City of Boston

Age Strong Commission Area Agency on Aging

Region VI

Area Plan 2026-2029

October 1, 2025- September 30, 2029

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Context

In preparation for the development of the FFY2026-2029 Area Plan, the Age Strong Commission conducted its Needs Assessment work from August 2024 through December 2024. The Needs Assessment team consisted of Age Strong staff and faculty and students from the University of Massachusetts Center for Social and Demographic Research on Aging. This team worked together to develop the Needs Assessment survey which was distributed to adults 60+ city-wide and convened older adults at in-person focus groups hosted in partnership with community partners. This year's Needs Assessment work combined the quadrennial AAA state planning as well as the septennial Age-Friendly planning work in order to make both planning processes more efficient and reduce the survey and participation burden on older adults.

The COVID-19 pandemic greatly impacted the ability of the Age strong Commission to conduct in-community work for the last planning the Area Plan, so it was greatly important to center the 2024 planning work around this approach. Twenty in-person focus groups and two Zoom focus groups were held between September 2024 and November 2024. To encourage participation and ensure that discussions were accessible to older adults, the AAA team collaborated with Title III grantee partners, older adult-serving organizations throughout the city, and Boston Housing Authority (BHA) older adult residential buildings to coordinate focus group dates and outreach for the event to encourage maximum participation.

Focus group attendance ranged from five to more than 20 participants. Many of the focus groups were joined by staff of the partner agencies' older adult residential building staff who helped the AAA bring the groups together. Each focus group was guided by a facilitation guide to ensure consistency across each conversation. The facilitation guide was translated into Spanish, Chinese, Cape Verdean and Haitian. While most focus groups were held as a group discussion, in order to accommodate diverse groups of older adults and their varying degrees of hearing and cognitive abilities, in some cases, the facilitator engaged the older adults by going to each participant to ask the questions in the facilitation guide.

Notes for focus groups conducted in a language other than English were taken in said language and then translated to English and shared with the AAA team. All final notes were retained as digital files for the AAA team to review and analyze.

Analysis from the 22 focus groups indicate that by and large Boston offers older adults excellent transportation, healthcare, and social opportunities. The MBTA's buses, Red Line trains, and programs like The RIDE make it easy to get around without a car. Walkability is

another major benefit, especially in neighborhoods like Jamaica Plain and the North End. The city is home to top-tier hospitals and senior-focused programs like PACE, which provide medical care, transportation, and support services. Many seniors moved to Boston specifically for its healthcare quality. While Boston is senior-friendly some neighborhoods could offer more local activities. Seniors also desire more excursions and earlier event times. However, the city excels in providing services, community connections, and opportunities for lifelong learning. With accessible healthcare, transportation, and a rich cultural scene, Boston is a welcoming and supportive place for older residents to age actively and comfortably.

Still, older Bostonians face significant challenges, including discrimination, transportation issues, safety concerns, and lack of accessible resources. Reports of harassment against elders, particularly in Asian communities, highlight the need for better security and support systems. Some seniors feel vulnerable to bullying, emphasizing the importance of safer public spaces. Additionally, access to information is inconsistent, with many relying on community boards, flyers, or word of mouth. Some seniors, especially homebound individuals, feel isolated due to a lack of effective outreach. Suggestions include robocalls, mail campaigns, and a centralized information hub. Housing remains a critical issue, with long waitlists, inaccessible buildings, and security concerns in senior housing complexes. High rent, property taxes, and financial strain make it difficult for elders to afford necessities

In addition to focus groups, the needs assessment team used surveys to collect data. Survey distribution was done in-person and electronically to ensure a broad reach to as many older adults across the service area. In order to develop a survey that encompassed the necessary dimensions of the Age-Friendly planning process as well as information identified by AGE, the Needs Assessment survey was developed in consultation with several City of Boston departments. The intention behind this was to ensure that questions aligned with appropriate measures used by other departments as well as City standards and/or guidelines on data collection. The final product was a 29-item survey which included questions about areas of concern, housing, civic engagement, ageism, current ways of getting information about events and resources, feelings of neighborhood inclusion, as well as demographic questions. Surveys were translated into twelve different languages including Spanish, Traditional Chinese, Simplified Chinese, Cape Verdean Creole, Haitian Creole, Portuguese, Vietnamese, Russian, French, Arabic, Somalian. These eleven languages represent the most commonly spoken languages in Boston other than English. The team distributed paper copies of the survey in these languages throughout the service area as well as created a webpage with information about the purpose of the Needs Assessment project with links to the online survey in each language. Title III grantee partners and older

adult-serving organizations throughout the city were asked to share the survey with their networks and encourage the older adults they serve to participate in this work.

A total of 837 surveys were collected from September to December meeting state reporting requirements. According to data analysis, the table below contains the top 10 most commonly reported needs by older adults who were asked to indicate their most important needs related to aging.

Table 1. Top 10 Reported needs

Need	**Older Adults (%)**
Transportation Access	62.80%
Staying Active/Wellness Promotion	62.20%
Affordable Health Care	61.40%
Leisure, Recreation, & Socialization	58.10%
Access to Health Care	54%
In-Home Support for Independence	53.90%
Affordable Housing	50.90%
Access to Services	50.50%
Nutrition Support	48.90%
Safety & Security	47.30%

N = 837

Notes. The reported sample size (N) is the number of respondents who reported at least one need.

In addition to a survey specifically for older adults, the team also developed a survey for aging service providers (n=43). These surveys were developed with the intention of understanding the needs of caregivers as well the unmet needs of older adults and which populations were seen as the most difficult to reach by aging service providers. These perspectives were essential to capture as part of the planning process so that an

interconnected and integrated approach to service delivery appropriately meets the needs of older adults and their caregivers.

Summary data from the provider survey indicated that the subpopulations that they found particularly difficult to reach were homebound (4 mentions) and isolated (3 mentions) older adults. The LGBTQIA+ community (7 mentions) was highlighted as a group facing unique challenges in accessing services and support. Non-English-speaking individuals, particularly Mandarin and Cantonese-speaking, Arabic-speaking, Creole-speaking, and Somali residents, were noted as difficult to reach due to communication barriers.

Additionally, providers were asked what they identify as the unmet needs of the populations they serve. The most commonly cited issue was transportation needs. Both affordable transportation (10 mentions) and non-medical transportation (2 mentions) were highlighted as significant barriers for older adults. Accessibility of transportation was also noted. Affordable and accessible housing (5 mentions) was frequently identified as a major unmet need. There were also specific mentions of LGBTQIA+ housing, housing for people with severe mental illness, and "enhanced group living environments" for older adults who could benefit from group living but do not need to be in a skilled nursing facility (2 mentions each). Food security (2 mentions) emerged as a concern, with providers noting the need for more programs to address high costs of food as well as accessing food.

Focus Areas

The 2026-2029 area plan has four key foci as designated by the Administration for Community Living (ACL) which aims to address the needs of those in the Age Strong service area as well as the strategies for addressing those needs.

Older Americans Act Core Programs
With the help of key partnerships from over twenty different organizations in the City of Boston, the AAA is able to deliver a variety of Title III services available in-person and virtually. Services are delivered in each of the seventeen unique neighborhoods in the City enabling older adults to lead enriching lives in the community of their choosing. The AAA strives to ensure the Title III services in each neighborhood reflect the cultural and linguistic diversity of the service area with many programs being offered in a multitude of languages and tailored to be culturally relevant to the participants.

Goal 1: Continue to fund and expand the network of older adult service agencies in the service area that provide Title III programming.

Objective: Provide Title III funded programs to older adults in Boston to support and increase their quality of life.

- Strategy: Continue to use the City of Boston Grant Program and Request for Proposal processes to Award the Title III Older American Act funds to older adult-serving organizations that provide supportive services, nutrition services, evidenced-based health promotion services, caregiver services, and Ombudsman services.

- Strategy: Conduct outreach to older adult-serving organizations across the service area to continually support a diverse network of partner agencies via the City of Boston's funding mechanisms.

  Measure: Increase the number of older adults in Boston receiving Title III-funded services by 10% annually to enhance their quality of life.

  Measure: Increase outreach efforts to at least 10 new organizations per year to diversify the network of Title III-funded service providers who submit proposals for Title III funding.

Goal 2: Address and prevent malnutrition in older adults by providing nutritious meals through the Title III nutrition program.

Objective: Work with the Title III Nutrition Program providers to ensure regular Malnutrition Screening Tool assessments are conducted for home-delivered and congregate meal recipients.

- Strategy: Conduct nutrition assessment at least once every 6 months or more frequently depending on whether the participant is deemed high-risk for malnutrition.

- Strategy: Title III Nutrition program partners will provide guidance on incorporating oral nutrition supplements into their diet as needed.

  Measure: Conduct nutrition assessments at least twice per year or more frequently for high-risk individuals.

  Measure: 100% of high-risk participants will receive follow-up screenings within three months of their initial assessment.

Objective: Work with nutrition programs to offer nutrition education and counseling for home-delivered and congregate meal recipients.

- Strategy: Offer nutrition counseling to clients and their family members who are at high risk of malnutrition.

- Strategy: Age Strong Commission will work with nutrition providers to put on collaborative programming during National Nutrition Month such as with in-person and virtual presentations and publishing articles in the Age Strong Seniority Magazine.

  Measure: Offer nutrition counseling to at least 90% of clients and family members identified as high-risk for malnutrition.

  Measure: Collaborate with nutrition providers to conduct at least four educational events per year during National Nutrition Month, including in-person and virtual presentations.

  Measure: Publish at least two articles annually on nutrition and malnutrition prevention in the Age Strong Seniority Magazine.

Goal 3: Ensure that Elder Justice is an inter-disciplinary and coordinated approach to reduce the instances of elder abuse, neglect, and exploitation over the next four years.

Objective: Work with local ASAPs to bolster the Boston Elder Protective Services Program at Central Boston Elder Services (CBES) and other elder justice programs in the service area.

- Strategy: CBES will work with local colleges and universities, hospitals and other healthcare agencies to expand internship programs and opportunities for young adults interested in aging services to address growing employment needs in the protective services field.

- Strategy: CBES will provide specific funding cycles aimed at helping nonprofit organizations establish and/or implement model Learning Management Systems and Internship programs to address employment needs and shortfalls.

- Strategy: Conduct outreach in coordination with the local ASAPs to promote the Title III-B Ombudsman Program to increase the number of volunteer ombudsmen and retain existing members who are able to identify and advocate on behalf of older adults in long-term care facilities.

- Strategy: AAA Constituent Services Team will continue to make referrals to CBES when working with older adults who may be eligible for protective services.

  Measure: Support CBES to increase the number of internships in protective services by 10% over the next four years through partnerships with local colleges, universities, hospitals, and healthcare agencies.

  Measure: Track and report the number of interns who transition into permanent roles within elder protective services annually.

  Measure: Conduct at least six targeted outreach campaigns annually to promote the Title III-B Ombudsman Program.

  Measure: Increase the number of volunteer ombudsmen by at least 20% over four years to enhance advocacy for older adults in long-term care facilities.

Objective: Work with Boston Police Department, Consumer Affairs, and Attorney General's Office to educate seniors and address issues around scams, safety, and consumer protection.

- Strategy: Work with the Boston Police Department to educate older adults about current scams and exploitation efforts as well as crime prevention techniques to protect themselves from victimization.

- Strategy: Conduct information campaigns via the Age Strong Communications Team to create educational materials about scams, consumer safety, and elder safety which will be shared widely through the service area.

  Measure: Collaborate with the Boston Police Department to provide quarterly workshops on scam awareness, financial exploitation, and crime prevention, aiming to engage at least 500 older adults annually.

Goal 4: Continue efforts to make Boston a more Age and Dementia-Friendly City

Objective: Renew and publish the next Age-Friendly Action Plan for the City of Boston

- Strategy: Conduct a planning process to hear from older adults in the service area about assets, challenges, and ideas for improvements for those who are aging.

- Strategy: Work with the Center for Social and Demographic Research on Aging at UMass Boston to synthesize and analyze data from the planning process. From this analysis work UMass Boston and the Age Strong Commission as well as other city and community stakeholders will create an Age-Friendly Action plan.

  Measure: Publish the next Age-Friendly Action Plan in collaboration with UMass Boston by Q4 of 2025.

Objective: Expand front facing Age-Friendly work within the City of Boston and community organizations, and businesses

- Strategy: Continue engaging older adults and integrating age-friendly concepts into City planning processes.

- Strategy: Strategy: Continue Age and Dementia-Friendly staff training and development opportunities for City staff and community organizations, as well as businesses seeking to become Age and Dementia-Friendly Certified.

- Strategy: Support expansion of the number of memory cafes hosted at the Boston Public Library to offer support to those experiencing memory loss and their care partners.

- Strategy: Collaborate with Boston Public Health Commission on implementing their BOLD Initiative strategic plan aimed at supporting Boston residents living with, or at high risk of, developing Alzheimer's or dementia, and their caregivers.

- Strategy: Enhance support for care partners of those living with memory loss by connecting them with existing resources and programs available about different supports for these individuals such as care navigation, support in the home and community.

  Measure: Increase the number of Age and Dementia-Friendly businesses to 100 by Summer 2025 and by 15% each following quarter through FFY2029.

  Measure: Increase the number of new care partners connected to resources each year throughout the FFY2026-2029 period.

Goal 5: Improve older adults' access to assistive technology and digital literacy training.

Objective: Work with Title III Program providers to deliver and expand opportunities to connect older adults to assistive technology and digital literacy training.

- Strategy: Continue to support existing service providers through Title III funds who offer digital literacy classes.

- Strategy: Support organizations, such as Massachusetts Association for the Blind, to increase resource outreach connecting older adults with low-vision or blindness to assistive technology options.

- Strategy: Advocacy and Benefit Specialists from Age Strong's Constituent Services Team will provide specific resources about existing opportunities for digital literacy and assistive technology as they deliver Information and Referral services.

- Strategy: Encourage the City of Boston Department of Innovation and Technology to prioritize funding for digital literacy and safety training focused on older adults through their Digital Equity Grant Program.

  Measure: Track and report the number of digital literacy sessions offered and the number of older adults trained each quarter via Title IIIB and AAA grant program reporting.

Greatest Economic Need and Greatest Social Need

Reaching older adults with the greatest economic and social need is imperative for the AAA to ensure that the most vulnerable in the service area are receiving services that support and maintain their health, independence, and dignity. The AAA aims to bridge service gaps, promote more equity, and strengthen the support of the aging service network by focussing a service delivery approach that prioritizes these older adults.

Goal 1: Ensure that services and resources are directed toward older adults who experience the greatest economic and social challenges, in alignment with the State Units on Aging (SUA) definitions of greatest economic need (GEN) and greatest social need (GSN).

Objective: Prioritize outreach to communities most at risk, including older adults with low income, those in isolated areas, and those from marginalized ethnic, racial, and cultural backgrounds.

- Strategy: Utilize neighborhood networks and community-based organizations to build trust and encourage service access.

- Strategy: Collaborate with social service agencies, housing providers, and faith-based organizations to identify and serve individuals facing significant economic and social challenges.

  Measure: Increase participation in services by at least 20% over two years among older adults identified as GEN/GSN

  Measure: Establish relationships with at least five new community organizations annually that serve high-risk older adults.

Goal 2: Address the non-medical factors influencing older adults' health and well-being, such as socioeconomic status, education, social support, and environment.

Objective: Use a social determinants of health (SDOH) approach to service delivery and program development to ensure older adults can age with dignity.

- Strategy: Improve access to information about available resources such as affordable housing, transportation, and social programming in the service area. Efforts will include distribution of informational materials at tabling events such as health and resource fairs, and utilization of the Age Strong Seniority magazine and local publications, websites and electronic newsletters and list services.

- Strategy: Improve access to SDOH like food, health care, housing, and transportation through benefit screening and application assistance; information, referral and enrollment assistance; and the direct provision of services.

- Strategy: Continue to support programs that expand educational opportunities that empower older adults with financial literacy, digital skills, and health management knowledge.

  Measure: Increase engagement with outreach materials annually, measured by website traffic, event attendance, and digital engagement analytics.

  Measure: Increase access to SDOH through enrollment assistance and direct provision of services.

Goal 3: Ensure that meal programs for older adults are culturally appropriate, dietary-specific, and medically tailored where necessary.

Objective: The Age Strong Commission will collaborate with the host sites of the Title III Home Delivered and Congregate Nutrition Program, Ethos and the Greater Boston Chinese Golden Age Center, to make meals available that are reflective of the cultural diversity of the service area. In addition, Age Strong will ensure that those meals are able to accommodate the dietary-specific or medical needs of the older adults receiving those meals.

- Strategy: Title III Nutrition program host sites will conduct regular assessments and gather feedback from program participants to ensure meals align with their cultural needs.

- Strategy: As required, the host sites will provide consultation to program participants requesting medically tailored meals (i.e. Allergen, Puree, Soft, Renal, Diabetic) and supplements.

  Measure: Host sites will distribute biannual participant satisfaction surveys to at least 80% of meal recipients to gather feedback on cultural preferences.

Goal 4: Promote social engagement and health improvements for older adults through flexible meal and wellness program options.

Objective: Work with Title III Nutrition Program host sites to explore a flexible service model that allows home-delivered meal recipients the option to join congregate meal sites and attend social activities based on their preferences and health needs.

- Strategy: Ensure meal sites are welcoming and accessible for individuals with mobility challenges or health conditions by providing necessary accommodations.

- Strategy: Explore opportunities for home-delivered meal participants with limited mobility and/or transportation options to join congregate sites virtually via Zoom or other video conferencing platforms.

- Strategy: In collaboration with the work being done at Age Strong to develop a comprehensive transportation plan for older adults, identify which modes of transportation would enable homebound or limited mobility home-delivered meals recipients to travel to congregate meal sites.

  Measure: Conduct a yearly survey to assess participant satisfaction and identify barriers to participation in meal and wellness programs.

  Measure: Launch a virtual meal and social engagement program at three sites by the end of FFY2027.

Goal 5: Ensure that older adults living with HIV/AIDS receive specialized support and services to improve their quality of life.

Objective: Promote access to healthcare, social support, and specialized services for older adults living with HIV/AIDS to enhance their well-being and reduce health disparities

- Strategy: Provide specialized health and wellness programs for older adults with HIV/AIDS, including mental health support, case management.

- Strategy: Offer training for providers and caregivers to address the unique needs of older adults with HIV/AIDS, including aging-related complications

- Strategy: Partner with organizations specializing in HIV/AIDS to ensure that older adults receive comprehensive care and support, including housing, transportation, and mental health services.

Measure: Increase access to healthcare, social support, and specialized services for at least 500 older adults living with HIV/AIDS over the next four years to enhance their well-being and reduce health disparities.

Goal 6: Continue to promote person-centered care with the help of the local Aging Service Access Points (ASAPs) that empowers older adults and caregivers to make decisions about their long-term services and supports (LTSS).

Objective: Prioritize outreach and programs such as the Options Counseling program that support older adults and/or their caregivers about their options to keep them in their community for as long as possible or get them back to their community as quickly as possible.

- Strategy: ASAPs will continue to develop individual service plans (ISP) with older adults and/or their caregivers in which goals are set for successful living within the community.

- Strategy: Monitor progress and make necessary changes to the individual service plan as it is being carried out with the help of the older adult and/or their caregivers to ensure a person-centered approach is maintained.

Measure: Conduct at least 10 community outreach events per year to educate older adults and caregivers about LTSS options in collaboration with the ASAPs.

Goal 7: Increase access to critical services, particularly for older adults who face mobility and transportation barriers

Objective: Develop a Comprehensive Transportation Plan for Older Adults.

- Strategy: Assess all available transportation options, including the Age Strong Shuttle, taxis, and ride-share services.

- Strategy: Identify gaps in service and opportunities to improve accessibility, rider experience, affordability, and convenience.

  Measure: Complete a citywide transportation assessment report by the end of FFY2027 that identifies available options, service gaps, and recommendations for improvements.

Objective: Enhance and Expand Age Strong Shuttle Services for older adults in Boston.

- Strategy: Maintain medical transportation services while expanding destinations to include other locations (senior programming, banks, religious services, etc.).

- Strategy: Evaluate ridership trends and adjust operations and services to improve accessibility and efficiency.

- Strategy: Maintain on-time performance ratings and explore technologies to improve scheduling and route efficiency.

- Strategy: Strengthen customer service training for shuttle drivers and staff to enhance rider experience.

  Measure: Increase the number of shuttle rides by 30% by the end of 2026.

Objective: Explore Insurance Reimbursement & Hospital Investment for Medical Rides.

- Strategy: This work includes researching eligibility and requirements for insurance reimbursement for medical rides. Age Strong would then engage hospitals and healthcare providers to explore potential funding partnerships. City operating funds currently used for reimbursable medical rides would be reallocated to expand non-reimbursable services, such as rides to social programs and other non-medical destinations.

  Measure: Complete an internal report outlining the pros and cons of seeking insurance reimbursement and hospital financial partnerships by the end of FY2026.

Objective: Modernize the Age Strong Taxi Coupon Program for older adults in the service area.

- Strategy: Age Strong will explore digital solutions to improve the purchasing and redemption process for taxi coupons and assess the feasibility of offering subsidies to address program inequities. Options will be assessed for potential program expansion.

  Measure: Identify options for a digital solution for taxi coupons by FFY2028

Objective: Expand partnership with Ride Share companies with services in the service area.

- Strategy: Build on existing partnership with rideshare companies

  Measure: Expand funding for the rideshare pilot by year three of the area plan.

Goal 8: Reduce the negative health impacts of social isolation among older adults.

Objective: Increase awareness, access to resources, and promote engagement opportunities that bring older adults together or connect them to community.

- Strategy: Continue to provide and fund city programs such as Age Strong citywide programming and the Expanding Engagement Grant that aim to promote social programming and expand outreach to underserved communities of older adults in Boston.

- Strategy: Support community-based programs that promote socialization among older adults, such as senior centers, faith-based organizations, senior-led community groups.

  Measure: Increase participation in city-supported social programs by 10% annually.

Expanding Access to Home- and Community-Based Services (HCBS)

Expanding, supporting, and strengthening HCBS programs is essential to the Age Strong Commission because they allow older adults to remain in their homes and communities, where they often feel the safest and most connected. With the help of the service area ASAPs, older adults receive services that promote their independence and enhance their quality of life. The AAA continues to have a strong relationship with the ASAPs to ensure a coordinated approach in getting older adults connected to HCBS programs.

Goal 1: Continue to support and, as resources allow, expand access to home and community-based services (HCBS) to support older adults and their caregivers, individuals with disabilities, and those living with Alzheimer's or related dementias in maintaining independence and aging in place.

Objective: Enhance the coordination of service delivery for HCBS among the local ASAPS.

- Strategy: Encourage collaboration among Aging Services Access Points (ASAPs), Aging and Disability Resource Consortia (ADRCs), and Independent Living Centers and the AAA to streamline service access.

- Strategy: Improve care coordination to provide seamless transitions between levels of care, including the Frail Elder Waiver, a home and community based services waiver that is designed to provide a comprehensive care plan to delay or avoid nursing home admission.

- Strategy: Strengthen care coordination between Medicaid, Medicare, and HCBS providers to improve continuity of care.

  Measure: Increase the number of collaborative meetings among the AAA, ASAPs, ADRC, and Independent Living Centers to at least quarterly by the end of FFY2027.

Objective: Age strong will collaborate with ASAPs to increase awareness and accessibility of HCBS throughout the service area.

- Strategy: Expand outreach efforts through targeted awareness campaigns, workshops, and digital resources to educate older adults, caregivers, and professionals about available HCBS.

- Strategy Expand Information & Referral (I&R) services to ensure older adults and caregivers can easily navigate available supports.

  Measure: Work with community partners to conduct at least six targeted awareness campaigns annually, utilizing digital, print, and community-based outreach.

Objective: Promote person-centered care approaches to HCBS delivery by the local ASAPs with the intention of promoting independence and aging in place.

- Strategy: Work with local ASAPs to provide regular training for care coordinators and direct care workers on person-centered care approaches. These trainings will also emphasize the importance of culturally responsive and tailored to the diverse needs of older adults and their caregivers.

- Strategy: Work to expand the integration of medical, behavioral health, and in-home services through programs like Senior Care Options (SCO).

  Measure: Work with ASAPs to hold quarterly training sessions for care coordinators and direct care workers, with at least 80% of staff completing training annually.

  Measure: Conduct post-training surveys to measure a 20% improvement in staff knowledge on culturally responsive, person-centered care approaches.

Goal 2: Facilitate the coordination of community-based, long-term care services to support older adults at risk of institutionalization, those in hospitals facing prolonged stays, and individuals in long-term care facilities who can safely return home with appropriate services.

Objective: Continue to strengthen community transitions support for older adults who with the proper support can return to their communities safely.

- Strategy: Work with the local ASAPs to promote the Community Transitions Liaison Program (CTLP) and Options Counseling Program to ensure seamless transitions from institutional settings to home.

- Strategy: Increase ASAPs outreach and engagement with hospital discharge planners, nursing facilities, and rehabilitation centers to identify individuals who would benefit from community transitions support.

- Strategy: Strengthen communication and coordination between CTLP case managers, ASAP nurses, and ASAP case managers to ensure continuity of care.

- Strategy: Age Strong and the local ASAPs will work together to provide ongoing and coordinated follow-up and support to individuals transitioning to community living to ensure long-term stability and prevent re-institutionalization.

  Measure: Track the number of outreach events and informational materials distributed to older adults, caregivers, and healthcare providers.

  Measure: Initiate conversations about potential partnerships with at least three additional hospitals or rehabilitation centers to enhance referral pathways by FFY2029

Caregiving

Caregivers are a foundational support for many older adults in Boston hoping to remain in their homes. For older adults who are also caregivers themselves, it can be challenging to have their own needs met while providing essential support to their loved ones or friends. The AAA with the help of Boston Senior Senior Home Care, the host site for the service area's Title III Caregiver Program, essential resources, training, and respite options aim to reduce the number of challenges caregivers face.

Goal 1: In partnership with Boston Senior Home Care, Age Strong will work to strengthen and support the direct care workforce.

Objective: Enhance the skills and knowledge of direct care staff to ensure high-quality caregiving.

- Strategy: Provide evidence-based training sessions for staff on a monthly basis.

- Strategy: Offer clinical supervision for licensed staff to maintain professional standards and best practices.

  Measure: Provide at least 12 evidence-based training sessions annually for direct care staff, ensuring participation of at least 80% of eligible staff per session.

Objective: Ensure caregivers receive high-quality care through continuous professional development.

- Strategy: Evaluate training effectiveness through feedback and performance assessments.

- Strategy: Identify emerging best practices and integrate them into staff education.

  Measure: Conduct quarterly caregiver training satisfaction surveys with at least an 80% positive response rate.

Goal 2: Help to Implement Actions from the National Strategy to Support Family Caregiving

Objective: Improve support services and resources for family caregivers.

- Strategy: Expand access to respite care and support services through the Family Caregiver Support Program (FCSP).

- Strategy: Increase caregiver awareness of available healthcare resources and empower them in care planning.

  Measure: Increase the number of caregivers utilizing respite care services by 10% within two years.

Objective: Strengthen family caregivers' ability to provide safe and responsible care.

- Strategy: Provide education and training programs tailored to caregivers' needs.

- Strategy: Offer financial and legal assistance resources to address caregiving challenges.

  Measure: Develop and implement quarterly caregiver training sessions, with at least 75% of participants reporting increased confidence in caregiving skills.

Goal 3: Improve coordination efforts of the Title III Caregiving program with the Lifespan Respite Care Program

Objective: Develop a comprehensive network of services to reduce caregiver stress and improve outcomes.

- Strategy: Align FCSP services with the goals of the Lifespan Respite Care Program.

- Strategy: Continue to offer and work to expand a broad range of support services, including counseling, training, and referrals, in addition to respite care.

  Measure: Align FCSP services with the goals of the Lifespan Respite Care Program by conducting biannual coordination meetings between program administrators.

Objective: Ensure caregivers have easy access to necessary support systems.

- Strategy: Promote awareness of available support networks through targeted outreach efforts.

  Measure: Increase outreach efforts by conducting six targeted awareness campaigns annually through social media, community events, and healthcare partnerships.

Goal 4: Strengthen Coordination with the National Technical Assistance Center on Grandfamilies and Kinship Families

Objective: Expand support for grandparents and kinship caregivers.

- Strategy: Enhance FCSP and KINnections (a program for grandparents caring for grandchildren) offerings to include supportive counseling, training, and peer support groups.

- Strategy: Ensure that legal and financial assistance resources are available to help families navigating caregiving responsibilities.

Measure: Maintain at least 75% participation retention in existing support groups and grow participation by 10% annually.