
Other- please specify:	6%	18

What best describes your role in the community? (Check all that apply): Other- please specify: - Text 18

Other- please specify:

Pastor

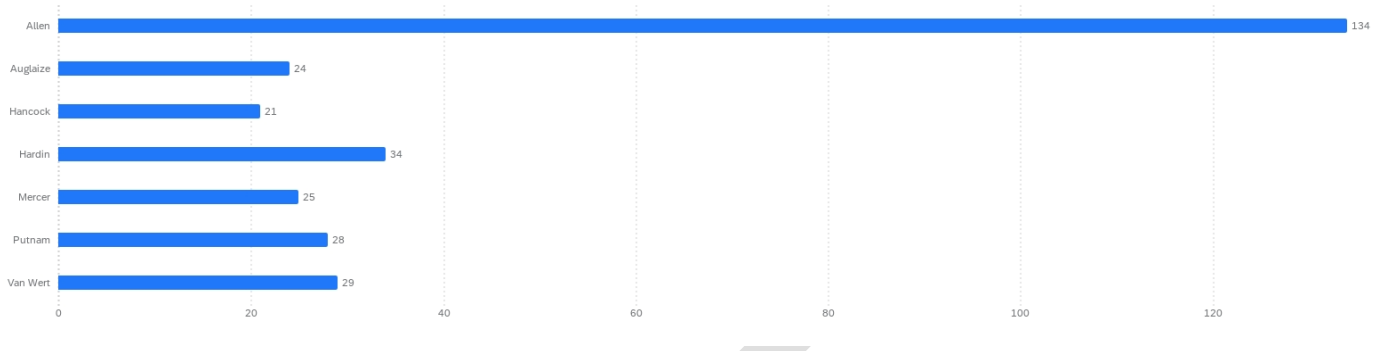
Retired

Long term care ombudsman

Handicap adult on Waiver

Parkinson's patient

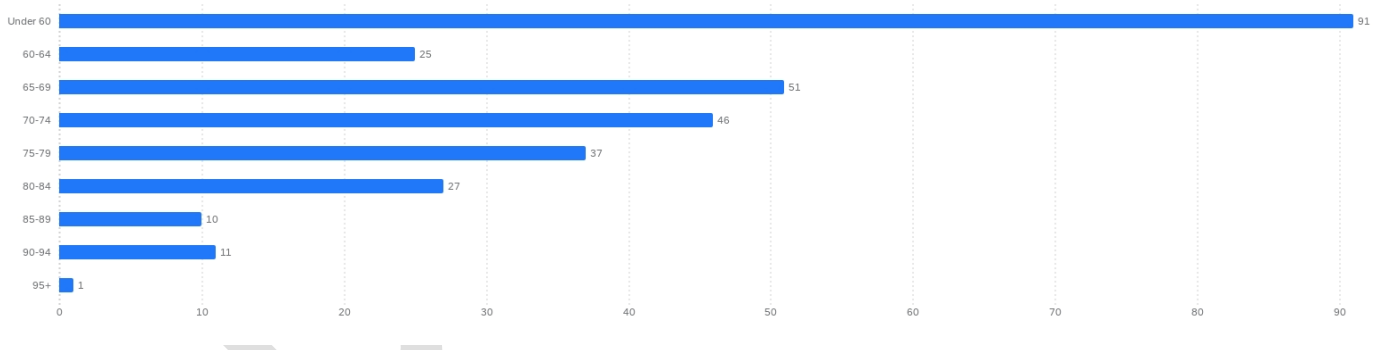
What county do you live in? 295



What county do you live in? 295

Q2 - What county do you live in?	Count	Count
Allen	45%	134
Auglaize	8%	24
Hancock	7%	21
Hardin	12%	34
Mercer	8%	25
Putnam	9%	28
Van Wert	10%	29

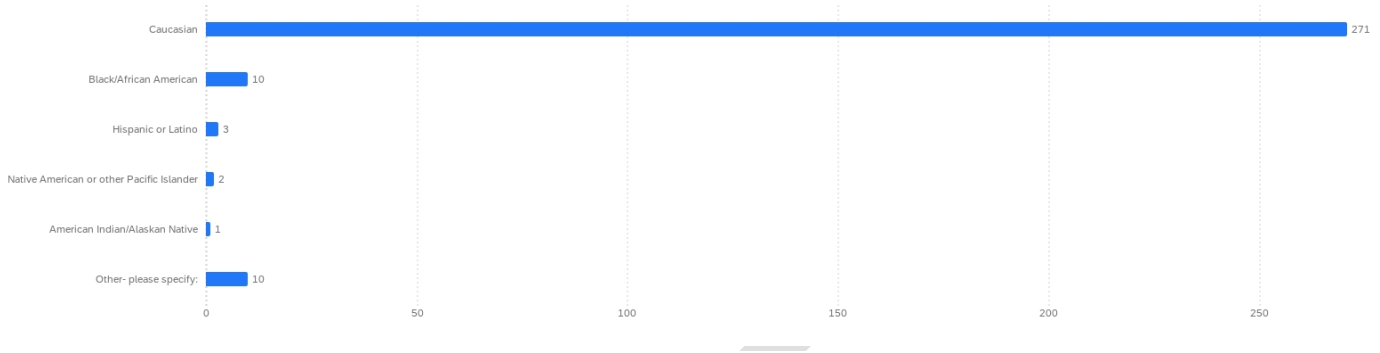
What age range do you fall in? 299



What age range do you fall in? 299

Q3 - What age range do you fall in?	Count	Count
Under 60	30%	91
60-64	8%	25
65-69	17%	51
70-74	15%	46
75-79	12%	37
80-84	9%	27
85-89	3%	10

Which of the following would you say is your race? 297



Which of the following would you say is your race? 297

Q4 - Which of the following would you say is your race? - Selected Choice	Count	Count
Caucasian	91%	271
Black/African American	3%	10
Hispanic or Latino	1%	3
Native American or other Pacific Islander	1%	2
American Indian/Alaskan Native	0%	1
Other- please specify:	3%	10

Which of the following would you say is your race?: Other- please specify: - Text 7

Other- please specify:

Mex American

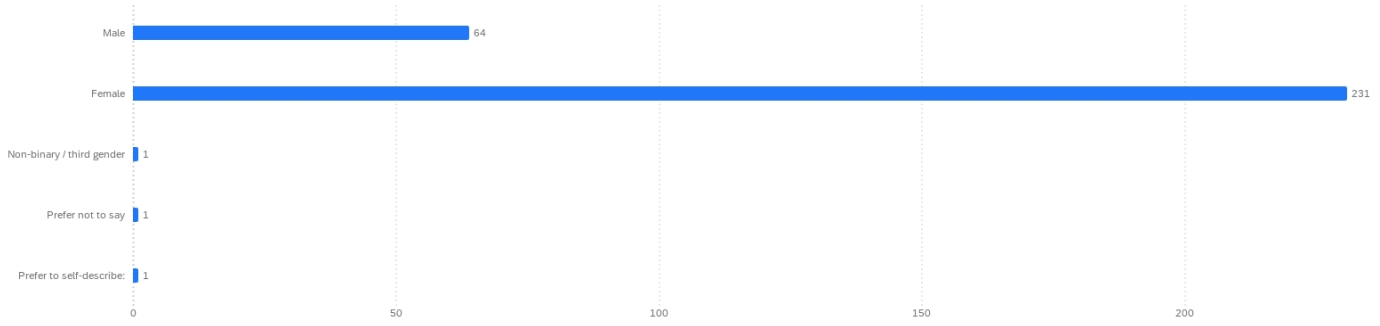
Human Race

Multi racial

Multi Racial

White

What is your gender? 298



What is your gender? 298

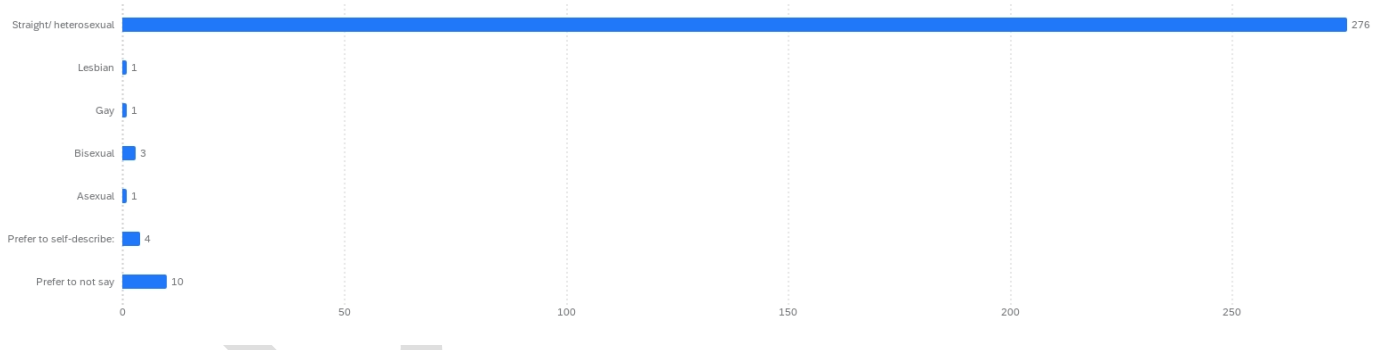
Q5 - What is your gender? - Selected Choice	Count	Count
Male	21%	64
Female	78%	231
Non-binary / third gender	0%	1
Prefer not to say	0%	1
Prefer to self-describe:	0%	1

What is your gender?: Prefer to self-describe: - Text 1

Prefer to self-describe:

Stupid question. I was born a female. Duh!

Do you identify as: 296



Do you identify as: 296

Q6 - Do you identify as: - Selected Choice	Count	Count
Straight/ heterosexual	93%	276
Lesbian	0%	1
Gay	0%	1
Bisexual	1%	3
Asexual	0%	1
Prefer to self-describe:	1%	4
Prefer to not say	3%	10

Do you identify as:: Prefer to self-describe: - Text 4

Prefer to self-describe:

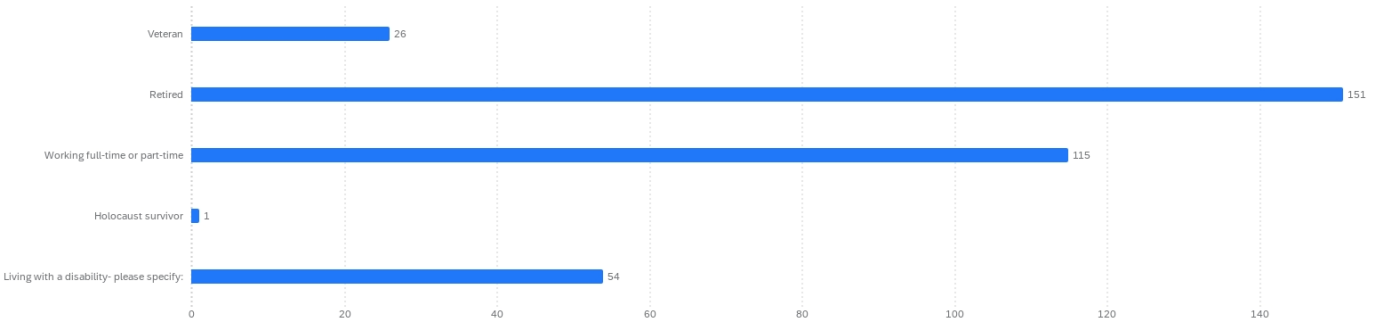
I'm a widow straight woman no flip flop

Straight

Im 100% straight

Why are you asking stupid questions?

Which of the following applies to you? (Check all that apply) 295



Which of the following applies to you? (Check all that apply) 295

Q7 - Which of the following applies to you? (Check all that apply) - Selected Choice	Count	Count
Veteran	9%	26
Retired	51%	151
Working full-time or part-time	39%	115
Holocaust survivor	0%	1
Living with a disability- please specify:	18%	54

Which of the following applies to you? (Check all that apply): Living with a disability- please specify: - Text 39

Living with a disability- please specify:

Multiple

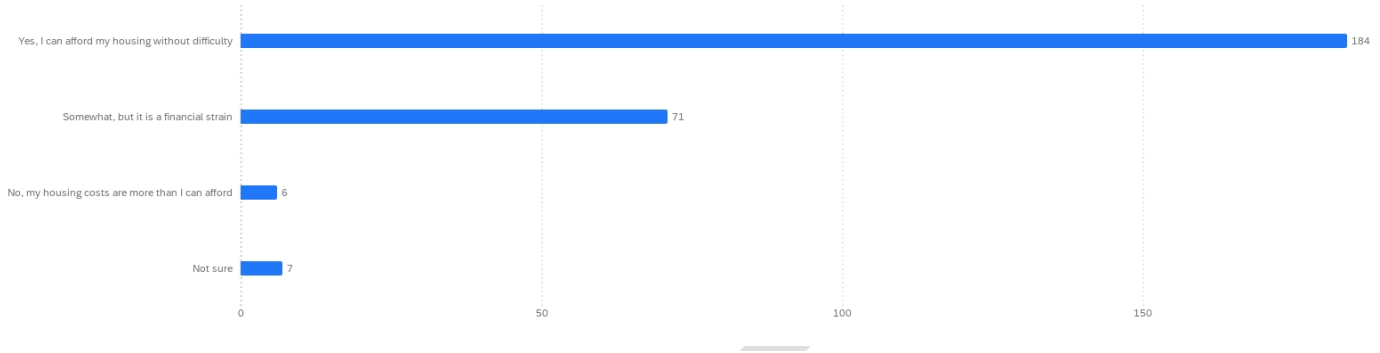
Walk with a walker

Low vision

major depression anxiety disorder

Diabetic, back issues.

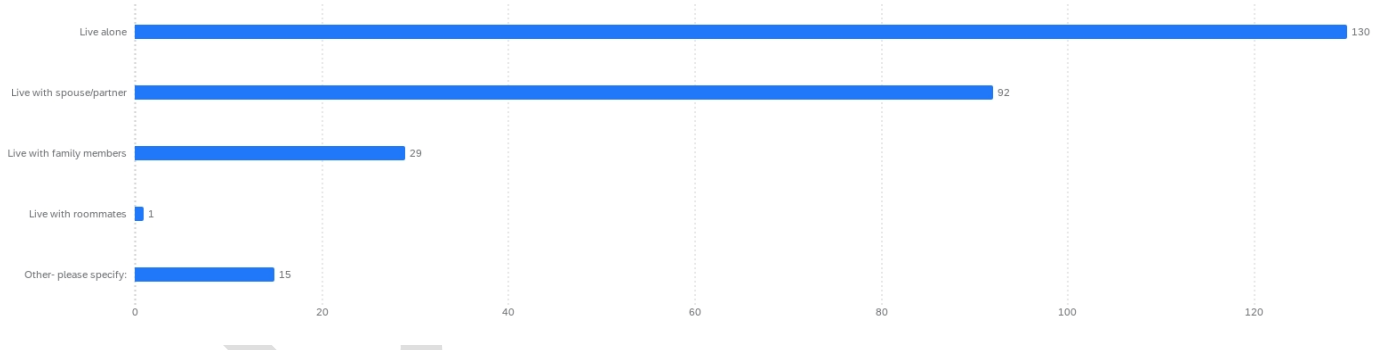
Are you able to afford your current housing (including rent or mortgage, utilities, and maintenance) without having to sacrifice other basic needs (such as food, medication, or transportation)? 268



Are you able to afford your current housing (including rent or mortgage, utilities, and maintenance) without having to sacrifice other basic needs (such as food, medication, or transportation)? 268

Q8 - Are you able to afford your current housing (including rent or mortgage, utilities, and maintenance) without having to sacrifice other basic needs (such as food, medication, or transportation)?	Count	Count
Yes, I can afford my housing without difficulty	69%	184
Somewhat, but it is a financial strain	26%	71
No, my housing costs are more than I can afford	2%	6
Not sure	3%	7

Which best describes your current living arrangements? 267



Which best describes your current living arrangements? 267

Q9 - Which best describes your current living arrangements? - Selected Choice	Count	Count
Live alone	49%	130
Live with spouse/partner	34%	92
Live with family members	11%	29
Live with roommates	0%	1
Other- please specify:	6%	15

Which best describes your current living arrangements?: Other- please specify: - Text 14

Other- please specify:

My daughter lives with me.

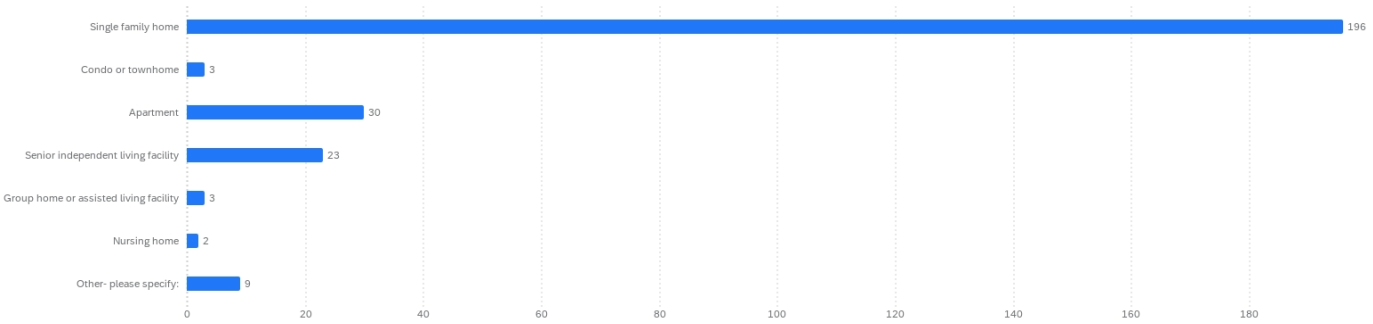
Taking care of my mom. Bad stroke. Can't stand

With my adult son who is autistic and has the same disease I have

I have a full time caregiver but I live alone.

Currently in nursing getting therapy

Which best describes your residence? 266



Which best describes your residence? 266

Q10 - Which best describes your residence? - Selected Choice	Count	Count
Single family home	74%	196
Condo or townhome	1%	3
Apartment	11%	30
Senior independent living facility	9%	23
Group home or assisted living facility	1%	3
Nursing home	1%	2
Other- please specify:	3%	9

Which best describes your residence?: Other- please specify: - Text 8

Other- please specify:

House trailer.

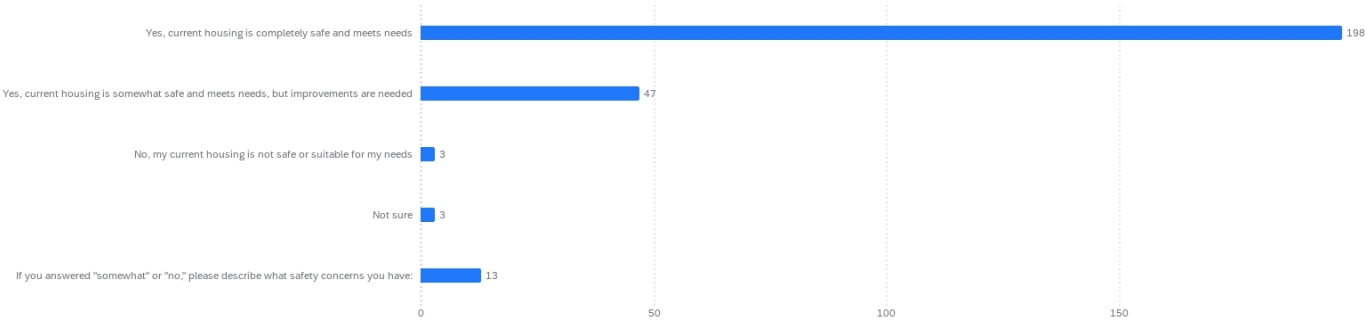
Mobile home

Camper - full time

Mobile home

air conditioners need fixed! carpets in lobby and social room need shampooed!

Do you feel that your current housing is safe and meets your physical needs... 264



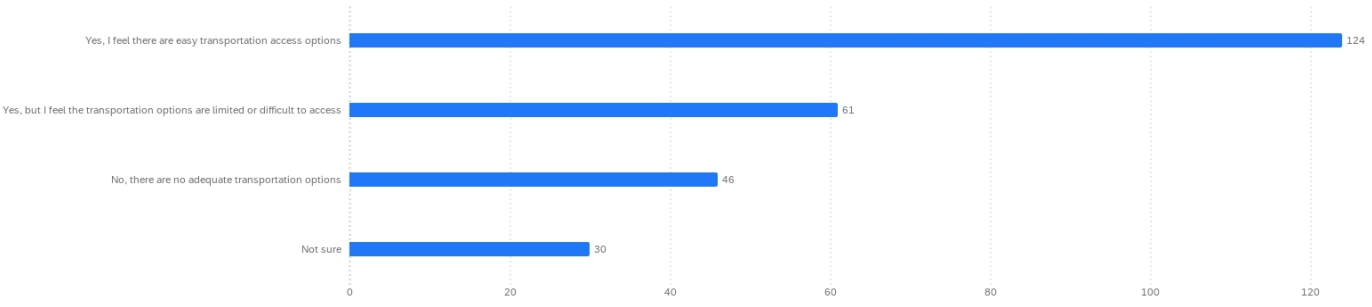
Do you feel that your current housing is safe and meets your physical needs... 264

Q11 - Do you feel that your current housing is safe and meets your physical needs (accessibility, easy to navigate, lighting, absence of hazards such as loose rugs or stairs without railings)? - Selected Choice	Count	Count
Yes, current housing is completely safe and meets needs	75%	198
Yes, current housing is somewhat safe and meets needs, but improvements are needed	18%	47
No, my current housing is not safe or suitable for my needs	1%	3
Not sure	1%	3
If you answered "somewhat" or "no," please describe what safety concerns you have:	5%	13

Do you feel that your current housing is safe and meets your physical needs...: If you answered "somewhat" or "no," please describe what safety concerns you have: - Text 12

If you answered "somewhat" or "no," please describe what safety concerns yo...
falling
Steps, tub.
stairs and loose flooring
critters keep burrowing through & knocking house off foundation-pulls roof away from structure also
I cannot clean and it is filthy

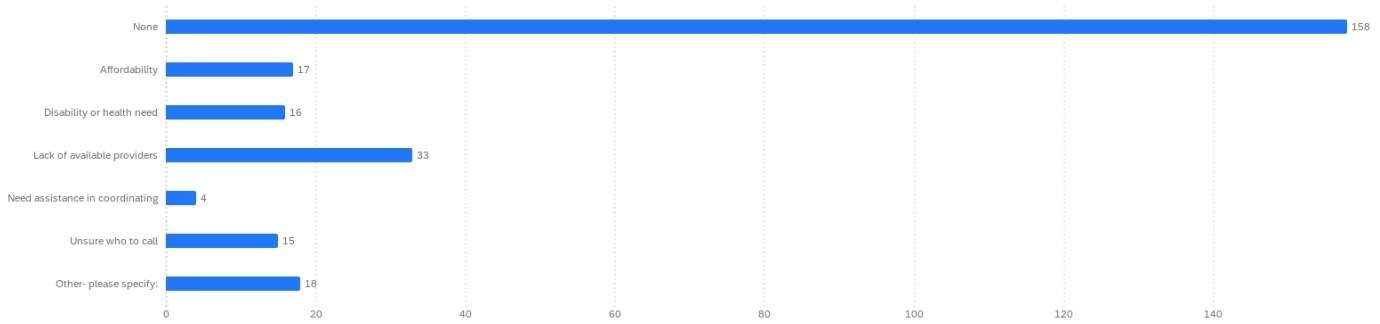
Are there adequate transportation options available in your community (buses, shuttles, taxis, or rideshare services) for older adults to access essential services in your community? (grocery stores, restaurants, pharmacies, banks)? 261



Are there adequate transportation options available in your community (buses, shuttles, taxis, or rideshare services) for older adults to access essential services in your community? (grocery stores, restaurants, pharmacies, banks)? 261

Q12 - Are there adequate transportation options available in your community (buses, shuttles, taxis, or rideshare services) for older adults to access essential services in your community? (grocery stores, restaurants, pharmacies, banks)?	Count	Count
Yes, I feel there are easy transportation access options	48%	124
Yes, but I feel the transportation options are limited or difficult to access	23%	61
No, there are no adequate transportation options	18%	46
Not sure	11%	30

What barriers do you experience to secure the transportation you need? 261



What barriers do you experience to secure the transportation you need? 261

Q13 - What barriers do you experience to secure the transportation you need? - Selected Choice	Count	Count
None	61%	158
Affordability	7%	17
Disability or health need	6%	16
Lack of available providers	13%	33
Need assistance in coordinating	2%	4
Unsure who to call	6%	15
Other- please specify:	7%	18

What barriers do you experience to secure the transportation you need?: Other- please specify: - Text 17

Other- please specify:

When people need a ride that includes on some holidays if they have it scheduled show up!!!!

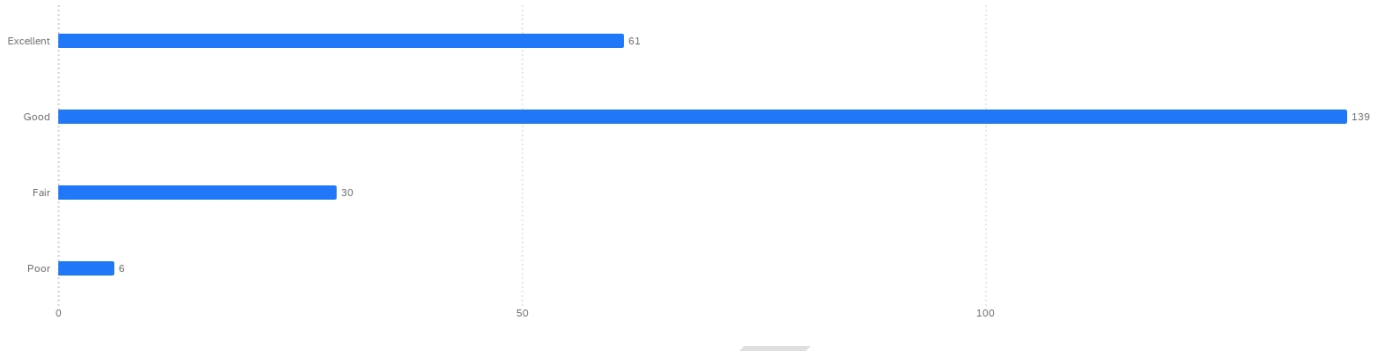
"I have friends who help!"

Call council on aging. Transportation

Difficult to schedule 4 days ahead as required

Drive myself, but struggle with money to get to appointments

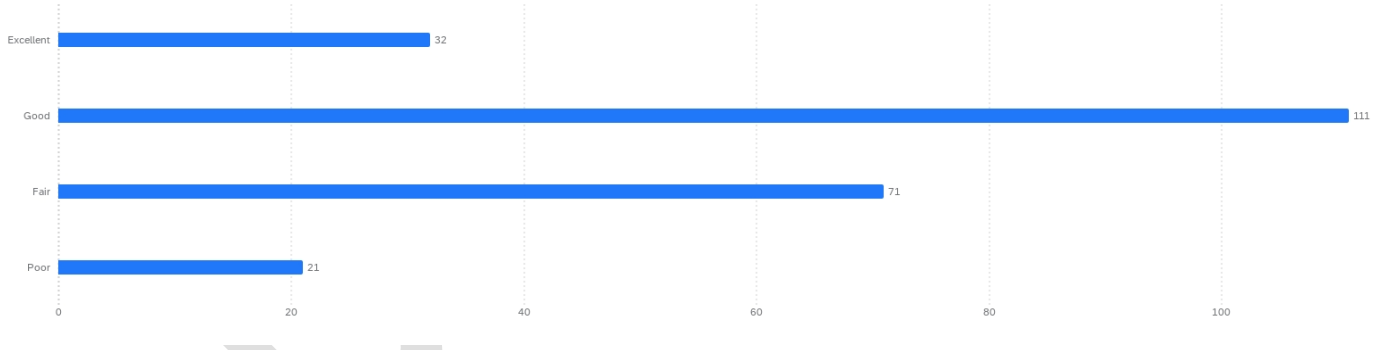
How would you rate your overall mental health? 236



How would you rate your overall mental health? 236

Q14 - How would you rate your overall mental health?	Count	Count
Excellent	26%	61
Good	59%	139
Fair	13%	30
Poor	3%	6

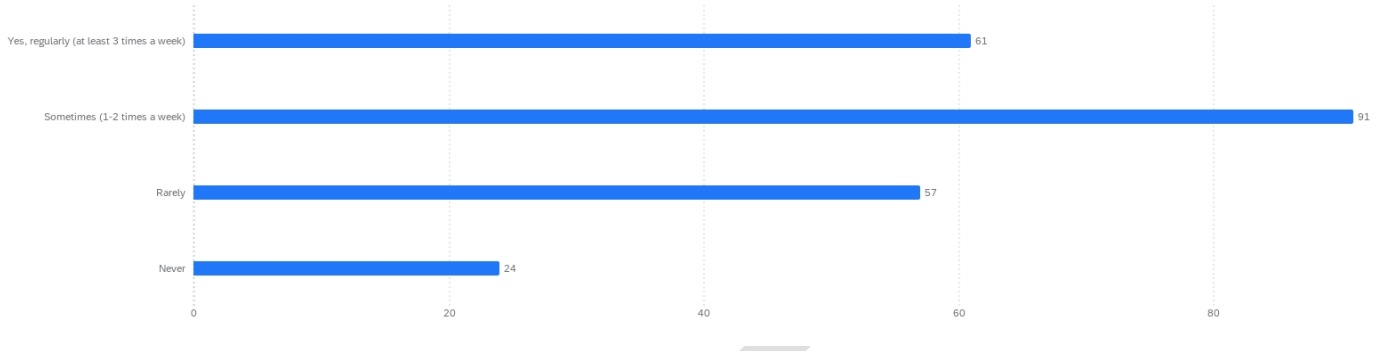
How would you rate your overall physical health? 235



How would you rate your overall physical health? 235

Q15 - How would you rate your overall physical health?	Count	Count
Excellent	14%	32
Good	47%	111
Fair	30%	71
Poor	9%	21

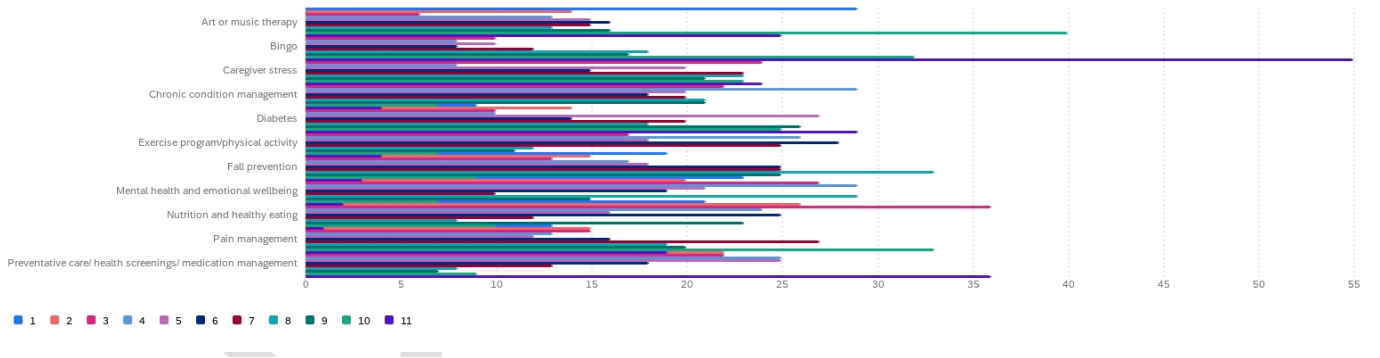
Do you engage in regular physical activity (walking, exercise, yoga, etc.)? 233



Do you engage in regular physical activity (walking, exercise, yoga, etc.)? 233

Q16 - Do you engage in regular physical activity (walking, exercise, yoga, etc.)?	Count	Count
Yes, regularly (at least 3 times a week)	26%	61
Sometimes (1-2 times a week)	39%	91
Rarely	24%	57
Never	10%	24

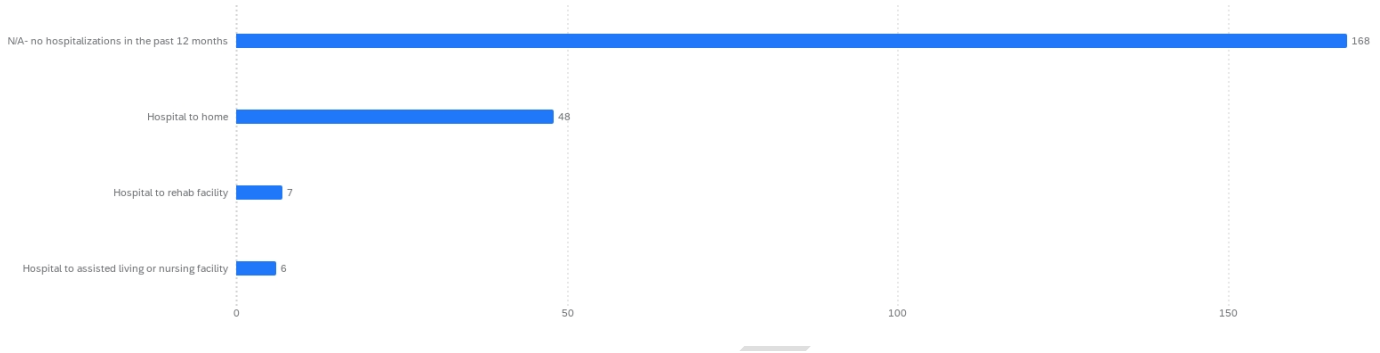
Rank your interest in the health and wellness subjects below. Drag each ite... 202



Rank your interest in the health and wellness subjects below. Drag each ite... 202

Rank your interest in the health and wellness subjects below. Drag each ite...	1	2	3	4	5	6	7	8	9	10	11
Art or music therapy	29	14	6	13	15	16	15	13	16	40	25
Bingo	12	20	10	8	10	8	12	18	17	32	55
Caregiver stress	16	5	24	8	20	15	23	23	21	23	24
Chronic condition management	18	22	22	29	20	18	20	21	21	7	4
Diabetes	9	14	10	10	27	14	20	18	26	25	29
Exercise program/physical activity	25	29	17	26	18	28	25	12	11	7	4

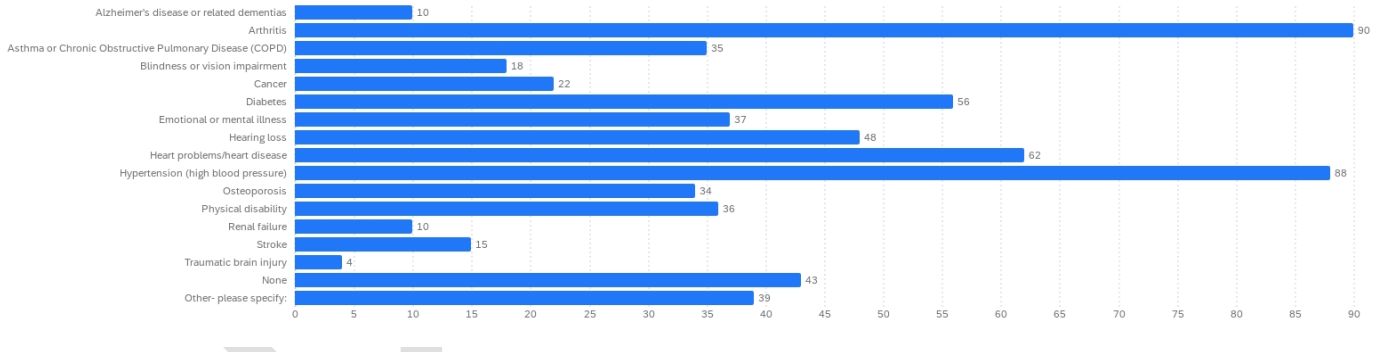
If you have been hospitalized in the past 12 months, where were you discharged to? 229



If you have been hospitalized in the past 12 months, where were you discharged to? 229

Q18 - If you have been hospitalized in the past 12 months, where were you discharged to?	Count	Count
N/A- no hospitalizations in the past 12 months	73%	168
Hospital to home	21%	48
Hospital to rehab facility	3%	7
Hospital to assisted living or nursing facility	3%	6

Have you been diagnosed with any of the following chronic health conditions... 232



Have you been diagnosed with any of the following chronic health conditions... 232

Q19 - Have you been diagnosed with any of the following chronic health conditions? (check all that apply) - Selected Choice	Count	Count
Alzheimer's disease or related dementias	4%	10
Arthritis	39%	90
Asthma or Chronic Obstructive Pulmonary Disease (COPD)	15%	35
Blindness or vision impairment	8%	18
Cancer	9%	22
Diabetes	24%	56
Emotional or mental illness	16%	37

Have you been diagnosed with any of the following chronic health conditions...: Other- please specify: - Text 36

Other- please specify:

Orthostatic hypertension, depression, anxiety

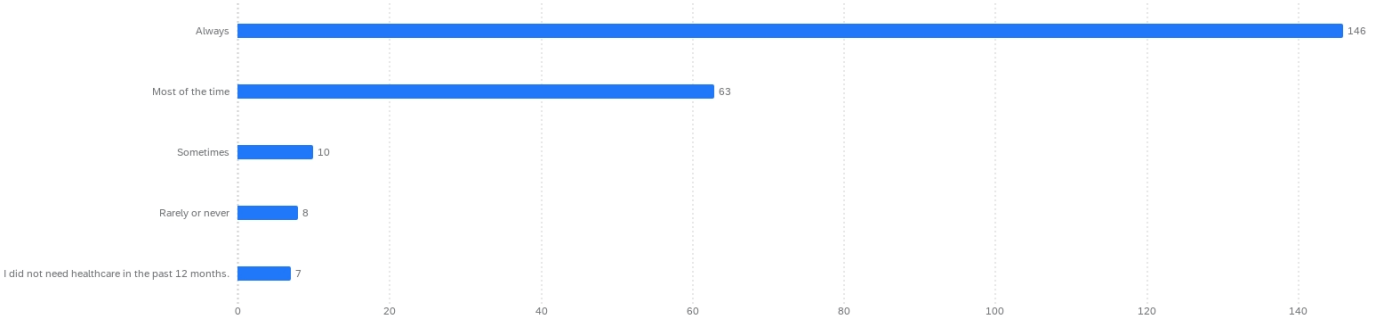
Pre diabetic

Narrowing of disks in lower back causing lower extremity pain

Primary parkinsonism

"Having bowel problems, taking calease it helps"

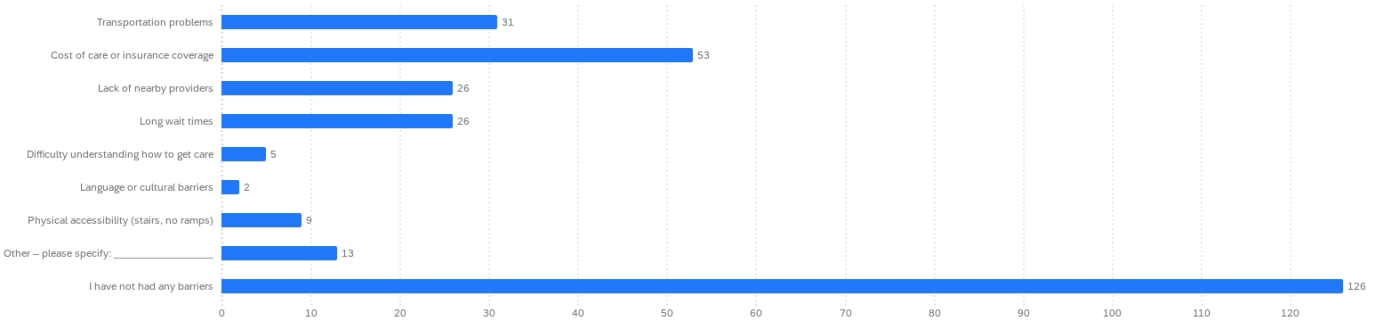
In the past 12 months, how often have you been able to get the healthcare you needed (including primary care, specialist care, mental health, or dental services)? 234



In the past 12 months, how often have you been able to get the healthcare you needed (including primary care, specialist care, mental health, or dental services)? 234

Q20 - In the past 12 months, how often have you been able to get the healthcare you needed (including primary care, specialist care, mental health, or dental services)?	Count	Count
Always	62%	146
Most of the time	27%	63
Sometimes	4%	10
Rarely or never	3%	8
I did not need healthcare in the past 12 months.	3%	7

What barriers, if any, have prevented you from getting the care you need? (... 230



What barriers, if any, have prevented you from getting the care you need? (... 230

Q21 - What barriers, if any, have prevented you from getting the care you need? (check all that apply) - Selected Choice	Count	Count
Transportation problems	13%	31
Cost of care or insurance coverage	23%	53
Lack of nearby providers	11%	26
Long wait times	11%	26
Difficulty understanding how to get care	2%	5
Language or cultural barriers	1%	2
Physical accessibility (stairs, no ramps)	4%	9

What barriers, if any, have prevented you from getting the care you need? (...: Other – please specify: _____ - Text 13

Other – please specify: _____

I had my gallbladder bursted February 23. Had to have emergency gallbladder surgery was at the Meadows in delphos and im having viving nurses twice aweek

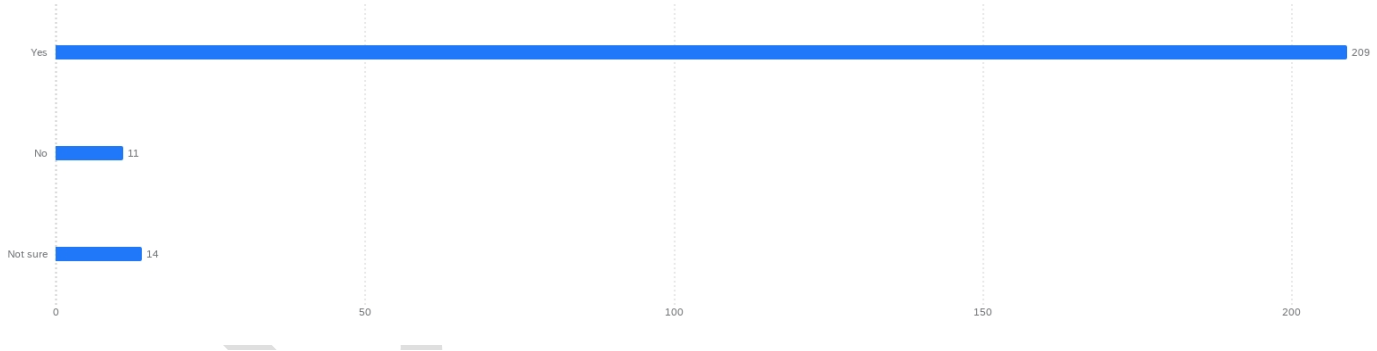
"I detest asking for help!"

Hearing & Dental

Cost of medication

I see all of my drs.when I have appointments only when I'm sick or in the hospital do I miss my appointments and they always know

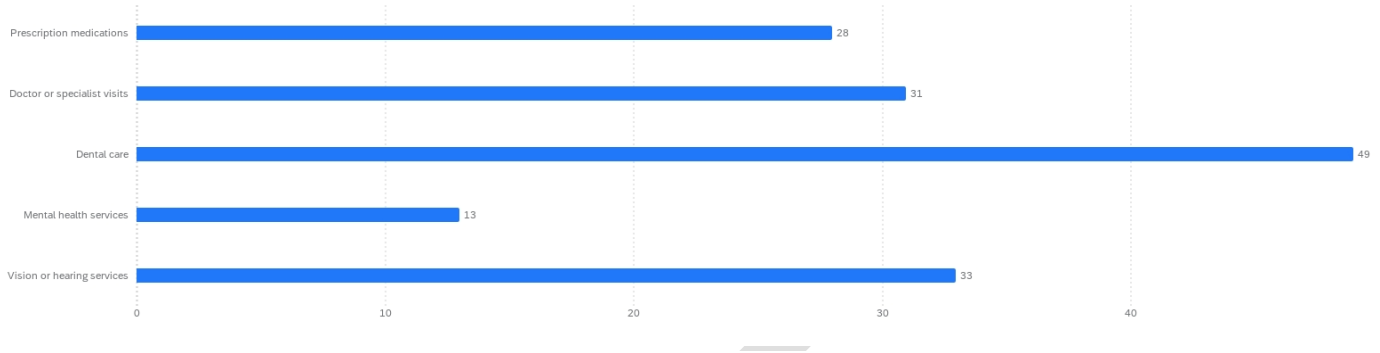
Do you have at least one person you can rely on for help when you have a health issue or emergency? 234



Do you have at least one person you can rely on for help when you have a health issue or emergency? 234

Q22 - Do you have at least one person you can rely on for help when you have a health issue or emergency?	Count	Count
Yes	89%	209
No	5%	11
Not sure	6%	14

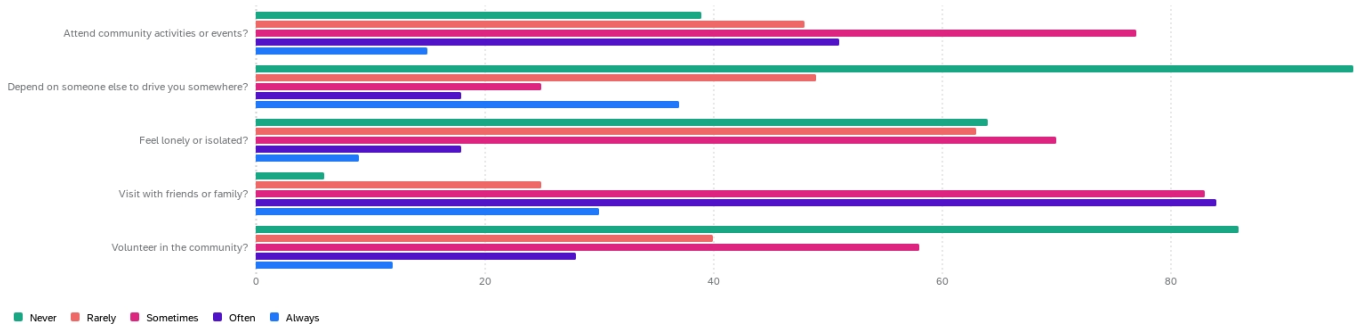
Have you delayed or gone without any of the following in the past 12 months due to issues with health coverage access or costs? (check all that apply) 85



Have you delayed or gone without any of the following in the past 12 months due to issues with health coverage access or costs? (check all that apply) 85

Q23 - Have you delayed or gone without any of the following in the past 12 months due to issues with health coverage access or costs? (check all that apply)	Count	Count
Prescription medications	33%	28
Doctor or specialist visits	36%	31
Dental care	58%	49
Mental health services	15%	13
Vision or hearing services	39%	33

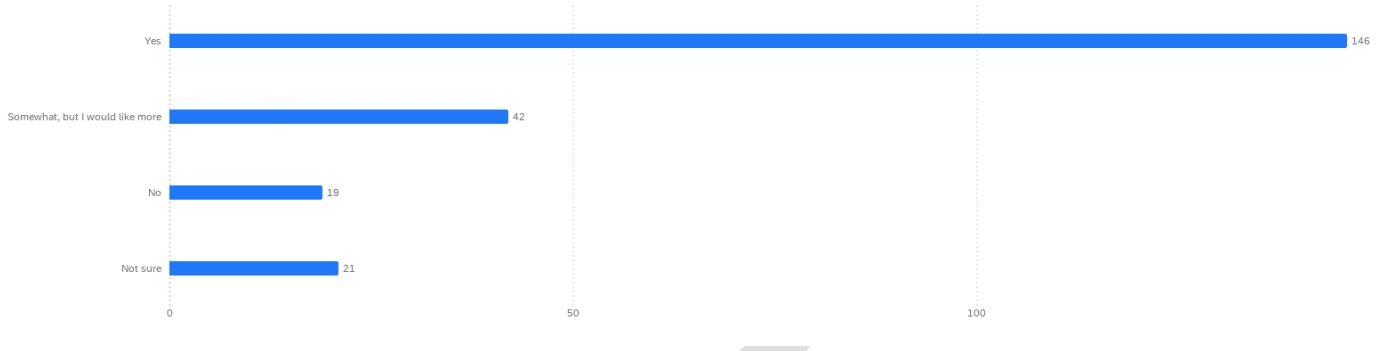
How often do you: 233



How often do you: 233

How often do you:	Never	Rarely	Sometimes	Often	Always
Attend community activities or events?	39	48	77	51	15
Depend on someone else to drive you somewhere?	96	49	25	18	37
Feel lonely or isolated?	64	63	70	18	9
Visit with friends or family?	6	25	83	84	30
Volunteer in the community?	86	40	58	28	12

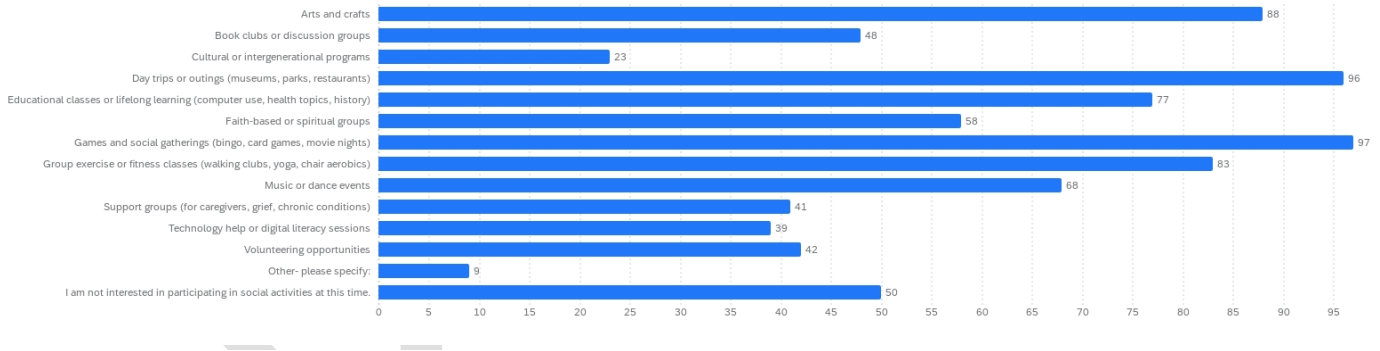
Do you feel you have enough opportunities to participate in social or community activities (events, clubs, educational programs, group outings)? 228



Do you feel you have enough opportunities to participate in social or community activities (events, clubs, educational programs, group outings)? 228

Q25 - Do you feel you have enough opportunities to participate in social or community activities (events, clubs, educational programs, group outings)?	Count	Count
Yes	64%	146
Somewhat, but I would like more	18%	42
No	8%	19
Not sure	9%	21

What types of social activities or opportunities would you be most interest... 224



What types of social activities or opportunities would you be most interest... 224

Q26 - What types of social activities or opportunities would you be most interested in participating in, if available in your community? (check all that apply) - Selected Choice	Count	Count
Arts and crafts	39%	88
Book clubs or discussion groups	21%	48
Cultural or intergenerational programs	10%	23
Day trips or outings (museums, parks, restaurants)	43%	96
Educational classes or lifelong learning (computer use, health topics, history)	34%	77
Faith-based or spiritual groups	26%	58
Games and social gatherings (bingo, card games, movie nights)	43%	97

What types of social activities or opportunities would you be most interest...: Other- please specify: - Text 7

Other- please specify:

I would like to join the YMCA, but my insurance does not cover Silver Sneakers.

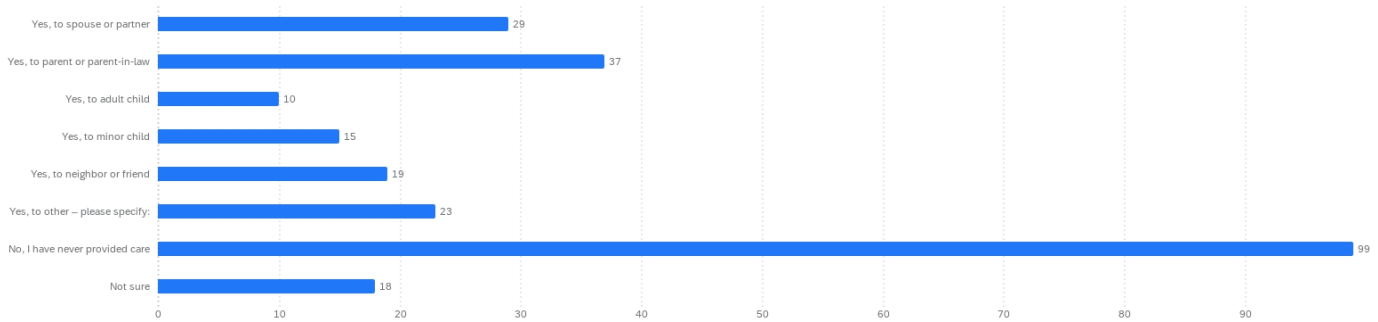
" I belong to 2 bible studies M-F Love it!"

Can't walk or stand. In wheelchair or recliner

I dont have time to participate

Sewing

Do you provide care or assistance on a regular basis to one or more family... 220



Do you provide care or assistance on a regular basis to one or more family... 220

Q27 - Do you provide care or assistance on a regular basis to one or more family members, friends, or neighbors due to age, disability, or chronic illness? If yes, who do you provide care for? (check all that apply) - Selected Choice	Count	Count
Yes, to spouse or partner	13%	29
Yes, to parent or parent-in-law	17%	37
Yes, to adult child	5%	10
Yes, to minor child	7%	15
Yes, to neighbor or friend	9%	19
Yes, to other – please specify:	10%	23
No, I have never provided care	45%	99

Do you provide care or assistance on a regular basis to one or more family...: Yes, to other – please specify: - Text 23

Yes, to other – please specify:

25 years ago

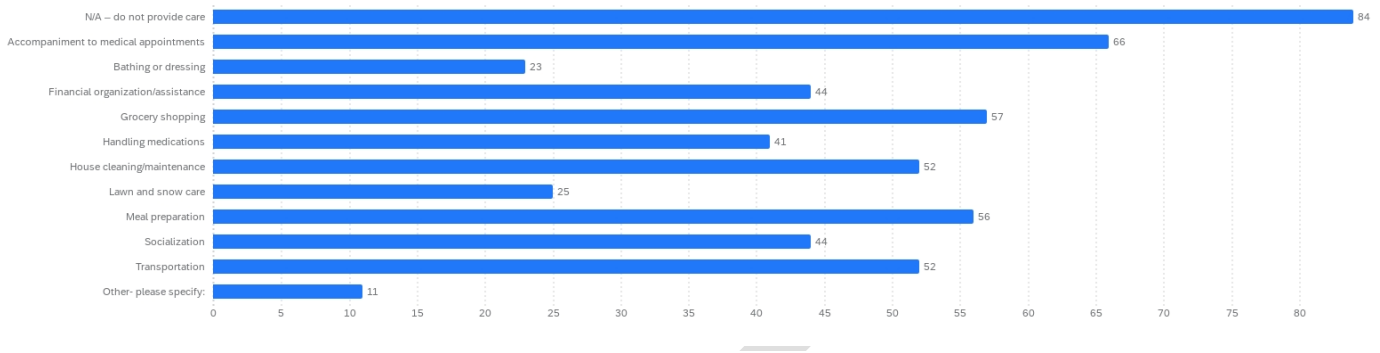
I am an outreach Coordinator who works with senior living facilities

I'm handicapped and can't walk

Sister

sibling

If yes, what types of care do you provide? 188



If yes, what types of care do you provide? 188

Q28 - If yes, what types of care do you provide? - Selected Choice	Count	Count
N/A – do not provide care	45%	84
Accompaniment to medical appointments	35%	66
Bathing or dressing	12%	23
Financial organization/assistance	23%	44
Grocery shopping	30%	57
Handling medications	22%	41
House cleaning/maintenance	28%	52

If yes, what types of care do you provide?: Other- please specify: - Text 11

Other- please specify:

Run errands

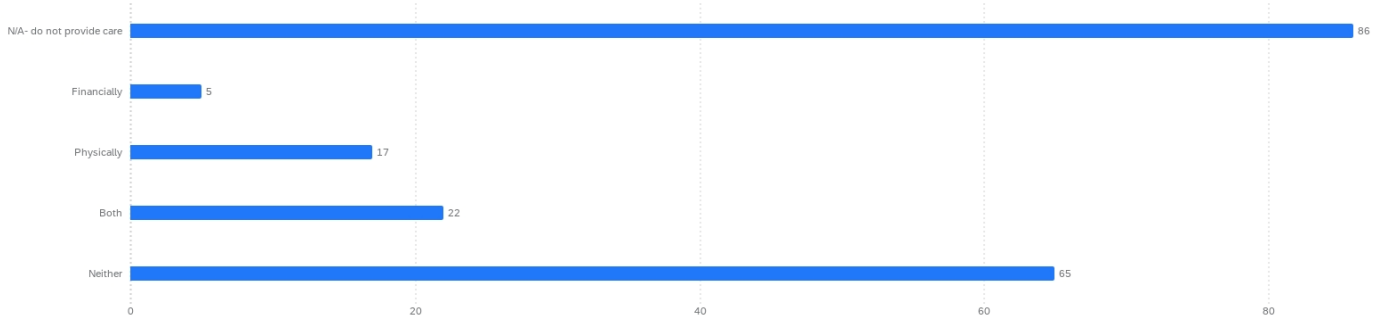
Peer support

Help moving or walking on occasion

I used to take care of my husband he was on hospice but I had him bathed and lotion on his body and dressed hair combed and deodorant on in his chair by the time the nurse would get there. After all that's what we are supposed to do help each other if we can right.

Daily check in by phone or computer

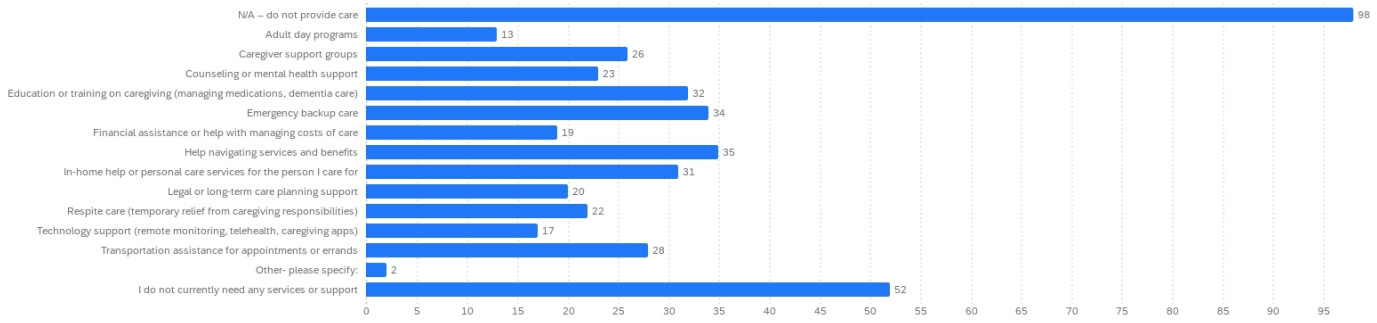
If yes, have you ever felt financially or physically burdened by your caregiving? 195



If yes, have you ever felt financially or physically burdened by your caregiving? 195

Q29 - If yes, have you ever felt financially or physically burdened by your caregiving?	Count	Count
N/A- do not provide care	44%	86
Financially	3%	5
Physically	9%	17
Both	11%	22
Neither	33%	65

As a caregiver, what services or supports do you feel would be most helpful... 205



As a caregiver, what services or supports do you feel would be most helpful... 205

Q30 - As a caregiver, what services or supports do you feel would be most helpful for your care situatio - Selected Choice	Count	Count
N/A – do not provide care	48%	98
Adult day programs	6%	13
Caregiver support groups	13%	26
Counseling or mental health support	11%	23
Education or training on caregiving (managing medications, dementia care)	16%	32
Emergency backup care	17%	34
Financial assistance or help with managing costs of care	9%	19

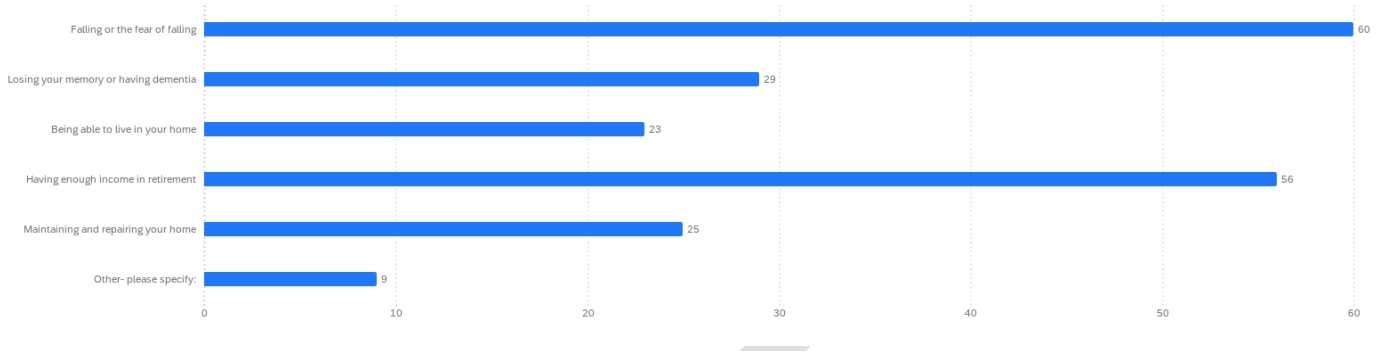
As a caregiver, what services or supports do you feel would be most helpful...: Other- please specify: - Text 2

Other- please specify:

Legal things such as wills and trusts

Medicare to pay for family members who provide in home care

Of the situations below, which concerns you the most? 202



Of the situations below, which concerns you the most? 202

Q31 - Of the situations below, which concerns you the most? - Selected Choice	Count	Count
Falling or the fear of falling	30%	60
Losing your memory or having dementia	14%	29
Being able to live in your home	11%	23
Having enough income in retirement	28%	56
Maintaining and repairing your home	12%	25
Other- please specify:	4%	9

Of the situations below, which concerns you the most?: Other- please specify: - Text 6

Other- please specify:

None

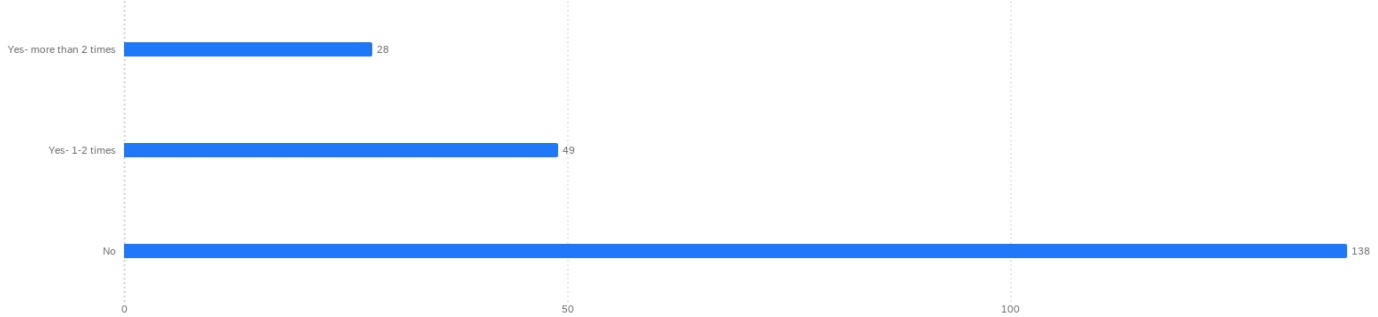
Hospital

Raising my children

Aging parents

None

Have you experienced a fall within the past year? 215



Summary of Focus Group Sessions

Nine regional focus groups were conducted across the PSA at identified Councils on Aging, senior centers, libraries, and independent living senior apartment complexes. A total of 174 older adults participated in the focus group process. At least one focus group session was conducted within each of the seven counties served by AAA3 to help ensure geographic representation and capture localized perspectives regarding service needs, barriers, and opportunities for future planning and system improvement.

County	Location	Total Sessions	Attendees
Allen	AAA3 Bingocize	1	15
Auglaize	Auglaize County Library	1	13
Hancock	50 North	1	39
Hardin	Ada (Beatitudes)	1	10
	COA Kenton	1	22
	COA Kenton	1	26
Mercer	COA Celina	1	20
Putnam	Medicare Bingo Kalida Fish and Game	1	17
Van Wert	COA Van Wert	1	12
		Total	**174**

Nutrition & Health

1.What is one thing that would help you (or the person you care for) eat better or manage health conditions, especially if living alone or on a tight budget?

Participants consistently identified affordability as the primary barrier to maintaining healthy eating habits and effectively managing health conditions, particularly for those living alone or on fixed incomes. Rising costs of groceries, medications, and utilities further exacerbate these challenges. Many individuals expressed difficulty accessing fresh, nutritious foods, noting limited availability through food banks and a lack of affordable options.

To address these concerns, participants emphasized the need for increased access to fresh produce through food banks, as well as expanded home-delivered meal services and congregate meal programs that also provide opportunities for social engagement. There was strong interest in nutrition education, including simple, cost-effective recipes and

practical health education classes. Access to dietitians and specialized dietary options, such as gluten-free meals, was also highlighted as important.

Additionally, participants underscored the importance of making health and wellness resources more accessible and less intimidating, suggesting options such as virtual classes or community-based programs. Creative, community-driven solutions—such as shared meal preparation, meal trains, and donation tables—were viewed as valuable strategies to support both nutrition and overall well-being. Enhanced access to personal care services was also identified as a key factor in promoting independence and better health outcomes.

Social Connection

2. What opportunities for socialization would you like to see expanded in your community?

Participants emphasized that social connection is essential to both physical health and emotional well-being. While many expressed satisfactions with existing programs offered through the Council on Aging and local senior centers, there was strong interest in expanding the variety and accessibility of social opportunities. Current offerings—such as crafts, games, fitness activities, and group events—were highly valued and described as instrumental in fostering a sense of community, purpose, and belonging.

Participants indicated a desire for more diverse, engaging, and modern activities beyond traditional options, including expanded exercise classes (e.g., chair yoga, line dancing), arts and crafts, educational sessions on aging, and group outings such as day trips. There was also interest in inclusive programming, such as singles groups and activities that encouraged participation without requiring a partner. Intergenerational programs were viewed positively, though some participants expressed preferences for structured interactions, particularly with younger children.

Key barriers to participation included transportation challenges, limited awareness of available opportunities, cost of certain programs, and concerns about social isolation. Free or low-cost programming was especially important, as some participants noted they could no longer afford external activities. Caregivers highlighted the need for additional support services, including respite care and training.

Overall, participants conveyed that social programming, particularly through trusted organizations like the Council on Aging—plays a critical role in reducing isolation, supporting mental health, and enhancing quality of life. Expanding accessible, affordable, and inclusive opportunities for social engagement was identified as a high priority.

Intergenerational Activities

3. What would encourage activities that bring younger and older generations together to reduce loneliness and foster relationships?

Intergenerational activities can play a significant role in reducing loneliness and fostering meaningful relationships between younger and older populations. Participants identified a wide range of engaging and inclusive opportunities that could strengthen these connections.

Suggested activities included social and recreational events such as board game nights, card games, music or karaoke evenings, dances, and movie nights paired with discussion groups. Creative and collaborative programs—such as all-ages choirs, craft sessions, and "carry-in" community meals—were also highlighted as effective ways to bring generations together in a relaxed and enjoyable environment. Additionally, partnerships between schools and older adult groups, such as combining school bands with senior musicians or organizing visits to nursing homes, were viewed as valuable opportunities for shared experiences and mutual learning.

Participants emphasized the importance of hands-on and service-oriented initiatives. Examples included creating care packages or shoebox gifts for children globally, participating in pen pal programs with students learning to write, and engaging in volunteer opportunities where youth

assist with activities such as meal service. These programs not only encourage interaction but also foster a sense of purpose and contribution across generations.

There was also interest in more flexible and innovative programming, such as pop-up events, seasonal gatherings like summer picnics, and cooking or nutrition classes in partnership with local culinary schools. Campaign-style initiatives, such as the Ohio Department of Aging's "Don't Fall For Me, Valentine" program, were particularly appreciated for their creativity and ability to engage diverse age groups.

However, participants noted some barriers to intergenerational engagement. These included a perceived lack of shared interests between age groups, limited awareness of available opportunities, and policies restricting grandchildren from attending certain programs at the Council on Aging. Addressing these challenges—by designing age-appropriate, mutually engaging activities and revisiting participation policies—could help increase involvement.

Overall, participants expressed strong interest in expanding intergenerational programming, particularly through interactive, purposeful, and inclusive activities that promote relationship-building and community connection.

Community Engagement

4. What would make it easier—or more appealing—for older adults to volunteer their time and talents in the community?

Community engagement among older adults can be enhanced by addressing practical barriers and improving awareness of available opportunities. Participants emphasized that transportation remains one of the most significant challenges to volunteering. Many older adults experience driving limitations or restrictions, which can make it difficult to consistently participate in community activities. Expanding transportation options or coordinating rides would greatly increase accessibility and participation.

In addition to transportation, participants highlighted the need for better communication and outreach. While many noted that their communities already offer a variety of volunteer opportunities, awareness remains a key issue. Suggestions included providing a centralized, easy-to-access list of opportunities and increasing promotion through non-digital channels such as grocery stores, libraries, newsletters, and direct phone calls. These methods were seen as more effective for reaching older adults who may not regularly use online platforms.

Participants also recommended having a dedicated coordinator to organize and communicate volunteer opportunities. This role could help match individuals with activities that align with their interests and skills, while also providing ongoing support and encouragement. Continued engagement through Council on Aging programs and familiar activities, such as bingo and social gatherings, was also identified to introduce and connect individuals to volunteer roles.

Overall, while communities may already offer ample opportunities for involvement, improving transportation access, strengthening communication strategies, and providing personalized coordination would make volunteering more accessible, appealing, and sustainable for older adults.

Caregiving Needs

5. What could be done to better support families who are providing care for older loved ones?

Supporting families who provide care for older loved ones requires a combination of accessible resources, practical assistance, and emotional support. Participants emphasized several key strategies that could significantly improve the caregiving experience.

A primary need identified was better access to information and resources. Caregivers expressed a desire for clearer, more consistent communication about available services, including support groups, educational tools, and community programs. Increasing awareness through targeted outreach and education particularly around caregiving skills such as safety and activities of daily living (ADLs)would help caregivers feel more confident and prepared in their roles.

Respite care emerged as one of the most critical needs. Caregivers highlighted the importance of having reliable options for temporary relief, such as volunteers or paid caregivers who can step in and provide care. This would allow caregivers time to rest, manage personal responsibilities, and maintain their own well-being. Some participants suggested that access to compensated caregiving support, regardless of Medicare eligibility, would significantly reduce financial and emotional strain—especially for individuals who must leave their jobs to care for a loved one.

Participants also noted the value of supportive services that foster connection and reduce isolation. Meal delivery programs and shared mealtime opportunities were seen as particularly meaningful, providing both nourishment and social engagement for caregivers and care recipients alike. In addition, expanding and promoting adult day center programs could offer structured support and engagement for older adults while giving caregivers consistent breaks during the day.

Finally, caregivers expressed interest in strengthening peer support networks, including condition-specific groups such as Alzheimer's support groups, as well as general caregiver support groups. These spaces provide emotional support, shared experiences, and practical advice that can ease the challenges of caregiving.

Overall, improving access to information, expanding respite and in-home support options, enhancing educational opportunities, and strengthening community-based programs would better equip and sustain caregivers in their essential role.

Access to Services

6. How can we make people more aware of available services and help them navigate these services more easily?

Improving awareness of available services and helping individuals navigate them more easily requires a coordinated approach focused on communication, accessibility, and community partnerships.

Participants emphasized the importance of consistent and accessible communication strategies. Traditional outreach methods were strongly preferred, including monthly

newsletters, radio announcements, community calendars (such as local event listings), and advertisements in newspapers. Distributing information through local businesses, libraries, and mail-based efforts—such as Every Door Direct Mail—was also identified as an effective way to reach a broader audience. While social media can play a role, participants noted concerns about misinformation and recommended using it cautiously as a supplemental tool rather than a primary source.

A centralized and easy-to-navigate system for information was another key recommendation. Participants expressed a need for a single, reliable source—such as a website or printed guide—that lists all available programs, services, and activities in one place. This would reduce confusion and make it easier for individuals to identify and access the resources they need.

Trusted community networks were seen as critical in spreading awareness. Faith-based organizations, word-of-mouth communication, and community events such as senior fairs or informational presentations were all highlighted as effective channels. Increasing opportunities for local organizations to present their services directly to the community would further enhance visibility and understanding.

Participants also underscored the value of personalized assistance. Social workers and staff members already play an important role in helping individuals navigate complex systems, such as Medicare and other support services. Expanding access to this type of one-on-one guidance could significantly improve individuals' ability to make informed decisions and connect with appropriate resources.

Finally, accessibility challenges—particularly related to transportation and infrastructure—were noted as barriers to service utilization. Limited transportation options and unsafe walking conditions, such as the lack of sidewalks in certain areas, can prevent individuals from reaching essential services. Addressing these barriers would further support access and engagement.

Overall, increasing awareness and improving navigation will require clear, centralized information; strong community-based outreach; trusted guidance from professionals; and attention to transportation and infrastructure needs that impact access.

Community Challenges

7. Among transportation, financial needs, and housing, which affects your community the most and why?

Participants identified housing, financial strain, and transportation as interconnected challenges affecting their community, with housing and financial needs emerging as the most significant overall concerns.

Housing was frequently cited as a primary issue, with participants noting a shortage of available units, rising rental costs, and limited access due to landlord restrictions. The lack of affordable housing options has created instability for many individuals, particularly those on fixed incomes. Participants emphasized that current Social Security benefits are often insufficient to keep pace with increasing rent and overall cost of living.

Financial needs were also identified as a major challenge, closely tied to housing affordability. Many participants reported difficulty covering basic expenses such as groceries and daily necessities. Limited access to diverse and affordable food options further compounds this issue, with some expressing a desire for additional grocery stores and more opportunities for social engagement, such as sit-down restaurants.

Transportation was another significant concern, impacting individuals' ability to access medical appointments, run errands, and remain socially connected. Participants highlighted issues such as limited-service availability, a lack of volunteers, unclear points of contact, and restricted

service hours. Infrastructure challenges, including road closures and limited parking, further complicate mobility. While transportation services are valued, participants expressed a need for expanded and more flexible options, including assistance to and from appointments. However, it was acknowledged that certain limitations, such as home health aides providing transportation, may be restricted due to liability concerns.

Overall, while all three areas are critical, housing affordability and financial strain were seen as having the greatest impact, with transportation acting as a key barrier that exacerbates these challenges. Addressing these issues in a coordinated manner would significantly improve quality of life and access to essential services within the community.

Housing & Affordability

8. Do you feel your current housing is safe, affordable, and meets your physical needs (accessibility, lighting, absence of hazards)?

Participants reported mixed experiences regarding the safety, affordability, and suitability of their current housing. While the majority indicated that their housing is generally safe and meets their basic needs, a notable portion expressed concerns related to affordability, maintenance, and accessibility.

Affordability emerged as a significant issue, particularly for individuals living on fixed or limited incomes. Even among those who feel their housing is safe, many reported that rising costs make it increasingly difficult to sustain. This highlights an ongoing gap between housing stability and financial feasibility.

Maintenance and upkeep were also identified as concerns. Some participants noted that landlords are not consistently addressing necessary repairs or updates, such as replacing worn carpeting or maintaining overall housing conditions. This contributes to a sense that, while housing may be functional, it is not always adequately maintained.

A key theme across responses was the need for accessibility improvements to support aging in place. Participants emphasized the importance of modifications such as grab bars, ramps, walk-in showers, and wider doorways to enhance safety and mobility within the home. Additionally, there was interest in access to reliable, affordable services for routine home maintenance and safety checks, including assistance with minor repairs and ensuring smoke and carbon monoxide detectors are functioning properly.

Overall, while many participants feel their housing is safe, concerns about affordability, maintenance, and the need for accessibility upgrades indicate that current housing does not fully meet the long-term needs of all residents. Addressing these gaps would be essential to ensuring safe, stable, and age-friendly living environments.

Summary

Participants expressed interest in increased on-site support to help them access benefits and services, particularly through scheduled sign-up events at the Council. They specifically requested opportunities to meet with benefits enrollment counselors to receive in-person

assistance, as many individuals are unsure how to navigate application processes independently. While some information is currently shared through newsletters and digital boards, participants noted that not all individuals are comfortable with technology or social media, reinforcing the need for hands-on guidance and multiple communication methods. Efforts to coordinate future sign-up events were well received and seen as a valuable step forward.

Through discussions, the most significant needs identified were transportation, affordable housing, and financial stability. Participants, especially those in rural areas—described ongoing challenges accessing healthcare and traveling to appointments. Housing was viewed as both limited and increasingly unaffordable, with many noting that Social Security income does not keep pace with rising living costs.

Navigating services were frequently described as complex, time-consuming, and discouraging. Participants emphasized the need for simplified systems, including a "no wrong door" approach, where individuals can easily access the right services regardless of where they enter. Improved outreach and clearer communication about available resources were also identified as priorities, although some participants acknowledged positive examples of coordinated local efforts and funding initiatives.

Emergency preparedness emerged as another area of concern. Experiences with tornadoes, severe weather, and the COVID-19 pandemic highlighted the need for stronger communication systems, reliable backup support, and clearly defined disaster response plans tailored to older adults.

Participants consistently expressed a desire to have a stronger voice in decisions that impact their lives. They called for more direct engagement with local leaders and policymakers, as well as programs that are responsive to the unique needs of their communities. Additionally, there was a clear need for better communication from healthcare providers and state agencies, along with guidance on long-term planning topics such as retirement, long-term care, and advance directives.

Finally, funding was identified as a cross-cutting concern. Both older adults and service providers noted that available resources have not kept pace with inflation or the growing aging population. Participants advocated for increased local funding, reduced administrative burden, and enhanced support for senior centers and caregivers to ensure sustainability and improved service delivery.

Themes

1. Advance Economic Stability for Older Adults

Address financial barriers impacting daily living by supporting access to affordable food, housing, healthcare, and community-based services, particularly for individuals on fixed or limited incomes.

2. Strengthen Food Security and Nutrition Access

Expand access to nutritious, affordable food through enhanced meal programs, food distribution systems, and nutrition education that promotes healthy, independent living.

3. Enhance Transportation and Mobility Options

Improve access to reliable, affordable, and flexible transportation services to support independence and ensure connection to healthcare, social engagement, and essential services.

4. Promote Social Connection and Reduce Isolation

Increase opportunities for meaningful social engagement through diverse, accessible, and inclusive programming that supports mental health and overall well-being.

5. Improve Service Awareness and System Navigation

Develop and implement coordinated communication strategies and centralized information systems to increase awareness of available resources and simplify access to services.

6. Support and Sustain Caregivers

Expand caregiver support through increased access to respite services, education, financial resources, and peer support to strengthen caregiver capacity and well-being.

7. Ensure Safe, Affordable, and Accessible Housing

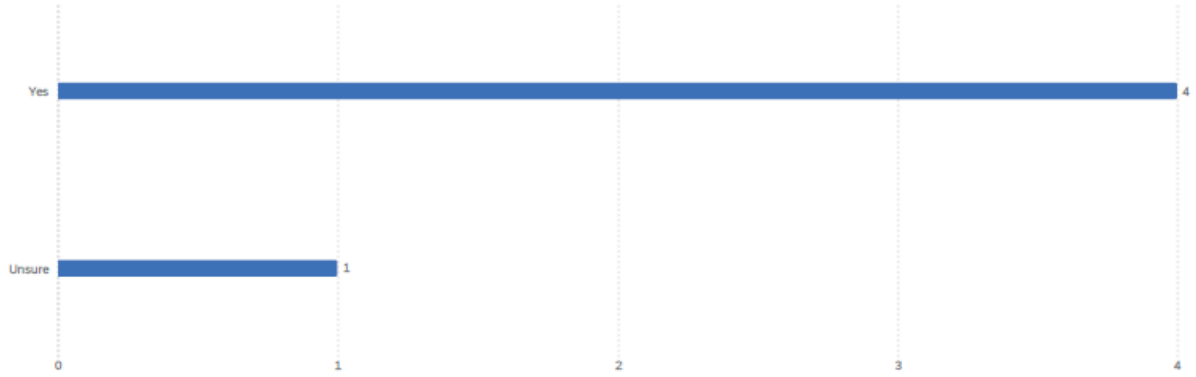
Promote housing stability by addressing affordability challenges, increasing availability of appropriate housing options, and supporting home modifications that enable aging in place.

8. Foster Community Engagement and Intergenerational Inclusion

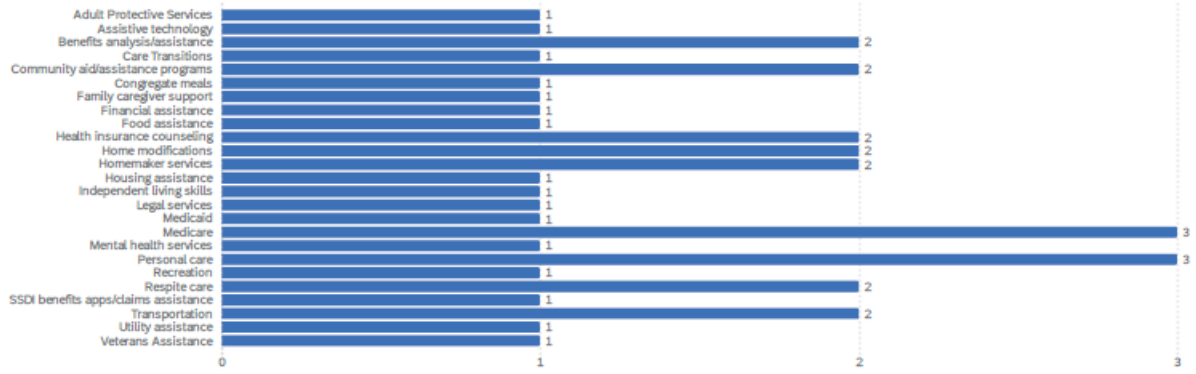
Encourage active participation in community life by expanding volunteer opportunities and intergenerational programs that promote purpose, inclusion, and community connection.

Information and Referral Survey Results

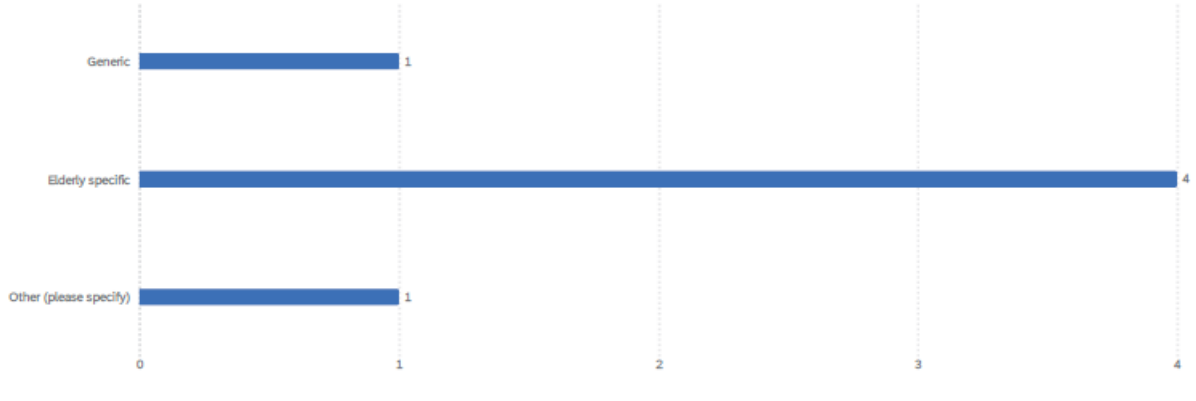
Q1: 1. Are you a service provider that provides information and referral (I&R), or similar services, within this planning and service area (PSA)? 5



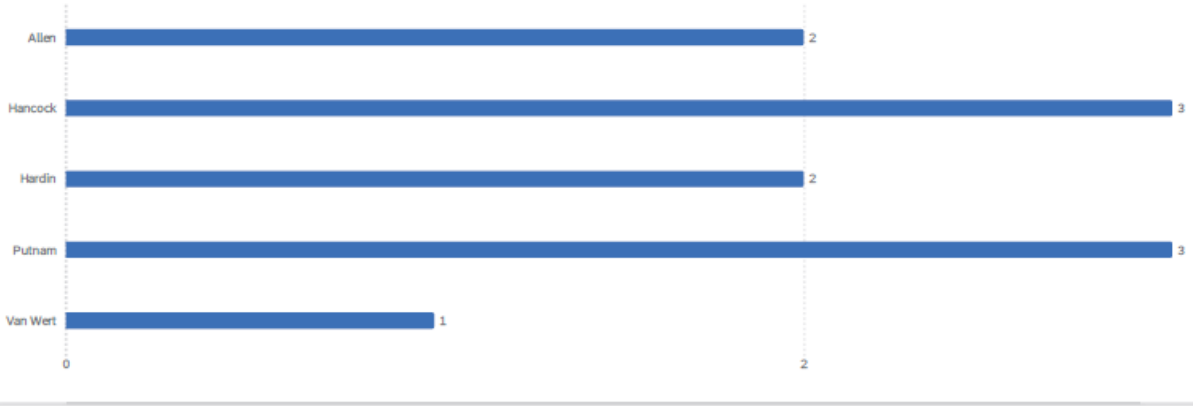
Q2: 2. Please identify the type and/or scope (generic or elderly specific, 24hour crisis line, etc.) of I&R services you offer (select all that apply): 5



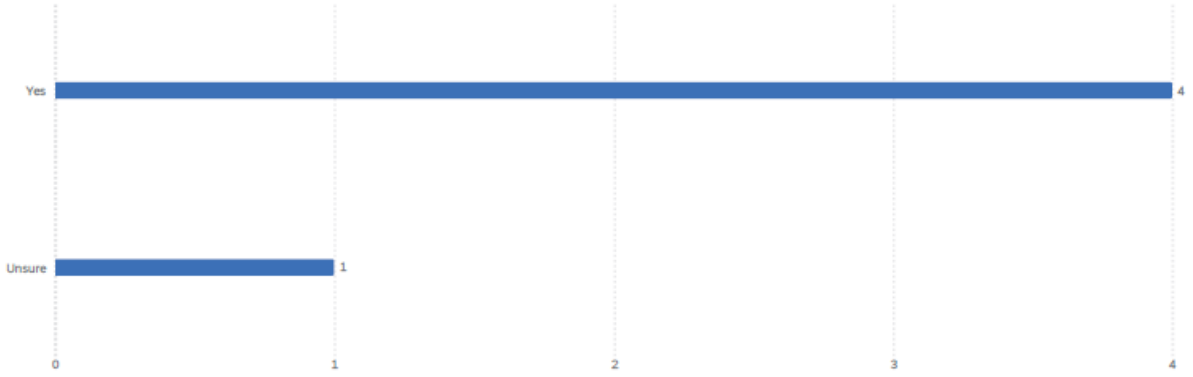
Q3: 3. I&R with the following scope (select all that apply): 5



Q4: 4. Please identify the geographical areas you serve: (select all that apply) 5



Q5: 5. Are the I&R services that you provide conveniently accessible by toll free or collect call to older individuals in the planning and service area? 5



Q6: 6. Describe the toll free or collect call accessibility of individuals living within the geographical area you serve 3

6. Describe the toll free or collect call accessibility of individuals livi...

We provide services thru local phone number and toll-free number. Individuals can also contact us through our website, social media, email and in person.

Office phone number
Website

We install ramps. Not sure this really applies to me

2027-2030 Strategic Area Plan Goals: Year 1

Priority Area (Please choose from drop down)	Financial well-being				
Goal #1	Older adults achieve and maintain financial stability by accessing affordable services, maximizing income supports, and reducing financial barriers to healthcare and essential needs				
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	The Financial Well-Being goal was developed directly from findings identified through AAA3's regional Needs Assessment process, including consumer surveys, stakeholder surveys, and focus groups conducted across the seven-county PSA. Findings consistently showed that rising costs of living, healthcare expenses, and difficulty accessing affordable services are placing increasing financial strain on older adults, particularly those living in rural communities and individuals with limited income. Needs Assessment findings identified healthcare affordability, prescription costs, food insecurity, and access to dental, vision, and hearing services as significant concerns impacting overall financial stability and well-being. Survey and focus group participants also reported confusion navigating public benefits and healthcare assistance programs, while community stakeholders emphasized the growing number of older adults struggling to meet basic needs despite potentially qualifying for assistance programs. The assessment further identified that older adults with the greatest social and economic need — including low-income individuals, rural residents, socially isolated older adults, caregivers, and individuals with chronic health conditions or disabilities — often experience additional barriers related to transportation, limited provider access, and lack of awareness of available benefits and community supports. Rural participants specifically noted fewer local resources and increased travel distances to access services. This goal directly addresses those identified needs by expanding access to public benefits enrollment assistance, reducing financial barriers to healthcare and essential services, increasing outreach to underserved and rural populations, and strengthening partnerships that improve access to affordable care and supports. Through the Benefits Enrollment Center, ADRC, and coordinated community partnerships, AAA3 will prioritize outreach and service connection efforts focused on individuals with the greatest social and economic need to improve financial stability, reduce out-of-pocket costs, and support older adults in remaining healthy and independent within their communities.				
Objectives	**Projected Start and End Dates**	**Type of Activity/Funding Source(s)**	**Staff Position(s) Assigned to Action Steps**	**Strategies**	**Measures**
1.1 Increase access to and utilization of public benefits and financial assistance programs to improve financial stability among older adults.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2030	OAA NCOA	Vice President of Community Living Services, Director of Aging & Disability, Benefits Enrollment Center Medicaid/Medicare Specialist	1. Leverage and expand Benefits Enrollment Center services to increase enrollment in public benefits and financial assistance programs 2. Conduct targeted outreach and enrollment assistance for underserved, rural, and high-need populations	# of applications submitted for public benefits by type (Medicare Part D, Medicare Savings Program, SNAP, and Medicaid) # of individuals enrolled in benefits as a result of assistance # of individuals reached through outreach and education efforts
1.2 Reduce financial barriers to healthcare and essential services to improve access to care and overall well-being.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2030	OAA NCOA	Vice President of Community Living Services, Director of Aging & Disability, Benefits Enrollment Center Medicaid/Medicare Specialist	1. Promote and connect individuals to programs and events that address gaps in dental, vision, and hearing services 2. Develop and expand partnerships to increase access to needed health care services within rural counties 3. Advocate for policies and initiatives that reduce out-of-pocket healthcare costs at the regional and state level	# of individuals connected to healthcare cost-reduction programs or services # of new or expanded partnerships established
What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Potential challenges to achieving this goal include rising healthcare and living costs, limited funding resources, increasing demand for assistance programs, and ongoing barriers accessing affordable healthcare services in rural communities. Additional challenges may include lack of awareness of available benefits, transportation limitations, and difficulty navigating complex enrollment systems. AAA3 will proactively mitigate these challenges by leveraging the ADRC and Benefits Enrollment Center to expand benefits enrollment assistance and targeted outreach efforts under Objective 1.1, particularly for underserved, rural, and high-need populations. Through Objective 1.2, the agency will strengthen partnerships with healthcare providers, community organizations, and local service agencies to improve access to affordable healthcare services and reduce out-of-pocket costs. AAA3 will also continue pursuing supplemental funding opportunities, utilizing regional data to identify emerging service gaps, and prioritizing outreach and referral efforts that connect older adults with the greatest social and economic need to essential benefits, healthcare supports, and financial assistance resources.				
Expected outcome(s) of this goal:	Older adults will experience increased financial stability through greater access to benefits, reduced out-of-pocket healthcare costs, and improved connection to affordable services. As a result, they will be better able to meet essential needs and maintain their health, independence, and overall well-being. % of participants reporting increased awareness of available healthcare benefits and services % of participants reporting improved access to healthcare benefits and support services				

Priority Area (Please choose from drop down)	Quality and coordinated healthcare
Goal #2	Older adults have increased access to affordable healthcare and essential services through comprehensive benefits enrollment, navigation support, and coordinated partnerships that reduce financial barriers and improve health outcomes.
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	This goal was developed directly from AAA3's regional Needs Assessment findings, which identified healthcare affordability, difficulty navigating benefits systems, and lack of awareness of available resources as major barriers for older adults across the PSA. Surveys and focus groups showed that many older adults struggle to access programs such as Medicare Savings Programs, SNAP, Medicaid, and Medicare Part D assistance despite potentially qualifying for support. Findings also showed that older adults with the greatest social and economic need — including low-income individuals, rural residents, caregivers, socially isolated older adults, and individuals with chronic conditions — often face additional barriers related to transportation, technology access, and navigating complex systems. Focus group participants consistently emphasized the need for more personalized assistance and coordinated navigation support. This goal directly addresses those needs by strengthening benefits enrollment assistance, expanding outreach to underserved and rural populations, improving care coordination, and integrating benefits screening into intake and service coordination processes. Through the ADRC, Benefits Enrollment Center, and community partnerships, AAA3 will work to reduce financial barriers and improve access to affordable healthcare and essential services for high-risk older adults throughout the region.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
3.3 Enhance care coordination and system navigation to increase enrollment in benefits and improve access to healthcare and essential services.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2030	OAA NCOA	Vice President of Community Living Services, Director of Aging & Disability, Benefits Enrollment Center Medicaid/Medicare Specialist	1. Leverage Benefits Enrollment Center services and Medicare/Medicaid Specialists to increase enrollment and completed applications for Medicare Part D, Medicare Savings Programs, SNAP, and Medicaid 2. Integrate benefits screening and enrollment support into intake, case management, and care coordination processes	# of completed BEC applications (by program type) # of individuals successfully enrolled in benefits Total amount of financial benefits assisted with through BEC # of LTCCs completed by intake staff
3.4 Increase awareness, visibility, and utilization of Benefits Enrollment Center services among older adults, caregivers, and community partners.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2030	OAA NCOA	Vice President of Community Living Services, Director of Aging & Disability, Benefits Enrollment Center Medicaid/Medicare Specialist, Director of Marketing & Communications	1. Conduct targeted outreach to older adults, caregivers, and underserved and rural populations to increase awareness and access to benefits 2. Promote Benefits Enrollment Center services through community events, healthcare providers, discharge planners, senior centers, housing sites, and partner organizations 3. Establish referral pathways with healthcare providers and community partners to increase access to BEC services	# of outreach events and presentations conducted (Benefit Checkups & Legal Aid of Western Ohio assessments) # of individuals reached through outreach efforts # of referrals received from community and healthcare partners

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Potential challenges to achieving this goal include increasing demand for benefits assistance, ongoing complexity within Medicare and Medicaid systems, transportation barriers, limited awareness of available programs, and staffing or capacity limitations among community partners. Rural older adults may also experience additional barriers related to internet access, technology literacy, and limited local service availability. AAA3 will proactively mitigate these challenges by leveraging the ADRC, Benefits Enrollment Center (BEC), and Medicare/Medicaid Specialists to provide coordinated outreach, enrollment assistance, and system navigation support. Through Objective 3.3, the agency will integrate benefits screening and enrollment support into intake, care coordination, and case management processes to improve early identification of needs and connection to services. Through Objective 3.4, AAA3 will conduct targeted outreach and strengthen referral pathways with healthcare providers, discharge planners, senior centers, housing sites, and community organizations to increase awareness and access to benefits among underserved and rural populations.
Expected outcome(s) of this goal:	Older adults will experience increased access to affordable healthcare and essential services through successful enrollment in benefits and improved navigation support. As a result, individuals will have reduced out-of-pocket costs, increased financial stability, and improved ability to manage their health and remain independent. % of participants reporting improved ability to access affordable healthcare and essential services % of participants reporting reduced financial barriers to healthcare and daily living needs

Priority Area (Please choose from drop down)	Community supports and services
Goal #3	Advance age-friendly policies and practices by integrating the Age-Friendly Communities framework into local planning efforts, including Community Health Improvement Plans (CHIP), to support livable, inclusive, and responsive communities for older adults.
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	This goal was developed directly from AAA3's regional Needs Assessment findings, focus groups, and stakeholder feedback, which identified the importance of creating communities that better support aging in place, accessibility, social connection, and coordinated service delivery for older adults. In September 2025, Ohio officially joined the AARP Network of Age-Friendly States and Communities, becoming the 13th state in the nation to receive this designation. AAA3 recognizes this as an opportunity to strengthen and expand Age-Friendly Communities efforts throughout the region, particularly within rural and underserved communities. Needs Assessment findings highlighted ongoing challenges related to transportation, housing, healthcare access, social isolation, and limited coordination of services, especially among older adults with the greatest social and economic need. Rural stakeholders also identified gaps in local planning related to accessibility, transportation, housing options, and opportunities for engagement. This goal directly addresses those findings by integrating the Age-Friendly Communities framework into Community Health Improvement Plans (CHIPs), strengthening cross-sector collaboration, and expanding age-friendly planning efforts into additional rural counties. Through Objectives 4.1-4.3, AAA3 will use local data, community partnerships, and technical assistance to help ensure older adults are connected to more accessible, inclusive, and responsive community supports and services.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
4.1 Integrate Age-Friendly Communities principles into the Allen County Community Health Improvement Plan (CHIP) to ensure aging is embedded in community health priorities and strategies.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2029	OAA	Vice President of Community Living Services, Director of Population Health, Director of Aging & Disability, Health Education Coordinator	1. Align Age-Friendly Communities domains with CHIP priorities to ensure consistency across planning efforts 2. Actively participate in CHIP planning processes to embed aging considerations and advocate for inclusion of older adult-specific measures and outcomes 3. Utilize local data (Needs Assessment, health data atlas, etc.) to inform and prioritize aging-related needs within CHIP strategies	Age-Friendly Communities framework included as a measurable goal within the Allen County CHIP (2026-2029 cycle) # of CHIP strategies that include older adult-specific measures or outcomes # of aging-related priorities informed by local data
4.2 Strengthen cross-sector collaboration to advance implementation of Age-Friendly initiatives.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2027	OAA	Vice President of Community Living Services, Director of Population Health, Director of Aging & Disability	1. Convene cross-sector partners (public health, healthcare, housing, transportation, local government) and formalize partnerships to support implementation of age-friendly initiatives 2. Leverage existing coalitions and networks to coordinate and align Age-Friendly efforts across sectors 3. Establish shared goals and accountability measures across partners to track progress on age-friendly initiatives	# of partners engaged in Age-Friendly initiatives # of cross-sector meetings or collaborative efforts conducted # of joint initiatives or projects implemented across sectors
4.3 Expand integration of Age-Friendly Communities principles into additional rural counties through local planning and CHIP alignment.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2030	OAA	Vice President of Community Living Services, Director of Population Health	1. Engage in rural county CHIP planning processes to advocate for and integrate Age-Friendly principles into local strategies 2. Utilize local data (Needs Assessment, health data atlas, etc.) to inform aging-related priorities within rural CHIP efforts 3. Provide technical assistance and guidance to rural communities on implementing Age-Friendly Communities frameworks	Age-Friendly Communities framework included in a rural county CHIP by end of calendar year 2030

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Potential challenges to achieving this goal include limited local capacity and resources to support Age-Friendly initiatives, competing community priorities, varying levels of engagement across sectors, and limited infrastructure in rural communities to support implementation efforts. Additional barriers may include transportation limitations, workforce shortages, and difficulty sustaining long-term collaboration across healthcare, public health, housing, transportation, and local government partners. AAA3 will proactively mitigate these challenges by leveraging Objectives 4.1-4.3 to strengthen cross-sector collaboration, align Age-Friendly Communities efforts with existing Community Health Improvement Plan (CHIP) processes, and utilize local Needs Assessment and health data to guide planning priorities. The agency will continue convening community partners, participating in CHIP planning efforts, and providing technical assistance to rural counties to support implementation of Age-Friendly principles. AAA3 will also utilize existing coalitions, community partnerships, and regional planning efforts to improve coordination, sustain momentum, and expand Age-Friendly initiatives throughout the PSA.
Expected outcome(s) of this goal:	Communities will increasingly incorporate Age-Friendly principles into local planning and decision-making, resulting in more inclusive, coordinated, and responsive systems that support older adults. As a result, older adults will experience improved access to services, greater community engagement, and enhanced quality of life. % of older adults reporting improved access to community services, supports, or opportunities for engagement that support aging in place % of community partners reporting increased integration of age-friendly principles into local planning and decision-making

Priority Area (Please choose from drop down)	Reliable transportation
Goal #4	Older adults have access to safe, reliable community transportation options, supported by increased safety awareness and practices that promote confidence, independence, and informed mobility decisions.
Rationale (Describe how your goal is linked to your needs assessment findings and how it addresses reaching services and supports to those with greatest social and economic need).	This goal was developed directly from AAA3's regional Needs Assessment findings, focus groups, and stakeholder feedback, which identified transportation and safe mobility as ongoing concerns for older adults across the PSA. Findings showed that many older adults, particularly in rural communities, face barriers related to limited transportation options, long travel distances, reduced mobility, and concerns about driving safety and independence. Focus group participants and community stakeholders also emphasized the importance of helping older adults maintain independence while ensuring they have access to safe transportation alternatives as driving abilities change. Older adults with the greatest social and economic need — including low-income individuals, rural residents, socially isolated older adults, and individuals with functional limitations — were identified as being at increased risk for transportation insecurity and social isolation when reliable mobility options are unavailable. This goal directly addresses those findings by expanding education, screening, and support related to safe driving practices and alternative transportation options. Through Objectives 6.4 and 6.5, AAA3 will conduct CarFit events, expand the Trusted Riders program, analyze local crash and safety data to inform outreach efforts, and provide education on transitioning from driving to alternative transportation options when appropriate. These strategies are intended to improve safety awareness, support informed mobility decisions, and help older adults remain connected to healthcare, essential services, and community activities throughout the region.

Objectives	Projected Start and End Dates	Type of Activity/Funding Source(s)	Staff Position(s) Assigned to Action Steps	Strategies	Measures
6.4 Improve older adults' ability to safely operate vehicles and access transportation services through education, screening, and support.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2028	OAA ODOT AmeriCorps	Vice President of Community Living Services, Director of Aging & Disability, Retired Senior Vounteer Program Project Director, Mobility Manager, Mobility Navigator	1. Conduct CarFit events to help older adults optimize the fit and safe use of their personal vehicles, improving comfort, visibility, and overall driving safety 2. Promote and expand the Trusted Riders program to recruit volunteer chaperones and increase utilization of the service, providing safe, supported transportation options for older adults	# of CarFit events conducted annually (target of 7) # of outreach events or recruitment efforts conducted (goal of participation in one Senior Resource Fair in each county annually to recuit volunteers) # of older adults participating in CarFit events # of volunteers recruited for Trusted Riders
6.5 Increase awareness of safe driving practices, road hazards, and alternative transportation options to reduce risk and promote safe mobility decisions.	Projected Start Date: January 1, 2027 Projected End Date: December 31st, 2028	OAA ODOT AmeriCorps	Vice President of Community Living Services, Director of Aging & Disability, Mobility Manager, Mobility Navigator	1. Analyze county-level fatal crash reports annually, with a focus on older adult involvement, to inform targeted education and outreach efforts during Older Driver Safety Awareness Week 2. Provide education on transitioning from driving to alternative transportation options when appropriate	# of safety education campaigns conducted annually # of outreach events or presentations on driver safety # of individuals transitioning to alternative transportation options following education/support

What challenges or barriers might prevent your AAA from achieving this goal? How will your agency proactively mitigate these challenges to stay on track?	Potential challenges to achieving this goal include limited transportation infrastructure in rural communities, difficulty recruiting and retaining volunteers for programs such as Trusted Riders, increasing transportation costs, and limited awareness of available mobility and driver safety resources among older adults. Additional barriers may include older adults' reluctance to transition away from driving, social isolation, and limited local capacity to support transportation alternatives. AAA3 will proactively mitigate these challenges by leveraging Objectives 6.4 and 6.5 to expand transportation safety education, increase outreach efforts, and strengthen volunteer-supported transportation options. The agency will continue conducting CarFit events, analyzing county-level crash and safety data to guide targeted outreach, and promoting Older Driver Safety Awareness initiatives to improve education and awareness. AAA3 will also expand recruitment efforts for the Trusted Riders program, participate in community resource fairs across the PSA, and provide education and support to help older adults transition to alternative transportation options when appropriate. These efforts will help improve mobility, safety, and continued community engagement for older adults throughout the region.
Expected outcome(s) of this goal:	Older adults will have increased awareness and confidence in safe driving practices and access to alternative transportation options, leading to safer and more informed mobility decisions. As a result, individuals will experience reduced risk of accidents, sustained independence, and continued engagement in their communities over time. % of CarFit participants reporting improved confidence in driving safety % of participants making safety adjustments to their vehicle or driving habits