
Yuba-Sutter Aging and Disability Action Plan: Implementation Playbook (July 2025 – June 2030)

Introduction

This Playbook is a practical tool for implementing Yuba and Sutter Counties' first-ever Local Aging and Disability Action Plan (LADAP). It is a companion to the full report, which will be available at www.adrc4.org/LADAP by June 30, 2025. The Playbook provides a clear roadmap to guide coordinated, community-based action from July 1, 2025 through June 30, 2030 (five years). It translates long-range goals into phased, actionable steps grounded in local data, community priorities, and cross-sector collaboration. The Playbook is designed to address the evolving needs of older adults, individuals with disabilities, and caregivers and to support steady progress over time. The Playbook was informed by a comprehensive needs assessment and shaped through two regional workshops and eight action planning meetings, with input from older adults, individuals with disabilities, caregivers, service providers, and community-based organizations.

Playbook Structure

The Implementation Playbook is organized into four main components:

- ▶ **Goals:** Broad priorities that frame the desired long-term outcomes of the Plan.
- ▶ **Strategies:** Focus areas of work within each goal.
- ▶ **SMART Objectives:** Specific, Measurable, Achievable, Relevant, and Time-bound objectives to provide a clear and structured approach to achieving the goals.
- ▶ **Phased Activities:** Implementation steps, including foundational work and early actions; expanded efforts that often involve a midpoint assessment; and long-term actions focused on sustainability and impact.

Yuba-Sutter LADAP: Implementation Playbook

Some objectives and activities remain intentionally broad to allow time for partner identification, feasibility assessment, and refinement of metrics and outcome measures.

Collaborative Implementation Approach

The Yuba-Sutter Aging and Disability Resource Connection (ADRC) will serve as the convening organization for implementation. Each of the five goal areas will be supported by ongoing Action Teams made up of cross-sector partners and community members with lived experience, including older adults, individuals with disabilities, and caregivers. These diverse voices will help guide implementation and inform decisions, keeping the work grounded in community realities and responsive to evolving needs. This is a collective, coordinated effort—no single agency can carry it alone. Ongoing collaboration across systems and communities is essential to ensuring the Plan remains inclusive, attainable, and rooted in shared ownership.

Metrics and Evaluation Approaches

To ensure that the Implementation Playbook remains adaptable and responsive to evolving community needs, each SMART Objective incorporates planned evaluation activities at key points during implementation. Depending on the nature of the objective, this may include mid-point assessments, annual reviews, or other evaluation strategies. These assessments will be used to monitor progress, refine approaches, and identify specific outcome metrics in collaboration with partners and stakeholders. This flexible evaluation structure allows the Plan to adapt to changing circumstances while ensuring accountability, continuous improvement, and long-term sustainability across the five-year planning period.

A Living Document

Importantly, this Implementation Playbook is not a final or fixed plan, it is the first iteration of a long-term roadmap. As we move forward, feedback, reflection, and course correction will be essential. The Plan will continue to be updated as the work progresses, partners are engaged, and new opportunities or challenges emerge. The Playbook provides a strong starting point, grounded in community voice and systems thinking, for coordinated implementation that is adaptive, accountable, and ready to evolve.

Navigating the Playbook

To support ease of use, the Implementation Playbook is structured so that readers can quickly move to each of the five goal areas. You can click on the goals listed below to jump directly to those sections of the Playbook.

- ▶ [Goal 1: Increase Affordable, Accessible Housing and Emergency Preparedness](#)
- ▶ [Goal 2: Enhance Transportation and Community Mobility](#)
- ▶ [Goal 3: Expand Access to Health Care and Caregiving Support](#)
- ▶ [Goal 4: Improve Food Security and Nutrition Availability](#)
- ▶ [Goal 5: Strengthen Social Participation and Community Engagement](#)

In addition to clicking the links above, readers can open the Bookmarks panel (usually found by clicking the ribbon or bookmarks icon in the PDF viewer) to quickly jump to each goal and strategy section.



Goal 1: Increase Affordable, Accessible Housing and Emergency Preparedness

SMART Objectives

Phased Activities

Strategy 1.1. Expand access to affordable, accessible housing options, supportive services, and community resources to enhance housing stability, promote aging-in-place, and increase and temporary and long-term housing availability.

SMART Objective 1.1.1. Draft: By June 2030, support at least two community-based organizations (CBOs) in pursuing funding and resources to develop and operate shelters and affordable housing that expand both temporary and long-term housing options across Yuba and Sutter Counties.

A mid-point assessment will be conducted to identify specific impact metrics related to housing development, funding secured, service capacity expansion, and policy or systems-change outcomes.

Years 1&2 (July 2025 – June 2027): Laying the Foundation & Building Capacity

- ▶ Establish a Housing/Emergency Preparedness Action Team. Identify key stakeholders, including CBOs, county agencies, advocacy groups, and service providers to collaborate on housing solutions.
- ▶ Develop a coordinated funding strategy to align grant applications and prevent competition from hindering efforts.
 - Explore the feasibility of securing an intern grant-writer within a partner organization to support CBOs in navigating funding opportunities.
- ▶ Engage at least two CBOs interested in developing shelters or affordable housing:
 - Assist them in assessing feasibility, navigating regulations, and connecting to funding sources.
 - Identify barriers such as zoning, fire safety regulations (e.g., sprinkler requirements), and permitting that could hinder project development.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> – Research and compile a list of relevant funding and grant opportunities tailored to their needs. ▶ Strengthen Community Education & Stakeholder Engagement to Support Local Investment <ul style="list-style-type: none"> – Coordinate efforts to identify and address barriers to cross-county housing access through education, collaboration, and information-sharing among CBOs, county partners, and community stakeholders. <ul style="list-style-type: none"> ▪ Milestone: By 2026, launch a series of ADRC-led trainings and community education efforts to build a network of informed community champions who can support the development of multi-unit housing and expanded access to rental subsidies for very low-income older adults and individuals with disabilities. – Trainings will focus on affordable housing programs that support independent living such as Section 8 (a federal program that helps low-income people pay for rental housing), Section 811 (affordable housing with supportive services for people with disabilities), and the Low-Income Housing Tax Credit (LIHTC, which supports development of affordable rental housing) – Organize at least two meetings or forums with local and state government representatives to share data, highlight community needs, and elevate the voices of residents with lived experience to inform and encourage local investment in housing solutions. <p>Year 3 (July 2027-June 2028): Mid-point Assessment</p> <ul style="list-style-type: none"> ▶ To ensure progress toward the 2030 goal, a mid-point assessment in Year 3 (July 2027 – June 2028) can help evaluate the effectiveness of activities and identify necessary course corrections. <p>Years 4 & 5 (July 2028 – June 2030): Implement Adjustments Based on Mid-point</p>

SMART Objectives	Phased Activities
	<p>Assessment Findings</p> <ul style="list-style-type: none"> ▶ Address barriers identified in the Year 3 assessment (e.g., funding gaps, permitting, cross-county access issues). ▶ Adapt strategies based on stakeholder feedback and evolving community needs. ▶ Develop a refined set of success metrics that will guide final evaluation and reporting.
<p>SMART Objective 1.1.2. Draft: By June 2030, identify and consolidate local resources and referral lists to connect residents with available, accessible housing options and home modification resources that support aging in place.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to resource accessibility, public awareness improvements, and service utilization.</i></p>	<p>Years 1 & 2 (July 2025 – June 2027): Laying the Foundation & Building Capacity</p> <ul style="list-style-type: none"> ▶ Assess available local housing and home modification resources to understand existing services and eligibility criteria. ▶ Compile and integrate existing resource lists (e.g., Sutter Network of Care, Habitat for Humanity Fix-It Funds, Craftsman for Christ, Medi-Cal Partnership programs). ▶ Engage with regional partners (e.g., Community Resource Project, 211, FindHelp website) to ensure reliable and up-to-date listings. ▶ Evaluate accessibility and public awareness of these resources, identifying gaps that prevent residents from accessing services. ▶ Work with stakeholders to develop strategies for increasing outreach and engagement, particularly among older adults and caregivers. <p>Year 3 (July 2027 – June 2028): Mid-point Assessment</p> <ul style="list-style-type: none"> ▶ A mid-point assessment will be conducted to evaluate progress, identify gaps, and refine strategies for the remainder of the initiative. This may include reviewing resource availability, service gaps, and public awareness efforts. <p>Years 4 & 5 (July 2028 – June 2030): Scaling Impact & Ensuring Sustainability</p>

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Refine and update the resource database based on Mid-point Assessment findings. ▶ Develop strategies for sustained public awareness, such as partnerships with healthcare providers, senior centers, and local agencies. ▶ Advocate for funding and policy changes to support home modifications and accessible housing programs. ▶ Explore additional resources and funding opportunities to expand home modification assistance.
<p>SMART Objective 1.1.3. Draft: By June 2030, collaborate with local stakeholders to improve public perceptions of affordable housing by increasing awareness of its benefits through education, storytelling, and targeted outreach initiatives.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to shifting public perceptions, increasing community engagement, and enhancing awareness of affordable housing benefits.</i></p>	<p>Years 1 & 2 (July 2025 – June 2027): Laying the Foundation & Building Awareness</p> <ul style="list-style-type: none"> ▶ Coordinate with partner organizations or committees (e.g., Homeless Consortium, Agency on Aging Area 4, etc.) with marketing and communications staff or support and committees to identify common misconceptions about affordable housing through community feedback and existing research. ▶ Develop key messaging and storytelling strategies that highlight real-life examples of affordable housing benefiting neighborhoods. ▶ Milestone: By November 2025, partner with the Sutter-Yuba Homeless Consortium and Habitat for Humanity to present at the Homeless Summit (homeless awareness month), providing education and real-life examples that counter misconceptions about affordable housing. ▶ Begin social media outreach and digital storytelling efforts to showcase the positive impact of affordable housing developments. ▶ Engage with local media and influencers to amplify awareness and encourage positive conversations about affordable housing. <p>Year 3 (July 2027 – June 2028): Mid-point Assessment</p>

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ A mid-point assessment will be conducted to evaluate progress, identify gaps, and refine strategies for the remainder of the initiative. This may include reviewing public awareness efforts, engagement levels, and remaining challenges in shifting perceptions of affordable housing. <p>Years 4 & 5 (July 2028 – June 2030): Scaling Efforts & Ensuring Sustainability</p> <ul style="list-style-type: none"> ▶ Develop a more comprehensive public awareness campaign informed by insights and successful strategies from Years 1–3. ▶ Expand education and outreach efforts to reach broader community audiences. ▶ Strengthen messaging through community-driven storytelling to highlight the positive impact of affordable housing. ▶ Ensure long-term sustainability by identifying funding opportunities and partnerships to maintain public engagement.
<p>Strategy 1.2. Strengthen local partnerships and support state initiatives to expand access to assisted living, residential care, and other community-based housing alternatives to increase choice options.</p>	
<p>SMART Objective 1.2.1. Draft: By June 2030, collaborate with key stakeholders to explore and prepare for participation in the Assisted Living Waiver (ALW) program to expand supportive housing options for older adults and individuals with</p>	<p>Years 1–2 (July 2025 – June 2027): Laying the Groundwork</p> <ul style="list-style-type: none"> ▶ Leverage and Expand the Goal 1: Housing/Emergency Preparedness Action Team. <ul style="list-style-type: none"> – Assess current representation in the Goal 1 Action Team to ensure alignment with ALW-related planning and outreach needs. – Expand stakeholder engagement to include key partners such as Harmony Health Community Medical Clinic, local assisted living providers, long-term care

SMART Objectives	Phased Activities
<p>disabilities in the Yuba-Sutter region.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to local readiness, stakeholder engagement, and access to ALW-covered services. Efforts in later phases will focus on sustaining momentum and supporting participation if feasible.</i></p>	<p>representatives, and community members with lived experience.</p> <ul style="list-style-type: none"> – FREED, as a core partner and Community Care Transitions agency, will continue to play a central role in coordinating activities and outreach related to ALW efforts. <p>▶ Conduct a Regional Feasibility Assessment and Lay the Groundwork for an ALW Application</p> <ul style="list-style-type: none"> – Research current ALW eligibility and provider requirements. – Assess capacity and interest of local assisted living providers to participate in the ALW. – Compile data on local assisted living availability and unmet need. – Engage FREED (as the Community Care Transitions agency), Harmony Health, county health and social services departments, and local providers in early assessment efforts to explore and support potential ALW application opportunities. <p>▶ Develop a Communications Strategy to Build Awareness of the ALW</p> <ul style="list-style-type: none"> – Create and share clear, accessible information about the Assisted Living Waiver for providers, community members, and local decision-makers. – Coordinate outreach efforts in partnership with the Goal 1. Action Team and FREED to increase understanding and support for the waiver. – Identify and support 1-2 “community champions” to help with outreach and engagement. <p>Year 3 (July 2027 – June 2028): Mid-point Assessment</p> <ul style="list-style-type: none"> ▶ Assess progress on outreach, stakeholder engagement, and regional readiness. ▶ Revisit feasibility based on state policy, provider capacity, and local momentum.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Adjust strategies as needed to support long-term access to the ALW. <p>Years 4–5 (July 2028 – June 2030): Scaling or Sustaining Efforts</p> <ul style="list-style-type: none"> ▶ Continue to strengthen provider relationships and community awareness. ▶ If feasible, begin supporting provider participation in the ALW. ▶ If not yet feasible, focus on sustaining readiness and exploring alternative solutions.
<p>SMART Objective 1.2.2. Draft: By June 2030, support state-level policy efforts to expand community-based housing options and improve hospital-to-home and long-term care (LTC) transition services for older adults and individuals with disabilities in the Yuba-Sutter region.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to engagement, visibility, and influence on state-level initiatives.</i></p>	<p>Years 1–2 (July 2025 – June 2027): Building the Foundation for State-Level Engagement</p> <ul style="list-style-type: none"> ▶ Engage Stakeholders to Shape Regional Messaging and Policy Priorities <ul style="list-style-type: none"> – Identify and invite partners to the Goal 1 Action Team, including those involved in community-based housing (e.g., assisted living, residential care, supportive housing) and those with transition-related experience (e.g., hospitals, SNFs, FREED, ILCs, case managers). – Ensure the Action Team includes diverse perspectives, including consumers with lived experience, to guide development of regional policy education priorities. – Collaborate with the Action Team to identify key issues and shared messages to elevate with state decision-makers. – Map current challenges in transition services and housing availability to support the development of region-specific insights and stories. ▶ Train and Support Community Champions <ul style="list-style-type: none"> – Identify and prepare at least two individuals with lived experience to share their stories and help communicate local needs. – Leverage training opportunities through the ADRC-led education efforts outlined in

SMART Objectives	Phased Activities
	<p>Objectives 1.1.1 and 1.2.1. and the SCAN Foundation grant, and Coordinate training and storytelling preparation to support participation in policy education efforts at the state level.</p> <ul style="list-style-type: none"> ▶ Coordinate Policy Education and Awareness Activities <ul style="list-style-type: none"> – Milestone: By Year 2, coordinate local participation in a state-level education event and support at least one community member to share their story directly with decision-makers. Support local participation in non-lobbying events like Advocacy Day, legislative site visits, or briefings with elected officials and agency leaders. – Develop education materials or messaging that connect local housing and transition challenges to statewide priorities and policy opportunities. ▶ Explore Tools to Track Engagement and Communication <ul style="list-style-type: none"> – Identify ways to document and track outreach to state-level partners, storytelling activities, and public education efforts. (align with Objective 4.1.1. and other local and state policy efforts across the plan) <p>Year 3 (July 2027 – June 2028): Mid-point Assessment</p> <ul style="list-style-type: none"> ▶ Assess progress on stakeholder engagement, consumer storytelling, and state-level education activities. ▶ Revisit regional messaging and refine strategies in response to state policy developments. ▶ Identify preliminary metrics to track visibility, engagement, and contribution to statewide efforts. <p>Years 4–5 (July 2028 – June 2030): Sustaining and Scaling Impact</p> <ul style="list-style-type: none"> ▶ Continue supporting community champions and partners in statewide policy education

SMART Objectives	Phased Activities
	<p>efforts.</p> <ul style="list-style-type: none"> ▶ Maintain engagement with state leaders through coordinated messaging, events, or briefings. ▶ Document and share regional contributions to state strategies through storytelling and cross-sector collaboration.
<p>Strategy 1.3. Strengthen resident access to local emergency response plans and systems to improve preparedness, resilience, and equitable emergency response.</p>	
<p>SMART Objective 1.3.1. Draft: By June 2030, partner with the Yuba and Sutter County Offices of Emergency Services (OES) and other key stakeholders to strengthen inclusive emergency preparedness planning and community engagement for older adults, individuals with disabilities, and high-need communities across the Yuba-Sutter region.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to improvements in planning processes, outreach reach, and readiness among at-risk</i></p>	<p>Years 1–2 (July 2025 – June 2027): Laying the Groundwork and Strengthening Coordination</p> <ul style="list-style-type: none"> ▶ Establish a Diverse, Cross-County Emergency Planning Group <ul style="list-style-type: none"> – Expand the existing Goal 1 Action Team to include representatives from the Yuba and Sutter County Offices of Emergency Services (OES), Health and Human Services (HHS), the local American Red Cross, and additional key partners such as FREED, public transit providers, shelter operators, culturally specific organizations, local Sheriff’s Offices, PG&E, the Camptonville Community Partnership, and other community leaders. <ul style="list-style-type: none"> ▪ Ensure the group reflects diverse perspectives by including individuals with lived experience of disability, aging, or barriers to emergency response. – Review current emergency preparedness plans (including the Access and Functional Needs [AFN] annex) to identify planning gaps for at-risk populations. – Align local efforts with state and federal guidance, including CalOES, FEMA, and the ADA, and begin identifying shared goals for inclusive preparedness.

SMART Objectives	Phased Activities
<p>populations.</p>	<ul style="list-style-type: none"> ▶ Support Inclusive Public Education and Outreach <ul style="list-style-type: none"> – Milestone: Coordinate with Yuba and Sutter County OES to confirm participation in planned events such as Spring Fire Awareness (April) and local “Be Prepared” fairs. <ul style="list-style-type: none"> ▪ Ensure outreach materials are accessible (e.g., plain language, large print, and translations in Spanish, Hmong, etc.) and inclusive of older adults and people with disabilities. – Expand presence at preparedness events and identify at least one new outreach opportunity (e.g., senior center engagement or foothill community event) in a high-need or hard-to-reach area. – Leverage the launch of 2-1-1 as a central hub for emergency preparedness and response resources. – Promote Code Red registration as a proactive step to ensure residents—especially those who are isolated or face communication barriers—receive real-time alerts. – Encourage use of community connectors (e.g., neighbors, family, or friends) as part of outreach efforts. Incorporate messaging like “Who are your 5?” to help residents build their own personal emergency support networks. – Use each community engagement or outreach event as an opportunity to gather input from older adults and individuals with disabilities about preparedness barriers, trusted communication channels, and preferred formats for alerts and education. <p>Year 3 (July 2027 – June 2028): Mid-point Assessment</p> <ul style="list-style-type: none"> ▶ Assess progress on inclusive emergency preparedness planning, stakeholder engagement, and outreach activities. ▶ Gather feedback from partners and community members to identify adjustments and

SMART Objectives	Phased Activities
	<p>improvement opportunities.</p> <ul style="list-style-type: none"> ▶ Identify initial impact metrics to track planning effectiveness and community reach moving forward. <p>Years 4–5 (July 2028 – June 2030): Scaling and Sustaining Efforts</p> <ul style="list-style-type: none"> ▶ Continue cross-county collaboration and update preparedness strategies based on evolving needs and lessons learned. ▶ Sustain participation in community events and maintain use of inclusive outreach materials. ▶ Support long-term coordination through shared tools, partner engagement, and routine planning updates.
<p>SMART Objective 1.3.2. Draft: By June 2030, build on existing emergency communication efforts by coordinating with the Yuba and Sutter County Offices of Emergency Services (OES), Health and Human Services (HHS), and community partners to assess and address communication gaps for individuals who are blind or visually impaired.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to improvements in emergency communication accessibility, community</i></p>	<p>Years 1–2 (July 2025 – June 2027): Explore Needs and Build Partnerships</p> <ul style="list-style-type: none"> ▶ Establish Partnerships <ul style="list-style-type: none"> – Coordinate with the Yuba and Sutter County Offices of Emergency Services (OES) and Health and Human Services (HHS) to identify existing communication practices and any current MOUs related to accessibility for individuals who are blind or visually impaired. – Reach out to organizations such as Services for the Blind, FREED, and Independent Living Centers (ILCs) to explore partnership opportunities and clarify roles in inclusive emergency communication. – If no agreement exists, explore the feasibility of a Memorandum of Understanding (MOU) or similar partnership model. ▶ Research Accessible Communication Tools and Channels <ul style="list-style-type: none"> – Conduct an inventory of emergency communication platforms currently in use (e.g.,

SMART Objectives	Phased Activities
<p><i>partnerships, and outreach effectiveness for individuals who are blind or visually impaired.</i></p>	<p>Code Red, Everbridge, radio, social media, SMS, and automated phone alerts).</p> <ul style="list-style-type: none"> – Evaluate the accessibility of these platforms for individuals who are blind or visually impaired (e.g., screen reader compatibility, audio-based alerts, tactile warnings). – Explore national and state-level models and guidance (e.g., from FEMA or the American Foundation for the Blind) to inform local strategy development. – Identify gaps in accessibility or coverage, especially in rural areas with limited cell/internet service or among high-need populations. – Consult with individuals with lived experience of vision loss and local advocates to understand real-world barriers and preferred communication formats. – If resource needs are identified, begin exploring potential funding options (e.g., CalOES grants, public health preparedness funds) to support future implementation. <p>Year 3 (July 2027 – June 2028): Mid-point Assessment</p> <ul style="list-style-type: none"> ▶ Evaluate progress in partnership development, system review, and identification of accessibility gaps. ▶ Determine feasibility of implementing strategies (e.g., audio alerts, alternate formats, staff training). ▶ Identify and begin tracking metrics such as number of agencies engaged, alert formats developed, or improvements in accessibility readiness. <p>Years 4–5 (July 2028 – June 2030): Implement, Scale, and Sustain Efforts</p> <ul style="list-style-type: none"> ▶ If feasible, implement one or more communication improvements for individuals who are blind or visually impaired (e.g., through pilot messaging, drills, or formal protocols). ▶ Maintain and strengthen partnerships to gather feedback, adjust messaging, and share

SMART Objectives	Phased Activities
	<p>lessons learned.</p> <ul style="list-style-type: none"> ▶ Institutionalize inclusive practices into local emergency plans, outreach templates, and OES/HHS training processes.
<p>SMART Objective 1.3.3. Draft: By June 2030, coordinate with the County Offices of Emergency Services (OES), Health and Human Services (HHS), the Aging and Disability Resource Connection (ADRC), and PG&E to explore and, if feasible, establish secure data-sharing or coordination protocols to support emergency planning for older adults and individuals with disabilities in Yuba and Sutter Counties.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to data-sharing coordination, emergency planning improvements, and outreach to high-risk populations.</i></p>	<p>Years 1–2 (July 2025 – June 2027): Strengthen Partnerships and Scope Coordination Feasibility</p> <ul style="list-style-type: none"> ▶ Strengthen Partnerships and Assess Feasibility of Data Coordination <ul style="list-style-type: none"> – Engage OES, HHS, FREED, ADRC, and PG&E to review existing coordination efforts, identify gaps, and define shared priorities. – Explore opportunities to share Access and Functional Needs (AFN) data or related information in compliance with HIPAA and confidentiality requirements. – Identify potential data sources to support proactive planning and outreach (e.g., OES, FREED, PG&E, IHSS, Meals on Wheels, 2-1-1 intake, warming center data). – Review external models such as Butte County’s SNAP Program, which uses IHSS lists for emergency planning. – Consult legal, IT, and privacy staff to determine what’s permissible, including options for voluntary release-of-information forms. ▶ Scope and Draft Possible Agreements <ul style="list-style-type: none"> – Outline potential MOUs or emergency coordination protocols between partners. – Define clear roles, data flows, and activation steps—particularly for scenarios involving power outages, fires, floods, severe weather events, and evacuations. <p>Year 3 (July 2027 – June 2028): Mid-point Assessment and Strategy Refinement</p>

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Conduct a mid-point assessment to evaluate coordination progress, partner alignment, and feasibility findings. ▶ Identify any legal, technical, or operational barriers that need to be addressed. ▶ Refine draft MOUs or data-sharing protocols based on feedback from legal, IT, and partner agencies. <p>Years 4–5 (July 2028 – June 2030): Implementation and Long-Term Coordination</p> <ul style="list-style-type: none"> ▶ Finalize and implement data-sharing protocols or partnership agreements, as appropriate. ▶ Build or strengthen infrastructure (e.g., workflows, contact lists, notification systems) to support sustainable coordination. ▶ Maintain ongoing collaboration through periodic review and partner check-ins to ensure protocols remain effective and up to date.
<p>SMART Objective 1.3.4. Draft: By June 2030, identify and address gaps in emergency shelter accessibility and accommodations to better support older adults and individuals with disabilities in Yuba and Sutter Counties.</p> <p><i>A mid-point assessment will be conducted to identify specific impact metrics related to shelter accessibility improvements, alternative accommodation strategies, and enhancements to</i></p>	<p>Years 1–2 (July 2025 – June 2027): Assess Needs, Surface Gaps, and Strengthen Collaboration</p> <ul style="list-style-type: none"> ▶ Review Current Shelter Systems and Identify Gaps <ul style="list-style-type: none"> – Coordinate with Yuba and Sutter County OES, HHS, shelter operators, and the local American Red Cross to review current shelter plans and procedures, including updates to the AFN annex, and clarify roles and responsibilities by county. – Review shelter site assessments maintained by OES and HHS (e.g., fairgrounds, churches, schools) to evaluate ADA compliance and identify needs for additional supports (e.g., space for mobility devices, alternatives to cots). – With support from FREED, validate accessibility data and assess opportunities for improvement.

SMART Objectives	Phased Activities
<p><i>intake processes and person-centered supports.</i></p>	<ul style="list-style-type: none"> – Engage individuals with lived experience (e.g., mobility, sensory, trauma-related needs) to identify real-world barriers and person-centered solutions. – Review COVID-era adaptations (e.g., hotel placements, shelter de-densification) to determine which practices could be adapted long term. – Explore regional models, such as Butte County’s Disability Action Center (DAC)-led planning, to identify best practices for inclusive sheltering. <p>▶ Explore Alternative Accommodations and Support Models</p> <ul style="list-style-type: none"> – Document common situations where individuals may be unable to safely access or remain in congregate shelters. – Assess the feasibility of alternative accommodations (e.g., hotel placements, sensory-friendly spaces, pre-identified community safe sites). – Identify barriers to implementing alternatives more systematically (e.g., limited outreach, lack of formal referral protocols). – Identify resource and policy needs to support shelter accessibility, including funding, staff training, enhanced intake tools, and partnership opportunities. <p>Year 3 (July 2027 – June 2028): Mid-point Assessment and Prioritization</p> <ul style="list-style-type: none"> ▶ Assess progress in identifying shelter gaps, evaluating accommodations, and strengthening community partnerships. ▶ Revisit findings from shelter site reviews, partner input, and lived experience engagement to prioritize feasible and high-impact improvements. ▶ Begin identifying and tracking relevant metrics (e.g., percentage of shelters meeting ADA standards, types of alternative accommodations available, staff/volunteer training

SMART Objectives	Phased Activities
	<p>participation).</p> <p>Years 4–5 (July 2028 – June 2030): Implement, Sustain, and Institutionalize Improvements</p> <ul style="list-style-type: none"> ▶ Support implementation of prioritized changes (e.g., intake process updates, physical improvements, quiet/sensory space integration). ▶ If feasible, formalize referral pathways and/or partnerships to support individuals needing alternative accommodations (e.g., hotel placements via FREED or other agencies). ▶ Institutionalize successful practices through shelter plan updates, staff/volunteer training protocols, and coordination frameworks with OES, HHS, and community-based partners.



Goal 2: Enhance Transportation and Community Mobility

SMART Objectives

Phased Activities

Strategy 2.1. Build and sustain public awareness of available and emerging local transportation resources through trusted community outreach.

SMART Objective 2.1.1. Draft: By June 2030, implement and sustain a coordinated multilingual transportation outreach initiative to increase awareness of available transportation services among older adults, non-English speakers, and individuals with disabilities in Yuba-Sutter.

A mid-point assessment will be conducted to evaluate engagement efforts, outreach effectiveness, and awareness improvements.

Year 1 (June 2025 – June 2026): Establish Provider Engagement & Baseline Awareness

- ▶ Collect baseline data on transportation awareness through provider feedback and a short community transportation awareness survey.
- ▶ Ensure the [Transit Related Information & Links - Yuba-Sutter Transit](#) is updated and accessible on the ADRC website, FREED, and Yuba-Sutter Transit.
- ▶ Ensure multilingual and accessible transportation resources (Hmong, Punjabi, Spanish, and Braille) are available to local service providers (e.g., caregivers, medical facilities, social service agencies, and cultural groups, such as growing Native American groups) in both rural and urban areas.
- ▶ Train at least five local service providers and community-based organizations annually on how to share transportation resources effectively with older adults and individuals with disabilities.

Year 2 (July 2026 – June 2027): Expand to Community Awareness Campaign

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Launch a targeted community awareness campaign using at least three outreach methods annually through 2030, such as Social media, Direct mail, Culturally tailored radio/TV spots, Community workshops/events) <p>Year 3 (July 2027 – June 2028): Midpoint Evaluation & Refinement</p> <ul style="list-style-type: none"> ▶ Measure awareness increase by distributing a follow-up Community Survey (including transportation awareness questions) to at least 250 residents by June 2028, comparing responses to baseline data from Year 1. ▶ Assess information access barriers by gathering feedback from key populations (older adults, non-English speakers, individuals with disabilities) on how they receive and use transportation information. <p>Year 4 (July 2028 – June 2029): Enhancing Outreach & Accessibility</p> <ul style="list-style-type: none"> ▶ Use findings from the Year 3 community survey and key population feedback to enhance outreach strategies, with a focus on multilingual, visually impaired, and hard-to-reach populations. ▶ Refine and expand partnerships with local organizations, disability advocacy groups, and cultural communities to improve outreach efforts.
<p>SMART Objective 2.1.2. Draft: By June 2026, partner with Transit to assess the need for a dedicated transportation trainer program by collecting data from riders, current travel trainers, and community</p>	<p>Year 1 (July 2025-June 2026) Needs Assessment & Decision-Making</p> <ul style="list-style-type: none"> ▶ Survey and interview riders to assess barriers to using transit, focusing on older adults, individuals with disabilities, and non-English speakers. ▶ Engage community partners, including community centers, schools, and Hmong outreach centers, to understand gaps in transit navigation assistance and explore

SMART Objectives	Phased Activities
<p>partners. Use findings to present recommendations to Transit leadership on whether a formalized program is needed.</p> <p><i>A mid-point assessment will be conducted to review progress on pilot development and implementation efforts, and to identify outcome metrics related to improvements in public transit usability and rider satisfaction among older adults. Proposed metrics may include increasing the percentage of older adults who rate public transit ease-of-use as "good" from a 2023 CASOA baseline of 19–21% to at least 30%.</i></p>	<p>volunteer-led training opportunities.</p> <ul style="list-style-type: none"> ▶ Monitor participation in Transit’s existing training efforts (including on-demand service expansion in Olivehurst & Linda), which will include travel training at farmers markets and local events over the next six months. ▶ Assess Transit’s staffing and resource capacity to determine if a formal travel trainer program is feasible. ▶ Present findings and recommendations to Transit leadership to determine whether a dedicated training program should be prioritized within their outreach operations. Survey/interview riders to assess barriers to using transit. <p>Year 2 (July 2026 – June 2027): Pilot & Initial Impact (If Need is Determined)</p> <ul style="list-style-type: none"> ▶ Pilot a transportation trainer program in at least three locations, prioritizing community centers, schools, and the Hmong outreach center. ▶ Develop and distribute multilingual, culturally tailored transit training materials in Hmong, Punjabi, Spanish, and Braille. <p>Year 3 (July 2027 – June 2028): Midpoint Evaluation & Refinement</p> <ul style="list-style-type: none"> ▶ Conduct a community survey in 2027 (aligned with broader transportation awareness efforts) to measure the increase in perceived ease-of-use. <p>Years 4-5 (July 2028-June 2030): Phase 3: Program Expansion & Long-Term Sustainability</p> <ul style="list-style-type: none"> ▶ Expand the trainer program to additional locations and underserved populations, with a focus on rural areas, visually impaired riders, and caregivers.

SMART Objectives	Phased Activities
<p>Strategy 2.2. Develop and enhance reliable, accessible transportation alternatives to meet the diverse needs of community members who do not drive, including rural and underserved populations.</p>	
<p>SMART Objective 2.2.1. Draft: By June 2030, assess funding needs and secure new funding sources to support programs that reduce transportation costs for low-income, elderly, and disabled individuals in Yuba-Sutter counties.</p> <p><i>A mid-point assessment will be conducted to evaluate funding progress, assess community affordability challenges, and refine strategies to sustain and expand transportation affordability programs.</i></p>	<p>Year 1 (July 2025 – June 2026): Funding Assessment & Partnership Development</p> <ul style="list-style-type: none"> ▶ Map out current funding sources and gaps, including: <ul style="list-style-type: none"> – The \$50,000-\$60,000 per quarter currently needed to keep transit passes affordable (\$10-\$20 per pass). – Costs associated with Mountain Transit and other services (\$10 local, \$20 city, \$60 airport). – Agencies that purchase and distribute passes (e.g., Foothill Resource Center). ▶ Identify financial needs beyond existing funding, including potential support for partner organizations that buy and distribute transit passes for older adults and individuals with disabilities. ▶ Create a coordinated list of organizations that subsidize or assist with transit passes to improve referrals and connect more individuals with available support. ▶ Investigate grant opportunities to sustain or expand programs, ensuring continued affordability. <p>Year 2 (July 2026 – June 2027): Grant Acquisition & Expansion</p> <ul style="list-style-type: none"> ▶ Apply for and secure funding to sustain or expand transit affordability programs.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Support partner organizations in securing funding for pass distribution. <p>Year 3 (July 2027 – June 2028): Midpoint Evaluation & Community Survey</p> <ul style="list-style-type: none"> ▶ Evaluate progress toward reducing affordability concerns, using community survey data to track changes in transportation cost challenges (currently 49-50%). ▶ Refine strategies based on survey findings to ensure funding reaches those in greatest need. <p>Years 4-5 (July 2028 – June 2030): Long-Term Sustainability</p> <ul style="list-style-type: none"> ▶ Continue securing funding and supporting partner organizations to sustain affordability programs. ▶ Adjust funding strategies based on ongoing community feedback and affordability trends.
<p>SMART Objective 2.2.2. Draft: By June 2026, partner with at least four medical providers to expand non-Medi-Cal transportation services, increasing ridership by at least 5% annually. While the primary focus is on non-Medi-Cal recipients, this initiative will also explore solutions for Medi-Cal patients experiencing transportation barriers.</p> <p><i>A mid-point assessment will be conducted to evaluate ridership trends,</i></p>	<p>Year 1 (July 2025 – June 2026): Build Partnerships & Expand Ridership</p> <ul style="list-style-type: none"> ▶ Partner with at least four medical providers (e.g., Ampla, Peachtree, Harmony Health, and Adventist) to coordinate and promote transportation services. ▶ Increase transportation ridership by at least 5% annually by improving access, scheduling, and outreach. ▶ Develop a system to track ridership growth and user feedback for future evaluation. <p>Years 2 & 3 (July 2026 – June 2028): Midpoint Evaluation & Adjustments</p> <ul style="list-style-type: none"> ▶ Assess ridership trends and determine if the 5% annual growth goal is being maintained or exceeded.

SMART Objectives	Phased Activities
<p><i>patient satisfaction, service accessibility, and progress toward sustaining expanded transportation services.</i></p>	<ul style="list-style-type: none"> ▶ Conduct a community survey to measure patient satisfaction, accessibility, and service effectiveness <p>Years 4-5 (July 2028 – June 2030): Sustainability</p> <ul style="list-style-type: none"> ▶ Address transportation barriers for both non-Medi-Cal and Medi-Cal recipients who may be struggling with access. ▶ Refine outreach and scheduling strategies to improve efficiency and meet evolving community needs.
<p>SMART Objective 2.2.3. Draft: By June 2026, partner with transportation providers to assess rural transportation gaps and identify the highest-need areas for expanding or establishing accessible community-based solutions, such as ride-share programs, volunteer driver networks, and public transit options.</p> <p><i>A mid-point assessment will be conducted to evaluate progress on pilot program implementation, service accessibility improvements, and strategies for sustaining expanded rural transportation options.</i></p>	<p>Year 1 (July 2025 – June 2026): Assess Needs & Establish Partnerships</p> <ul style="list-style-type: none"> ▶ Identify specific rural transportation gaps by analyzing existing services and unmet needs, with a focus on areas like the City of Sutter. ▶ Engage transportation providers, community organizations, and stakeholders to explore potential solutions. ▶ Determine feasibility of expanding community-based solutions, such as ride-share programs, volunteer driver networks, and public transit options. ▶ Develop a tracking system to measure transportation accessibility and ridership trends. <p>Years 2-3 (July 2026 – June 2028): Pilot and Mid-Point Evaluation</p> <ul style="list-style-type: none"> ▶ Implement and evaluate pilot programs to address identified rural transportation needs. ▶ Conduct a community survey in Year 3 to assess impact and refine strategies. <p>Years 4-5 (July 2028 – June 2030): Sustainability & Long-Term Planning</p> <ul style="list-style-type: none"> ▶ Secure funding or policy support to sustain successful programs.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Adjust and expand services based on ridership trends and ongoing community feedback.
<p>Strategy 2.3. Promote and implement initiatives that strengthen community mobility and safety for older adults, individuals with disabilities, and underserved communities.</p>	
<p>SMART Objective 2.3.1 Draft: By June 30, 2027, engage local transit providers, healthcare systems, and community organizations to identify service gaps and assess opportunities to support existing or emerging efforts that improve access to medical care, employment, and essential services for older adults and individuals with disabilities in Yuba and Sutter Counties.</p> <p><i>A mid-point assessment will be conducted to evaluate the feasibility of Action Team support for identified service improvements, establish relevant outcome metrics, and determine whether a revised long-term implementation objective should be developed.</i></p>	<p>Years 1–2 (July 2025 – June 2027): Build Partnerships, Assess Gaps, and Identify Feasible Service Improvements</p> <ul style="list-style-type: none"> ▶ Engage partners such as transportation providers (e.g., Yuba-Sutter Transit, Mountain Transit), healthcare organizations, FQHCs, disability advocates, and individuals with lived experience to participate in the Goal 2. Action Team for coordinated planning. ▶ Assess existing and emerging efforts service improvements (e.g., expanded micro-transit, dial-a-ride programs, ride coordination, medical van partnerships, voucher models) and identify underserved areas and potential gaps. ▶ Review and map current transportation programs and funding streams to determine where coordination or enhancements could be most impactful. ▶ Gather direct input from older adults and individuals with disabilities, especially in rural and foothill communities, to prioritize needed service features (e.g., door-to-door service, scheduling flexibility, language access). ▶ Explore underutilized models and programs such as: <ul style="list-style-type: none"> – Medi-Cal/Partnership Health Plan medical transportation reimbursement. – Gas card assistance programs (e.g., United Way or the former FREED model). – Flexible or voucher-based transportation programs.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Identify one or two service enhancements where the Action Team may offer value by supporting partner efforts through data sharing, outreach assistance, or letters of support. ▶ Conclude Phase 1 with a feasibility determination regarding whether the Action Team can support local efforts, and whether a revised long-term objective should be developed in Phase 2. <p>Year 3 (July 2027 – June 2028): Refine Priorities and Assess Readiness for Support</p> <ul style="list-style-type: none"> ▶ If feasibility was confirmed in Phase 1, the Action Team will conduct a Year 3 assessment to establish relevant metrics and revise the SMART objective to reflect a long-term implementation focus. ▶ Revisit community priorities and assess which efforts are ready for Action Team support (e.g., new grant applications, pilot testing, or expansion planning). ▶ Continue gathering feedback from older adults and people with disabilities to shape service design and equity considerations. ▶ Provide assistance to partner-led efforts by contributing letters of support, sharing data, and supporting engagement efforts. ▶ Determine how the Action Team can best align with or amplify local efforts. <p>Years 4–5 (July 2028 – June 2030): Contribute to Implementation Support, Track Progress, and Promote Sustainability</p> <ul style="list-style-type: none"> ▶ Assist with ongoing outreach, data gathering, or community storytelling to help sustain and evaluate partner-led service improvements. ▶ Help track indicators of community impact (e.g., reduced missed appointments, increased satisfaction, improved rural access) through qualitative or collaborative data

SMART Objectives	Phased Activities
	<p>sharing.</p> <ul style="list-style-type: none"> ▶ Collaborate with local partners to explore funding opportunities, operational partnerships, or policy changes that can support the long-term sustainability of service improvements. ▶ Document how the Action Team’s supportive role has contributed to lasting changes, and share findings with stakeholders to build momentum for future efforts.
<p>SMART Objective 2.3.2. Draft: By June 30, 2027, collaborate with local transit agencies, public works departments, and regional partners such as SACOG to identify opportunities to support planned or existing infrastructure projects that improve accessibility and comfort at transportation hubs and bus stops for older adults and people with disabilities.</p> <p><i>A mid-point assessment will be conducted to evaluate the feasibility of Action Team support for infrastructure accessibility improvements, establish relevant outcome metrics, and determine whether a revised long-term implementation objective should be developed.</i></p>	<p>Years 1–2 (July 2025 – June 2027): Build Partnerships, Assess Opportunities, and Determine Feasibility</p> <ul style="list-style-type: none"> ▶ Engage transportation providers, planners, disability advocates, and individuals with lived experience to identify service improvements, align with existing efforts, and participate in the Goal 2. Action Team for coordinated planning. ▶ Meet with local transit agencies (e.g., Yuba-Sutter Transit, Mountain Transit), public works departments, and SACOG to learn more about planned and existing infrastructure projects related to bus stops and transportation hubs. <ul style="list-style-type: none"> ○ Invite representatives from these agencies to participate in the Goal 2. Action Team to promote coordination and shared planning. ▶ Review and share relevant data and insights, including SACOG’s prior hub studies and local community feedback (e.g., surveys, focus groups), to inform prioritization and partner-led planning. ▶ Assess feasibility of supporting existing or emerging efforts (e.g., infrastructure enhancements at transit hubs), such as assisting with community engagement, outreach, or identifying funding. ▶ Conclude Phase 1 with a feasibility determination regarding whether the Action Team

SMART Objectives	Phased Activities
	<p>can support local efforts, and whether a revised long-term objective should be developed in Phase 2.</p> <p>Year 3 (July 2027 – June 2028): Support Project Planning and Community Engagement</p> <ul style="list-style-type: none"> ▶ If feasibility was confirmed in Phase 1, the Action Team will conduct a Year 3 assessment to establish relevant metrics and revise the SMART objective to reflect a long-term implementation focus. ▶ Work with infrastructure partners to identify and refine priority locations for accessibility improvements, informed by community feedback, feasibility findings, and regional planning efforts. ▶ Validate proposed improvements with older adults and individuals with disabilities to ensure lived experience informs final design elements (e.g., seating, lighting, shelter, accessible parking, restrooms). ▶ Assist with data sharing, letters of support, and stakeholder engagement to strengthen partner-led proposals and align efforts with broader transportation and capital improvement plans. <p>Years 4–5 (July 2028 – June 2030): Contribute to Implementation, Track Progress, and Promote Sustainability</p> <ul style="list-style-type: none"> ▶ Support implementation of accessibility improvements at selected bus stops or transportation hubs by assisting with outreach, community engagement, and awareness-building. ▶ Maintain ongoing communication with implementation partners to monitor progress, share updates through the Action Team, and help address challenges as needed. ▶ Consider gathering qualitative feedback from older adults and individuals with disabilities

SMART Objectives	Phased Activities
	<p>on whether improvements are enhancing safety, comfort, and usability.</p> <ul style="list-style-type: none"> ▶ Support sustainability planning by collaborating with partners to explore long-term maintenance strategies and potential funding opportunities to expand or replicate successful improvements.
<p>SMART Objective 2.3.3. Draft: By June 30, 2027, collaborate with local jurisdictions, including county and city public works departments, to identify opportunities to support improvements in public parking access and signage, focusing on increasing ADA-compliant spaces for older adults and individuals with disabilities.</p> <p><i>A mid-point assessment will be conducted to evaluate the feasibility of Action Team support for parking accessibility improvements, establish relevant outcome metrics, and determine whether a revised long-term implementation objective should be developed.</i></p>	<p>Years 1–2 (July 2025 – June 2027: Build Partnerships, Identify Opportunities, and Assess Feasibility)</p> <ul style="list-style-type: none"> ▶ Convene local public works and planning departments (e.g., Yuba County, Sutter County, City of Marysville, City of Yuba City) through the Goal 2. Action Team to explore current or planned parking efforts and identify opportunities for collaboration. ▶ Invite participation from older adults and individuals with disabilities with lived experience to help identify parking-related barriers and share insights into usability, signage clarity, and enforcement challenges. ▶ Review and share existing data and community input, such as survey responses and focus group feedback describing challenges with accessible parking, signage, and distance to services. ▶ Collaborate with jurisdictional partners to explore how the Action Team can support planned or emerging efforts, such as through data sharing, letters of support, or community engagement assistance. <ul style="list-style-type: none"> – Give early consideration to the City of Marysville as a potential priority area for partnership, given recent policy discussions, infrastructure needs, and its concentration of medical and business services. ▶ Conclude Phase 1 with a feasibility determination regarding whether the Action Team can support local efforts, and whether a revised long-term objective should be

SMART Objectives	Phased Activities
	<p>developed in Phase 2.</p> <p>Year 3 (July 2027 – June 2028): Support Project Development and Community Engagement</p> <ul style="list-style-type: none"> ▶ If feasibility was confirmed in Phase 1, the Action Team will conduct a Year 3 assessment to establish relevant metrics and revise the SMART objective to reflect a long-term implementation focus. ▶ Collaborate with jurisdictional partners to refine parking improvement plans or identify specific locations for enhanced ADA-compliant spaces, signage upgrades, or improved enforcement practices. ▶ Validate proposed improvements with older adults and individuals with disabilities to ensure lived experience informs practical design and placement decisions. ▶ Assist partners by sharing accessibility data, contributing letters of support, or helping align projects with local priorities and community feedback. <p>Years 4–5 (July 2028 – June 2030): Contribute to Implementation, Monitor Progress, and Promote Sustainability</p> <ul style="list-style-type: none"> ▶ Support outreach and engagement around completed improvements to promote awareness of enhanced accessible parking and signage. ▶ If feasible, gather qualitative input from individuals with lived experience to understand how improvements have impacted safety, clarity, and usability. ▶ Collaborate with partners to identify sustainability strategies, depending on available resources, such as incorporating feedback mechanisms, documenting outcomes, or supporting replication of successful efforts in other high-need areas.



Goal 3: Expand Access to Health Care and Caregiver Support

SMART Objectives

Phased Activities

Strategy 3.1. Strengthen partnerships and collaboration among healthcare and support organizations to improve access and integration of services.

SMART Objective 3.1.1. Draft: By June 2030, conduct an annual assessment of healthcare stakeholder participation and recruit at least three additional healthcare-related organizations (e.g., hospitals, health clinics, care coordination entities, or community-based organizations) to support implementation of the Yuba-Sutter Aging and Disability Action Plan.

Annual progress reviews will begin in Year 1 to reassess strategies, refine metrics, and strengthen stakeholder engagement.

Years 1–2 (July 2025–June 2027): Laying the Foundation

- ▶ Convene the Goal 3: Health Care and Caregiving Action Team through the ADRC.
- ▶ Conduct a stakeholder analysis to assess current healthcare representation and identify engagement gaps.
- ▶ Begin outreach to at least one new organization from key sectors, such as hospitals, Federally Qualified Health Centers (FQHCs) and community health clinics, county public health clinics, Care coordination entities (e.g., MSSP, IHSS, managed Medi-Cal), community-based organizations serving older adults and caregivers, providers serving culturally and linguistically diverse populations and rural communities.
 - Align with existing efforts and forums, such as Dr. Luu’s regional rural coordination committee and the Yuba-Sutter Healthcare Council
- ▶ Develop and implement a structured onboarding process for new partners, including clear expectations for participation and sustainability.
- ▶ Launch an initial review of implementation strategies and partnership goals by the end of Year 1, adjusting approaches based on partner feedback, policy changes, and

SMART Objectives	Phased Activities
	<p>emerging needs.</p> <ul style="list-style-type: none"> ▶ Establish a process for annual review and refinement of Action Team strategies and metrics, including documentation of progress and course corrections. <p>Years 3–5 (July 2027–June 2030): Sustain and Expand</p> <ul style="list-style-type: none"> ▶ Continue annual assessments of partner participation, sector representation, and engagement effectiveness. ▶ Expand outreach as needed to strengthen representation across all key sectors. ▶ Support integration of new partners and adapt strategies to meet evolving healthcare and caregiving challenges in the region. ▶ Plan for post-2030 sustainability by embedding Action Team functions into long-term ADRC infrastructure and community-based partnerships.
<p>SMART Objective 3.1.2. Draft: By June 2027, assess gaps in healthcare and support service availability across rural areas of Yuba and Sutter Counties, and identify at least three specific opportunities to expand Medi-Cal or CalAIM-funded programs and other community-based services in partnership with rural providers, managed care plans, and other key stakeholders.</p> <p><i>A mid-point assessment will be conducted to monitor progress, identify rural health advocacy priorities, and</i></p>	<p>Years 1–2 (July 2025–June 2027): Assess Needs and Build Partnership</p> <ul style="list-style-type: none"> ▶ The Goal 3. Health Care and Caregiving Action Team will partner with key stakeholders, including managed care plans, rural clinics, community-based organizations (CBOs), behavioral health providers, and transportation partners. ▶ Map healthcare and support service gaps across underserved rural communities in Yuba and Sutter Counties (e.g., Live Oak, Linda, Olivehurst, Wheatland, Foothills). ▶ Identify 3 priority opportunities service expansion, including: <ul style="list-style-type: none"> – Increasing access to local pharmacies (noted barrier in Foothills) – Leveraging CalAIM funding streams, such as Enhanced Care Management (ECM) and Community Supports (e.g., Community Health Worker benefit) – Addressing transportation barriers through coordinated outreach and low-cost

SMART Objectives	Phased Activities
<p><i>refine strategies to strengthen service expansion efforts.</i></p>	<p>mobility strategies</p> <ul style="list-style-type: none"> ▶ Engage outreach and communication partners, such as AAA4’s communications specialist, to support awareness and coordination. ▶ Develop a rural services expansion strategy, with consideration for launching 1–2 pilot community initiatives from the 3 opportunities identified above based on readiness and identified need. ▶ Begin tracking rural service use and access barriers in priority areas to inform future measurement and evaluation. <p>Year 3 (July 2027–June 2028): Midpoint Assessment and Strategy Refinement</p> <ul style="list-style-type: none"> ▶ Conduct a midpoint progress review, reassessing rural service gaps, partner engagement, and evolving priority needs. ▶ Identify metrics and outcomes to track rural service expansion progress, equity improvements, and access enhancements. ▶ Refine and adapt the rural expansion strategy as needed, based on data, partner input, and implementation feedback. ▶ Update the SMART Objective as necessary to reflect lessons learned and guide continued work through 2030. <p>Years 4-5 (July 2028-June 2030): Pilot and Scale Rural Access Solutions <i>(Note: This phase remains broad and flexible, pending findings from the midpoint assessment.)</i></p> <ul style="list-style-type: none"> ▶ Consider Piloting 1–3 rural service expansion opportunities, based on the planning and readiness work completed in prior years. ▶ Continue annual monitoring and evaluation, incorporating feedback from rural residents, providers, and stakeholders to refine approaches.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Support the scaling of successful strategies across additional rural areas and embed rural health access improvement goals into broader ADRC and Action Plan implementation structures.
<p>SMART Objective Draft: By June 2030, assess and strengthen partnerships with CalAIM service providers, including Medi-Cal managed care plans and community-based organizations, to improve system-wide collaboration and expand access to integrated healthcare and social supports for older adults and individuals with disabilities in Yuba and Sutter Counties.</p> <p><i>Annual progress reviews will begin in Year 1 to monitor implementation, promote alignment, and inform coordination improvements.</i></p>	<p>Years 1–2 (July 2025–June 2027): Strengthen CalAIM Coordination Infrastructure</p> <ul style="list-style-type: none"> ▶ Map current CalAIM Community Supports and Enhanced Care Management (ECM) services and provider coverage across Yuba and Sutter Counties. ▶ Convene a coordination meeting with key partners, including: <ul style="list-style-type: none"> – Partnership HealthPlan of California (confirmed as the only Medi-Cal managed care plan in the region) – Community-based organizations positioned to become or currently serving as CalAIM providers – Health and Human Services (HHS), ADRC, and existing networks such as the Yuba-Sutter Healthcare Council ▶ Clarify who is offering which CalAIM services, where duplications or gaps exist, and how clients are currently referred and navigated to services. ▶ Begin development of a shared CalAIM coordination and implementation plan, incorporating sustainability considerations from the outset. ▶ Assess the capacity of CBOs to deliver CalAIM services and identify what supports (training, technical assistance, etc.) may be needed. ▶ Identify opportunities for early coordination improvements, such as coordinated referral pathways, shared training sessions, joint outreach materials ▶ Reach out to the NorCal CalAIM Collaborative Planning and Implementation Group to

SMART Objectives	Phased Activities
	<p>explore relevant tools and models that could be adapted for Yuba-Sutter.</p> <ul style="list-style-type: none"> ▶ Conduct annual reviews of partner engagement, coordination effectiveness, and alignment with community needs. <p>Years 3–5 (July 2027–June 2030): Ongoing Coordination and System Expansion</p> <ul style="list-style-type: none"> ▶ Define and refine metrics and outcome measures, recognizing that measures may focus on coordination progress rather than direct service outcomes. ▶ Update the SMART Objective as needed to reflect lessons learned, changing policy or funding environments, and system readiness. ▶ Continue annual reviews and partner convenings to assess progress and support shared learning. ▶ Identify and prioritize emerging opportunities to enhance integrated service access, particularly in response to changes in community need or federal/state CalAIM guidance. ▶ As appropriate, pilot and expand small-scale coordination improvements. ▶ Support partner agencies in scaling improvements, expanding service access, and enhancing community outreach and navigation strategies. <p>Work toward embedding CalAIM coordination infrastructure into broader ADRC, HHS, and county health planning systems to support long-term integration and sustainability.</p>
<p>Strategy 3.2. Expand caregiver support services and strengthen the caregiver workforce to meet growing community needs.</p>	
<p>SMART Objective 3.2.1. Draft: By June 2030, implement and evaluate a multi-</p>	<p>Years 1–2 (July 2025–June 2027): Campaign Development and Launch</p>

SMART Objectives	Phased Activities
<p>year, multi-channel campaign to promote caregiving as a rewarding and sustainable career, resulting in increased awareness and at least a 10% increase in individuals entering the caregiving workforce in Yuba and Sutter Counties, including greater representation from rural and underserved communities.</p> <p><i>A mid-point assessment will be conducted to evaluate campaign messaging effectiveness, workforce impacts, and outreach strategies, and to inform any needed adjustments.</i></p>	<ul style="list-style-type: none"> ▶ Establish a baseline: Identify and document the current caregiving workforce in Yuba and Sutter Counties, including IHSS providers, agency-based caregivers, and informal caregivers where feasible. Disaggregate data by geography, language, and community demographics to support future equity goals. ▶ Assess projected workforce gaps based on demographic trends, aging population data, and current demand. ▶ Develop campaign goals, messaging, and branding with input from partners such as Comfort Keepers, FREED, ADRC, and local workforce boards. Include culturally affirming messaging that reframes aging and caregiving as part of meaningful life experiences. ▶ Emphasize recruitment of caregivers from rural, low-income, and culturally diverse communities, with multilingual materials (e.g., Spanish, Punjabi, Hmong). ▶ Launch at least two targeted outreach efforts (e.g., social media series, school-based outreach, community events) to promote caregiving as a meaningful, long-term career. ▶ Develop materials to promote: <ul style="list-style-type: none"> – IHSS and private caregiving opportunities, including eligibility, reimbursement, and potential income for family caregivers – Career pathways in caregiving, including long-term growth and entry into related fields (e.g., nursing, behavioral health) ▶ Collaborate with local high schools and colleges to explore internships or career exploration programs, ensuring liability and insurance needs are addressed through coordination with school districts and caregiving agencies. <p>Year 3 (July 2027–June 2028): Midpoint Assessment and Strategic Refinement</p>

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Conduct a mid-point review to assess effectiveness of campaign messaging and communication channels, reach among rural and underrepresented communities, workforce impacts (e.g., increases in caregiving applications, IHSS enrollment) ▶ Use findings to refine campaign messaging, audiences, and delivery methods, based on what’s resonating. ▶ Explore new or adjusted outreach strategies to deepen community engagement and increase workforce interest. <p>Years 3–5 (July 2027–June 2030): Sustain and Scale Campaign Impact</p> <ul style="list-style-type: none"> ▶ Maintain and adapt outreach efforts based on assessment findings and community feedback. ▶ Support partner agencies and providers in scaling up messaging, sharing resources, and expanding recruitment pipelines. ▶ Promote continued awareness of financial supports and caregiver education opportunities. ▶ Continue annual monitoring of campaign reach, impact, and workforce outcomes to ensure sustainability. ▶ Ensure continued alignment with county and regional workforce development initiatives and aging services systems.
<p>SMART Objective Draft: By June 2030, establish and strengthen a sustainable caregiver support network in Yuba and Sutter Counties by promoting, enhancing, or supporting at least two</p>	<p>Years 1–2 (July 2025–June 2027): Partner Engagement and Program Mapping</p> <ul style="list-style-type: none"> ▶ Strengthen the regional caregiver support network by coordinating existing organizations, building alignment across programs, and identifying shared opportunities to enhance caregiver well-being.

SMART Objectives	Phased Activities
<p>ongoing caregiver support groups, training programs, or counseling services that meet the needs of family and unpaid caregivers.</p> <p><i>Annual reviews will begin in Year 1 to assess caregiver needs, program utilization, and opportunities to expand reach, improve equity, and enhance caregiver well-being supports across the region.</i></p>	<ul style="list-style-type: none"> – Identify and partner with caregiver support organizations and programs to join the Goal 3. Action Team (e.g., Freedom Home Health and Hospice Care, Sutter County Alzheimer’s Group, Foothills Compassionate Care, Summerfield, and the new CNA training program launching in 2025). – Invite caregivers to participate in the Goal 3 Action Team to ensure their lived experiences inform strategy development, outreach priorities, and program improvement efforts. – Map existing caregiver support and training services across Yuba and Sutter Counties, documenting what’s offered, who’s served, and where gaps exist. <ul style="list-style-type: none"> ▶ Engage caregivers directly to understand what types of support are most needed (e.g., emotional support, practical skills, peer connection), and how services can be made more accessible for those with limited time, internet, or transportation. ▶ Assess partner capacity and identify barriers to reaching underserved caregivers, including those in rural areas, non-English speakers, and unpaid caregivers not connected to formal systems. ▶ Promote Freedom Home Health and Hospice Care and other caregiver support offerings, including support groups, training workshops, and monthly caregiver resource emails, through IHSS and ADRC networks to ensure broader caregiver awareness and participation. ▶ Develop a shared outreach and sustainability strategy to increase participation, strengthen network coordination, and begin tracking outcomes related to caregiver engagement, satisfaction, and support access. <p>Years 3–5 (July 2027–June 2030): Assess Progress and Expand Access</p> <ul style="list-style-type: none"> ▶ Conduct annual reviews of caregiver support partnerships, service reach, and

SMART Objectives	Phased Activities
	<p>caregiver feedback to assess progress and identify opportunities for improvement.</p> <ul style="list-style-type: none"> ▶ Explore strategies to expand access and equity, with a focus on rural areas, non-English-speaking caregivers, and culturally diverse communities. ▶ Support ongoing sustainability by refining outreach efforts, strengthening partner coordination, and integrating caregiver supports into broader aging and disability initiatives.
<p>Strategy 3.3. Promote mental health, dementia-friendly practices, and brain health through coordinated education, outreach, and support services.</p>	
<p>SMART Objective 3.3.1. Draft: By June 2026, the Goal 3 Health Care and Caregiving Action Team will assess the feasibility of sustaining existing dementia-friendly training and community-based support services in Yuba and Sutter counties through collaborative partnerships, funding opportunities, and culturally responsive strategies.</p> <p><i>If feasibility is determined, appropriate metrics and outcome measures will be developed to guide a longer-term objective focused on sustaining and potentially expanding dementia-friendly</i></p>	<p>Year 1 (July 2025–June 2026): Feasibility Assessment and Stakeholder Engagement</p> <ul style="list-style-type: none"> ▶ Identify and engage additional stakeholders, such as Sutter-Yuba Behavioral Health, Sutter County Public Health, Alzheimer’s Association, IHSS, FREED, Comfort Keepers, and local caregivers. ▶ Conduct a feasibility assessment to determine how the Goal 3 Health Care and Caregiving Action Team and ADRC can help sustain and strengthen existing dementia-friendly efforts—through communications support, partnership-building, funding connections, or infrastructure coordination. ▶ Partner with the Healthy Brain Initiative (HBI) to assess opportunities for continued support of its dementia-friendly caregiver training and peer support programs in Yuba and Sutter counties. Explore strategies to help sustain the program beyond current funding timelines. ▶ Review dementia-friendly models used in other rural or aging-focused communities across California and nationally to identify promising practices.

SMART Objectives	Phased Activities
<p><i>supports.</i></p>	<ul style="list-style-type: none"> ▶ Explore funding and partnership opportunities to support sustained or expanded program delivery by lead organizations. <p>Year 2 (July 2026–June 2027): Partner Support, Community Input, and Planning for Long-Term Sustainability <i>(Note: Contingent on Feasibility Determination in Phase 1)</i></p> <ul style="list-style-type: none"> ▶ Support partner organizations (e.g., HBI, Alzheimer’s Association, Sutter-Yuba Behavioral Health) in launching or continuing dementia-friendly training and peer support services. <ul style="list-style-type: none"> – Assess access considerations, including alternative meeting and training sites outside of government buildings (e.g., community-based organizations, clinics, caregiver-serving agencies). ▶ Collaborate with partners to identify relevant outcome measures and tracking tools to evaluate participation, equity, and effectiveness. ▶ Assist with ongoing outreach, public awareness, and community engagement efforts in collaboration with partners. <ul style="list-style-type: none"> – Gather input from local caregivers to identify content and delivery needs for training and support services. ▶ Coordinate with AAA4’s communications specialist to assist lead organizations with public outreach, caregiver engagement, and awareness-building efforts. <ul style="list-style-type: none"> – Identify culturally and linguistically appropriate approaches, ensuring services can be offered in multiple languages and formats (e.g., in-person, virtual, print). ▶ Begin outlining a shared approach for longer-term program support, including potential roles, funding strategies, and evaluation needs. <p>Year 3 (July 2027–June 2028): Identify Metrics and Reframe as a Long-Term</p>

SMART Objectives	Phased Activities
	<p>Objective</p> <ul style="list-style-type: none"> ▶ In collaboration with partner organizations, define success metrics and outcome measures based on community feedback, activity results, and implementation progress. ▶ Assess whether conditions support the development of a new long-term objective to sustain and/or expand dementia-friendly caregiver training and support services through 2030 and beyond. ▶ Draft a reframed objective, aligned with identified needs, equity goals, and available resources, for potential inclusion in future annual work plans. ▶ Institutionalize annual review and feedback mechanisms to support ongoing learning, equity, and adaptation. <p>Years 4–5 (July 2028–June 2030): Sustainability and Potential Expansion Support</p> <ul style="list-style-type: none"> ▶ Help coordinate development of a sustainability strategy, supporting lead partners in identifying long-term funding sources, staffing models, and infrastructure needs. ▶ If appropriate, help identify opportunities to expand program reach to new populations or geographies within Yuba and Sutter counties. ▶ Maintain the Goal 3 Action Team’s role in convening partners, tracking progress, sharing best practices, and ensuring alignment with the broader Aging and Disability Action Plan.
<p>SMART Objective 3.3.2. Draft: By 2030, implement a recurring, culturally inclusive community education campaign that increases awareness, reduces</p>	<p>Years 1–2 (July 2025 – June 2027): Campaign Co-Design, Community Engagement, and Foundation Building</p> <ul style="list-style-type: none"> ▶ Build cross-sector partnerships to co-lead campaign design and coordination (e.g., Public Health, Behavioral Health, FREED, Alzheimer’s Association, Legal Center for

SMART Objectives	Phased Activities
<p>stigma, and connects older adults and people with disabilities in Yuba and Sutter counties to mental health supports, cognitive health screenings, and advance care planning resources.</p> <p><i>A mid-point assessment will be conducted to evaluate campaign reach, cultural relevance, message effectiveness, and audience engagement, and to refine outcome metrics and outreach strategies as needed.</i></p>	<p>Seniors, Cultural and linguistic community organizations, Partnership HealthPlan, Peer navigators and community health workers, and Senior service providers and caregivers)</p> <ul style="list-style-type: none"> ▶ Gather community input to ensure messaging reflects lived experience and community tone. <ul style="list-style-type: none"> – Engage older adults, individuals with disabilities, caregivers, and trusted providers. – Include underrepresented and linguistically diverse groups (e.g., Spanish-, Hmong-, Punjabi-speaking residents). ▶ Review and adapt existing awareness campaigns from other counties or states to inform campaign structure, framing, and messaging. ▶ Co-develop campaign content, including: <ul style="list-style-type: none"> – Mental and cognitive health as part of overall wellness – Reducing stigma and normalizing help-seeking – Importance and empowerment of Advance Health Care Directives – Encouragement of early screening and provider conversations ▶ Develop a multilingual, culturally relevant campaign strategy, including content creation in Spanish, Hmong, Punjabi, and other key languages. ▶ Launch the initial campaign during Year 2 using community-rooted formats and trusted messengers: <ul style="list-style-type: none"> – Flyers, social media, community workshops, radio, PSAs, Advance Directive fairs, senior centers, and service sites – Delivery through peer navigators, senior service providers, Pam and others doing

SMART Objectives	Phased Activities
	<p>direct outreach</p> <p>Year 3 (July 2027 – June 2028): Midpoint Evaluation and Campaign Refinement <i>(Note: Contingent on foundational activities completed in Phase 1)</i></p> <ul style="list-style-type: none"> ▶ Conduct a midpoint evaluation to assess campaign reach, visibility, audience engagement, and the cultural clarity and resonance of key messages. ▶ Refine campaign materials, messaging, and outreach strategies based on community feedback and lessons learned from implementation. ▶ Revisit and update the SMART Objective as needed to incorporate specific outcome metrics and measurement strategies for long-term tracking and impact. <p>Years 4–5 (July 2028 – June 2030): Scaling, Integration, and Sustainability</p> <ul style="list-style-type: none"> ▶ Expand campaign efforts to additional communities, languages, and settings based on findings from earlier phases. ▶ Collaborate with partners to apply shared outcome measures and track progress toward increased awareness, behavior change, and resource utilization. ▶ Support integration of the campaign into broader local health and aging initiatives, and identify long-term funding or ownership opportunities.



Goal 4: Improve Food Security and Nutrition Availability

SMART Objectives

Phased Activities

Strategy 4.1. Educate the community on nutrition and food security needs and local resources.

SMART Objective 4.1.1. Draft: By June 2030, collaborate with local leaders and community organizations to conduct at least eight targeted outreach and education activities aimed at local, state, and federal government officials to increase awareness of nutrition and food security needs in Yuba and Sutter Counties.

A mid-point assessment will be conducted to evaluate outreach impact, refine messaging and engagement strategies, and identify outcome metrics to guide continued advocacy efforts.

Years 1–2 (July 2025 – June 2027): Build the Foundation & Launch Outreach

- ▶ Convene a Nutrition and Food Security Action Team to align messaging, identify audiences, and coordinate outreach efforts.
- ▶ Develop presentation materials with current data, local stories, and tailored messages for local, state, and federal audiences.
- ▶ Conduct 2-3 outreach presentations to priority audiences (e.g., Board of Supervisors, commissions, state/federal representatives), with at least one presentation prioritized early to address pressing federal funding concerns. These presentations will focus on community needs, funding challenges, and the critical role of public investment in sustaining essential programs. Existing resources, such as the LADAP website, will be shared to support informed dialogue and enhance data visibility among decision-makers.
 - **Early Milestone:** The Yuba County Commission on Aging’s May update to the BOS (not yet calendared) and upcoming district-level town halls offer immediate outreach opportunities to raise visibility and integrate nutrition messaging.
- ▶ Create a tracking tool to monitor engagement, responses, and advocacy outcomes.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Establish a system for annual data reporting on local food security needs and outreach efforts. <p>Year 3 (July 2027 – June 2028): Midpoint Assessment & Planning for Next Phase</p> <ul style="list-style-type: none"> ▶ Conduct a follow-up community survey to reassess local nutrition and food security needs. ▶ Review outreach impact and refine messaging, materials, and engagement strategies. ▶ Identify additional metrics or priorities to guide continued outreach and advocacy. <p>Years 4–5 (July 2028 – June 2030): Resume Outreach & Sustain Efforts</p> <ul style="list-style-type: none"> ▶ Resume 2-3 targeted presentations per year using updated data and insights from the assessment. ▶ Continue advocacy and community engagement in alignment with emerging opportunities. ▶ Share a final summary or advocacy toolkit that includes lessons learned, materials developed, and calls to action for post-2030 sustainability.
<p>SMART Objective 4.1.2. Draft: By June 2030, collaborate with community partners to increase access to accurate, up-to-date information about local food, nutrition, and nutrition education resources in Yuba and Sutter Counties by reviewing, updating, and promoting existing resource directories.</p>	<p>Years 1–2 (July 2025 – June 2027): Coordinate Partners & Review Resources</p> <ul style="list-style-type: none"> ▶ Collaborate with community organizations such as senior centers, churches, farmers markets, Commissions on Aging, and health centers to identify key resources and access points. ▶ Identify and review existing directories and platforms (e.g., 2-1-1, Sutter County resource directory, Harmony Health, CBO websites) that list food and nutrition resources.

SMART Objectives	Phased Activities
<p><i>A mid-point assessment will be conducted to gather community perspectives on resource awareness, evaluate directory accessibility and content relevance, and refine outreach strategies to strengthen impact and sustainability.</i></p>	<ul style="list-style-type: none"> ▶ Map trusted community organizations and leaders—especially those serving diverse aging and disability populations, as well as organizations that support family and paid caregivers and culturally specific communities (e.g., IHSS, FREED, Hmong Outreach Center, Latino Outreach Center, Punjabi community leaders, churches, etc.)—who can help disseminate and reinforce this information, particularly in communities with limited digital access. ▶ Develop a strategy to ensure updated information is shared through multiple formats and languages, including English, Spanish, Punjabi, Hmong, ASL, and Braille. ▶ Engage Nutrition/Food Security Action Team members to regularly review resource lists and coordinate with directory owners to ensure content remains current, aligned, and accessible to diverse communities. <p>Year 3 (July 2027 – June 2028): Midpoint Assessment & Strategy Refinement</p> <ul style="list-style-type: none"> ▶ Conduct a community survey to assess awareness and accessibility of food and nutrition resource information. ▶ Use findings to refine outreach strategies and explore potential metrics or impact measures to guide future efforts. <p>Phase 3: Expand Reach & Sustain Access (Years 4–5: July 2028 – June 2030)</p> <ul style="list-style-type: none"> ▶ Continue promoting updated resource information through community partners and community channels. ▶ Establish a shared approach for maintaining and updating directories over time. ▶ Identify long-term strategies to support equitable access and collaboration beyond 2030.

SMART Objectives	Phased Activities
<p>Strategy 4.2. Collaborate with community partners to identify and address food security priorities, with a focus on enhancing access to nutritious foods, particularly for underserved populations.</p>	
<p>SMART Objective 4.2.1. Draft: By June 2030, build community partnerships to strengthen food distribution infrastructure and improve access to locally grown and unsold or surplus food that would otherwise go to waste from local farms, vendors, and food programs for residents of rural and underserved areas in Yuba and Sutter Counties.</p> <p><i>Annual progress reviews will begin in Year 1 to assess partnership development, early distribution activities, and opportunities to refine strategies for expansion, sustainability, and impact measurement.</i></p>	<p>Year 1 (July 2025 – June 2026): Assess Needs & Establish Partnerships</p> <ul style="list-style-type: none"> ▶ Identify and map potential partners, including local farmers, food vendors, community-based organizations, and food programs interested in sourcing or distributing locally grown or surplus food. ▶ Assess food access gaps in rural and underserved areas (e.g., Foothills, Olivehurst), including current distribution frequency, reach, and barriers. ▶ Explore regulatory, logistical, and liability considerations related to food recovery (e.g., storage, transportation, food safety). ▶ Begin formalizing partnerships with at least two farms and two food distribution partners (e.g., churches, Meals on Wheels, Foothill Food Pantry). ▶ Explore funding opportunities to support expanded distribution, infrastructure, or coordination needs. ▶ Initiate annual progress reviews to track partnership development, identify emerging distribution opportunities, and guide adjustments to early strategies. <p>Years 2–3 (July 2026 – June 2028): Strengthen Coordination & Pursue Targeted Expansion</p> <ul style="list-style-type: none"> ▶ Continue strengthening partnerships and identify roles for coordination, sourcing, and delivery (e.g., through a food hub or logistical partner like Yuba Kami or the Yuba-Sutter Food Bank). ▶ If funding and capacity allow, support pilot efforts in one or more high-need

SMART Objectives	Phased Activities
	<p>communities to increase access to locally grown or surplus food.</p> <ul style="list-style-type: none"> ▶ Begin tracking informal indicators of reach and impact (e.g., partner feedback, observed increase in access or participation). <p>Years 4–5 (July 2028 – June 2030): Sustain and Scale Efforts as Feasible</p> <ul style="list-style-type: none"> ▶ Support the continuation of effective approaches and explore opportunities to expand to additional sites if funding and capacity are available. ▶ Formalize long-term agreements (e.g., MOUs) with key partners to support coordination and sustainability. ▶ Pursue funding, policy, or infrastructure support to maintain and grow access to locally grown and recovered food for rural and underserved communities.
<p>SMART Objective 4.2.2. Draft: By June 2027, partner with local healthcare systems and Medi-Cal providers to explore the feasibility of a “Food as Medicine” approach in Yuba and Sutter Counties, including strengthening referral pathways to the Medically Tailored Meals (MTM) program.</p> <p><i>A mid-point assessment will be conducted to evaluate partnership development, provider engagement, and referral pathway feasibility, and to identify outcome metrics for potential long-term expansion.</i></p>	<p>Year 1 (July 2025 – June 2026): Establish Partnerships & Raise Awareness</p> <ul style="list-style-type: none"> ▶ Engage Medi-Cal providers (e.g., Partnership HealthPlan, Kaiser Permanente) and local clinics and hospitals (e.g., Peachtree, Harmony Health, Adventist Health, Ampla) to assess interest, eligibility criteria, and referral workflows for MTM and food prescription models. ▶ Leverage existing MTM educational materials and identify additional outreach tools (e.g., referral cards, information sheets explaining the Food as Medicine approach) to support provider and patient engagement. Align with broader efforts to promote local nutrition and food access resources (see Objective 4.1.2) to ensure healthcare providers can effectively connect clients to available services. ▶ Develop a preliminary list of potential referring providers and partner organizations, and begin outreach to explore future pilot opportunities. ▶ Explore opportunities to align Food as Medicine promotion with chronic disease

SMART Objectives	Phased Activities
	<p>management programs, hospital discharge planning, or case management workflows.</p> <p>Year 2 (July 2026 – June 2027): Assess Feasibility</p> <ul style="list-style-type: none"> ▶ Gather feedback from healthcare and community partners on early engagement, outreach tools, referral barriers, and program alignment. ▶ Assess community interest and awareness through surveys or partner interviews. ▶ Use findings to determine whether and how to move forward with a broader Food as Medicine objective in future years. <p>Years 4–5 (July 2028 – June 2030) Sustain and Scale Efforts as Feasible <i>(Note: if feasibility is confirmed and objective is expanded)</i></p> <ul style="list-style-type: none"> ▶ Continue effective Food as Medicine strategies and explore expansion to additional providers and community sites. ▶ Provide training and outreach support to healthcare and community partners to increase referrals and program integration. ▶ Formalize partnerships and referral processes (e.g., discharge or care coordination protocols). ▶ Pursue funding, policy, or infrastructure support to sustain and grow the model for high-need populations in rural and underserved communities.
<p>SMART Objective 4.2.3. Draft: By June 30, 2030, annually assess, identify, and implement strategies to increase awareness of and enrollment in CalFresh among older adults and individuals with</p>	<p>Year 1 (July 2025 – June 2026): Launch Coordinated Outreach and Engagement</p> <ul style="list-style-type: none"> ▶ Engage local partners already involved in CalFresh outreach (e.g., AAA4, H&HS, FREED, ADRC, food banks, Harmony Health, Meals on Wheels, Public Health, colleges) to align and coordinate messaging.

SMART Objectives	Phased Activities
<p>disabilities in Yuba and Sutter counties.</p> <p><i>Annual progress reviews will begin in Year 1 to refine outreach strategies, evaluate enrollment impacts, and identify opportunities to connect participants with additional nutrition resources and supports.</i></p>	<ul style="list-style-type: none"> ▶ Map current outreach activities and identify geographic, cultural, and population-based gaps (e.g., older adults, rural areas, multilingual communities, tech-limited households). ▶ Develop and launch a culturally responsive outreach campaign, emphasizing: <ul style="list-style-type: none"> – Application guidance and support – Strategies to reduce stigma and the value of CalFresh benefits (e.g., access to vouchers, healthy food incentives) ▶ Milestone: Leverage CalFresh Awareness Month (May) and build on trusted local systems (e.g., food delivery programs, clinics, senior centers) for outreach. ▶ Initiate tracking processes for outreach impact to inform future refinements. <p>Years 2–5 (July 2026 – June 2030): Ongoing Refinement, Scaling, and Alignment</p> <ul style="list-style-type: none"> ▶ Conduct annual reviews of campaign reach, enrollment trends, and barriers to participation; update materials and strategies accordingly. ▶ Leverage the Community Survey (if feasible in Year 3) to assess awareness, perceptions, and enrollment challenges to inform campaign refinements. ▶ Expand outreach partnerships and approaches in underserved areas, maintaining a strong focus on cultural relevance and trusted messengers. ▶ Coordinate with complementary initiatives, such as CalFresh Healthy Living and Blue Zones food access efforts, to promote healthy eating and economic supports through integrated messaging. ▶ Assess opportunities to scale and sustain outreach efforts, including integration into existing agency communications, recurring campaigns, and funding/resource

SMART Objectives	Phased Activities
	alignment.
<p>SMART Objective 4.2.4. Draft: By June 30, 2030, support the development of at least one accessible community garden in an identified priority area of Yuba and Sutter counties, paired with integrated, culturally inclusive education on planting, harvesting, cooking, and healthy eating for older adults and individuals with disabilities.</p> <p><i>If a garden is successfully developed, a Year 5 assessment will be conducted to evaluate participation, education reach and impact, and opportunities for long-term sustainability.</i></p>	<p>Years 1–2 (July 2025 – June 2027): Site Identification, Partnership Development, and Planning</p> <ul style="list-style-type: none"> ▶ The Goal 4 Action Team will engage local partners and community members to co-design the initiative, drawing on land access, lived experience, and educational or programmatic expertise. Potential partners include: <ul style="list-style-type: none"> – AAA4, CalFresh Healthy Living, Blue Zones, Seniors on the Go, Steve Danback, UC Cooperative Extension, Yuba-Sutter Farm Bureau, Public Health, schools, and tribal organizations. ▶ Identify high-need sites based on indicators such as food insecurity, poverty, limited produce access, and community interest or capacity for long-term maintenance. ▶ Assess feasibility and infrastructure needs, including secure fencing, water access, ADA accessibility, and sustainable maintenance models (e.g., hosted sites or shared community plots). ▶ Adapt existing education programs—covering planting, harvesting, food safety, nutrition, and simple meal preparation—to ensure cultural and linguistic relevance. ▶ Engage older adults and people with disabilities directly in shaping the garden layout and education components to reflect their needs and preferences. <p>Years 3–4 (July 2027 – June 2029): Garden Development and Education Implementation</p> <ul style="list-style-type: none"> ▶ Support development of at least one accessible community garden in a priority location, in collaboration with committed partners identified in Phase 1. ▶ Implement education programming in multiple formats (in-person, print, visual) with a

SMART Objectives	Phased Activities
	<p>focus on inclusion, accessibility, and relevance to older adults and diverse cultural communities.</p> <ul style="list-style-type: none"> ▶ Conduct inclusive outreach and promotion through trusted messengers and organizations already serving the target population. ▶ Track participation and gather community feedback on who is engaging, barriers encountered, and suggestions for improving both the garden and education components. <p>Year 5 (July 2029 – June 2030): Year 5 Assessment and Sustainability Planning</p> <ul style="list-style-type: none"> ▶ Conduct a comprehensive evaluation of garden participation, education reach, and impact, including stories or testimonials where possible. ▶ Explore long-term sustainability options, such as stewardship by hosting organizations, shared-use plots, integration with food hubs or co-ops, or alignment with existing food/nutrition programs. ▶ Document lessons learned and identify opportunities to replicate, scale, or integrate this model into broader food security or healthy aging strategies.



Goal 5: Strengthen Social Participation and Community Engagement

SMART Objectives

Phased Activities

Strategy 5.1. Strengthen partnerships and promote initiatives that enhance coordination, improve service delivery, and expand inclusive, age- and disability-friendly programs.

SMART Objective 5.1.1. Draft: By September 2025, Yuba and Sutter Counties will achieve official AARP Age-Friendly designation and begin using livable communities resources to implement the Local Aging and Disability Action Plan (LADAP), including cross-sector implementation aligned with the Age-Friendly 9-domain framework.

Metrics and longer-term implementation milestones will be developed during Phase 1 to guide cross-sector alignment, progress tracking, and sustainability planning.

Year 1 (July 2025–June 2026): Foundations, Partnership Building, & Enrollment

- ▶ **Early milestone:** Obtain letters of support from the Yuba and Sutter County Commissions on Aging and include them in the LADAP as part of the finalized plan (target: May 2025).
- ▶ Submit letters of support from the Yuba and Sutter Boards of Supervisors to AARP to initiate Age-Friendly designation (target: July 2025).
- ▶ **Milestone:** Achieve official Age-Friendly designation for both counties (target: September 2025).
- ▶ Establish a bi-county Goal 5 Action Team on Social Participation and Community Engagement to guide implementation.
 - Assign co-chairs across all five LADAP goal areas.
 - Engage cross-sector partners to support implementation efforts, including Behavioral Health, APS, transportation, parks, and community-based organizations.
 - Ensure participation from both counties and meaningful engagement of older adults,

SMART Objectives	Phased Activities
	<p>people with disabilities, and community members.</p> <ul style="list-style-type: none"> ▶ Launch a public communications and media campaign to raise awareness and promote engagement. <ul style="list-style-type: none"> – Share community success stories, promote engagement opportunities, and highlight progress toward livable communities. ▶ Begin aligning Age-Friendly implementation with other regional and state-funded planning initiatives. <p>Years 2–3 (July 2026–June 2028): Cross-Sector Implementation and Progress Tracking</p> <ul style="list-style-type: none"> ▶ Develop and adopt a longer-term implementation objective that builds on the Age-Friendly designation and LADAP integration, with milestones aligned through June 2030. ▶ Use AARP’s livable communities framework and toolkit to guide implementation across the 9 domains. ▶ Track designation milestones and report progress in coordination with the LADAP implementation team. <ul style="list-style-type: none"> – Integrate designation milestones into the broader LADAP implementation timeline and tracking framework. – Use AARP reporting guidance for consistent measurement. ▶ Identify and launch early win projects that promote livable, inclusive communities for all ages and abilities. <p>Years 4–5 (July 2028–June 2030): Evaluation, Adaptation & Sustainability</p> <ul style="list-style-type: none"> ▶ Evaluate the impact of Age-Friendly implementation activities and their alignment with

SMART Objectives	Phased Activities
	<p>LADAP goals.</p> <ul style="list-style-type: none"> ▶ Update community priorities and Action Team activities based on data, community feedback, and emerging needs. ▶ Develop sustainability strategies, including funding sources, partnerships, and policy supports. ▶ Continue to share stories and outcomes to build momentum for ongoing livable community investments.
<p>SMART Objective 5.1.2. Draft: Beginning June 2025 through June 2030, cross-sector partners across Yuba and Sutter Counties will annually assess and map aging and disability programs and services to identify funding gaps and overlaps, align resources with community priorities, and strengthen coordination for greater impact.</p> <p><i>Metrics and implementation milestones will be developed during Phase 1 following initial planning and assessment activities to guide ongoing alignment, progress tracking, and system improvements.</i></p>	<p>Year 1 (June 2025–June 2026): Planning, Partnerships & Scope Definition</p> <ul style="list-style-type: none"> ▶ Leverage the existing Goal 5 Action Team to guide initial planning and coordination. ▶ Engage a broad range of cross-sector partners, including agencies, nonprofits, and community-based organizations, with attention to underrepresented groups (e.g., Punjabi community groups, ADRC extended partners). ▶ Define the general scope and goals of the mapping effort, including what will be captured and how it will be used. ▶ Identify practical and accessible methods for gathering input (e.g., provider surveys). ▶ Outline shared criteria for identifying service gaps, overlaps, or coordination opportunities. ▶ Convene one or more coordination meetings to gather input and confirm approach. <p>Year 2 (July 2026–June 2027): Asset Mapping & Analysis</p> <ul style="list-style-type: none"> ▶ Carry out the mapping process using the methods identified in Year 1, with a focus on input from service providers and community partners.

SMART Objectives	Phased Activities
	<ul style="list-style-type: none"> ▶ Compile available information on programs, services, and barriers to access. ▶ Identify general themes related to duplication, gaps, or opportunities for collaboration. ▶ Share a summary of findings with partners to support collective planning and funding efforts. <p>Years 3–5 (July 2027–June 2030): Ongoing Review, Alignment & Impact Tracking</p> <ul style="list-style-type: none"> ▶ Conduct a brief annual review of the resource map to reflect key changes in services, funding, or community needs. ▶ Maintain the map as a working tool that can evolve over time based on partner input and available capacity. ▶ Continue convening partners as needed to explore alignment opportunities and share updates. ▶ Use findings to support joint planning, funding strategies, and service coordination. ▶ Share lessons learned and any improvements in access, equity, or system efficiency.
<p>SMART Objective 5.1.2. Draft: Beginning June 2025 through June 2030, coordinate with trusted cultural partners to strengthen and expand culturally specific social engagement opportunities for underrepresented older adults and people with disabilities in Yuba and Sutter Counties, including Hmong, Latino, Punjabi, and other communities, by supporting</p>	<p>Year 1 (June 2025–June 2026): Partnership Building & Community Input</p> <ul style="list-style-type: none"> ▶ Identify and engage trusted cultural partners, such as the Hmong Outreach Center, Latino-serving nonprofits, and Punjabi-American and Punjabi-Christian groups using culturally sensitive, trust-building approaches. ▶ Assess current culturally specific social engagement opportunities and identify where older adults and people with disabilities may be underserved. ▶ Begin connecting community members to existing programs through culturally responsive outreach and communication strategies; consider leveraging resources such as the AAA4 Communications Specialist to support this effort.

SMART Objectives	Phased Activities
<p>participation in existing programs and co-developing new efforts in response to community needs.</p> <p><i>Metrics will be developed following the initial assessment of existing programs, service gaps, and community-driven priorities to guide program development, outreach, and evaluation strategies.</i></p>	<ul style="list-style-type: none"> ▶ Work with cultural leaders and community members to understand preferred types of gatherings and cultural values around connection. <p>Year 2 (July 2026–June 2027): Program Support, Targeted Communications & Gap Identification</p> <ul style="list-style-type: none"> ▶ Support existing culturally specific engagement programs through coordination, promotion, and resource-sharing in collaboration with community partners. ▶ Build on early communications efforts to implement targeted outreach strategies that reflect each community’s language and values. ▶ Increase visibility and participation in ongoing programs using culturally appropriate materials and media (e.g., radio, flyers, social media, word of mouth). ▶ Identify where culturally specific programs are still limited or underutilized, and document ideas from partners and community members for new or adapted offerings, such as culturally themed meal gatherings or other culturally relevant activities that promote connection. <p>Years 3–5 (July 2027–June 2030): Community-Led Program Pilots & Sustainability Planning</p> <ul style="list-style-type: none"> ▶ Collaborate with cultural partners to support the launch of up to three new culturally specific engagement programs in response to the gaps and ideas identified in Phase 2. <ul style="list-style-type: none"> – Examples may include a culturally themed “Dine Around Town” group, language-specific game nights, or intergenerational activities led by cultural centers. ▶ Provide support with promotion, coordination, or materials, while allowing partners to lead design and implementation in ways that reflect their community's voice. ▶ Explore opportunities for shared or sustainable funding (e.g., local grants, sponsorships,

SMART Objectives	Phased Activities
	<p>or in-kind support).</p> <ul style="list-style-type: none"> ▶ Develop simple methods to document participation, feedback, and outcomes in collaboration with partners. ▶ Adapt and scale efforts based on lessons learned, ensuring programs remain flexible, culturally relevant, and responsive to community needs.
<p>Strategy 5.2. Strengthen communication access and raise public awareness to connect residents with essential resources, ensuring equity, inclusion, and accessibility for all.</p>	
<p>SMART Objective 5.2.1. Draft: Beginning June 2025 through June 2030, collaborate with cross-sector partners to assess, coordinate, and promote information and assistance (I&A) resources, ensuring accessibility, cultural and linguistic inclusion, and digital equity for older adults and individuals with disabilities.</p> <p><i>Metrics and implementation milestones will be developed based on findings from Phase 1 to guide outreach improvements, service coordination, and accessibility strategies.</i></p>	<p>Year 1 (June 2025–June 2026): Partnership Building, Resource Assessment & Accessibility Planning</p> <ul style="list-style-type: none"> ▶ Engage cross-sector partners through the Goal 5 Action Team, including ADRC, FREED, libraries, health plans, HHS departments, United Way, and Information and Assistance (I&A) providers. ▶ Map existing I&A resources (e.g., phone lines, websites, printed materials, navigators) and identify gaps in accuracy, access, and reach—especially for rural, non-English-speaking, low-literacy, and digitally disconnected populations. <ul style="list-style-type: none"> – Assess the status of Yuba County’s 2-1-1 system and explore feasibility for future expansion or alignment in Sutter County. ▶ Identify promising practices and partners to support digital literacy access (e.g., AARP OATS, broadband efforts, libraries), and explore co-promotion opportunities with culturally trusted groups. ▶ Promote accessibility standards (e.g., plain language, screen reader compatibility, multilingual formats), and explore integration with the ADRC website and links to

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	<p>partner-maintained tools that are kept up to date.</p> <ul style="list-style-type: none"> ▶ Develop a strategy to annually identify outreach and connection opportunities, and support I&A providers by flagging outdated information and sharing community feedback to improve access across digital, print, phone, and in-person formats. <p>Years 2–5 (July 2026–June 2030): Strengthen Coordination, Outreach & Continuous Improvement</p> <ul style="list-style-type: none"> ▶ Collaborate with I&A providers and partners to support outreach strategies that improve awareness, accessibility, and navigation for older adults and individuals with disabilities. ▶ Continue working with culturally trusted organizations to connect residents with services through multiple access points (e.g., digital, print, phone, in-person). ▶ Share feedback from community members to help I&A providers and partners identify areas for improvement or updates. ▶ Promote visibility of available resources through coordinated messaging, success stories, and partner communications. ▶ Maintain momentum through ongoing collaboration and regular assessment of outreach and connection strategies.
<p>Strategy 5.3. Expand lifelong learning, community involvement, and civic engagement opportunities for older adults and people with disabilities.</p>	
<p>SMART Objective 5.3.1. Draft: Beginning July 2025 through June 2030, support the delivery of at least one annual educational training for</p>	<p>Year 1 (July 2025 – June 2026): Engage Partners, Confirm Scope, and Launch Planning</p> <ul style="list-style-type: none"> ▶ Ensure the Goal 5 Action Team includes partners already engaged in fraud prevention and education efforts, such as AARP, Adult Protective Services (APS), AAA4, local

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<p>service providers and trusted community messengers and implement a coordinated outreach campaign to raise awareness of financial exploitation and scams among older adults, individuals with disabilities, and caregivers in Yuba and Sutter Counties, reaching at least 500 people annually.</p> <p><i>Outreach methods, trusted messengers, and detailed strategies will be further defined during Phase 1 based on partner input, training content development, and community engagement needs.</i></p>	<p>financial institutions (e.g., River Valley Community Bank), and senior-serving organizations.</p> <ul style="list-style-type: none"> ▶ Review and compile existing outreach materials and training resources (e.g., AARP toolkits, APS guidance, DOJ resources, AAA4 campaign materials, financial institution seminars) to inform a local train-the-trainer model and coordinated campaign. ▶ Explore the inclusion of elder abuse prevention messaging, considering AAA4’s regional campaign status and potential OAA funding. Identify any additional partners needed. ▶ Hold a planning session that includes service providers (e.g., Meals on Wheels, IHSS, APS, H&HS), caregivers, older adults, and individuals with disabilities to co-design: <ul style="list-style-type: none"> – Training content for service providers and community messengers – Messaging formats and outreach strategies for caregivers and the public ▶ Identify trusted outreach channels (e.g., churches, senior centers, food delivery programs, libraries, health fairs) and develop a tracking system for outreach and training reach. ▶ Confirm and refine the initial outreach target (minimum 500 people annually), with flexibility to adjust based on Year 2 evaluation. <p>Year 2 (July 2026 – June 2027): Implement and Evaluate Annual Outreach and Training</p> <ul style="list-style-type: none"> ▶ Deliver at least one annual training for service providers, caregivers, and trusted community messengers, incorporating materials and input gathered in Phase 1. ▶ Launch the public outreach campaign through trusted settings and platforms, targeting older adults, individuals with disabilities, and caregivers. ▶ Track outreach participation and engagement using the monitoring system created in

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	<p>Phase 1.</p> <ul style="list-style-type: none"> ▶ Gather feedback from participants and partners on message clarity, training impact, and preferred formats. ▶ Assess and evaluate progress toward outreach and training goals, refine strategies, and confirm or adjust the annual reach target. ▶ Use assessment findings to inform Phase 3 activities and improvements. <p>Years 3–5 (July 2027 – June 2030): Refine, Scale, and Sustain Engagement</p> <ul style="list-style-type: none"> ▶ Continue delivering at least one annual training and maintaining the outreach campaign, updating content and strategies based on feedback. ▶ Expand outreach to new audiences or settings (e.g., caregiver networks, senior housing sites, faith communities) as feasible. ▶ Share impact stories and outcomes to build trust, promote awareness, and maintain stakeholder momentum. ▶ Collaborate with partners to explore long-term sustainability, including funding opportunities or integration into existing communications.
<p>SMART Objective Draft 5.3.2.: By June 30, 2027, identify and explore opportunities to support a local organization in the development of an online volunteer opportunities webpage that highlights community needs and supports recruitment efforts, especially in rural and underserved areas of Yuba</p>	<p>Years 1–2 (July 2025 – June 2027): Build Partnerships, Explore Feasibility, and Identify Opportunities</p> <ul style="list-style-type: none"> ▶ Ensure the Goal 5 Action Team includes partners involved in volunteer coordination and digital access efforts, such as AAA4, senior centers, libraries, community nonprofits, potential website service providers or platform hosts, and Yuba County Health & Human Services, which is currently coordinating a 2-1-1 project focused on emergency services (with uncertain potential for expansion). ▶ Meet with potential lead organizations, such as Yuba County H&HS (2-1-1 provider),

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<p>and Sutter Counties.</p> <p><i>A Year 2 assessment will evaluate feasibility, platform accessibility, community and partner interest, and infrastructure needs to inform whether to proceed with a long-term implementation plan and success metrics.</i></p>	<p>resource centers, trusted nonprofits, or digital platform partners, to assess feasibility, infrastructure, and interest in managing or hosting a centralized volunteer opportunities webpage.</p> <ul style="list-style-type: none"> ▶ Gather input from older adults, individuals with disabilities, and rural residents to identify features that would make the platform accessible, relevant, and easy to use. ▶ Review successful models (e.g., Nevada County 2-1-1, “Just Served Yuba-Sutter”) to identify best practices and scalable elements. ▶ Compile a list of local organizations with existing volunteer infrastructure (e.g., similar to AAA4’s programs with background checks), and explore opportunities to link their programs through the ADRC or LADAP website, pending legal/technical review. ▶ Conclude Phase 1 with a feasibility determination regarding whether the Action Team can support local efforts, identify a potential lead organization, and determine if a revised long-term objective should be developed in Phase 2. <p>Year 3 (July 2027 – June 2028): Define Next Steps and Refine Objective Based on Feasibility Findings</p> <ul style="list-style-type: none"> ▶ If feasibility is confirmed, revise the SMART objective to reflect long-term goals and define the Action Team’s supporting role (e.g., outreach, promotion, or community engagement). ▶ Offer input or resources, as appropriate, to support the lead organization’s development of an implementation plan, based on findings from Phase 1 and community input. ▶ Help shape outreach strategies that prioritize accessibility, rural engagement, and alignment with the needs of older adults and individuals with disabilities. ▶ Collaborate with partners to define success metrics, such as site traffic, volunteer

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	<p>engagement, or the number of participating organizations.</p> <p>Years 4–5 (July 2028 – June 2030): Support Launch, Community Engagement, and Sustainability Planning</p> <ul style="list-style-type: none"> ▶ Promote the volunteer opportunities webpage through trusted community channels, including partners already engaged in outreach to older adults, caregivers, and individuals with disabilities. ▶ Assist the lead organization with gathering community feedback on usability, accessibility, and relevance to ensure the resource remains inclusive and effective. ▶ Share lessons learned, success stories, or engagement insights with stakeholders to help refine and strengthen ongoing efforts. ▶ Collaborate with partners to explore sustainability strategies, such as integrating the resource into regional outreach systems or identifying future funding or maintenance opportunities.
<p>SMART Objective 5.3.3. Draft: Beginning July 2025 and by June 30, 2030, in partnership with workforce development agencies, disability advocates, and senior-serving organizations, annually promote inclusive employment practices for adults aged 50+ and individuals with disabilities by identifying and sharing examples of flexible work models, phased retirement options, workplace</p>	<p>Years 1–2 (July 2025 – June 2027): Build Partnerships, Compile Practices, and Assess Feasibility</p> <ul style="list-style-type: none"> ▶ Ensure the Goal 5 Action Team includes partners such as FREED, workforce development boards, America’s Job Centers/One-Stops, economic development agencies, senior-serving organizations, chambers of commerce, and inclusive employers. ▶ Engage older adults and individuals with disabilities to bring lived experience into discussions and help shape outreach and storytelling strategies. ▶ Compile examples of flexible work models, phased retirement options, inclusive hiring practices, and workplace accommodations in use or adaptable in Yuba and Sutter

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<p>accommodations, and inclusive hiring strategies.</p> <p><i>A mid-point assessment will determine feasibility for launching a local recognition effort, identify relevant success metrics, and inform whether the objective should be revised to reflect long-term implementation goals.</i></p>	<p>Counties.</p> <ul style="list-style-type: none"> ▶ Identify and document local or regional organizations already advancing these practices to inform outreach, promotion, and potential recognition efforts. ▶ Begin annual outreach efforts to promote inclusive employment practices through community newsletters, partner websites, social media, and public events. ▶ Review existing recognition models (e.g., digital badges, employer spotlights) and survey local employers or partners to gauge interest in a potential program. ▶ Conclude Phase 1 with a feasibility determination regarding whether the Action Team can support a local recognition effort and whether a revised long-term objective with defined success metrics should be developed in Phase 2. <p>Year 3 (July 2027 – June 2028): Promote Practices and Refine Strategy Based on Feasibility Findings</p> <ul style="list-style-type: none"> ▶ If warranted based on Phase 1 findings, revise the long-term objective to include support for a local employer recognition program and define clear success metrics (e.g., reach of outreach activities, number of employers engaged, practices adopted). ▶ Continue and expand annual outreach to promote flexible work models, phased retirement options, workplace accommodations, and inclusive hiring practices. ▶ Highlight local employers demonstrating inclusive employment practices through storytelling, informal recognition, and partner spotlights. ▶ Assess the reach and impact of outreach and promotion activities and determine whether to scale or formalize recognition efforts in Phase 3. <p>Years 4–5 (July 2028 – June 2030): Sustain Outreach and Support Recognition Efforts</p> <ul style="list-style-type: none"> ▶ Continue annual outreach and promotion of inclusive employment practices, sharing

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	<p>updated examples through trusted community and partner channels.</p> <ul style="list-style-type: none">▶ Support visibility of participating employers through informal recognition, digital badges, storytelling, or public campaign elements.▶ Gather feedback from employers, older adults, and individuals with disabilities to evaluate reach and refine messaging.▶ Collaborate with partners to explore sustainability strategies, including alignment with workforce programs, funding sources, or policy initiatives that can expand or sustain the effort.