DRAFT Howard County Area Plan for Aging and Disability Services for 2027 to 2030

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Howard County Area Plan for Aging and Disability Services

1. Executive Summary (1000 word max) –

Provide an overview of how your AAA will leverage local and state directed resources to address the needs of older Marylanders and their caregivers now and begin preparing for a more longevity ready future in your PSA.

Howard County is aging well, yet beneath strong indicators lies growing vulnerability among older adults. While median income, insurance coverage, and educational attainment exceed state averages, recent analyses including the 2025 Community Health Indicators, Health Assessment Survey, Community Health Needs Assessment by Johns Hopkins Howard County Medical Center, and the ALICE Report from United Way of Central Maryland demonstrate a key reality: averages mask hardship. Nearly half of older households may be financially strained when measured against cost-of-living thresholds rather than the Federal Poverty Level. Food insecurity, chronic disease, fall-related injuries, transportation barriers, social isolation, and rising behavioral health concerns are persistent and interconnected challenges. These findings reinforce priorities outlined in this Area Plan.

The Howard County Office on Aging and Independence (OAI) has structured this Plan around four strategic goals designed to prepare residents not only to live longer, but to live well, safely, affordably, and with dignity.

Goal 1: Empower Older Adults, Adults with Disabilities, and Caregivers

OAI advances a person-centered, "No Wrong Door" system anchored by Maryland Access Point (MAP), Options Counseling, and caregiver supports. By integrating information and assistance, SHIP counseling, SOAR, and benefits enrollment initiatives, OAI ensures residents can access Medicare, Medicaid, SNAP, energy assistance, and long-term services efficiently and equitably.

Caregiver supports remain central to system sustainability. Through respite coordination, dementia education, support groups, and digital caregiver platforms, OAI strengthens caregiving networks that prevent premature institutionalization.

The County's re-designation as an AARP Age-Friendly Community (2025–2029) reinforces a long-term commitment to inclusion, access, and equity. Howard County joined the AARP Network of Age-Friendly States and Communities in 2019, completing a multi-year process that included a community needs assessment, resident and stakeholder engagement, and development of the initial Age-Friendly Action Plan. In this second phase, over 45 action items guide

improvements in navigation, outreach to underserved populations, emergency preparedness, and culturally responsive engagement.

Goal 2: Bolster Support for Vulnerable Older Adults

Although only 5% of older adults fall below the Federal Poverty Line according to the Census Bureau, economic fragility extends far beyond poverty. OAI prioritizes individuals with greatest economic and social need, including those living alone, experiencing housing cost burden, managing chronic conditions, or at risk of isolation.

Protective services, case management, and in-home supports stabilize individuals at risk of neglect, exploitation, or institutional placement. Partnerships with healthcare providers, housing agencies, and community organizations allow earlier intervention and safer transitions from hospital to home.

Local health surveys confirm rising concerns related to social isolation and behavioral health. OAI responds by embedding social connection strategies within 50+ Centers, expanding solo aging supports, and strengthening referral pathways for behavioral health services.

Goal 3: Prepare Marylanders to Afford Longevity

Longevity without financial security creates instability. This Plan directly addresses housing affordability, economic vulnerability beyond poverty, and benefits optimization.

OAI promotes aging in the right place through home modification programs, rental stabilization assistance, shared housing initiatives, and waiver-based in-home supports. Housing strategies are integrated with fall prevention, caregiver services, and case management to reduce costly institutionalization.

The ALICE analysis reinforces the need to move beyond poverty metrics and address cost burden, food insecurity, and fixed-income fragility. OAI strengthens SNAP outreach, Medicare Savings Program enrollment, energy assistance referrals, and financial counseling through partnerships including the County's Financial Empowerment Center.

Transportation, identified in the Community Health Needs Assessment as a major barrier, is addressed as determinant of health and economic stability. Cross-sector coordination improves mobility options that support healthcare access, food security, and social participation.

Goal 4: Optimize Health, Wellness, and Mobility

Health promotion, nutrition, and equitable systems of care form the foundation of longevity readiness.

OAA-funded congregate and home-delivered meal programs provide both nutritional and social interventions. Medically tailored meals, nutrition counseling, SNAP enrollment support, and the Senior Farmers Market Nutrition Program address the intersection of food insecurity and chronic disease.

Evidence-based programs supported through Title IIID funding including chronic disease self-management, fall prevention, and balance training to individuals and their caregivers reduce hospitalizations and improve quality of life. Falls prevention is elevated as a priority given its identification in the Community Health Needs Assessment and its strong correlation with hospitalization and loss of independence.

Health promotion extends beyond the six 50+ Centers through a Centers Without Walls approach, multilingual programming, partnerships with the hospital and the Health Department, and outreach into housing communities, libraries, and faith settings.

Advanced care planning, where approximately 70% of local older adults already report having directives, is recognized as both a strength and an opportunity to close remaining gaps through targeted outreach.

Cross-Sector Alignment and Systems Leadership

While countywide indicators show Howard County performing well overall, this Area Plan acknowledges hidden vulnerability and focuses on measurable impact rather than broad generalizations. OAI is positioned not only as a service provider, but as a systems convener — aligning with hospital community benefit initiatives, participating in local health improvement coalitions, and coordinating with housing, transportation, and public health partners.

The Plan emphasizes:

- Economic stability beyond poverty thresholds
- Food security as a clinical and social determinant
- Falls prevention and mobility as cost-avoidance strategies
- Transportation access as a structural driver of health
- Social connection and caregiver resilience as public health priorities

Performance measures across the four goals track service utilization, benefits enrollment, hospital diversion, fall risk reduction, nutrition access, and expanded reach among populations with greatest need.

Howard County’s demographic future requires more than strong averages. It requires targeted action, coordinated systems, and sustained collaboration. Through this Four-Year Area Plan,

OAI advances a comprehensive strategy to ensure that all residents particularly those most vulnerable, can age with health, security, mobility, and connection.

Howard County is preparing for an aging population; it is building a longevity-ready community.

The following sections detail how these strategic priorities translate into measurable action across systems coordination, economic security, housing stability, health optimization, and caregiver support.

2. Aging in Maryland

A. Discuss how your AAA conducts needs and opportunity assessments for your PSA (750 word max) -

The Office on Aging and Independence (OAI), in an effort to ensure responsive and high-quality services, utilizes a variety of mechanisms to continually inform itself related to needs and opportunity in the County. These processes include, but are not limited to:

- Utilization of the Commission on Aging (COA), made up of fifteen (15) community members who are active or retired professionals, as an advisory body to provide feedback on activities of the OAI, lobby local and state officials, and assist with community educational forums.
- Surveys (in paper and on-line via SurveyMonkey) to gain insights into the needs and opinions of a broader range of county residents. These include, but are not limited, to community wide surveys, as well as targeted surveys of participants at the 50+ Centers. A summary of the most recent surveys (Community Survey, Attachment I A and 50+ Center Survey, Attachment I B) will be included in the Area Plan as an attachment.
- Listening sessions, conducted through our Age-Friendly initiative, where smaller focus groups of individuals are invited to give more nuanced and in-depth feedback (a summary of the most recent listening sessions will be included in the Area Plan as Attachment I C).
- Staff meetings are conducted by the OAI Administrator on a quarterly basis to both share information and solicit feedback. The OAI also conducts anonymous surveys of staff, as well as leadership of partner agencies, to solicit feedback related to gaps in service, and recommendations on new or improved initiatives (a summary of the most recent staff/partner survey will be included in the Area Plan as Attachment I D).
- Leadership of OAI regularly reviews Performance Measurement data, along with administrative data to determine if patterns in activities and services are indicative of

trends that can guide future policies. An example of a review of administrative data for the 50+ Centers as Attachment I E.

- Leadership, and managers, have access to peer reviewed published articles, via a staff member who is an adjunct professor at the University of Maryland. Managers can request literature reviews on selected topics, as well as copies of peer reviewed articles, which are provided, along with an assessment of the empirical rigor of those publications.

Ongoing community input is welcomed via email to agefriendly@howardcountymd.gov and at all Age-Friendly activities and events. Transparency is a key priority for this cycle which will also welcome ongoing input from stakeholders. Progress will continue to be incorporated into the Age-Friendly Howard County webpage available at www.howardcountymd.gov/agefriendly and shared in periodic emails to Age-Friendly subscribers via Constant Contact.

B. Discuss how your AAA ensures OAA compliance (750 word max)

The Howard County Office on Aging and Independence (OAI) is committed to full compliance with all requirements of the Older Americans Act (OAA) and associated federal and state regulations. OAI maintains a comprehensive framework of oversight, training, policy development, and continuous quality improvement to ensure that all programs, services, and operations meet or exceed statutory and regulatory standards.

To strengthen organizational accountability and coordination, OAI established an OAA Compliance Work Group, led by the Operations Division Manager. This cross-functional work group includes program managers, fiscal staff, and administrative leadership and is charged with monitoring regulatory updates, reviewing programmatic compliance, identifying gaps, and recommending operational improvements. The work group meets regularly to review compliance requirements, discuss implementation challenges, and coordinate efforts across divisions to ensure consistent application of OAA standards.

As part of this initiative, all program managers were tasked with reviewing and becoming familiar with the relevant sections of the OAA applicable to their respective program areas. This structured review ensures that staff responsible for program implementation, service delivery, contracting, monitoring, and reporting possess a thorough understanding of eligibility requirements, service priorities, fiscal accountability, and reporting obligations.

OAI conducted a comprehensive review and update of its policies and procedures to align with the revised OAA guidelines that became effective October 1, 2025. This proactive approach ensured that all operational protocols, contractual requirements, fiscal controls, and service

delivery standards reflected current federal and state guidance. Updated policies addressed key compliance areas including, but not limited to, client eligibility determination, prioritization of services, data collection and reporting, grievance procedures, nutrition program standards, procurement processes, subcontractor monitoring, and fiscal oversight.

To support continuous compliance, OAI maintains a robust monitoring and quality assurance framework. This includes routine internal audits, fiscal reviews, contract monitoring visits, program performance evaluations, and client feedback mechanisms. These processes enable early identification of compliance issues, support timely corrective actions, and promote continuous service improvement. Monitoring findings are reviewed by leadership and the OAA Compliance Work Group to ensure accountability.

OAI also prioritizes staff training and professional development related to OAA compliance and person-centered service delivery. All staff are completing the Jewish Federations of North America (JFNA) Person-Centered Trauma-Informed Care training by March 31, 2026, as required by the OAA. Additional training initiatives include internal workshops on topics such as, communication best practices, cultural competency, staff wellness, and dementia care.

Strong contract oversight is another cornerstone of OAI's compliance strategy. All service providers are required to adhere to OAA standards, contractual performance measures, reporting requirements, and fiscal accountability provisions. OAI conducts routine monitoring of provider performance, including desk audits, on-site visits, fiscal reviews, and outcome evaluations. Contracts are structured to reinforce compliance expectations, service quality standards, and corrective action protocols when deficiencies are identified.

OAI also ensures compliance through data-driven planning and reporting systems that support transparency, accountability, and performance measurement. Program data is routinely reviewed to ensure service delivery aligns with OAA priorities, targets populations with the greatest social and economic need, and supports equitable access across communities. This data is used to inform strategic planning, funding allocation, and service adjustments.

3. Longevity Ready Maryland

Goal 1: Build a Longevity Ecosystem

- Cross-sector coordination (500 word max) –
  Through its leadership of Age-Friendly Howard County, OAI is operationalizing the Longevity Ready Maryland goal to Build a Longevity Ecosystem through intentional

cross-sector coordination embedded across the County's 2025–2029 Action Plan. The Plan's three Pillars: Health & Wellbeing, Living & Mobility, and Community & Inclusion, are structured to align public agencies, healthcare systems, nonprofits, businesses, educational institutions, and residents around shared, measurable outcomes that strengthen both lifespan and health span. OAI convenes and formalizes partnerships with Johns Hopkins Howard County Medical Center to streamline hospital-to-community referrals; with the Local Health Improvement Coalition to expand data-informed resource mapping; with the Offices of Housing, Transportation, Emergency Management, and Consumer Protection to advance housing stability, transit access, emergency preparedness, and fraud prevention; and with faith-based and community-based organizations to extend trusted, culturally responsive outreach. The Action Plan also advances regional collaboration by establishing and sustaining a Maryland Age-Friendly Network, positioning Howard County as both a local implementer and a statewide connector of best practices. Cross-sector initiatives such as the Primary Care Access pilot in 50+ Centers, the micro-transit shuttle serving rural and under-resourced areas, the Age-Friendly Business Certification Program, dementia-friendly systems change, caregiver workforce partnerships with higher education institutions, and volunteer-driven mobility and accessibility audits demonstrate an ecosystem approach that integrates health care, social supports, the built environment, economic stability, and civic engagement. By embedding longevity planning into existing service platforms including nutrition programs, caregiver supports, digital inclusion efforts, and advocacy training, OAI ensures that longevity is not a standalone initiative, but a coordinated framework guiding policy, program design, and community investment. This infrastructure of collaboration strengthens accountability, reduces duplication, improves care navigation, and builds collective capacity so residents of all ages and abilities can thrive in a connected, resilient, and longevity-ready County.

- Justice, equity, and inclusion (500 word max) –

OAI continues to be a vital advocate for older adults, forging strategic alliances with various community entities including hospitals, the department of social services, first responders, and faith-based organizations. Such collaborations have proven effective in dismantling barriers, thereby facilitating a "no wrong door" policy for service access. This approach also tackles systemic challenges affecting low-income older adults, Limited English Proficient (LEP), individuals with disabilities, and those experiencing social isolation, family caregivers, and LGBTQIA+ residents. Select trainings on racism, equity, disability-specific accommodations, and others are mandated throughout the year to

prepare staff for working with diverse populations.

With the growth of the (LEP) community, it is essential that OAI services and programs are delivered in a linguistically and culturally competent manner. To effectively serve a diverse population, outreach efforts must be targeted and written materials translated. OAI's efforts to date include the recruitment and hiring of staff fluent in Korean, Mandarin Chinese, and Spanish; the delivery of evidence-based programs in multiple languages; culturally appropriate service provision; and the exploration of culturally relevant meal options within both congregate and home-delivered meal programs. Additionally, OAI has partnered with local multicultural organizations to expand ethnic and cultural programming at the 50+ Centers. These partners include the Korean American Senior Association, K-Youth, Indian Cultural Association, Howard County Chinese School, Chinese American Senior Association of Howard County, and the Chinese American Parent Association of Howard County.

To further support the rights of residents in long term care and home and community based settings, OAI through its Ombudsman program, initiated the Emergency Medical Services (EMS) Outreach Initiative in December 2024. This program aims to enhance protections for older adults residing in long-term care facilities. This effort has, so far, provided specialized training to 328 EMS personnel, thanks to a collaboration with the county's Mobile Integrated Community Health (MICH) program. The training curriculum includes the Ombudsman's responsibilities, how to resolve complaints, identifying signs of abuse and neglect, and the proper reporting procedures. A particularly valuable aspect of the program was its emphasis on the regulatory distinctions between assisted living and skilled nursing facilities. This information was previously unavailable to EMS personnel, yet it's crucial for them to evaluate the quality of care and recognize when a facility's practices are inadequate.

- Maximizing volunteerism (500 word max) –

Volunteerism is a cornerstone of Howard County's longevity ecosystem and will remain central to OAI's strategy through 2030. Building on strong civic engagement demonstrated during the first Age-Friendly Howard County initiative where more than 100 residents participated in domain workgroups that advanced universal design, improved readability of public materials, and strengthened community planning.

Over the next four years, OAI will grow a diversified volunteer corps reflecting the cultural, linguistic, and generational diversity of Howard County. Recruitment will prioritize bilingual and multicultural volunteers, individuals with lived caregiving experience, and older adults

seeking purposeful engagement. Partnerships with faith-based organizations, service clubs, higher education institutions, and corporate volunteer programs will broaden outreach and create intergenerational pathways into service.

Volunteers will be strategically integrated into four priority areas:

1. Community Navigation and Access to Services
Trained volunteers will support Maryland Access Point outreach, assist with benefits education, and expand digital inclusion efforts through technology mentoring and telehealth navigation. Growth targets include increased SHIP and Senior Medicare Patrol counseling capacity and expanded multilingual outreach to reduce disparities in benefits access.

2. Long Term Care Advocacy
OAI will increase recruitment and training of Long-Term Care Ombudsman volunteers to strengthen resident advocacy in nursing homes and assisted living facilities. Volunteer engagement will be aligned with measurable outcomes including complaint resolution timeliness, resident education sessions, and expanded family outreach.

3. Health Promotion and Social Connection
Volunteer lay leaders will continue facilitating evidence-based programs such as Chronic Disease Self-Management and Powerful Tools for Caregivers. OAI will implement a succession planning model to ensure continuity of trained leaders and reduce program disruption. Volunteers will also support social connection initiatives, group facilitation, and community engagement designed to reduce isolation among individuals with greatest social need.

4. Age-Friendly and Community Improvement Initiatives
Through the Age-Friendly Howard County Action Plan (2025–2029), volunteers will participate in walk audits, housing and transportation advocacy, emergency preparedness education, and neighbor-helping-neighbor yard assistance events. These activities strengthen livable communities while fostering civic leadership among older adults.

OAI will formalize volunteer infrastructure by enhancing training curricula, implementing role-specific competencies, and using performance metrics to track impact, retention, and service expansion. Recognition and leadership development opportunities will support long-term engagement.

Neighbor-helping-neighbor models will remain an important complement. OAI will continue coordinating referrals and outreach with the Village in Howard and similar community-based efforts to ensure seamless support for aging in place.

OAI strengthens service delivery and the aging services workforce pipeline by hosting interns in social work, gerontology, occupational therapy, and nutrition. Interns gain hands-on experience assisting with program activities, client engagement, and resource coordination. Internships enhance OAI's capacity to serve the community and help prepare future professionals to work with older adults.

By 2030, OAI's goal is to expand volunteer capacity across service domains from 1,500 volunteers to 2,000 volunteers annually, increase culturally responsive engagement, and embed volunteers into prevention, protection, and navigation strategies. Through intentional recruitment, structured training, and measurable outcomes, volunteerism will continue to strengthen a coordinated, inclusive system that promotes independence, dignity, and community connection.

Coordination with Maryland Department of Health SHIP (500-word max) –

OAI advances Maryland Department of Health State Health Improvement Plan (SHIP) through leadership and participation in the Local Health Improvement Coalition (LHIC). OAI staff serve as co-chairs and members of workgroups addressing Healthy Living and Healthy Minds priorities and contributed to the FY26–FY28 Community Health Improvement Plan process. This engagement ensures alignment between SHIP objectives and OAI's strategic priorities under Longevity Ready Maryland.

Priority Area 1: Chronic Disease

- OAI emphasizes prevention, early intervention, and chronic disease management through integrated community supports. In partnership with Johns Hopkins Howard County Medical Center, OAI delivers AgeWell, a low-cost exercise program prioritized in areas of greatest economic need. Title IIID funding supports evidence-based programs including Chronic Disease, Diabetes, and Chronic Pain Self-Management, as well as arthritis and balance programs. Diabetes workshops are offered in English, Spanish, Korean, and Chinese to reduce disparities.

- The 50+ Centers and partner locations offer group exercise, personal training, walking and cycling clubs, and virtual options. Outreach campaigns during Heart Health and Diabetes Awareness months reinforce prevention messaging.
- New initiatives include refining a hospital discharge referral pathway to MAP, OAI programs, and community resources to reduce readmissions and improve continuity of care; expanding SNAP outreach to reduce food insecurity; connecting post-cardiac rehabilitation patients to community-based wellness programs; and partnering with faith-based and community organizations to establish resilience circles supporting chronic condition management and peer connection.

Priority Area 2: Access to Care

- OAI addresses structural barriers related to navigation, affordability, transportation, language access, and digital connectivity. Strategies include telehealth training, patient portal education, multilingual digital literacy expansion, and advocacy for affordable internet. OAI will pilot a Primary Care Access Program within 50+ Centers, serving at least 300 older adults annually, and collaborate with Community Health Workers to strengthen care navigation.
- Transportation initiatives include a micro-transit pilot with the Office of Transportation and the Regional Transportation Agency of Central Maryland to connect rural and underserved residents to medical and resource hubs, and expanded transportation links between 55+ communities and 50+ Centers.
- Caregiver infrastructure will be strengthened by expanding utilization of the Trualta caregiver platform and increasing outreach to diverse caregivers. Recruitment of bilingual staff and partnerships with cultural and faith-based organizations will improve language and cultural responsiveness. Utilization will be measured through platform enrollment, active user data, caregiver participation in learning modules, and referrals generated through outreach and partner organizations to the Trualta platform.

Priority Area 5: Behavioral Health

- OAI integrates behavioral health across programs through partnerships with the Health Department Bureau of Behavioral Health, National Alliance on Mental Illness, Sheppard Pratt, and My Life Foundation. Initiatives include Mental Health First Aid and substance use prevention training (including Korean-language offerings), naloxone training, suicide prevention awareness (988), Chronic Pain Self-Management, and facilitation of the Older Adult Mental Health Forum.

- OAI also participates in police Crisis Intervention Training and statewide coalitions addressing mental health and aging. New initiatives include minority mental health training for staff and expanded resilience circles promoting mental health and social connection.

Goal 2: Promote Economic Opportunity

Caregiving supports (500-word max)

The Howard County Office on Aging and Independence (OAI) strengthens Maryland's multigenerational workforce by stabilizing and supporting family caregivers, who are essential contributors to both household and state economic resilience. Without adequate support, caregivers frequently reduce work hours or exit employment, creating financial strain and workforce instability. OAI's strategy focuses on workforce retention, skill-building, and sustainable caregiving infrastructure.

Through the National Family Caregiver Support Program (NFCSP), OAI prioritizes respite as a workforce stabilization strategy. Respite services including in-home care, adult day services, and short-term residential options enable caregivers to maintain employment while protecting their physical and mental health. Over the four-year Area Plan period, OAI will expand outreach to caregivers at greatest social and economic need, streamline referrals through Maryland Access Point, and increase equitable access to respite resources. Measures of success include increased respite utilization, improved caregiver self-reported well-being, and reduced work disruption among employed caregivers.

OAI enhances caregiver competency and confidence through structured education and digital supports. The Trualta caregiver portal provides 24/7 access to training modules, peer connection, and practical skill development. OAI will expand enrollment, integrate condition-specific training, and increase awareness among employers and healthcare partners to ensure caregivers can access support before crisis occurs.

To strengthen the paid caregiving workforce, OAI collaborates with workforce development partners and training institutions to promote career pathways in home- and community-based services. Educational workshops and leadership development opportunities will support recruitment and retention of direct care workers, addressing growing demand in the long-term services and supports sector.

Through coordinated respite expansion, training, navigation, and workforce partnerships, OAI advances economic stability for caregivers while strengthening the broader care infrastructure necessary for a longevity-ready Maryland.

Long-term care dementia navigation (500-word max)

OAI enhances economic opportunity by delivering coordinated dementia navigation services that reduce crisis-driven costs, stabilize families, and support continued workforce participation. As cognitive impairment rates increase, early identification and streamlined access to services are essential to maintaining household financial security and reducing long-term public expenditures.

Through Maryland Access Point and Dementia Navigation services, OAI provides person-centered information, referral, and care planning for individuals experiencing cognitive changes and their caregivers. Staff conduct quarterly dementia-focused outreach and utilize validated screening tools to guide referrals and next steps. Caregivers receive needs assessments, respite coordination, and ongoing education designed to reduce stress, prevent employment disruption, and delay costly institutional care.

OAI will strengthen referral pathways with healthcare providers, including hospital discharge planning teams, to ensure timely connection to community-based supports following diagnosis or hospitalization. Success measures include increased dementia-specific referrals, improved service linkage rates, reduced caregiver crisis contacts, and increased utilization of home- and community-based services.

Dementia-friendly workforce and community training further support economic resilience. OAI provides cross-sector education to businesses, first responders, libraries, and community organizations to improve inclusive service delivery and workplace responsiveness. These

efforts promote age- and dementia-inclusive employment practices and strengthen customer engagement.

OAI also serves as a host site for the Senior Community Service Employment Program (SCSEP), supporting placements within nutrition programs and 50+ Centers. OAI will explore expanded SCSEP opportunities aligned with dementia-friendly outreach, digital inclusion, and community engagement initiatives. Outcomes will include participant skill development, increased training hours, and transitions to unsubsidized employment.

By integrating early navigation, caregiver stabilization, workforce engagement, and cross-sector training, OAI supports families in maintaining employment, reduces avoidable healthcare utilization, and strengthens economic sustainability across the lifespan.

Employment for all (500-word max)

OAI advances age-inclusive employment strategies that support older workers, strengthen employer engagement, and promote economic competitiveness. Recognizing the value of experienced workers, OAI focuses on reducing barriers, enhancing skills, and expanding age-friendly workplace practices.

OAI partners annually with the Jewish Council for the Aging of Greater Washington to host a virtual 50+ Employment Expo during Older Americans Month. The expo connects more than 500 job seekers with age-friendly employers, career coaching, and workforce resources while addressing age bias and highlighting transferable skills. OAI will expand employer participation and track outcomes such as job placements, employer retention, and participant satisfaction.

As a host site for the Senior Community Service Employment Program (SCSEP), OAI provides subsidized training opportunities within nutrition programs and 50+ Centers. Participants gain hands-on experience, strengthen workplace competencies, and prepare for transition to unsubsidized employment. Over the Area Plan period, OAI will assess opportunities to expand SCSEP placements in high-demand service areas, including benefits

outreach, digital support, and program operations. Performance indicators include increased participant hours, skill attainment, and successful employment transitions.

Through the 2025–2029 Age-Friendly Action Plan, OAI will pilot an Age-Inclusive Workforce Initiative focused on digital literacy, leadership development, and employment readiness. This initiative will support workforce reentry and career advancement, particularly for individuals impacted by caregiving responsibilities or economic disruption.

Additionally, OAI will implement an Age-Friendly Business Certification Program to recognize businesses demonstrating inclusive hiring, accessible customer service practices, and supportive workplace environments. The goal is to certify at least 100 businesses by 2029, strengthening employer awareness and inclusive economic growth.

Together, these strategies position older adults as vital contributors to Maryland's economy while ensuring that workforce systems are prepared for demographic change.

Goal 3: Prepare Marylanders to Afford Longevity

Affordable Housing (Under 500 Words)

The Howard County Office on Aging and Independence (OAI) advances affordable housing stability by expanding aging-in-place options, strengthening wrap-around services, and coordinating housing-related supports for individuals at greatest economic and social need. Through Maryland Access Point (MAP), OAI serves as a centralized entry point connecting older adults and individuals with disabilities to housing stabilization programs and home- and community-based services (HCBS).

- **Expanding Aging in Place and Wrap-Around Services**
  OAI prioritizes community-based alternatives to institutional care through the Supportive Services for Older Adults Program (SOAP), Senior Care, Community Options Waiver, and Community Living Program (CLP). These programs provide case management, in-home supports, and gap-filling resources that prevent premature nursing home placement.

Wrap-around services include caregiver support, dementia navigation, chore services, and transportation partnerships, ensuring that housing stability is supported holistically.

Through the Age-Friendly Howard County Action Plan, OAI collaborates with planning, housing, and community partners to advance affordable housing strategies, universal design, transportation access, and social connection—key components of long-term housing sustainability.

- **Home Repair and Accessibility Modifications**
  OAI reduces displacement risk by improving safety and accessibility within existing housing stock. The Community Living Program (CLP) and Older Adult Home Modification Program (OAHMP) provide assessment-led home modifications, including grab bars, ramps, railings, stair glides, and accessible bathroom upgrades. Licensed occupational therapists conduct individualized assessments to reduce fall risk and prevent costly institutionalization. Services are prioritized for low-income homeowners and renters, with defined caps to ensure equitable distribution of funds.

  OAI also coordinates referrals to additional housing repair and loan programs to leverage broader community resources.

- **Housing Stability and Cost Burden Reduction**
  Recognizing high housing costs within the County, OAI supports rental stabilization efforts for income-eligible households age 62+ who pay more than 30% of income toward rent. Time-limited rental subsidies, eviction prevention supports and coordinated entry partnerships reduce housing loss and homelessness risk.

  Innovative housing models further expand affordability. The HoCo Home Share program connects homeowners with available rooms to vetted residents seeking affordable housing, creating mutually beneficial arrangements that increase financial stability and reduce isolation.

  Measures of success include reduced institutional placements, increased home modification completions, improved housing stability rates among rental assistance recipients, and expanded access to affordable shared housing options. Through coordinated housing, HCBS, and stabilization strategies, OAI strengthens economic security and enables residents to age safely in their communities.

Financial Stability (Under 500 Words)

OAI promotes financial security as a core strategy to prepare residents for longevity. Economic vulnerability increases risk of housing instability, food insecurity, and premature institutionalization. OAI addresses financial stability through coordinated benefits access, fraud prevention, financial education, and direct assistance—prioritizing those with greatest economic and social need.

- **Financial Literacy and Counseling**
  In partnership with the Howard County Office of Consumer Protection, OAI promotes and will host workshops from the County's Financial Empowerment Center (FEC) at 50+ Centers. The FEC will provide free, professional one-on-one financial counseling to help residents reduce debt, improve credit, build savings, and access safe financial products. Integrating FEC services into senior center programming strengthens long-term financial planning, particularly for individuals navigating retirement transitions, caregiving expenses, or recovery from financial setbacks.
- **Benefits Access and Income Optimization**
  Through MAP, SHIP, MIPPA, and SOAR initiatives, OAI helps residents maximize income supports including SNAP, Medicare Savings Programs, energy assistance, and Medicaid. Benefits screening tools and in-person counseling reduce under-enrollment and improve affordability of healthcare and basic needs. Performance measures include increased benefits enrollment, reduced out-of-pocket healthcare costs, and expanded SNAP participation among eligible older adults.
- **Gap-Filling and Emergency Assistance**
  OAI administers means-tested programs such as SALS, Senior Care, and Medicaid waiver services to stabilize vulnerable residents. Flexible funds—including local donations and Federal Financial Participation—support urgent needs such as eviction prevention, utility shutoff avoidance, vision and hearing care, and other critical expenses not otherwise covered.
- **Fraud Prevention and Consumer Protection**
  Through SHIP and Senior Medicare Patrol programming, OAI provides education on fraud prevention and financial exploitation. Community workshops and targeted outreach strengthen awareness and reporting mechanisms.

Objectives for the Area Plan period include expanding referrals to the Financial Empowerment Center (FEC), increasing benefits enrollment among eligible residents, reducing the risk of financial exploitation through consumer education, and strengthening early intervention for housing and utility instability. Progress will be monitored through performance measures consistent with reporting expectations of the Maryland Department of Aging and the Administration for Community Living. These measures include tracking the number of FEC

referrals generated through OAI programs; increases in benefits screenings and successful enrollments through benefits and options counseling services; the number of participants reached through financial literacy and fraud prevention education; and Information and Assistance and case management data related to housing and utility support referrals. Outcome indicators will include benefits secured, increased financial stability among participants, and improved housing or utility stabilization. Through the alignment of financial literacy, benefits optimization, and protective services, OAI will strengthen long-term economic security for older adults and caregivers.

Streamlining Access to Services and Benefits (Under 500 Words)

OAI advances a comprehensive "No Wrong Door" system to streamline access to services and benefits, integrating Maryland Access Point (MAP), SHIP, SOAR, Options Counseling, and Medicaid administrative claiming into a coordinated, person-centered framework.

- **Centralized Access and Navigation**
  MAP serves as the single-entry point for information, referral, assistance, and options counseling. Resource specialists provide in-person, phone, and virtual access at multiple community locations, including 50+ Centers. Digital benefits screening tools allow residents to quickly assess eligibility for Medical Assistance, SNAP, energy assistance, and other programs, reducing barriers to entry.
- **Person-Centered Home- and Community-Based Supports**
  Through Options Counseling and Level One Screen processes, OAI provides forward-looking planning that helps residents understand long-term services and supports before crisis occurs. Coordination with the Community Options Waiver, SALS, Senior Care, and home modification programs ensures individuals can remain in the least restrictive setting appropriate to their needs.
- **Alignment with State and Local Resources**
  OAI aligns SOAR, MIPPA, SHIP, VEPI, and FFP resources to maximize funding impact and avoid duplication. Formal referral pathways with hospitals, housing agencies, behavioral health providers, and community-based organizations strengthen care transitions and prevent service fragmentation.
- **Process Improvements and Performance Measures**
  OAI is implementing improved data tracking, standardized referral protocols, and enhanced staff training to ensure timely eligibility determinations and service connections. Success measures include reduced time from intake to service authorization,

increased waiver enrollment, expanded benefits uptake, and decreased crisis-driven placements.

By strengthening navigation infrastructure, coordinating funding streams, and embedding person-centered planning, OAI ensures residents can efficiently access affordable housing supports, financial assistance, and community-based services—preparing Howard County residents to afford longevity with dignity and independence.

Goal 4: Optimize health, wellness, and mobility

Equitable systems of care (1000-word max) –

Howard County has been re-designated as an AARP Age-Friendly Community for 2025–2029, affirming its commitment to building systems that support longevity, independence, and equitable access to care. The Age-Friendly Howard County Action Plan includes more than 45 measurable action items across the pillars of health and wellbeing, livability, and community connection, each with defined timelines and partners.

Advancing Health and Wellbeing

Health and wellbeing are defined as the ability for individuals to live long, productive, and meaningful lives. OAI advances this through coordinated efforts to:

- Improve care navigation and access to affordable healthcare.
- Increase participation in community-based health promotion programs.
- Reduce preventable hospitalizations and institutional placements.
- Strengthen emergency preparedness and public health resilience.

Through Maryland Access Point (MAP), Options Counseling, SHIP, and Medicaid administrative claiming (FFP), OAI ensures residents particularly those with greatest economic and social need, can access timely services and benefits. MAP functions as a coordinated entry system connecting individuals to waiver services, chronic disease programs, caregiver supports, transportation, and behavioral health referrals.

Trusted community networks including 50+ Centers, faith communities, multicultural organizations, and housing sites, serve as platforms for delivering health education, peer support, and resilience-building programs. Outreach prioritizes individuals disconnected from care, those with limited English proficiency, solo agers, and residents in communities experiencing socioeconomic disparities.

Living, Mobility, and Aging in the Right Place

The Age-Friendly framework also emphasizes physical environment and infrastructure to ensure residents can safely age in the right place. OAI collaborates with County planning, housing, and transportation agencies to advocate for:

- Affordable and accessible housing options, including Accessory Dwelling Units (ADUs). Recent local legislation (CB3-2026) passed, which expands opportunities for the construction of ADUs, including small detached cottages, garage apartments, townhome basement units, and in-law suites.
- Dementia-friendly and pedestrian-safe transportation systems.
- Multimodal transit access that supports non-drivers.
- Universal design and accessibility standards.

Through MAP, Community Living Program (CLP), and home modification initiatives, residents receive education, environmental assessments, and direct supports that reduce fall risk and improve mobility within the home and community.

Emergency preparedness and resilience are integrated into programming to ensure older adults are supported before, during, and after public health events. Coordination with the Health Department and emergency management strengthens communication pathways and continuity of services.

The second Age-Friendly cycle emphasizes cross-sector collaboration. By aligning County agencies, healthcare institutions, nonprofits, and residents, Howard County strengthens its collective ability to respond to demographic shifts and emerging health needs. Progress is measured through expanded access to health services, increased program participation, improved mobility indicators, and reduced disparities in care access.

Nutrition (1000-word max)

OAI recognizes nutrition as a critical component of health and wellness for older adults and incorporates a food is medicine approach across its nutrition programs. OAI addresses hunger and food insecurity through an integrated nutrition strategy that combines meal services, education, and community partnerships. The Congregate Meals Program provides nutritious weekday meals at sites across the county, promoting both nourishment and social connection. Homebound individuals are supported through Home Delivered Meals, including medically tailored meals for those with chronic conditions, reducing barriers to access and improving health outcomes. Medically tailored meals provide nutritionally appropriate food designed for individuals with specific health conditions, helping manage chronic diseases, improve health

outcomes, reduce hospitalizations, and support individuals in maintaining independence at home. Emergency meal kits further address immediate food needs.

Nutrition education is a key component of OAI's approach, with individualized one-on-one consultations from a Registered Dietitian, group presentations, and hands-on learning opportunities designed to improve nutrition literacy among older adults. OAI also connects individuals to community-based food resources by assisting with SNAP applications and referrals to local food pantries, expanding access beyond direct meal services.

All meals provided meet OAA and Maryland Department on Aging nutrition standards of meeting 1/3 of Dietary References Intakes (DRIs) and are designed to prevent malnutrition and support a food-is-medicine approach. Nutrition risk screening is incorporated into participant assessments to identify unmet needs and facilitate referrals to nutrition consultations, SNAP assistance, Howard County Food Bank, and additional resources.

Nutrition Education and Chronic Disease Prevention

OAI provides:

- Individualized consultations with a Registered Dietitian.
- Group education aligned with national health observances (i.e. Heart Health, National Nutrition Month)
- Multilingual nutrition workshops in partnership with multicultural organizations including Korean-American Senior Association (KASA) and Chinese-American Senior Association (CASA).
- Integrated programming pairing Chronic Disease Self-Management Education (CDSME) with healthy congregate meals.

By Spring 2026, Nutrition Specialists will expand onsite SNAP enrollment support, strengthening coordination with MIPPA and MAP initiatives.

Farmers Market and Community Partnerships

Through the Senior Farmers Market Nutrition Program, OAI increases access to fresh produce while supporting local agriculture in partnership with the Howard County Office of Agriculture. Redeployment strategies will allow point-of-distribution produce access and coordinated community resource engagement.

OAI actively participates in the Local Health Improvement Coalition (LHIC) Healthy Living Workgroup and Healthier Choices Coalition to align strategies with broader county health priorities.

Workforce and Innovation

Partnerships with local colleges strengthen workforce capacity through internships in nutrition. Volunteers and interns enhance meal service, outreach, and education.

Performance measures include:

- Increased congregate and home-delivered meal participation.
- Reduced food insecurity among screened participants.
- Expanded SNAP enrollment.
- Increased culturally responsive programming.

Health promotion (1000-word max) –

OAI promotes physical, mental, cognitive, and social well-being through innovative programs, services, and events offered throughout the 50+ Centers and throughout the community. These efforts focus on individuals living with chronic conditions, with the goal of improving overall health and brain vitality by expanding access to programs including options for virtual participation.
Health promotion programs are selected with consideration of community feedback as well as existing data and strategic plans of internal and external partner agencies. In addition, OAI works closely with the Health Department and Johns Hopkins Howard County Medical Center as part of a Local Health Improvement Coalition (LHIC) workgroup that aims to provide healthy lifestyle activities for disease prevention through improved access to healthy foods, health education, safe physical activity opportunities, and healthcare.

In FY26, OAI administered a community survey to encourage input related to programs and services. The results showed significant interest in fitness assessments. In response, OAI plans to increase fitness assessment offerings in FY27 to two Focus on Fitness events per year.

OAI expands its reach to those not already attending the 50+ Centers by embracing a Centers Without Walls concept and supporting accessible programs. OAI has developed community-based programming aimed at reaching older adults where they live and gather. Health promotion programs such as CDSME and relevant presentations are delivered at 55+ communities, senior apartment buildings, and widely used community venues such as libraries and churches. Virtual

and outdoor recreation programming are also a way to reach individuals outside of the 50+ Center walls. For example, Cycle2Health attracts males who are over 60 years old. Howard County serves a diverse demographic that includes individuals who don't speak English as their first language. To make CDSME programs accessible to this population, OAI has translated promotional and program materials, and coordinated with program leaders to deliver programs in Spanish, Korean, and Chinese.

OAI also maintains and values strategic internal and external cross sector relationships that drive interest and participation. Some examples of successful internal cross sector relationships include pairing congregate lunches with CDSME workshops and efforts around solo aging, such as the SeniorsTogether support group expansion to include a Thriving Solo Together support group to build on the successes of a solo aging seminar developed by Maryland Access Point. External cross sector relationships bring new referrals and opportunities to leverage incentives available through community partners. For example, in collaboration with the Howard County Health Department, participants in the diabetes self-management workshops received vouchers for healthy food at a local grocery store. Other successful examples of referral include those with Johns Hopkins Howard County Medical Center related to CDSME programs. The hospital posts upcoming programs on their online portal and select doctors make referrals. New in FY2027, OAI plans to work with the hospital's cardiac rehabilitation team to offer exercise options at the 50+ Centers for individuals recently discharged from cardiac rehab.

Title IIID funds and revenue support evidence-based programs ranked highest level tier by the Administration of Community Living. Funds are used for instructor payment and training. Programs are offered at various locations and times to reach a diverse population. Participants 60 and over are encouraged to make a donation for the viability of the program. Those 59 and under pay the actual fee to participate. For FY2027- FY2030, Title IIID funds will be used to support the following evidence-based programs in the community:

- Better Balance (ongoing)
- The Arthritis Foundation Exercise Program (ongoing)

OAI in collaboration with the Department of Veterans Affairs and the University of Maryland, Baltimore County (UMBC) tested the feasibility and safety of Better Balance which was found during a randomized clinical trial to be effective for people with a chronic condition affecting balance or for those who simply feel unsteady on their feet.

The Arthritis Foundation Exercise Program is a low impact physical activity program proven to reduce pain and decrease stiffness. The class includes gentle range-of-motion exercises that are suitable for all fitness levels and abilities.

In addition, OAI will continue to offer various highest-level tier evidence programs in partnership with the Howard County Health Department, Johns Hopkins Howard County Medical Center, and My Life Foundation. Programs are funded utilizing revenue in FY2027-FY2030 to include:

- Chronic Disease Self-Management Program
- Chronic Pain Self-Management Program
- Diabetes Self-Management Program
- Powerful Tools for Caregivers

As non-evidence-based programs, OAI offers health screening and referrals, health education, physical activities, and health services. Some examples include group exercise classes, peer support groups, outdoor recreation, presentations related to health observances, relevant health screenings, Mental Health First Aid, Healthy Hearts Ambassador Program, and alternative services such as reiki and massage. Instructor fees are paid for using revenue. A grant from Johns Hopkins Howard County Medical Center helps support the delivery of Agewell, a low-cost exercise class option for community members who live in areas of greatest socioeconomic need.

Future leaders of volunteer-led evidence-based and non-evidence-based health promotion programs are most often recruited from current program participants who express interest in the subject matter and a desire to take on leadership roles, as well as through outreach at college and career fairs. For exercise-based programs, recruitment also occurs through word of mouth from other instructors and via NeoGov, Howard County's job listing portal. Volunteers serve as lay leaders for the Chronic Disease Self-Management Education program, facilitators for SeniorsTogether, and ride leaders for Cycle2Health. All prospective leaders and volunteers are interviewed prior to training, with interview processes tailored by program to ensure appropriate fit, readiness, and alignment with program goals.

Once selected, leaders and volunteers receive required program-specific training to ensure fidelity to the model. In addition, all volunteers sign an agreement. Ongoing support is a key component of retention efforts. OAI maintains regular communication with volunteers, recognizing them as the "eyes and ears" of the programs by actively listening to feedback, incorporating recommendations when appropriate, and providing timely assistance as needs arise. To further encourage retention and satisfaction, volunteers and leaders are recognized

throughout the year through appreciation events and acknowledgements. When applicable, stipends are provided to honor their time and commitment.

Client Journey Map – (Attachment I F)

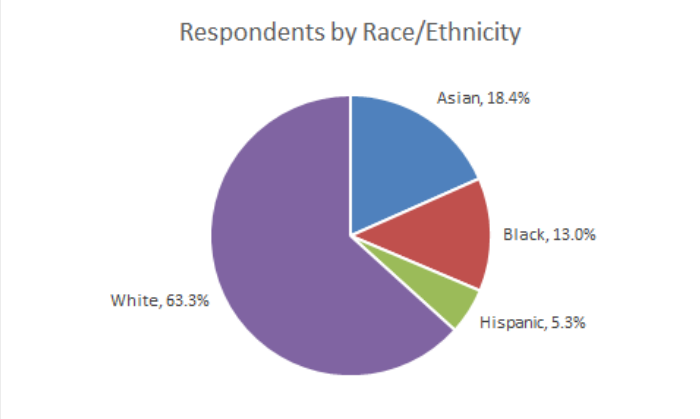
COMMUNITY SURVEY 2026

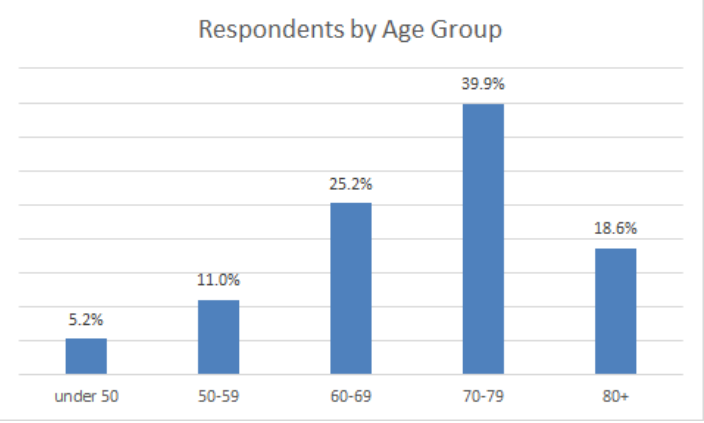
A total of 398 individuals responded to the survey. Overall, respondents appeared to be proportional to usage at 50+ Centers on the basis of age group, and racial/ethnic group. Respondents were skewed towards higher educational attainment (compared to Census figures), though that might be a reflection of those individuals that attend the 50+ Centers (OAI does not collect educational attainment data from Center participants).

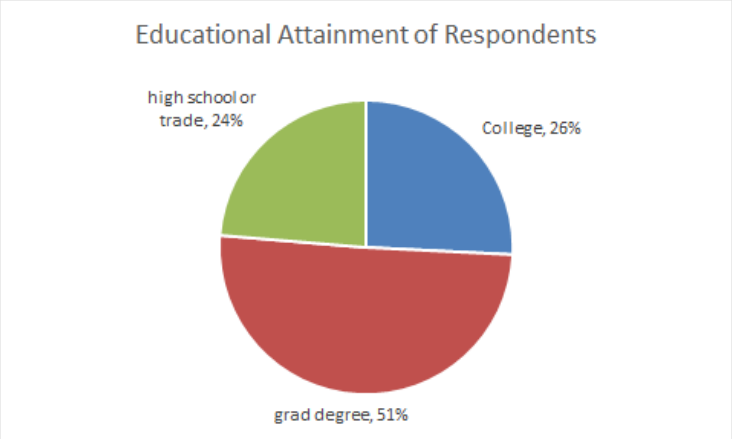
Respondent population was highly skewed in terms of educational attainment. Overall, 77% of respondents reported a college degree (with 51% reporting a graduate level degree). Census data (ACS 2024) indicates that among individuals age 65, only 59% of individuals in the County had a college degree.

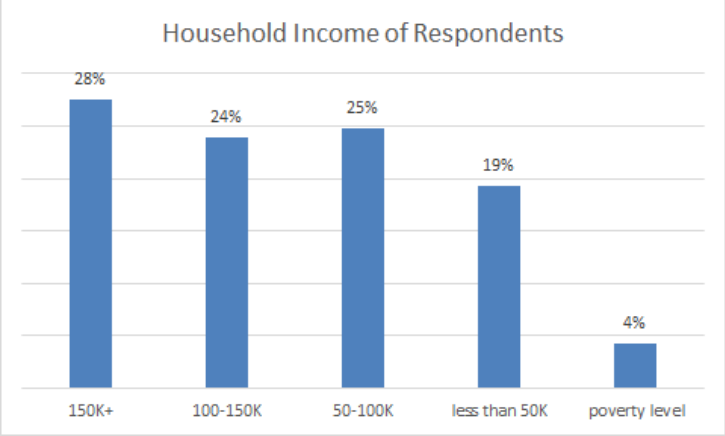
Consistent with the bias in educational attainment, household incomes of respondents were also inflated compared to Census data (i.e., 52% of respondents, most of whom were retired, reported household incomes in excess of $100,000).

Hispanic survey respondents were systematically different in terms of age compared to the other race/ethnic groups (75% of Hispanic respondents were under the age of 60 compared to an average of 13% across non-Hispanic individuals). Likewise, only 10% of Hispanic respondents were age 70+, compared to 62% of non-Hispanic respondents.



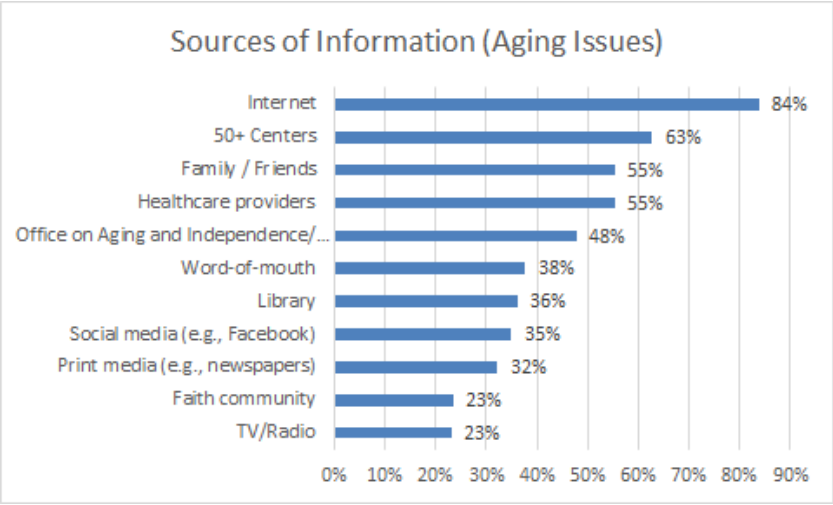






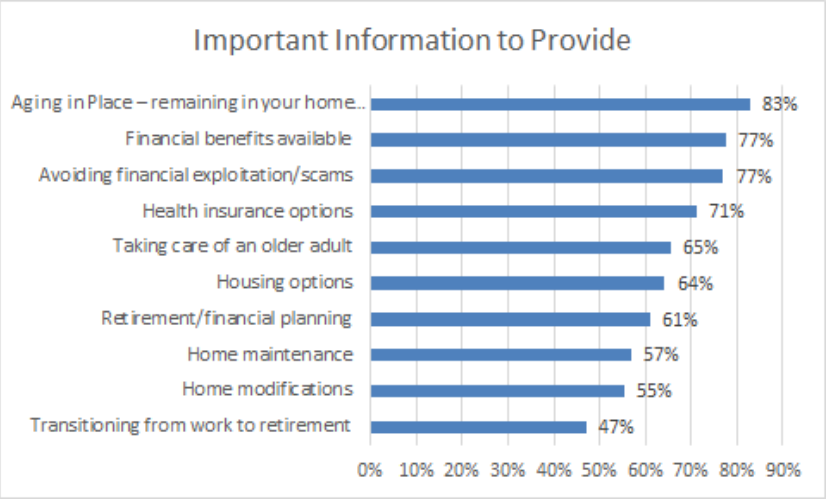
Sources of Information: Respondents were asked what was the likelihood of different sources of information they would use to find out information related to aging.

Respondents who identified as Hispanic differed in response patterns compared to other individuals, indicating a higher usage of “social media” and reliance on “faith community”, and less reliance on “50+ Centers” as sources of information.



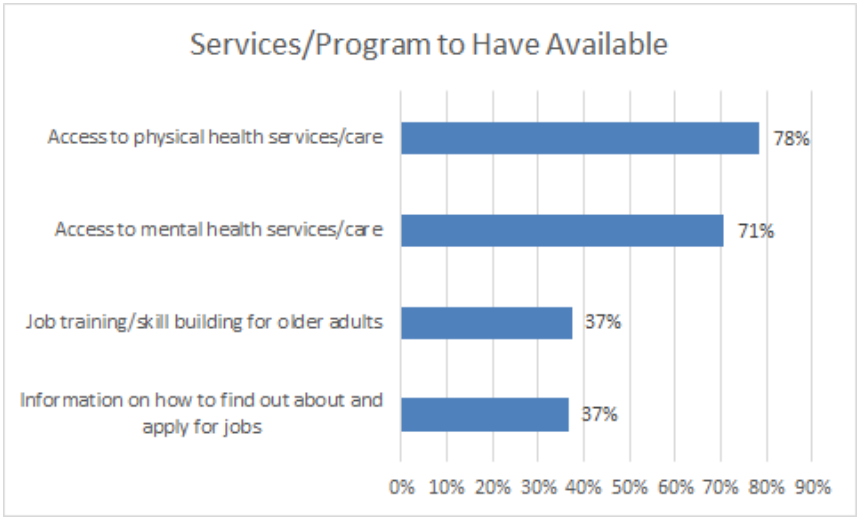
Available Information: A question asked about specific types of information that individuals wanted to have available to them.

On average, females were slightly desiring of more information than males, across all topics except for "home modifications".



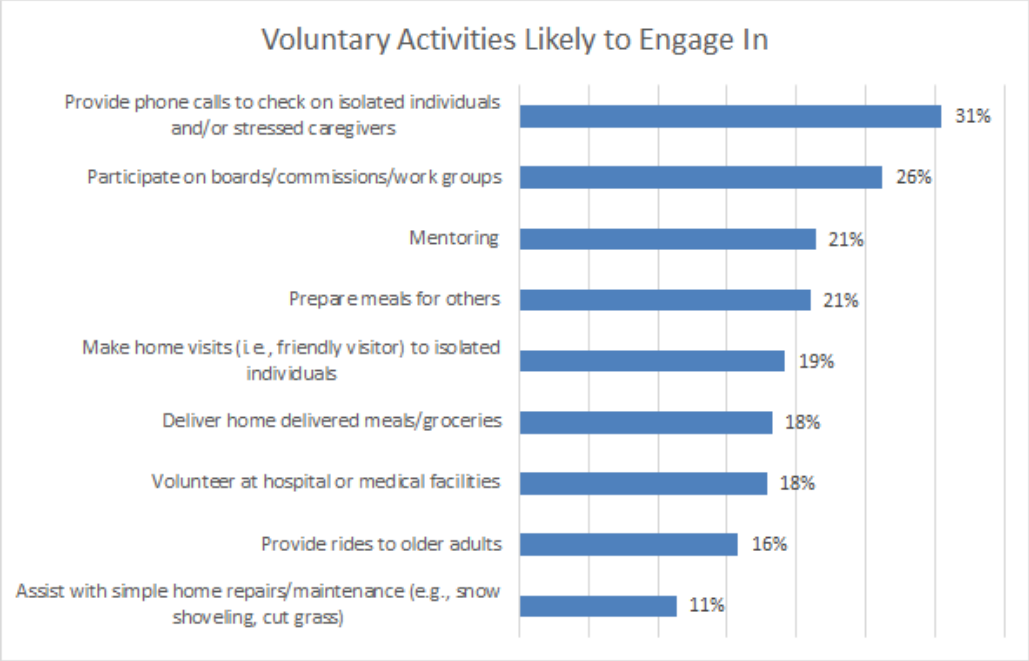
Job or Access Questions: A question was asked as to specific programs or services that people were wanting the County to provide. Females, compared to males, were more interested in each of the categories asked about.

Hispanics reported more interest in job training or skill building, as well as information on applying for jobs (likely due to younger age of these respondents).



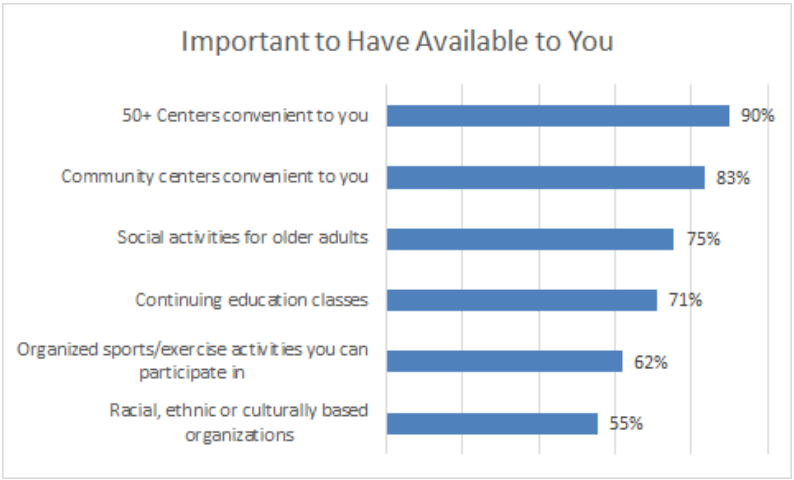
Volunteerism: A question asked about nine (9) different types of voluntary activities, and whether the individuals had an interest in participating in the following year if asked.

- Black and Hispanic respondents reported more likelihood to volunteer (across most categories)
- Hispanics were particularly more likely to volunteer to do: home visits, and home repairs,
- Females more likely: meal preparation
- Males more likely: home repairs/maintenance, mentoring, boards/commissions

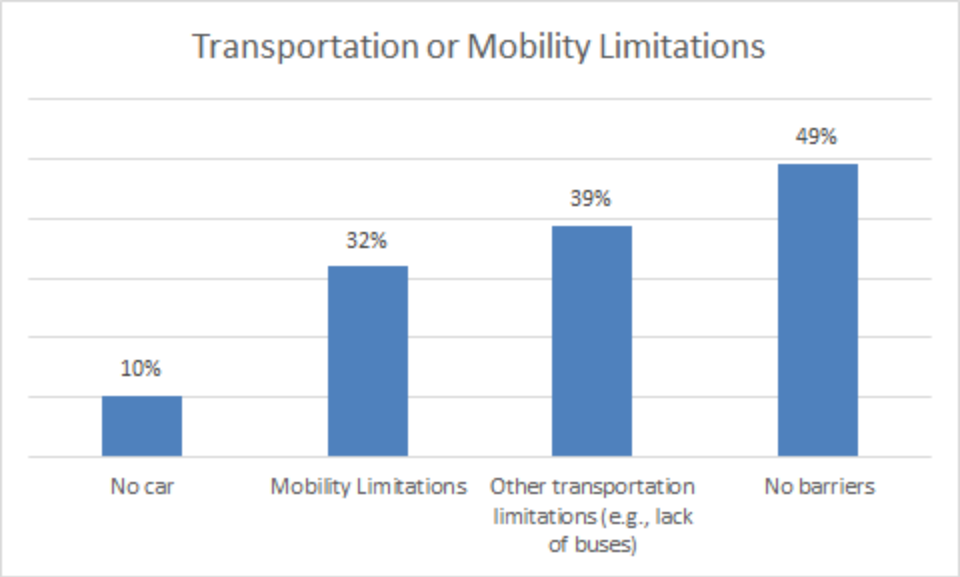


Activities and Centers: Another question asked about interest in types of activities:

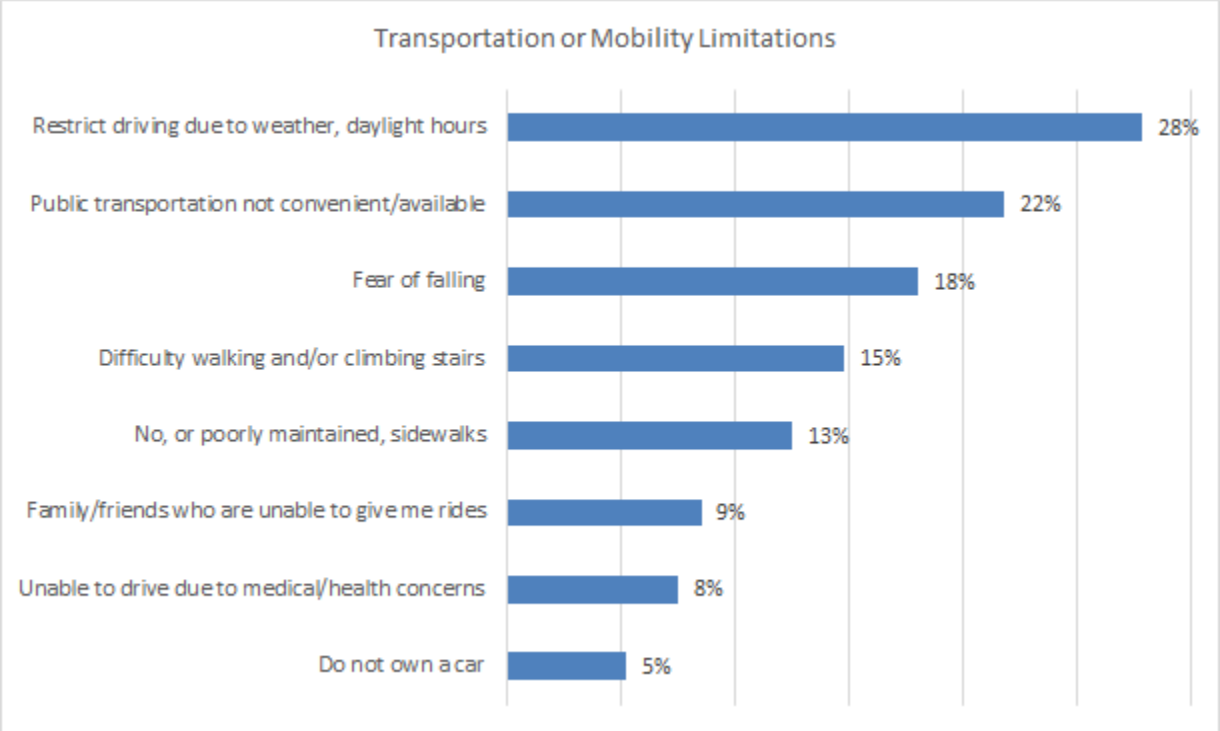
- Females more interested in: continuing education, social activities, race/ethnic/cultural organizations, organized sports/exercise



Transportation and Mobility Limitations

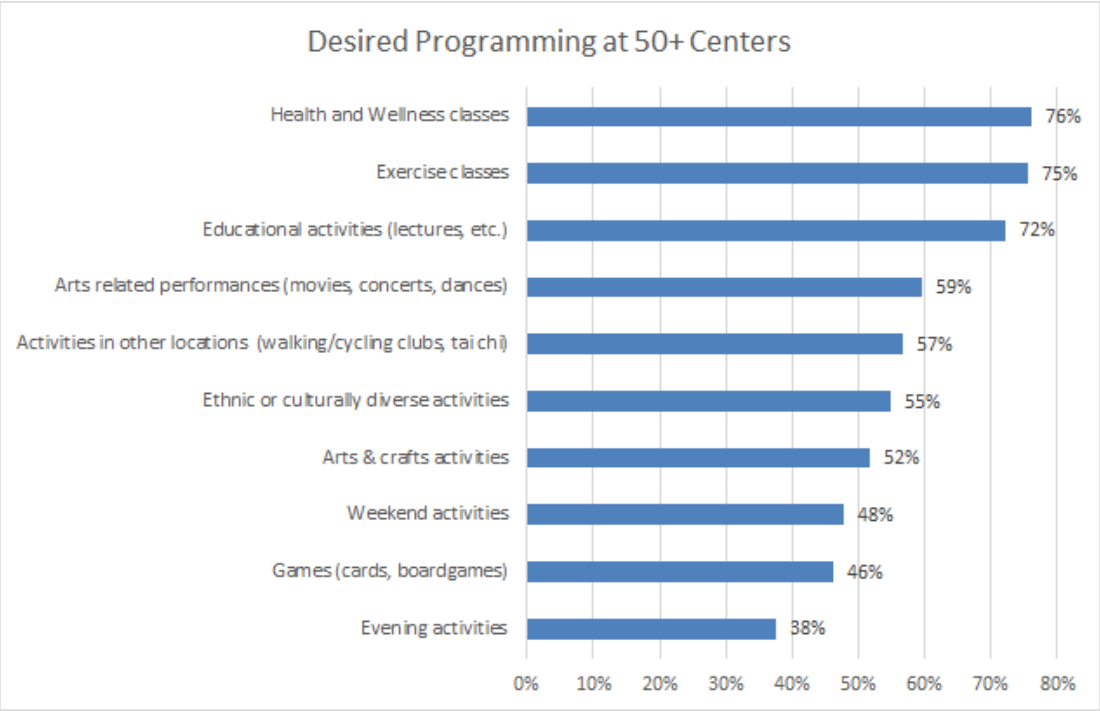


Transportation and Mobility Limitations (specific barriers)

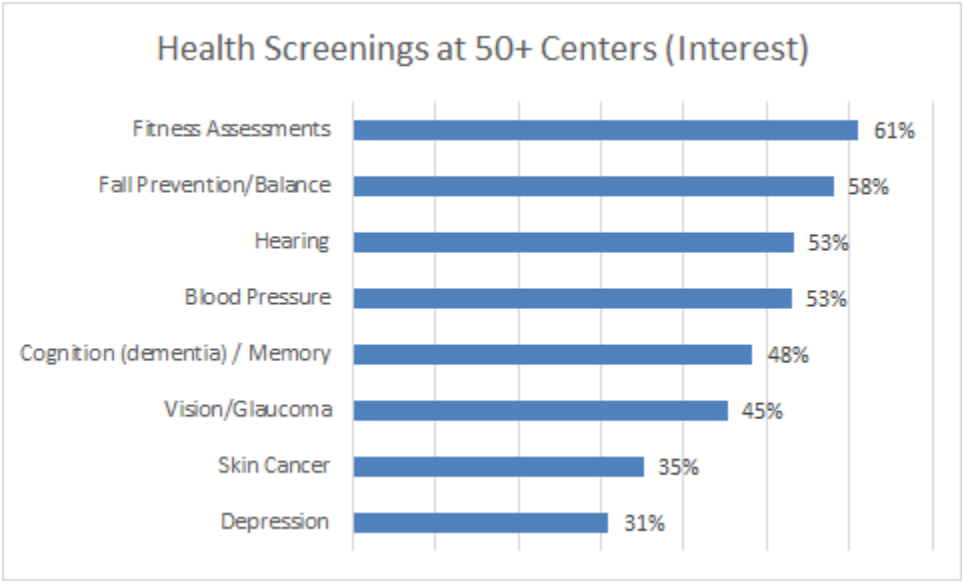


50+ Center Programming: Respondents were asked about specific activities or programming they desired at 50+ Centers:

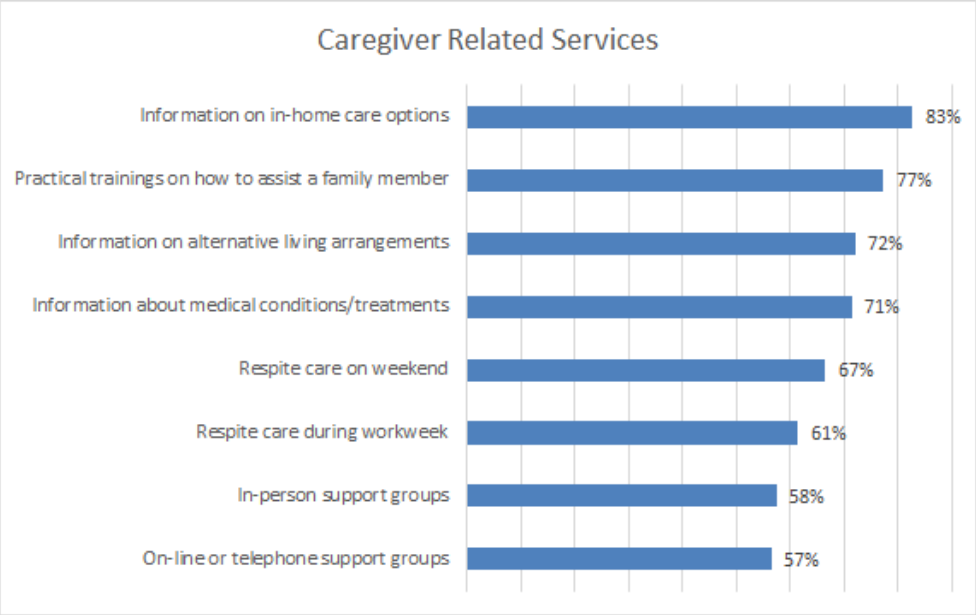
- Females more interested in: exercise classes, arts/crafts, arts related programming,
- Hispanics wanted more evening and weekend activities (likely a result of these respondents being younger and more likely in the workforce)
- Black and Hispanic wanted more: games, arts/crafts



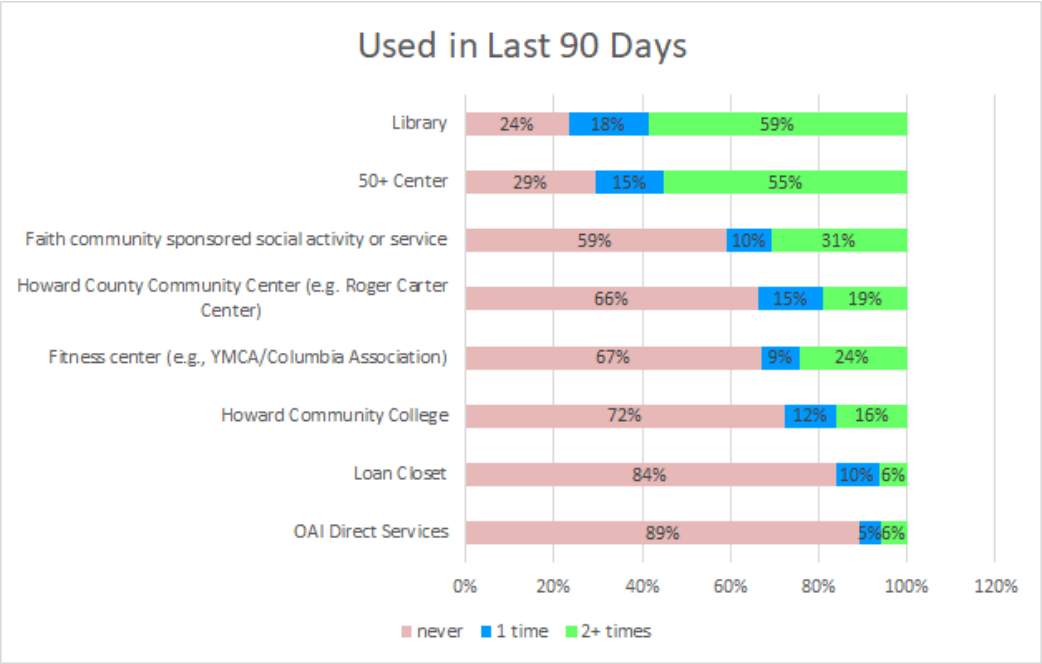
Health Screenings at 50+ Centers: 87% of respondents stated an interest in one or more health screenings (survey asked about 8 different types of screenings).



Services for Caregivers: A question asked people about a scenario where they were providing assistance to a family member or friend (i.e., caregiver), and what services they would be interested in having available.



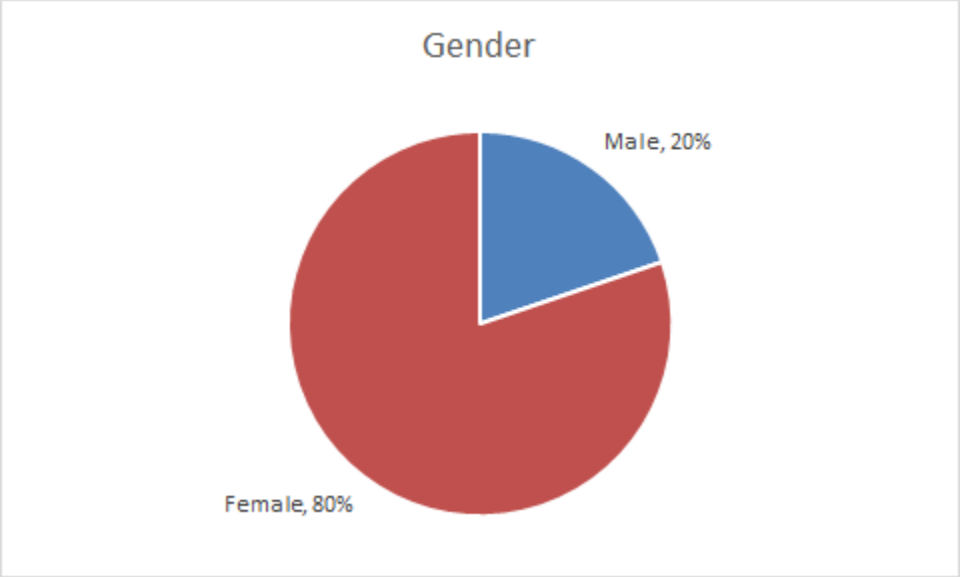
Activities or Services Used Recently: A question asked about whether they, in the last 90 days, had used any of eight different services or programs. A sizable proportion of surveys were collected at 50+ Centers, resulting in a heavy bias towards that particular service location.

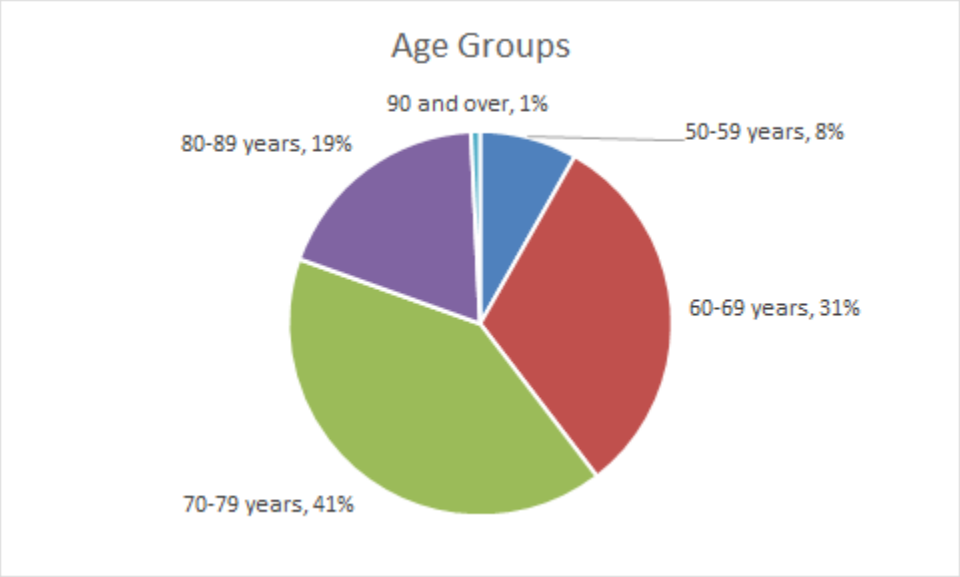


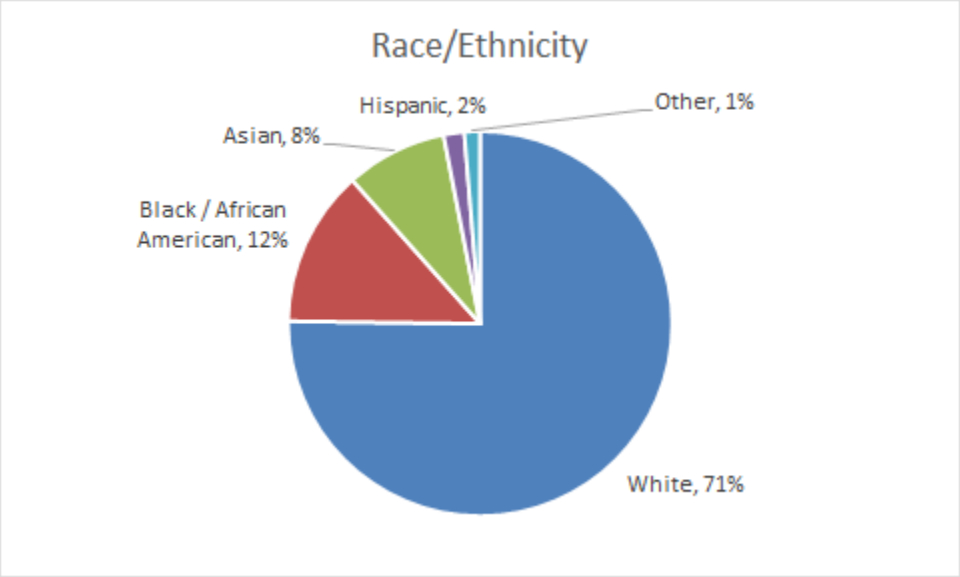
50+ Center Survey: October 2025

923 responses through October 2nd

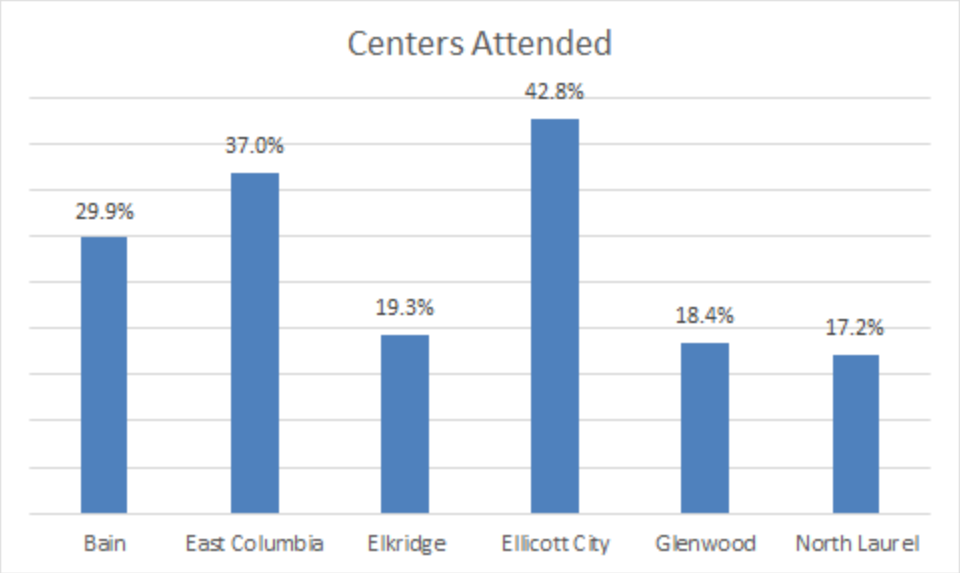
80% female (among those that indicated gender)

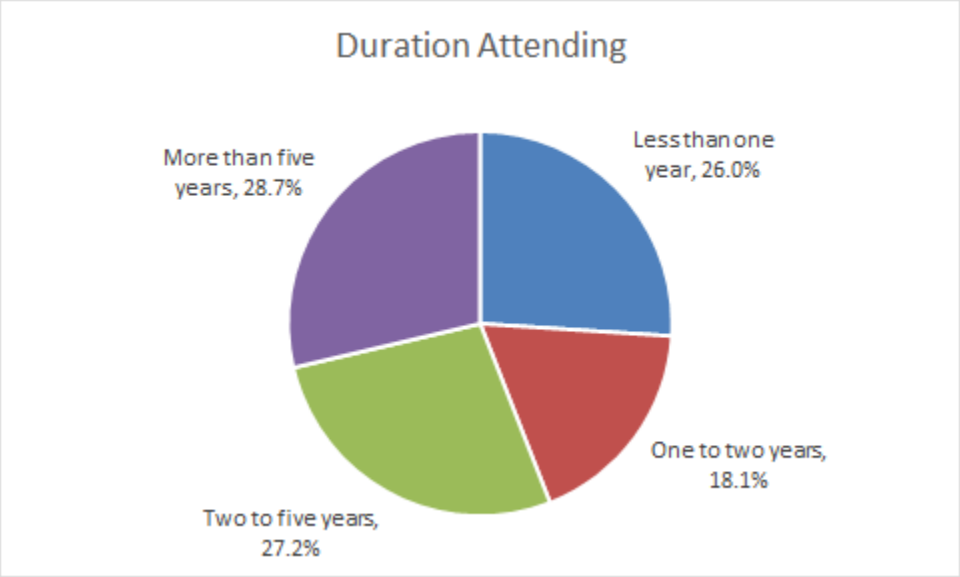


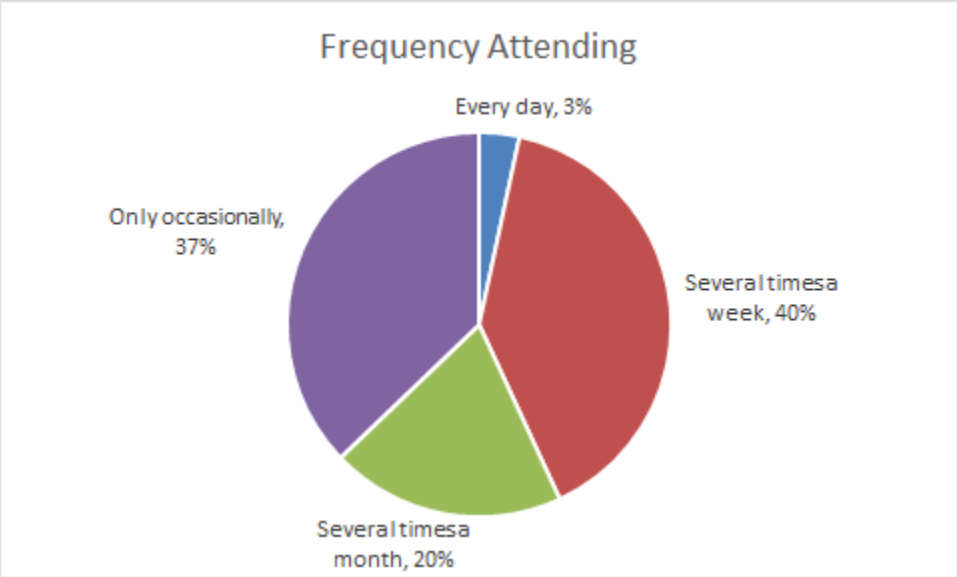




Centers Attended by Respondents. 39% of respondents reporting attending 2+ Centers, with the average number of Centers attended was 1.65 per respondent

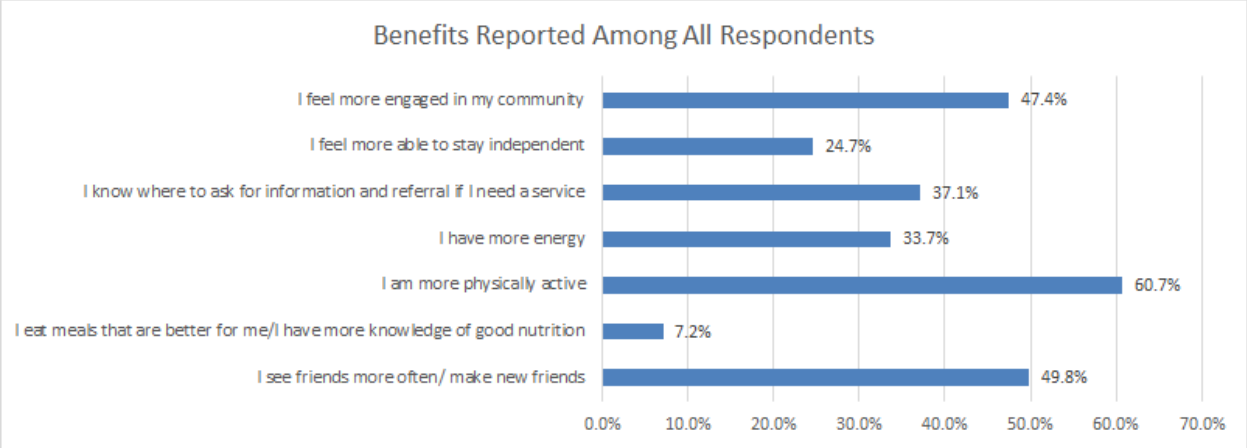






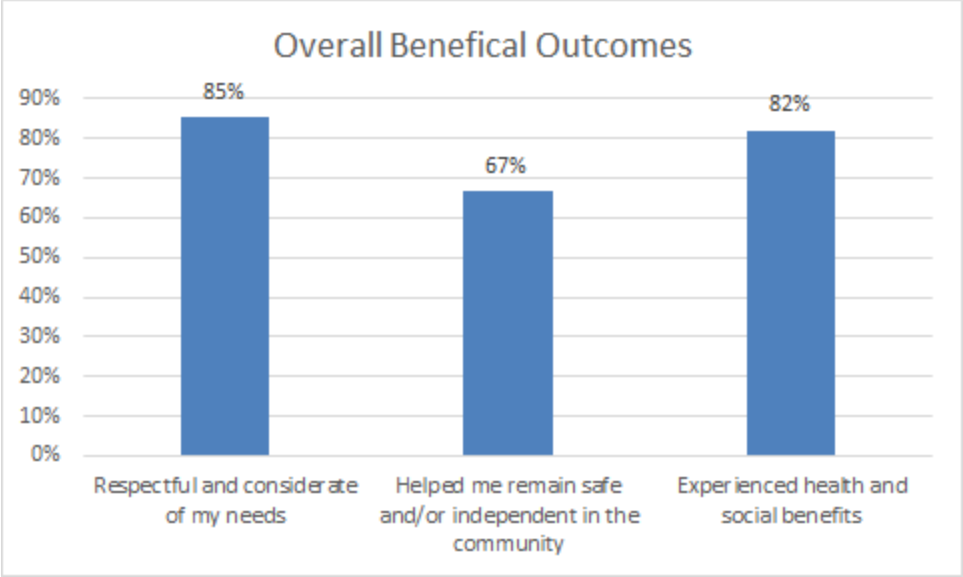
Long-term users of Centers (2+ years) were also more likely to attend frequently (week or daily), with 58% of those that attended 2+ years stating they attended weekly or more often compared to 27% of those that have attended less than 1 year.

Benefits reported by All Respondents



Some benefits were reported in higher frequency by those who attended frequently (weekly or daily); such as:

- Seeing friendly more often or making new friends (71% vs. 50% overall)
- More physically active (85% vs. 61% overall)
- More energy (55% vs. 34% overall)
- More engaged in community (55% vs. 47% overall)



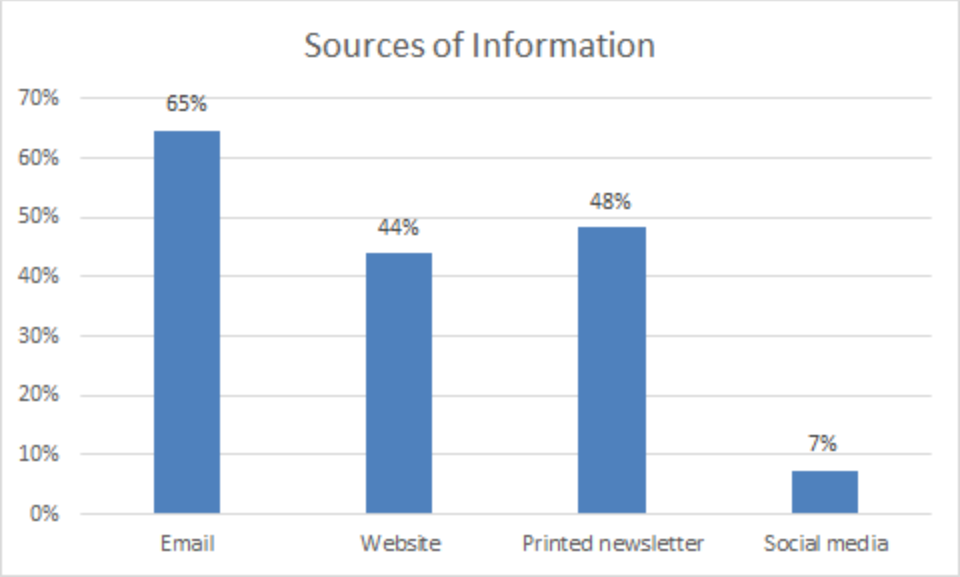
Satisfaction with 50+ Centers:

- 89% overall
- 98% among those that attend weekly or daily
- 73% among those that attend only occasionally

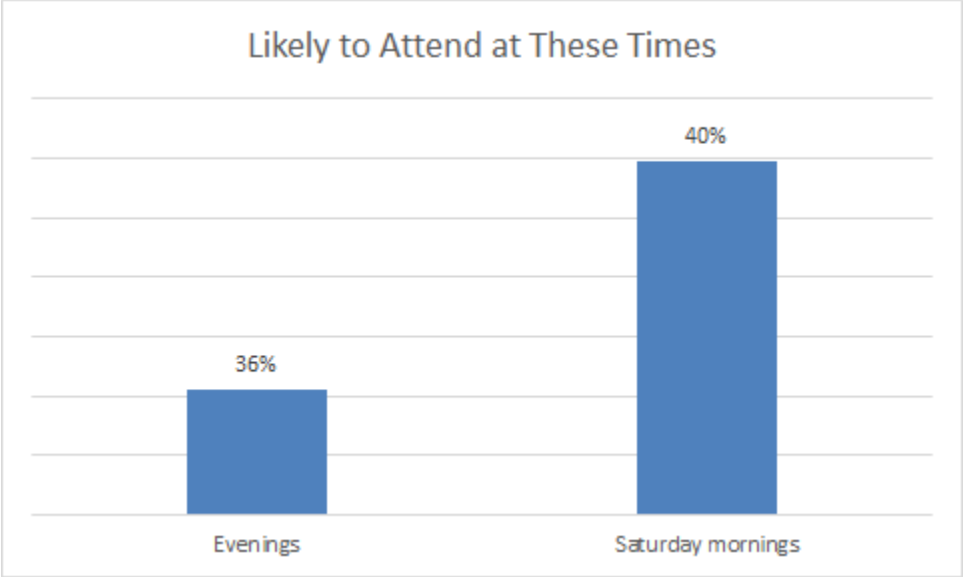
Programming & Activities

- Exercise (50%) and Fitness Room (35%) were the most frequently cited activities.

- Exercise/Fitness more prominent among younger and more frequent (weekly) participants
- Males more likely to cite fitness room than females (48% vs. 30%)
- Females more likely to cite Exercise/dance classes (55% vs. 29%)
- After exercise related activities the most common cited were:
  - 29% Continuing Ed
  - 25% Social activities
  - 22% Health & Education
  - 20% Consumer education
  - 19% Music/creative expression
  - 10% meals
- Females twice as likely (relative to males) to engage in music/expressive arts and "special events"
- 26% of Asians reported participating in meals



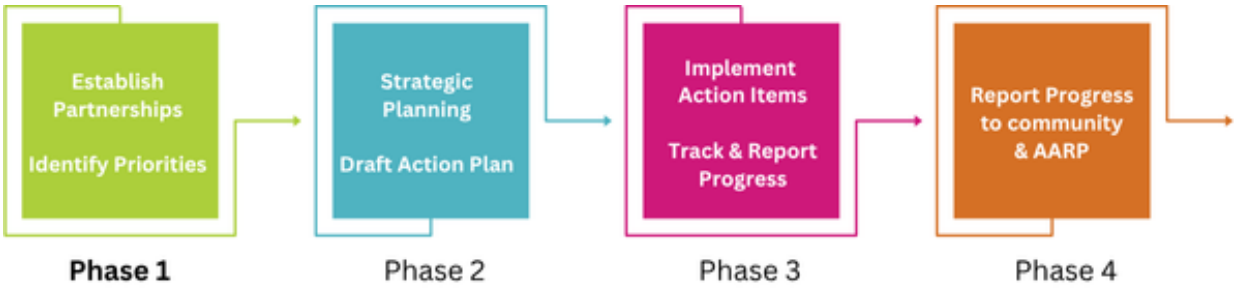
Primary source of information was email with no differences by age group.


Likely to Attend at These Times
40%
36%
Evenings
Saturday mornings

Age-Friendly Howard County

MISSION:
To create a livable community where everyone feels **safe**, **welcomed** and **engaged**.

VISION:
Howard County will be a **vibrant**, **inclusive** and **livable** community where people of all ages and abilities can thrive.



2025-2029 Age-Friendly Action Plan

Be a driving force to build a safer, healthier, and more livable community.

Community & Inclusion

This pillar focuses on making HoCo a more inclusive place for everyone, regardless of age or ability. It ensures businesses and services are accessible and welcoming to all.

Inclusion

Dementia-Friendly Communities

Age-Friendly Businesses

Health & Well-being

This pillar focuses on health, well-being and the ability for people to live long, productive lives. It includes efforts to enhance resiliency in the community and redefine productivity from economic output to achievement through meaningful engagement, quality of life, personal growth, and social contribution.

Resilience

Longevity

Workforce Development

Living & Mobility

This pillar addresses the physical environment and needs of the community to ensure that people have access to affordable, appropriate housing and transportation options. Efforts will support independence and mobility for residents and visitors of all ages and abilities.

Housing

Transportation

How will you be involved?

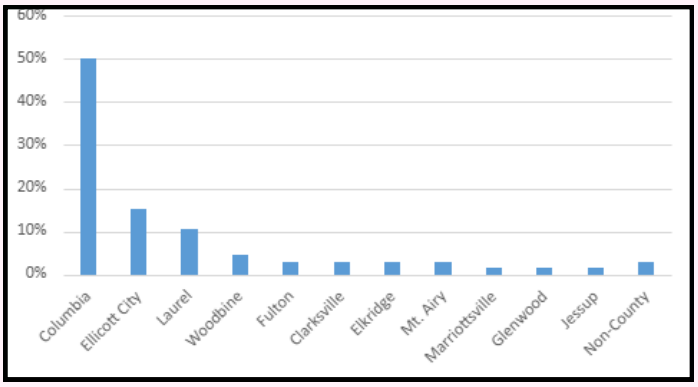
Howard County
Office on Aging and Independence

Age-Friendly Howard County

Listening Sessions 2025 Summary

7 Sessions | 91 attendees
Stats for 78 attendees →
Largest Session: Bain (23)
Smallest Session: PTW (5)

Demographics	
Male	24%
Columbia	50%
Ellicott City	15%
Laurel	11%



Cross-Cutting Themes

- Desire to age in place, but may not know how or be able to
- Frustration with overdevelopment and lack of comm. input
- Need for inclusive public spaces
- Community voices want action, not just input collection

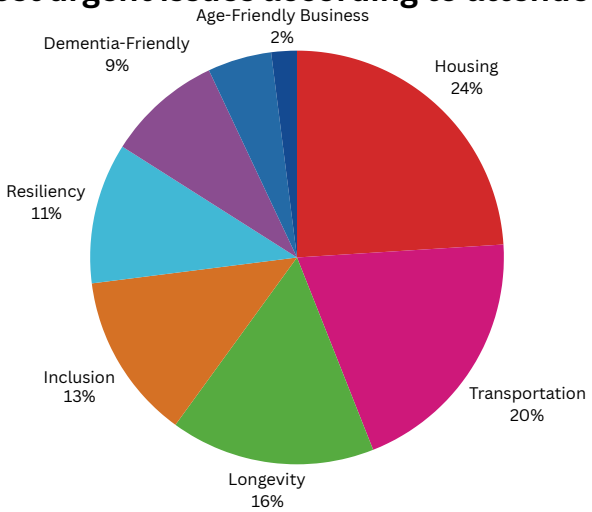
Community Strengths

- 50+ Centers
  - Welcoming spaces for activities and connection
- Libraries
  - Inclusive, informative, and trusted
- Parks & Trail Systems
  - Clean, accessible, and navigable
- Communication Resources
  - Ball Bulletin, e-newsletters and bulletin boards are primary sources for information

Community Challenges

- Housing Stress
  - Rising prices, taxes and utilities
  - Lack of right-sizing options
  - No rent control
  - Costly maintenance, challenge to find trusted contractors
- Transportation
  - Lack of sidewalks
  - Limited bus shelters/benches
  - Aggressive driving
- Healthcare Gaps
  - Long waits for care (triage)
  - Few local providers
  - Transport barriers to appt
- Public Safety
  - Increasing crime/concerns at the mall
  - Night driving (lack of lighting)
  - Pedestrian safety and comfort

Most urgent issues according to attendees:



Describe Howard County in one word:

STAFF & PARTNER SURVEY: February 2026

Q1: Most effective ways for OAI to stay informed of needs, preferences, lived experiences

Partners (n = 7): overarching emphasis from partners was for "face-to-face" data collection on an on-going basis

- Regular/on-going outreach process – quarterly or more often, not annually ("feedback loop") using "face to face" information gathering.
    - Residents: 50+ Centers, Senior Apartment Buildings, rural residents
    - Agency partners: home care agencies, hospitals, SNFs, ADC, behavioral health partners, faith communities, food pantries, libraries, rec centers,
- Needs assessments (e.g, representative sample of HoCo population)
- Data sharing and trend monitoring with partners (i.e., shared dashboard … referral volume, wait times, unmet needs)

Staff (n = 17) - overarching emphasis from staff revolved around collecting data from already known sources (i.e., staff and people already engaged with OAI). Less often cited were efforts to gather information from people not already engaged with OAI but means of accomplishing this were not clearly spelled out.

- Annual community surveys, focus groups, community listening sessions, individual interviews
    - Process for surveys: newsletters, mailings lists, QR codes, front desk of 50+ Centers, front desk of community centers,
- Listen to what staff have to share:
    - Staff have direct contact with clients
    - Internal OAI All Staff meetings (more sharing of information from staff upwards to OAI Director)
- Feedback (listening) sessions with people already attending 50+ Centers (e.g., focus groups)
- Seek feedback from people NOT already engaged (attending 50+ Centers) … method unclear
- Utilize social media to get feedback (process not stated)
- On-going process, rather than annual process

Q2: Gaps in services or supports

Partners (n = 7) – emphasis from partners was on direct services to clients (e.g., housing, transportation, nutrition, respite care).

- Long list of needs with little priorization (e.g., affordable housing, home repairs/modifications, house cleaning, transportation, financial assistance, home delivered meals, food access, respite care, caregiver trainings, increased paid caregiver workforce, pet control)
- Limited reference to process gaps:
    - "warm hand-offs" between different providers (e.g., exiting hospitals or SNFs)
    - Dementia navigation/coaching
    - Culturally sensitive/responsive services

Staff (n = 17) – emphasis among staff is on expansion of focus of services (e.g., younger people with disabilities, Latinos, males, solo agers) and on expansion of communication and coordination (i.e., providing more mechanisms for disseminating knowledge and information to the public).

- Communication/coordination (help guide people to where they need to go)
    - Provide unbiased information to residents
    - Information/guidance via all possible means (e.g, zoom, social media, recorded sessions, FAQs)
    - Increase community awareness/knowledge
    - Guidance/coaching to navigate process/services
- Expand focus
    - Services to people with disabilities who are under age 60, including services to youth that are aging out of K-12 services
    - Programming directed to those ages 50-65
    - Latino community
    - Solo agers/widows/widowers
    - Males (under represented)
- More oversight of providers (e.g., AL/SNFs)
- More direct services
    - Congregate meals at all 50+ Centers daily
    - Popular 50+ programming in evenings or weekends
    - Given stigma about "senior centers", consider offering programming outside the walls of 50+ Centers
    - Mental health offerings (workshops, stress relievers, education – not therapy)
    - Transportation

Q3: How can OAI strengthen its coordination/partnership role

Partners (n = 7): emphasis was on regular (quarterly or monthly) meetings and process improvements (e.g., liaisons for complex cases and "no wrong door")

- Quarterly or monthly meetings with community partners (e.g., interagency task force)
- OAI liaisons with community partners to assist with complex cases
- "no wrong door" referral pathway with warm handoffs
- Active sharing of resources/tools (joint trainings on selected topics, resource tools, real time information)

Staff (n = 17) – overarching belief was that OAI was/is doing a lot of stuff, and the problem is that community is unaware of what is already available. Hence, emphasis was on sharing information (tabling, ambassadors, outreach). Only one staff response addressed regular/on-going meetings between OAI and community providers

- Attend community events (tabling) … share information
    - "nothing" additional needed
    - Let people/agencies know what we are already doing
    - "better educate others about what we do"
    - Ambassadors to promote/share what we are already doing
- Coordination activities:
    - Coordination/training with other County offices/departments (e.g., fire and rescue)
    - Coordinate with local/small businesses (not clear how)
    - Coordinate with faith communities
    - LHIC type model (with other County departments)
    - Physician's offices
- Weekly update meetings (brief, 30 minutes or less) - utilization ZOOM/Teams

Q4: How to improve access to services/benefits

Partners (n = 7): Emphasis on streamlining of intake processes, along with broad (often vague) references to outreach and wrap around services.

- Process improvements:
  - "no wrong door" that allows all forms of intake (electronic, phone, in person, etc.)
  - Warm handoffs
  - Mechanism to accept referrals outside normal business hours
  - "fast track" processes for crisis situations
- Themes:
  - Wrap around services
  - Targeting those unaware of services (most needy)
  - Community outreach (e.g., senior housing, churches, food pantries, libraries, clinics)
  - Language and culturally sensitive
- Specific services:
  - Dementia navigation
  - Caregiver education
  - Respite options

Staff (n = 14) – staff focused on three avenues: 1) additional OAI staff, 2) more outreach to the community to let them know what OAI already provides, and 3) focusing on more information dissemination so that residents are better equipped to handle situations on their own.

- More staffing
  - Expand MAP staffing
  - Expand administrative support to programs (reduce burden on direct service staff)
- More outreach:
  - Public not aware of what we currently provide
  - Ambassador team to promote OAI services
- Knowledge/information:
  - More workshops/training
  - Nutrition education
  - Online platforms (e.g., Trualta)

Q5: Workforce and Volunteer Engagement

Partners (n = 7): suggestions related to workforce primarily rely on increased benefits (competitive pay, childcare, flexible scheduling). One respondent suggested that community college can offer micro-credentialing or increased CNA/GNA training. Suggestions related to volunteerism focused on centralization of volunteer opportunities (county website), volunteer recognition/appreciation, and better defined volunteer roles.

- Volunteerism:
  - Central county managed website for volunteerism
  - Regular recognition/appreciation
  - Clearly defined volunteer tasks/roles
  - Micro-volunteering (short, flexible time commitments)
  - Transportation or mileage reimbursement
  - "seniors helping seniors" (how this could be implemented was left unclear)
- Workforce issues:
  - Competitive pay, transportation, flexible scheduling, childcare
  - Subsidized senior work initiatives (e.g., job training, retool skills)
  - Career pathways
  - Partner with community colleges to create CNA/GNA pipelines
  - Micro-credentialing, paid training
  - Dementia training as standard

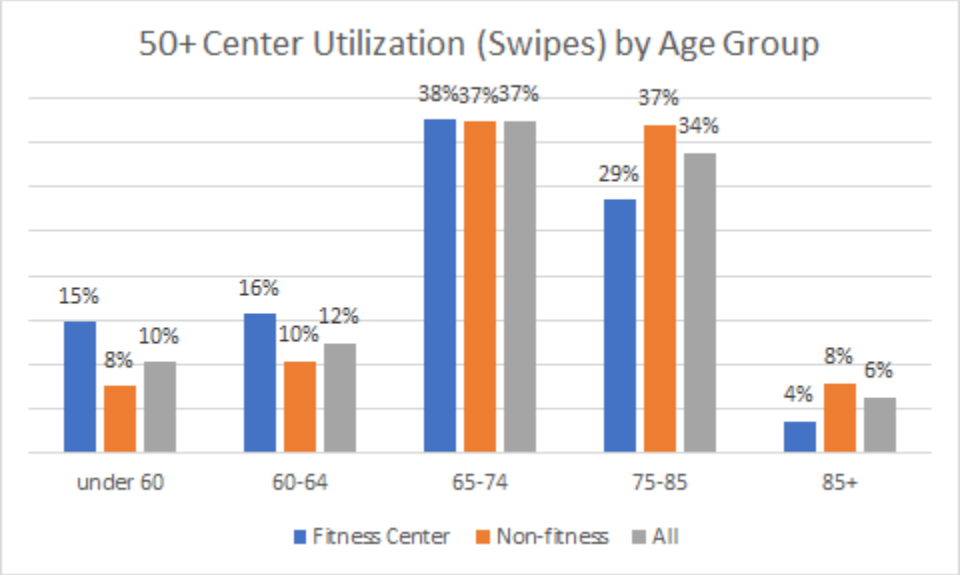
Staff (n = 15) – Staff focus on volunteerism focused on broader dissemination (to public) of volunteer opportunities, and increased recognition/appreciation. One respondent suggested that the passive approach to volunteerism (i.e., post opportunities and wait for people to reach out to you) is too limiting. That person proposed a "direct ask" approach; whereby you solicit people to a volunteer group, and then reach out to them for specific tasks ("ask").

- Volunteerism: broad recognition of value of volunteers but gap in suggestions on how to improve engagement
  - Dedicated volunteer manager for OAI
  - Disseminate volunteer opportunities
    - OAI digital newsletter
    - Volunteer fairs
  - Streamline the volunteer process (make it less intimidating)
  - Volunteer appreciation/recognition, paid volunteer opportunities (stipends) and track hours
  - Flexible volunteer opportunities
  - "direct ask" … create volunteer membership and instead of passively waiting for people to volunteer, reach out to them with specific asks
- Workforce:
  - Morale (within OAI): Camaraderie building exercises, share lunches

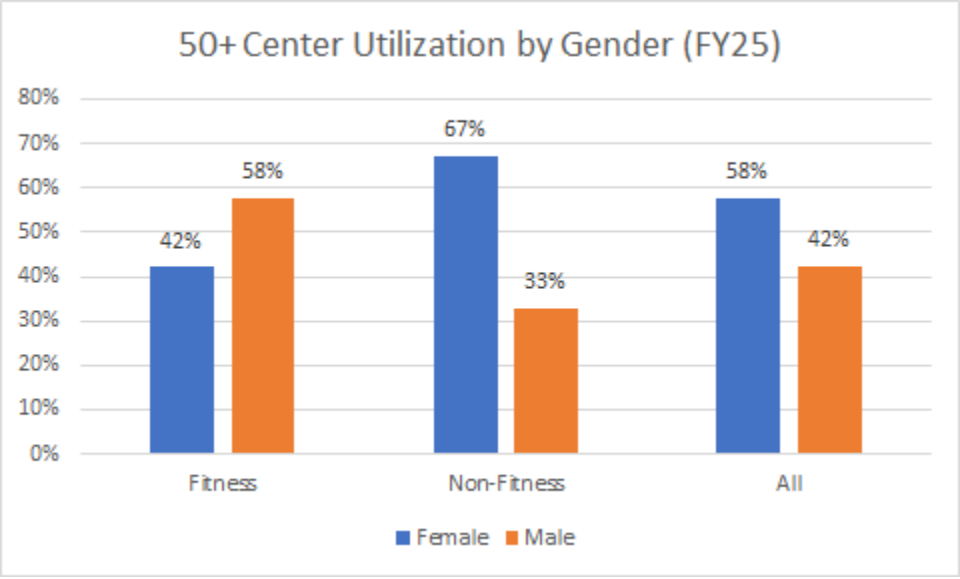
- External (non-OAI) workforce … improvements driven by market forces (pay) outside of our control

Utilization of 50+ Centers by Demographic Information

Merged data from client database (ServicePoint) where demographic are captured with ActiveNet (County activity registration platform) utilization data for FY25. Data reflected below represents duplicated utilization, not unduplicated usage.



Overall, bulk of 50+ Center utilization was among those ages 65-84 (71%).
People age 50-59 made up 10% of all usage, but 15% of fitness center usage. Fitness center usage, compared to non-fitness center usage declined with age.



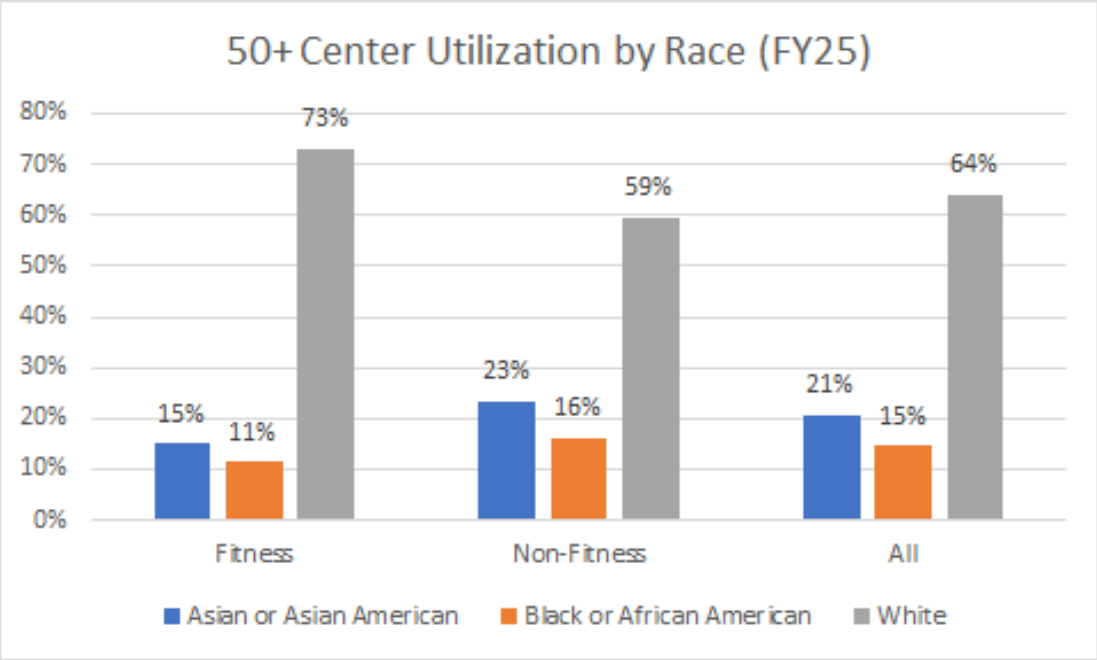
Census data tells us that in HoCo:

- Among those 65+, females make up 55% of population, or a 1.2 to 1 ratio
- Among those 75+, females make up 57% of population, or 1.3 to 1 ratio

Among all usage of 50+ Center

- Females made up 58% of usage, or 1.4 to 1 ratio
- Among Fitness Center usage: females made up 42% or 0.7 to 1 ratio
- Among non-fitness center usage: females made up 67% of usage, or 2.0 to 1 usage
- Among the subset of usage activities captured in ActiveNet (registered activities) the ratio was 3.3 to 1 (female to male)
    - Some activities had an even higher disparity:
        - Cooking 14.7
        - Arts & Crafts 12.5
        - Dance 8.8
        - Trips & Tours 6.9

This data trend is consistent with observation I made as part of interviews with participants at 50+ Centers a number of years ago (under Barbara Scher), where males I interviewed at Centers stated that there were few things offered at Centers that interested them (aside from card games and billiards).

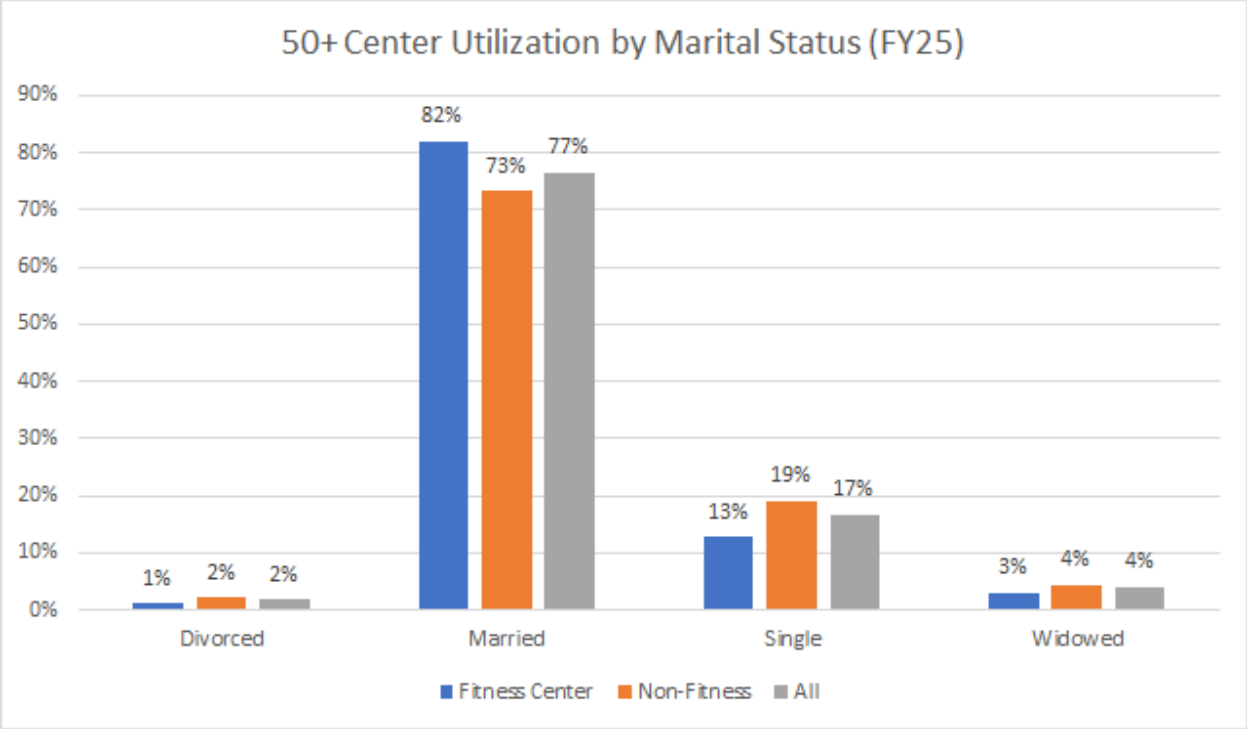


Census data indicates for those age 55+:

- White Non-Hispanics make up 65% of population
- Black/African-Americans are 16%
- Asian/Pacific Islander are 14%

Among usage of 50+ Center (as captured by swipes):

- Whites are 64% (among fitness center usage it is 71%)
- Blacks are 15% (among fitness center usage it is 11%)
- Asians are 21% (among fitness center it is 15%)



Census data for those ages 65+ indicates:

- 59% married
- 22% widowed
- 12% divorced
- 3% single

Marital status data was missing to a large degree, so analysis is tentative at best.

- 77% reported being married, compared to 59% of what Census data would project

One of the original intents of Senior Centers, in the Older Americans Act, was to provide a socialization avenue for single/divorced/widowed older adults, who otherwise might be isolated and lonely. Based on this data, it appears that we are not achieving this goal.

CLIENT JOURNEY MAP

Awareness & Access

The community client recognizes a need for help (e.g., housing, caregiving, healthcare, etc.) and reaches out directly to MAP. Other touchpoints include OAI website, phone call to Department of Community Resources & Services, walk-ins at 50+ Centers or referral from another agency or community partner.

01

Intake & Assessment

The client contacts the MAP program. The MAP specialist gathers information, assesses client's situation, and identifies specific needs and eligibility for various services through a person-centered approach. This stage often involves data entry and initial assessment.

02

Intake & Assessment

Based on the assessment, the MAP specialist provides the client with relevant information, options, and specific referrals to OAI internal programs (Senior Care, Community Living Program, Caregiver Support, Dementia Care, etc.) or other community organizations (e.g., links to the Benefits.gov website or a local food bank).

03

Service Delivery, Resolution and Follow-up

The client connects with the referred resources and receives the required assistance. The Information & Assistance program may follow up to ensure a successful connection was made and needs are being met and the client's original problem is addressed. The MAP program gathers feedback via surveys on the services provided and client satisfaction, which helps in future program optimization and demonstrates impact.

04

Advocacy & Ongoing Support

In some cases, the client might require further assistance if the initial referrals to other community partners were not successful. OAI emphasizes a No Wrong Door approach and refers clients to partners with a warm handoff. Satisfied clients may become advocates, referring others to the MAP program.

05

Howard County
Office on Aging and Independence