Upper Shore Aging

Respect | Independence | Purpose

COMMUNITY NEEDS ASSESSMENT

RIVERS & ROADS CONSULTING

Message from Leadership

Dear Friends, Neighbors, and Community Partners,

On behalf of the Board of Directors of Upper Shore Aging, Inc., I am pleased to share our Community Needs Assessment for Caroline, Kent, and Talbot Counties. Upper Shore Aging serves more than 31,000 older adults across the Upper Shore through 17 programs designed to help seniors remain healthy, safe, and independent at home. As the Area Agency on Aging for our three-county region, we have both a responsibility and a privilege: to advocate for seniors, administer critical state and federal programs, and help ensure that the systems meant to support older adults actually work—day in and day out—for the people who need them most.

This Needs Assessment is one of the most important tools we have to do that work well.

Our environment is changing quickly. Costs are rising. Housing pressures are intensifying. Technology is reshaping how healthcare and benefi ts are accessed. Scams are becoming more sophisticated. Family caregivers are stretched thin. And policy shifts at the federal level have the potential to change the ground beneath Medicaid and Medicare in ways that will be felt most acutely in rural communities like ours. At the same time, our region continues to age—meaning the number of older adults who may need support will grow each year, not just in the distance, but in the near term.

In a fast-paced and uncertain environment, good intentions are not enough. We need clear information, shared understanding, and coordinated action. This report is our effort to step back, take stock, and look comprehensively at what older adults and caregivers on the Upper Shore are experiencing—today—and what the data suggests we must be ready for next.

Throughout the Needs Assessment, you will see a consistent theme: no single program, agency, or county can solve these challenges alone. Aging touches everything—healthcare access, transportation, food security, home safety, caregiver support, social connection, and affordability.

We are anxious to share this overview with other agencies, support groups, and individuals who join us in this work. We hope that others may benefit from the analyses found in the Needs Assessment in their own work and we hope to strengthen our partnerships so that we may collaborate when possible.

The Needs Assessment underscores the value of enhanced communication among all who serve seniors on the Eastern Shore. By understanding the mission and programs of other agencies, and by sharing with them the mission and programs of Upper Shore Aging, we can all improve access to services for seniors across our three counties.

Most importantly, this report reflects Upper Shore Aging's unwavering commitment to the seniors we serve. We are proud of what our staff and partners accomplish every day. At the same time, we do not take the future for granted. This assessment is part of how we ensure we are thinking comprehensively and planning responsibly—so we can adapt, improve, and respond to evolving needs with clarity and purpose.

Thank you to everyone who contributed insights, data, and perspective to inform this work. I also want to thank our partners at Rivers & Roads Consulting for helping us develop a clear, cohesive report that is designed to be used—not shelved. And to our community: thank you for trusting Upper Shore Aging. We remain committed to earning that trust through thoughtful planning, strong advocacy, and steady action.

We invite you to read the Needs Assessment, share it with others, and join us in the work ahead. Supporting seniors is not only about services—it is about ensuring that every older adult on the Upper Shore can live with dignity, safety, and connection in the community they call home.

With appreciation,

Kay Brodie, President

Board of Directors

Upper Shore Aging, Inc.

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Introduction & Purpose

Upper Shore Aging, Inc. commissioned this Needs Assessment to create a clear, shared understanding of the conditions shaping how residents age on Maryland's Upper Shore—and what those conditions mean for service delivery, partnerships, and long-term planning. While the region benefits from deeply committed providers and community networks, stakeholders consistently describe a system that can feel fragmented to navigate, with duplicative intake processes and information that is often collected and stored separately across entities. This report is intended to help align the conversation around the most pressing needs, identify where coordination and capacity are most constrained, and provide a practical foundation for Upper Shore Aging and its partners to make decisions grounded in evidence.

This document synthesizes quantitative and qualitative information already in use across the aging and human services landscape—supplemented by local perspective—to present an integrated narrative of needs across Caroline, Kent, and Talbot Counties. Where the report references pre-2020 data, readers should interpret those findings as a baseline that may underestimate current conditions, given the lasting effects of the COVID-19 era on health access, workforce capacity, caregiver strain, and social isolation. The sections that follow are organized to help readers move from context, to findings, to implications: first establishing the purpose and scope of the assessment, then summarizing key themes, and then detailing the underlying conditions that shape risk, access, and quality of life for older adults and caregivers across the service area.

Stakeholder Engagement Highlight

6 focus groups and 8 separate interviews. Focus groups were held in Denton, Chestertown, Easton, St. Michaels, Federalsburg, and Tilghman Island.

Acknowledgment

Upper Shore Aging, Inc. extends its sincere appreciation to the many seniors and stakeholders who took time to participate in community listening sessions held across the Upper Shore, including Denton, Chestertown, Easton, Federalsburg, St. Michaels, and Tilghman Island. We are grateful for the candor, thoughtfulness, and lived experience shared during these conversations. The insights offered—both the challenges and the strengths—were essential to grounding this Needs Assessment in the everyday realities of aging on the Upper Shore, and to ensuring the report reflects what matters most to seniors who are working to remain safe, healthy, and independent at home.

In addition, we are deeply grateful to the individuals and organizations who participated in individual stakeholder interviews and shared their expertise, perspective, and on-the-ground knowledge of the local service system. These interviews included: Carrie Ottey (Talbot County Health Department, Director Senior Services); Rachel Smith (Talbot County Commission on Aging); Childlene Brooks (Brookletts Place – Talbot County Senior Center); Rosemarie Curlett (Amy Lynn Ferris Senior Center); Christine Harrington (Londonderry – CEO/Executive Director); Julie Lowe (Talbot Interfaith Shelter); Mary Moran (Upper Shore Aging – MAP & SHIP Coordinator); Lynn Mielke (Talbot County Council Member, Commission Liaison); Michelle Nichols (Delmarva Community Services – Interim President/CEO); and Sara Rich (Choptank Community Health – President & CEO). Their contributions helped validate the needs reflected in the data and added important nuance about how seniors actually experience services—especially where capacity constraints, inconsistent access, and fragmented pathways create barriers that can be difficult to quantify.

Collectively, the stakeholder engagement process reinforced several consistent themes that echo throughout this report: transportation as a primary barrier to accessing services even when they exist; the need for clearer, more coordinated navigation and up-to-date information; workforce and provider shortages that limit in-home and healthcare supports; affordability pressures tied to housing, food, and utilities; uneven technology readiness and confidence; and the continued importance of social connection and community-based programming. These themes are woven throughout the Needs Assessment and strengthen the report's central conclusion: supporting seniors on the Upper Shore requires not only strong programs, but a more connected, easier-to-navigate system that helps older adults and caregivers access the right support at the right time.

Upper Shore Aging, Inc. Leadership

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About Upper Shore Aging

Upper Shore Aging is the Area Agency on Aging (AAA) for Caroline, Kent, and Talbot Counties, serving more than 31,000 older adults across the Upper Shore region through 17 comprehensive programs designed to help seniors remain healthy, safe, and independent at home—rather than entering nursing homes or assisted living facilities. As one of 19 AAAs statewide, Upper Shore Aging administers state and federal aging services under the supervision of the Maryland Department of Aging (MDoA), carrying out a role that Maryland mandates in every county to ensure older residents have access to coordinated supports and a dedicated advocate at the local and regional levels.

Because Caroline, Kent, and Talbot are smaller counties, Upper Shore Aging provides a shared regional structure that is more cost-effective than three separate agencies while still remaining closely connected to local needs and service networks. In this capacity, Upper Shore Aging develops and administers programs and services while serving as a chief advocate for the seniors it supports. The organization's programs are designed to work cooperatively—both to address immediate needs and to strengthen long-term quality of life—by helping older adults stay connected to resources, maintain their independence, and remain engaged in their communities for as long as possible.

Mission

Upper Shore Aging provides programs that enable seniors in Caroline, Kent, and Talbot counties to live healthy, rewarding, independent lives in their own homes.

Vision

An Upper Shore where seniors live in familiar surroundings with respect, independence, and purpose.

Service Area

Upper Shore Aging's service area includes Caroline, Kent, and Talbot Counties. These counties share many rural characteristics—distance between population centers, limited transportation options for non-drivers, and service networks that often rely on a mix of public agencies, nonprofits, and volunteers. In this geography, even small barriers (a lack of clarity about where to start, a missed connection between agencies, a delayed referral) can cascade into postponed care, caregiver strain, and preventable crises for older adults. This assessment treats the three counties as a connected region while still recognizing that service delivery structures and local capacity can vary meaningfully from place to place.

Consultants

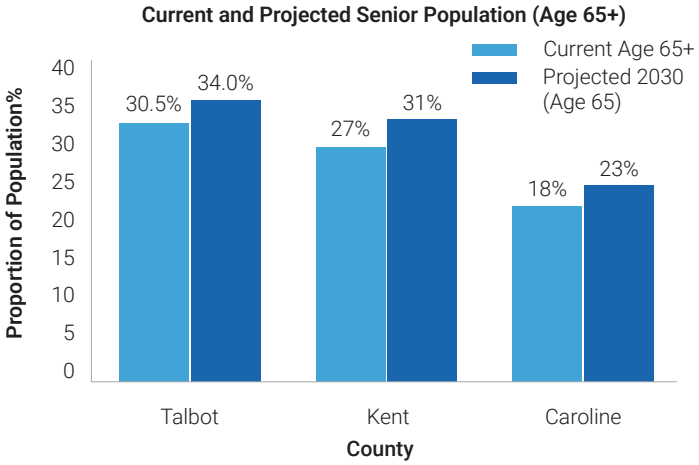
Rivers & Roads Consulting served as Upper Shore Aging's partner in preparing this Needs Assessment. Rivers & Roads is a Maryland-based strategy consulting firm that supports mission-driven organizations and public-sector partners with research synthesis, stakeholder-informed planning, and clear, decision-ready writing. The firm's work sits at the intersection of community development, organizational strategy, and implementation—helping clients translate complex information into actionable direction, stronger partnerships, and fundable priorities. In this engagement, Rivers & Roads' role was to organize the narrative, strengthen cohesion across sections, and ensure the final product reads as one integrated document that can be used confidently by leadership, partners, and funders.

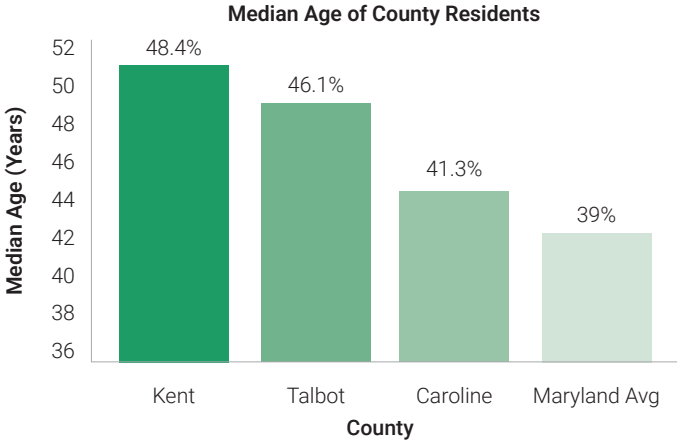
Chris Wheedleton, ***Consultant***
Margaret Knudsen, ***Consultant***

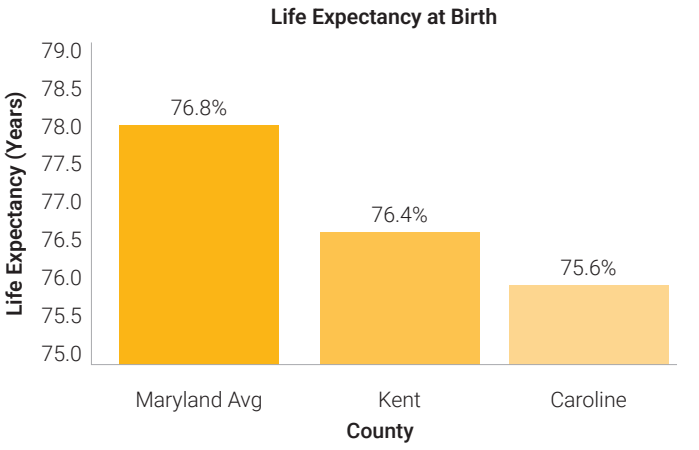
The Aging Trajectory of the Upper Shore

With Upper Shore Aging's service area and role established, the next question is scale: how quickly is the Upper Shore aging, and what does that trajectory mean for the region's ability to support older adults at home? Caroline, Kent, and Talbot Counties—home to more than 31,000 residents aged 60 and older—are at the forefront of Maryland's aging curve. Talbot County now has the highest proportion of seniors in the state, with 30.5% of residents age 65 or older, up from 20.4% in 2010. Kent follows closely at more than 27%, and Caroline—while younger—has climbed to 18% and is on a clear upward path. Median ages reinforce the same pattern: Kent stands at 48.4 years, Talbot at 46.1, and Caroline at 41.3—all significantly above the state average of approximately 39.

These trends reflect both aging in place and in-migration by retirees. Looking ahead, the growth is expected to continue: by 2030, Talbot's 65+ population is projected to reach 34%, Kent's to exceed 31%, and Caroline's to surpass 21%. In practical terms, that translates into a net increase of about 2,800 seniors during the next five years—roughly 350 new older adults each year who may need services such as meals, housing modifications, transportation, and caregiver support.







At the same time, longevity outcomes indicate that aging on the Upper Shore is occurring alongside real health disparities. Caroline and Kent Counties have some of the lowest life expectancy rates in Maryland, with Caroline averaging 75.6 years (2.4 years below the state average) and Kent at 76.4 years. These lower figures underscore the urgency of interventions that improve not only lifespan, but "healthspan"—the number of years older adults can remain healthy and independent—especially in a rural context where systemic barriers to care can compound risk over time.

IMPLICATIONS

The Upper Shore's demographic trajectory is not gradual—it is compounding. With Talbot and Kent already among Maryland's oldest counties and all three counties projected to continue aging through 2030, demand for in-home supports, nutrition, transportation, housing modifications, and caregiver assistance will grow steadily each year. The region's lower life expectancy in Caroline and Kent further suggests that service planning must address both access and prevention, not just volume—strengthening the systems that keep older adults stable at home while reducing avoidable decline.

IMPLICATIONS

Financial Vulnerability:
Poverty and ALICE

As the Upper Shore's older adult population grows, the region's ability to support aging in place will be shaped not only by health needs, but by household economics. Official poverty rates suggest improvement—Caroline's poverty rate declined from 16.5% to 12.9%, and Kent's from 13.1% to 9.5%—but those figures do not capture the number of households living just above the poverty line while still unable to meet basic costs. In the Upper Shore, that "in-between" group is substantial and is often described through the ALICE framework: households that are Asset-Limited, Income-Constrained, and Employed.

Alice Households

County	% of Households Below ALICE Threshold (2021)
Caroline	49%
Kent	46%
Talbot	39%

The 2023 United Way ALICE Report underscores how widespread this vulnerability is across the service area. In 2021, 49% of households in Caroline County were below the ALICE Threshold, compared to 46% in Kent and 39% in Talbot. In practical terms, that means a significant portion of households are routinely forced to make tradeoffs that can accelerate instability for older adults—skipping medications, delaying home repairs, or choosing between groceries and heating. This pressure is often intensified when older adults live alone, lack nearby family support, and rely on community services to remain safe and stable in their homes.

Food Insecurity

Food insecurity is one of the clearest ways financial strain becomes visible—and one of the most consequential for older adults managing chronic conditions. SNAP (Supplemental Nutrition Assistance Program) is a critical lifeline, yet enrollment among eligible older adults remains consistently low. In Maryland, only about 67% of eligible seniors receive benefits, and participation drops further in rural areas. The Upper Shore's high ALICE rates and significant senior poverty indicate that many older adults may qualify for SNAP but are not enrolled, whether due to stigma, lack of awareness, or difficulty navigating the application process (USDA Food and Nutrition Service, Office of Policy Support, 2022).

Local pantry information helps translate "eligibility gaps" into everyday reality. In Talbot County, seniors make up roughly 35% of weekly pantry clients, a strong signal that many older adults who may qualify for SNAP are still relying on emergency food support. That reliance also shows up in service demand: Upper Shore Aging's FY2023 program report notes the Senior Care Nutrition Program provides more than 8,000 congregate meals and more than 40,000 home-delivered meals each year, yet need continues to rise and waiting lists persist as costs increase. County meeting minutes similarly reflect growing concern about seniors' ability to afford groceries as inflation and the expiration of pandemic-era relief funds added pressure.

Across the Upper Shore, a small set of high-capacity providers functions as a critical safety net. In Talbot County, St. Vincent de Paul (SVdP) in Easton distributed more than 845,000 pounds of food in 2022—valued at approximately $1.2 million. The Easton pantry serves more than 700 families per month, supported by volunteers collecting and distributing donations from local grocery stores four times per week.

Kent County's Food Pantry plays a similar stabilizing role through an open-access model, welcoming any resident in need and allowing pantry visits every two weeks—removing referrals and paperwork as barriers at the point of service. In Caroline County, while pantry-level data is limited, countywide indicators show sustained demand: the county averaged 6,636 SNAP participants per month in 2022, and overall food insecurity is estimated at 11.9%.

These local efforts matter most when they are connected to the larger distribution backbone—and to one another. Maryland's Food Bank reported that in FY24 it distributed more than 52 million pounds of food through more than 780 community partner sites. But in rural areas, rising food costs and limited transportation can still leave older adults physically separated from reliable food sources. The most effective response is therefore both practical and coordinated: strengthen partnerships among providers (pantries, churches, county agencies, and aging services), expand mobile options where feasible, and better integrate pantry access with other aging supports so food insecurity is addressed alongside transportation, health, and in-home stability needs.

IMPLICATIONS

Food insecurity on the Upper Shore is not a peripheral issue—it is a core aging-in-place issue. The fact that seniors represent roughly 35% of weekly pantry clients in Talbot County, alongside rising demand and waiting lists for home-delivered and congregate meals, signals that a growing number of older adults are relying on emergency food systems to stay stable at home. When pantries become a routine source of support—as they are through major providers like SVdP in Talbot and open-access models in Kent—access and coordination become as important as supply. For Upper Shore Aging and its partners, the priority is to treat nutrition as an integrated service: aligning meal programs, pantry networks, SNAP outreach, and transportation solutions so that older adults are not forced to navigate multiple disconnected systems to meet a basic need—especially in a rural context where a missed connection can quickly become a health crisis.

IMPLICATIONS

Seniors Living Alone & At Risk of Isolation

Rural life often means physical distance—and for older adults, that physical distance can quickly become social distance. Nationally, about 11% of households are led by someone age 65 or older who lives alone, and in communities like Chestertown, that share rises to about 22%. On Maryland's Upper Shore, the scale is concrete: according to the U.S. Census Bureau's American Community Survey (ACS) 5-year table DP02 (2018–2022), there are 1,085 seniors living alone in Kent County, 874 in Caroline County, and 2,131 in Talbot County—more than 4,000 people in total.

Seniors Living Alone - U.S. Census Bureau

County	Number of Seniors Living Alone
Kent County	1,085
Talbot County	2,131
Caroline County	874

Source: American Community Survey

Living alone does not automatically mean someone is isolated—but it can increase vulnerability, especially when combined with financial strain, limited mobility, and fewer nearby supports. In practice, that vulnerability can show up as missed medical care, malnutrition, depression, cognitive decline, or premature institutionalization. Nationally, about one-third of adults ages 50–80 report feeling lonely "sometimes or often," according to the National Poll on Healthy Aging—essentially unchanged from pre-pandemic levels. In 2023, the U.S. Surgeon General elevated the issue further by declaring loneliness and social disconnection a public health crisis, linking poor social connection with a 29% higher risk of heart disease, a 32% higher risk of stroke, about a 50% higher risk of developing dementia in older adults, and a 26–29% higher risk of premature death—an overall mortality effect comparable to smoking about 15 cigarettes per day.

On the Eastern Shore, those risks intersect with rural realities—long drives, limited public transit, and constrained housing options—that make regular in-person contact and routine care harder to maintain. The regional hospital system underscores the same concerns: University of Maryland Shore Regional Health's 2024–2025 Community Health Needs Assessment cites provider shortages, distance-to-care barriers, and the need for programs that help older adults remain safely at home—conditions that can intensify the consequences of living alone. Local outcomes point in the same direction. Life expectancy in several Upper Shore counties trails the Maryland average, reflecting how chronic disease risk, access challenges, and social determinants—including isolation—accumulate over time. Maryland's State Health Improvement Plan (SHIP, 2024) similarly prioritizes chronic disease and access to care statewide, reinforcing how transportation, distance, and limited service availability interact with aging in place.

Crucially, research distinguishes living alone (an objective household status) from social isolation and loneliness (limited interaction or the subjective feeling of disconnection). It is the isolation that drives the steepest health penalties. CDC analyses using 2022 Behavioral Risk Factor Surveillance System (BRFSS) data link loneliness and poor social/emotional support with worse mental health indicators across multiple states, reinforcing that disconnection is both widespread and clinically meaningful. Coupled with the Surgeon General's advisory, the evidence base is clear: weakened social ties are associated with worse adherence to medical regimens, faster functional decline, earlier nursing-home entry, and shorter lifespans.

Put together, the Eastern Shore picture is stark: thousands of older adults living alone across Kent, Caroline, and Talbot; elevated loneliness at the national level that almost certainly has local parallels; documented physiologic risks from isolation; and rural access barriers that make both connection and care harder. In this context, social isolation is not a byproduct of aging—it is a core risk factor shaping whether older adults get timely preventive care, maintain nutrition and medication routines, preserve cognitive and mental health, and age in place safely.

Why this matters for program design is straightforward: interventions that increase routine social contact (such as friendly-visitor models, transportation to congregate meals, and volunteer "care circle" networks), reduce access friction (including ride vouchers, mobile clinics, and telehealth navigation support), and stabilize housing or utility costs can measurably improve health trajectories—and, as the Surgeon General notes, may reduce risks for cardiovascular events, dementia, and premature mortality.

IMPLICATIONS

In a rural region, isolation is not an abstract quality-of-life concern—it is a measurable health risk with direct consequences for emergency utilization, institutionalization, and the viability of aging in place. With more than 4,000 seniors living alone across the three counties and strong national evidence linking disconnection to higher risks of dementia, cardiovascular disease, and premature mortality, the Upper Shore's aging network will need to treat social connection as core infrastructure—integrating it into nutrition, transportation, housing stability, and care navigation rather than addressing it as a standalone "nice-to-have."

IMPLICATIONS

Disability and Aging
Overlapping Challenges

The risks associated with aging in place are compounded when older adults are also navigating disability—particularly in a rural region where transportation, in-home supports, and accessible housing options can be limited. Disability prevalence rises sharply with age, and the Upper Shore follows national patterns. Across Caroline, Kent, and Talbot counties, an estimated 14.5%–16.8% of the total population lives with a disability, according to the U.S. Census Bureau's American Community Survey (ACS 2022 5-Year Estimates).

Among residents aged 65 and older, disability rates increase significantly—ranging from approximately 34% to 42%, depending on the county. Caroline County's overall disability prevalence is estimated at 14.9%, with disability among residents aged 65+ ranging from roughly 36–39%. Kent County shows the highest overall disability prevalence at 16.8%, with disability among residents aged 65+ ranging from roughly 40–42%. Talbot County's overall disability prevalence is estimated at 14.5%, with disability among residents aged 65+ ranging from roughly 34–37%. These figures are drawn from ACS Table S1810 ("Disability Characteristics").

Disability Prevalence by County

County	% Total Population w/ Disability	% Population 65+ w/ Disability (ACS-Verified Range)
Caroline County	14.9%	~36–39%
Kent County	16.8%	~40–42%
Talbot County	14.5%	~34–37%

Source: U.S. Census Bureau, American Community Survey, 2022 5-Year Estimates, Table S1810 "Disability Characteristics."

IMPLICATIONS

With more than one-third of older adults in each county experiencing disability—and a projected increase to at least 9,000–10,000 seniors living with a disability by 2030—the Upper Shore will face rising demand for coordinated, practical supports that keep people stable at home. This is not a "single-program" challenge; it requires a connected service pathway that links accessible housing and home modifications, transportation options, caregiver supports, and case management so that disability does not become the trigger that forces premature moves into institutional care.

IMPLICATIONS

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Technology Readiness of the Senior Population

As disability and chronic conditions become more common with age, the "front door" to care and support increasingly runs through technology—patient portals, telehealth visits, online benefits enrollment, and even basic communication with providers and family. Yet technology adoption among older adults remains uneven. Nationally, about 75% of adults aged 65–69 use the internet, but usage drops to around 44% among those over 80, reflecting a steep decline in connectivity at the ages when health needs often intensify (Pew Research Center, 2024). Rural seniors face additional barriers beyond age alone, including limited broadband coverage, affordability constraints, and lower digital literacy.

At the county level, overall broadband access appears relatively strong—but the topline numbers can mask senior-specific gaps. According to the U.S. Census Bureau's American Community Survey (2018–2022), about three-quarters of households in Kent, Caroline, and Talbot Counties report having broadband service (ACS Table B28002). However, because older adults are consistently less likely to subscribe than the general population, these countywide household averages almost certainly overstate true connectivity among seniors in the Upper Shore.

Local initiatives reflect both the demand for expanded connectivity and the practical importance of closing the digital divide for older residents. In 2025, the Maryland Department of Housing and Community Development awarded Talbot County more than $1 million to extend broadband to "difficult to serve" properties. Easton Utilities' Easton Velocity project has already connected more than 2,500 rural households and plans to reach 4,400. At the same time, community access points are expanding: the Talbot County Senior Center at Brookletts Place opened a 20-station computer lab funded by a T-Mobile Hometown Grant to provide hands-on training and support, and the Talbot County Free Library lends WiFi hotspots at no cost—helping residents without home service get online for telehealth, email, and benefits enrollment.

For the Upper Shore, the core issue is not simply whether digital tools exist, but whether they are realistically usable for the older adults who most need them. Without training, device access, and ongoing technical support, telehealth, online benefits enrollment, and digital social engagement tools may not reach the seniors they are designed to serve.

A 2025 JAMA Network Open study reinforces this gap nationally, finding that only 65% of older U.S. adults had ever used a patient portal and fewer than half had tried telehealth—evidence that adoption still lags well behind availability.

IMPLICATIONS

Digital access is now a prerequisite for equitable access to healthcare, benefits, and social connection—but the Upper Shore's seniors are not uniformly positioned to participate. With internet use dropping sharply among the oldest adults and countywide broadband averages likely overstating senior connectivity, the region's aging network will need to treat digital literacy, devices, and reliable broadband as enabling infrastructure—especially if telehealth and online enrollment are expected to reduce access barriers in a rural service area.

IMPLICATIONS

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Financial Scams Targeting Seniors

As more services, benefits, and personal communications move online, older adults are increasingly exposed to sophisticated financial scams—often at the exact moment when fixed incomes, cognitive changes, and social isolation can make recovery especially difficult. Financial exploitation is a rapidly growing threat on the Upper Shore and across the country. National research estimates that 5.4% of cognitively intact older adults living in the community experience financial fraud or scams each year (Anderson, Journal of Elder Abuse & Neglect, 2017). More recent federal reporting underscores how costly these incidents have become: the FBI's 2024 Elder Fraud Report estimates older adults lost $3.4 billion in 2023—an 11% increase in a single year—with average losses nearing $34,000 per victim.

Even these alarming figures likely understate the problem. Experts consistently note that financial exploitation is significantly underreported, as many older adults feel stigma, shame, or uncertainty about how—or whether—to report being targeted. On the Upper Shore, that underreporting risk is compounded by the realities of rural life: fewer nearby "second opinions," fewer easily accessible consumer support resources, and fewer informal check-ins that can help catch suspicious activity early.

The tactics themselves continue to evolve, but a familiar theme remains dominant: impersonation. Government-impersonation schemes—especially those claiming to be from the Social Security Administration (SSA) or the Internal Revenue Service (IRS)—remain among the most common. According to the Federal Trade Commission's 2024 fraud data, consumers reported more than $76 million in losses to government-impersonation scams paid in cash in 2023—nearly double the losses reported in 2022 (FTC, 2024). Losses among older adults are rising sharply as well: from 2020 to 2024, the number of adults aged 60+ who lost $10,000 or more to impersonation scams increased more than fourfold, underscoring the growing sophistication and success of these schemes (FTC Data Spotlight, 2025).

Federal agencies continue to warn that these scams are persistent and increasingly convincing. The Social Security Administration's Office of the Inspector General issues frequent scam alerts describing waves of SSA phone impersonation scams, many involving spoofed caller IDs, threats of legal action, or demands for immediate payment (SSA OIG, Scam Alerts, 2024–2025). These alerts emphasize that actual losses and victim counts are significantly higher than reported, because many older adults do not recognize the fraud, feel ashamed, or are unsure how to report it.

Research also helps explain why older adults are targeted and why certain scams succeed. Age-related cognitive changes, slower processing speeds, and social isolation increase susceptibility to common fraud tactics (Chopik et al., 2023, Journal of Gerontology). In rural regions like the Upper Shore, these vulnerabilities are compounded by isolation and limited access to resources, which can make it harder to verify information or quickly seek support.

State-level data shows Maryland is far from immune. In 2024, Marylanders aged 60 and older reported 3,231 incidents of fraud, with total losses exceeding $80 million; the most common scam categories included tech support, government impersonation, romance, and investment scams (Human Cyber Security Knowledge, seniors.hcsk.org). The Maryland Department of Aging reports that in Fiscal Year 2021, Adult Protective Services received 7,116 reports of abuse, neglect, self-neglect, and exploitation of vulnerable adults (MDOA Fact Sheet, 2021).

At the local level, scams surface in Upper Shore counties as well, even if comprehensive public reporting is limited. In March 2024, the Kent County Sheriff's Office issued a scam alert warning residents about fraudulent calls from someone impersonating an officer—an important reminder that rural communities are not spared. Similarly, during a 2023 meeting of Talbot County's Public Accountability Board, law enforcement officials reported noticing an increase in elder fraud and highlighted efforts to expand outreach through senior centers. Yet despite these alerts and acknowledgments, publicly available county-level data on elder financial exploitation in Kent, Caroline, and Talbot remains limited. Agencies such as Adult Protective Services and local Departments of Social Services almost certainly have caseloads that capture the scope more precisely, but statistics are not routinely published—leaving the true scale of the problem in these rural counties largely undocumented.

For the Upper Shore, where the senior population is growing faster than the state average, these trends point to a practical prevention agenda: media literacy training, scam-awareness campaigns, and trusted local channels for reporting and intervention. Without these supports, rural older adults remain disproportionately at risk of losing life savings, dignity, and independence to increasingly sophisticated fraud.

IMPLICATIONS

Fraud prevention on the Upper Shore is not just consumer education—it is a stability strategy for aging in place. With losses climbing nationally, government-impersonation scams accelerating, and Maryland seniors reporting more than $80 million in fraud losses in 2024, even a small number of successful scams can rapidly destabilize an older adult's housing, nutrition, and healthcare access. Given that local data is limited and underreporting is common, the region will benefit from strengthening "trusted pathways" for verification and reporting—using familiar touchpoints like senior centers and aging-service providers—so older adults and caregivers have somewhere to turn before a suspicious call becomes a financial emergency.

IMPLICATIONS

Housing Pressure, Aging Homes, and High Costs

Building on the growing risks highlighted in the prior section, housing instability represents another pathway by which older adults can lose independence—often gradually, and then all at once. Most older adults in the Upper Shore region live in owner-occupied homes, but ownership does not necessarily guarantee stability. Because Caroline, Kent, and Talbot counties have relatively small populations, some detailed Census indicators—such as homeownership rates and housing conditions—are available only at the Public Use Microdata Area (PUMA) level, which groups neighboring counties into a region of at least 100,000 residents to produce more reliable estimates.

Using this regional dataset, the homeownership rate across the Mid-Shore is approximately 73.7%, reflecting that a large majority of older adults are aging in place. However, the quality and affordability of these homes vary widely. Many properties are older, poorly insulated, or physically inaccessible, creating challenges for seniors as they attempt to remain safely at home. Housing costs compound these pressures. In 2023, the median property value in Talbot County was $398,300—significantly higher than national benchmarks—while Kent County's median of $307,100 sits only slightly above national averages. For seniors living on fixed incomes, the burden of property taxes, utilities, maintenance, and critical repairs can quickly become unsustainable, even for those who own their homes outright.

Statewide data from the Maryland Department of Housing and Community Development (DHCD) shows that homeownership is increasingly out of reach for many households. In 2022, only 49% of Maryland households could afford the median-priced home, down from 75% in 2000. For older adults seeking to downsize into more accessible homes, this affordability gap constrains options and limits housing turnover. Affordable senior housing remains limited, and retrofitting homes or moving into accessible rental options often is not feasible for ALICE seniors. Without strategic investment, this housing gap will continue to grow—and with it, the risk of injury, premature institutionalization, or displacement. Needs assessments from broader regional stakeholders, such as UM Shore Regional Health, also point to the importance of integrating home safety upgrades—like addressing lead hazards or architectural accessibility—because these factors critically influence seniors' ability to age in place (including maintaining independence and preventing falls). Expanding direct assistance or partnerships targeting home modifications could greatly reinforce aging-in-place strategies.

These pressures are not limited to homeowners. Housing affordability challenges are affecting residents across Maryland, including the Upper Shore, where rising costs place significant pressure on older adults living on fixed incomes. For every 100 low-income households in Maryland earning below 50% of Area Median Income (AMI), only 56 affordable rental homes are available, placing Maryland among the states with the most severe affordable housing shortages according to the National Low Income Housing Coalition (NLIHC). Nearly 30% of renters statewide spend more than half their income on housing, a level defined as "severely cost burdened" and well above the national average. The National Low Income Housing Coalition reports that 74% of Maryland's low-income families face this level of housing cost burden, forcing trade-offs between housing and essentials such as healthcare, food, and transportation, according to a white paper commissioned by Fello Communities (formerly Chesapeake Neighbors).

The DHCD Housing Report 2025 notes that the Upper Eastern Shore has a shortage of 153 affordable and available homes for every 1,000 extremely low-income renter households (0–30% AMI). Among low-income senior renters statewide, 55% are cost-burdened, compared to just 12% of senior homeowners. This gap underscores the acute need for affordable senior rental units—Maryland has roughly 31,000 subsidized senior homes, serving a population of more than 62,000 extremely low-income senior renters. The crisis is especially acute in Talbot County, which has experienced the highest rent growth in Maryland. According to CoStar Group data cited in the Fello white paper, rents in Talbot County have increased by 45% since 2019—more than double the rate of any other county in the state. This rapid escalation places long-term residents—particularly seniors—at risk of displacement and makes it more difficult for essential workers and caregivers to live near the populations they serve.

High rental costs and housing instability also create ripple effects throughout the community. Families relocating in search of lower rents may face disruptions to employment, longer commutes, and instability in children's education. For older adults, these pressures can undermine the ability to age in place, increase social isolation, and accelerate moves into institutional settings when affordable, accessible housing is unavailable.

At the same time, the region's aging housing stock creates significant safety and repair needs—particularly for low-income homeowners. Rebuilding Together Eastern Shore (RTES) addresses critical housing repair and accessibility needs for low-income homeowners, many of whom are older adults seeking to age in place. The Housing Assistance Council has identified approximately 2,000 inadequate housing units in the region, with a concentration in Kent County. Maryland Poverty Profiles show that Kent County's deep poverty rank rose from 12th to 8th between 2016 and 2020. To evaluate and prioritize repairs, RTES uses a 25-point home safety checklist adapted from U.S. Department of Housing and Urban Development (HUD) guidelines. Typical repairs focus on health and safety concerns such as roofing, plumbing, electrical hazards, accessibility modifications, and energy efficiency, with an emphasis on preventative maintenance to help homeowners avoid more costly structural problems later on.

Regional studies further illustrate the scale of the challenge. The 2022 Eastern Shore Regional Housing Study found that more than half of the area's housing stock was built before 1979, with a predominance of single-family and mobile homes that require significant upkeep. At the same time, many households—especially low-income and senior households—face high housing cost burdens, which limit their ability to invest in maintenance and accessibility improvements. RTES is currently partnering with Washington College to conduct a housing condition survey in Kent County; when complete, this study will provide localized data to better quantify senior housing repair and accessibility needs, complementing regional findings and strengthening the case for expanded home modification and repair programs.

IMPLICATIONS

Housing instability on the Upper Shore is not just a "housing" issue—it is a direct driver of preventable health decline and premature loss of independence. With a large share of older adults aging in place in homes that may be inaccessible or in disrepair, even modest cost pressures (taxes, utilities, repairs) can push fixed-income seniors into unsafe conditions, crisis-driven moves, or institutional settings. For Upper Shore Aging and regional partners, the data suggests a clear need to treat home safety modifications, repair access, and affordable senior rental options as core "aging-in-place infrastructure"—supported by stronger cross-sector coordination and localized condition data (such as the Kent County housing survey now underway).

IMPLICATIONS

Transportation

Housing stability and home conditions are only part of what makes aging in place possible. Even when an older adult has a safe home, they still need a reliable way to reach medical care, groceries, pharmacies, congregate meals, and social supports—many of which are not close by on the Upper Shore.

Caroline, Kent, and Talbot counties are deeply rural, and for seniors who no longer drive, everyday errands can become a significant logistical challenge. Recent Census data show that average commute times range from about 25.8 minutes in Talbot County to 27.0 minutes in Kent County and more than 31 minutes in Caroline County, underscoring the long distances residents must travel for daily needs (U.S. Census Bureau, American Community Survey 2022 5-Year Estimates, Table DP03: Selected Economic Characteristics). Paratransit availability is inconsistent and often limited to weekday hours or certain geographies.

Average Commute Times

County	Average Commute Times
Talbot County	25.8 Minutes
Kent County	27 Minutes
Caroline County	31 Minutes

Source: U.S. Census Bureau

The result is often missed medical appointments, skipped social outings, and growing dependence on neighbors, family, or overburdened nonprofits. Seniors without support networks are at particular risk of slipping through the cracks. As the senior population expands, creative transportation solutions—such as volunteer driver networks, regional mobility hubs, or rideshare subsidies—will be essential to close gaps and prevent avoidable health and safety consequences tied to immobility.

Delmarva Community Transit (DCT) plays a vital role in addressing transportation barriers for seniors and residents without reliable private vehicles across Dorchester County and the Upper Shore. In 2023, the system provided more than 81,000 passenger trips, with approximately 38% delivered through demand response services—an option that is particularly important for older adults with mobility limitations or those living far from fixed bus routes. With a relatively small fleet of 22 vehicles in maximum service, DCT covered more than 437,000 annual revenue miles and nearly 19,500 revenue hours.

DCT's data also underscores why demand response services matter in rural geographies: demand response demonstrates higher passengers-per-hour efficiency (7.2) than fixed-route bus service (3.4), reflecting its ability to meet individualized travel needs such as medical appointments, grocery shopping, and social activities. At the same time, fixed-route service faces sustainability challenges in rural contexts, with just 0.1 passengers per mile—suggesting that traditional bus models may struggle to achieve efficiency at the scale and density needed on the Upper Shore. This data supports the need to explore expanded on-demand, flexible, senior-focused transport solutions, along with broader coordination with regional transit partners to close service gaps.

IMPLICATIONS

Transportation is a “force multiplier” for nearly every issue in this needs assessment—nutrition access, health outcomes, housing stability, and social connection. When transportation is unreliable, seniors are more likely to delay care, miss preventive services, withdraw from community life, and lean more heavily on already-stretched informal and nonprofit supports. Strengthening and coordinating the region’s transportation options—especially demand response and other flexible models—will be essential to helping more older adults remain safely at home rather than entering higher-cost institutional settings.

IMPLICATIONS

Cultural and Language Shifts

As mobility supports expand, the region's changing demographics also matter—services must be accessible and trusted across cultural and language differences, especially for older adults who may be hesitant to seek help or face communication barriers.

Within the Upper Shore region—defined here as Kent, Caroline, and Talbot Counties—the majority of older adults are currently white and English-speaking, but the region's demographics are shifting. Approximately 6–7% of residents across the three counties identify as Hispanic or Latino, with county-level shares generally ranging from the mid-5% range in Kent and Caroline Counties to higher levels in Talbot County (U.S. Census Bureau, ACS 2022 5-Year Estimates, Table DP05: ACS Demographic and Housing Estimates). Across the region, about 5% of households report speaking Spanish at home (ACS 2022 5-Year Estimates, Table S1601: Language Spoken at Home).

The proportion of foreign-born residents also varies by county, ranging from approximately 4.4% in Kent County to about 8–9% in Talbot County, with many residents originating from Central America and the Caribbean (ACS 2022 5-Year Estimates, Table DP02: Selected Social Characteristics). As these populations age, the number of Latino and immigrant seniors in the Upper Shore is expected to grow.

Percent of Population Foreign-Born

County	% of Population Foreign-Born
Kent County	4.4%
Caroline County	6.8%
Talbot County	8.5%

Source: U.S. Census Bureau's American Community Survey

This shift elevates the importance of building service pathways that feel approachable and trustworthy across cultures—particularly for residents who may be hesitant to engage with government systems. Practical steps such as bilingual outreach staff, translated materials, and intentional relationship-building with multicultural communities are not "add-ons"; they are core capacity for a region where demographic change is already underway.

IMPLICATIONS

As the Upper Shore's cultural and linguistic makeup evolves, the effectiveness of aging services will increasingly depend on language access and trust—not just program availability. With a measurable and growing Latino and foreign-born presence across the three counties, Upper Shore Aging and its partners will be better positioned if culturally and linguistically competent engagement is built into everyday operations (outreach, intake, referrals, and caregiver communication), rather than treated as an occasional accommodation.

IMPLICATIONS

The Sandwich Generation on Maryland's Upper Shore (and Statewide)

Following the transportation and access challenges described above, it is important to recognize how much of the region's aging-in-place "infrastructure" is carried informally—by family members who are trying to support older parents while also caring for children. Across the Upper Shore, more households are managing both responsibilities at the same time, and the combined load strains time, savings, and health—especially in rural places with fewer services and longer travel times.

Statewide and national data help clarify why this pressure is becoming more common. According to Pew Research Center, Americans in their 40s are the most likely to be "sandwiched," and 54% have a parent age 65 or older while also raising a minor child or financially supporting an adult child (Pew Research Center, 2022). At the same time, unpaid family caregiving has grown to 53 million adults, with nearly one in four caregivers providing more than 40 hours per week. This workload mirrors full-time employment and increasingly includes caregivers who are raising children at the same time (AARP/NAC, 2020; AARP Maryland summary, 2025).

For rural caregivers, the challenge is intensified by the same structural barriers that show up throughout this needs assessment. Rural caregivers experience heightened anxiety, social loneliness, and access barriers because health and social services are sparse and transportation gaps are common—factors that map directly onto the Upper Shore's geography (L'Heureux et al., 2022; National Rural Health Association, 2020).

Maryland's aging network recognizes how central family and informal caregivers are to keeping older adults at home. The Maryland Family Caregiver Support Program—delivered through local Area Agencies on Aging—exists to stabilize these households with respite, information, and resource navigation (Maryland Department of Aging, n.d.). The state has also elevated coordination through the Maryland Commission on Caregiving, which calls for shared data, clearer respite pathways, and a model caregiver program to align local and state supports (Maryland Commission on Caregiving Annual Report, 2023). These policy directions reflect what Upper Shore caregivers report in community meetings: when the same household is responsible for children and an aging parent, even small disruptions—such as lost Medicaid coverage after redetermination, a waitlist for in-home help, or a lack of broadband for telehealth—can cascade into missed work, debt, and accelerated institutionalization (Georgetown Center for Children and Families, 2025; AARP/NAC, 2020).

Demographic shifts suggest this is not a temporary condition. According to the Maryland Department of Planning's ACS analysis, Maryland's household mix is changing as the population ages, with many jurisdictions seeing shifts in family composition, income, and caregiving needs (Maryland Department of Planning, 2024). On the Upper Shore, that tilt intersects with rural constraints such as distance to services, limited transit, and uneven digital access—so families are often forced to shoulder more coordination themselves (NRHA, 2020; L'Heureux et al., 2022). In practice, this means the "sandwich" is less a metaphor than a schedule: school pickups and homework on one end, medication management, meals, and medical visits on the other—often performed by the same adult, on the same day, with little backup (AARP/NAC, 2020; AARP Maryland, 2025).

What this implies for local strategy is straightforward. Strengthening Maryland's existing caregiver infrastructure on the Shore—including Maryland Access Point "front doors," caregiver respite, evidence-based self-management programs, and strong referral loops with DSS and LMBs—will help these households stay intact. Pew's findings suggest the share of middle-aged adults navigating dual responsibilities is already high and likely to grow as older Marylanders live longer and adult children remain financially tethered to parents (Pew Research Center, 2022). Aligning county programs around one coordinated entry, transportation solutions, and broadband-supported care can convert state policy intent into day-to-day relief for sandwiched families on the Upper Shore (Maryland Department of Aging, n.d.; Maryland Commission on Caregiving, 2023).

IMPLICATIONS

The Upper Shore's ability to help seniors remain safely at home is tightly linked to the stability of caregiver households. When caregivers are balancing children and older parents—often while navigating long distances, limited transit, and uneven digital access—small system breakdowns (coverage disruptions, waitlists, and telehealth barriers) can quickly become household crises with real economic and health consequences. Strengthening respite and navigation supports through Maryland's existing caregiver infrastructure—and tightening referral pathways and coordinated entry—reduces the likelihood that burnout and logistical overload become the tipping point that forces premature institutionalization.

IMPLICATIONS

Medicaid-Accepting Nursing Homes:
Limited Availability for Upper Shore Seniors

As caregiving demands intensify across the Upper Shore, many families eventually reach a point where care at home is no longer sufficient. At that stage, access to long-term care becomes a pivotal (and time-sensitive) issue—especially for older adults in Caroline, Kent, and Talbot counties who live on fixed incomes and rely on Medicaid to cover nursing home costs. Medicaid enrollment itself is significant in the region: in 2023, about 22.7% of Caroline County residents, 18.5% of Kent County residents, and 16.8% of Talbot County residents were enrolled in Medicaid, reflecting the program's role as a primary safety net in rural communities (Georgetown University Center for Children & Families, 2023). Many of these enrollees are older adults who depend on Medicaid for services that Medicare does not cover, particularly long-term care.

Percent of Residents Enrolled in Medicaid (2023)

County	Percent Medicaid Enrollment
Caroline	22.7%
Kent	18.5%
Talbot	16.8%

Source: Georgetown University Center for Children & Families

The supply of Medicaid-accepting nursing facilities, however, is extremely limited. Across Upper Shore Aging's service area, there are only seven Medicaid-accepting nursing homes, with a combined capacity of fewer than 700 beds. Caroline County has just two facilities with about 187 total beds; Kent County has three facilities totaling roughly 228 beds; and Talbot County has two facilities providing about 285 beds. According to SeniorGuidance, citing a Medicare report, Kent County's facilities include University of Maryland Shore Nursing & Rehabilitation (98 beds), Chestertown Nursing & Rehab (92 beds), and Heron Point of Chestertown (38 beds), all of which accept Medicaid. Most of these facilities serve both Medicaid and Medicare residents and typically operate at or near full capacity, creating long waiting lists and very few immediate openings.

Medicaid-Accepting Nursing Homes and Bed Counts

County	Number of Medicaid-Accepting Nursing Homes (# of Beds)	Approximate Total Capacity
Caroline County	2 facilities (100 + 87 beds)	~187
Kent County	3 facilities (98 + 38 + 92 beds)	~228
Talbot County	2 facilities (90 + 195 beds)	~285

Source: SeniorGuidance

When local Medicaid beds are unavailable, the consequences extend beyond inconvenience. The shortage can disrupt continuity of care and separate seniors from family, friends, and familiar support networks when they must relocate outside the county for placement. This strain is also visible in community-based programs that help delay or prevent nursing home placement. In Talbot County, the Senior Care Program—operated through Adult Evaluation and Review Services (AERS)—served 207 low-income seniors in FY2024 but still carried a waitlist of 31 individuals who qualified but could not be served due to limited funding (Talbot County Government, 2024). The existence of waitlists for community-based supports underscores how Medicaid demand already exceeds available resources.

Together, the data reveal a systemic bottleneck: Medicaid is heavily relied upon by older residents of the Upper Shore, yet the number of Medicaid-accepting nursing home beds and the capacity of community-based programs fall short of need. Without expanded long-term care capacity or enhanced Medicaid-covered home- and community-based service alternatives, the gap between demand and available resources will continue to widen as the region's senior population grows—leaving some of the most vulnerable older adults without timely, local options for care.

IMPLICATIONS

Limited Medicaid-accepting nursing home capacity—paired with waitlists in programs designed to keep low-income seniors stable at home—creates a compounding risk for Upper Shore families: when needs escalate, there may be no timely "next step" available locally. For Upper Shore Aging and its partners, this reinforces the urgency of strengthening diversion pathways (in-home supports, case management, caregiver assistance, and benefits navigation) while also improving care-transition coordination with hospitals, discharge planners, and long-term care providers—so that seniors are less likely to face avoidable placement crises or be pushed out of their home county when care needs intensify.

IMPLICATIONS

Uncertain Federal Policy Shifts

Medicaid and Medicare in Transition

After reviewing the limited availability of Medicaid-accepting long-term care options on the Upper Shore, it is important to name a growing external pressure that will shape nearly every local strategy discussed in this report: rapid policy change at the federal level. Sweeping shifts to Medicaid and Medicare are reshaping the national landscape and creating a highly uncertain operating environment for states and local communities.

The most immediate disruption stems from the end of the COVID-19 Public Health Emergency (PHE). During the emergency period, states were required to maintain continuous Medicaid enrollment; now, with redeterminations underway, eligibility is being reassessed for every enrollee. Nationally, millions have already lost coverage—often not because they are ineligible, but because of administrative hurdles such as paperwork errors or missed deadlines (National Health Law Program, 2023). For rural regions like Maryland's Eastern Shore, where many older adults and low-income families rely on Medicaid for long-term care, these coverage disruptions introduce new risks of gaps in care and rising uncompensated costs for local providers.

Beyond the unwinding of PHE-era protections, new federal legislation adds additional volatility. The 2025 budget reconciliation package—known as the "One Big Beautiful Bill Act" (OBBBA)—introduces significant structural changes. According to the Georgetown Center for Children and Families, the law reduces federal Medicaid payments to states by hundreds of billions of dollars over the next decade (Georgetown Center for Children and Families, 2025). It also mandates more frequent eligibility checks, which historically increase churn and coverage losses, particularly among seniors with complex documentation requirements (Center for Medicare Advocacy, 2025). In addition, OBBBA restricts states' reliance on provider taxes, a common financing mechanism used to generate matching funds for Medicaid. Although a federal court struck down CMS's attempt to broaden these restrictions beyond its statutory authority, the ruling leaves the policy environment unsettled and states unsure how far financing flexibility will ultimately extend (Reuters, 2025).

On the Medicare side, OBBBA projects automatic cuts totaling roughly $500 billion across eight years beginning in 2026 (Kiplinger, 2025). Certain eligibility definitions have been narrowed, excluding some non-citizen groups, while debates continue about the future of telehealth coverage, prescription drug reimbursement, and home- and community-based services. Uncertainty is already visible in how care is delivered: temporary PHE-era expansions in telehealth and related flexibilities are being scaled back or reinterpreted (Time, 2023). For rural seniors—where digital access is already uneven—these shifts could reduce options for affordable, accessible care.

For the Eastern Shore of Maryland, the implications are particularly acute. Medicaid redeterminations may result in thousands of residents in Kent, Caroline, and Talbot Counties losing coverage even if they remain technically eligible, due to paperwork challenges and limited local assistance. Federal funding cuts are likely to intensify long-term care pressures by threatening reimbursement rates for nursing homes and home- and community-based providers that already operate at or near capacity—further constraining the limited number of Medicaid-accepting nursing home beds in the region. Restrictions on provider financing could weaken Maryland's ability to leverage provider taxes, destabilizing budgets in rural areas where margins are already slim. Beginning in 2026, Medicare cuts may ripple through Eastern Shore hospitals, clinics, and physician practices that serve disproportionately older populations, potentially leading to service cutbacks or consolidation. At the same time, uncertainty over telehealth coverage could roll back a critical access point for rural seniors—especially those with limited transportation—while ongoing broadband and digital literacy gaps compound inequities.

Taken together, these statutory and regulatory changes create a volatile policy environment where forecasting the future of Medicaid and Medicare is exceptionally difficult. For state and county leaders on the Eastern Shore, even modest adjustments to coverage, financing, or reimbursement can reverberate through already fragile local service networks. Strategic planning must therefore account for multiple scenarios—ranging from deep Medicaid cuts and narrower Medicare coverage to partial preservation of pandemic-era flexibilities—while simultaneously building local resilience through service integration, cross-county collaboration, and diversified funding streams.

IMPLICATIONS

For Upper Shore Aging and its partners, “aging in place” strategies are becoming more time-sensitive—and more financially consequential. As eligibility churn increases and reimbursement uncertainty grows, older adults who are already on the margin are more likely to experience interruptions in coverage, delays in care, or forced transitions into higher-cost settings. In a region where provider capacity is already constrained, the practical takeaway is clear: the Upper Shore will need stronger benefits navigation, tighter coordination among service providers, and contingency planning that assumes policy instability—so seniors do not bear the cost of federal uncertainty through preventable crises at the local level.

IMPLICATIONS

Turning Statutory Mandates into Practice

Lessons from the MAC Center

Across Kent, Caroline, and Talbot Counties, silos of services, information, and data collection have been repeatedly identified in both research and community listening sessions. Residents and providers describe a fragmented system where aging services, social supports, and family programs operate in parallel rather than in coordination, creating confusion for those seeking help and inefficiencies for agencies tasked with providing it.

This fragmentation stands in contrast to the responsibilities clearly outlined in Maryland law. Under HB 36 (2025), each Area Agency on Aging must "operate a single point of entry program to assess the needs of older adults and their caregivers and provide appropriate services," including information and referral, needs assessment, and service linkage (HB 36, Ch. 33, 2025). Local Departments of Social Services are likewise charged to "administer social service and public assistance activities" in each county (§ 3-302, Human Services Article), with county DSS boards directed to advise directors, review evaluations, and advocate for program improvements (§ 3-503). In addition, every county must maintain a Local Management Board (LMB) (§ 8-301), which is required to "strengthen decision-making at the local level," design and implement coordinated strategies aligned with a five-year local plan, and maintain standards of accountability for agreed results for children, youth, and families (§ 8-303).

Yet despite these statutory charges, service delivery in the Upper Shore remains fragmented. Information is collected separately by each entity, databases are rarely interoperable, and community members often must complete duplicative intake processes to access programs. In recent community meetings, participants described the difficulty of navigating multiple entry points, with little clarity about which agency could provide comprehensive assistance. There are risks when natural silos occur across multiple agencies working on vital services and challenges facing seniors like those listed in this report—risks that can leave gaps for older adults on fixed incomes, families under economic stress, and those facing barriers such as limited transportation or digital access.

In community meetings across the Upper Shore, participants often cited the MAC Center in Salisbury as an example of how an Area Agency on Aging can operate as both a service provider and a regional convener. MAC, Inc., founded in 1972 and serving as the Area Agency on Aging for four Lower Shore counties, has developed a comprehensive hub that integrates nutrition programs, wellness and self-management education, caregiver support, care transitions, legal services, and information and referral into a single, accessible entry point. Its Living Well Center of Excellence, funded by the Administration for Community Living and recognized by the Maryland Department of Aging, trains providers statewide to deliver evidence-based programs such as chronic disease and falls prevention workshops, provides technical assistance and licensing, and manages data to ensure consistency and measurable outcomes.

What distinguishes the MAC model is not only its breadth of services, but also its alignment with state and federal expectations for integration, collaboration, and data-driven decision-making. The center's Maryland Access Point (MAP) function offers a clear and consistent "no wrong door" experience for older adults and caregivers, linking participants quickly to the right mix of programs.

While this level of coordination is notable, it is important to recognize that Upper Shore Aging already operates excellent MAP programs in Kent and Caroline Counties, where staff are deeply trusted for their responsiveness and one-on-one support. Efforts are currently underway to strengthen and expand MAP services in Talbot County, ensuring consistent access to high-quality navigation services across the region.

The Senior Care program structure also varies across counties, reflecting the flexibility of Maryland's aging network and Upper Shore Aging's ability to adapt. In Caroline and Kent Counties, Senior Care services are provided directly by Upper Shore Aging, allowing for direct case management and close coordination with in-home and community supports. In Talbot County, services are delivered through the Health Department using funds administered by Upper Shore Aging, a model that leverages existing infrastructure while maintaining program oversight and accountability.

In this context, MAC serves as a complementary model—not a replacement—for the Upper Shore's existing strengths. It demonstrates how an Area Agency on Aging can integrate evidence-based wellness programs, data systems, and regional partnerships under one umbrella to improve efficiency and reach. Replicating elements of MAC's structure—such as its unified service hub, cross-county partnerships, and emphasis on evaluation—could help Upper Shore Aging build on its current foundation. The goal is not to duplicate MAC's framework, but to adapt its best practices to the Upper Shore's unique geography, community networks, and proven record of personalized service.

IMPLICATIONS

The Upper Shore's service fragmentation is not simply a "coordination challenge"—it is a practical barrier that can force older adults and caregivers to navigate multiple entry points, repeat intake steps, and fall through gaps created by non-interoperable systems. The MAC Center offers a concrete, Maryland-based example of what "single point of entry" and a "no wrong door" experience can look like in practice, including stronger integration of services and more consistent data practices that support measurable outcomes. For Upper Shore Aging, the opportunity is to build on its already-strong MAP presence in Kent and Caroline while accelerating consistent navigation capacity in Talbot—and to use the needs assessment findings to strengthen cross-county alignment, reduce duplicative pathways, and improve how information is shared across the regional aging network.

IMPLICATIONS

Strategic Implications for Upper Shore Aging

This needs assessment signals a shifting operating environment for Upper Shore Aging (USAInc.) as the Area Agency on Aging serving more than 31,000 seniors across Caroline, Kent, and Talbot counties. Across the report, the same message surfaces repeatedly: aging in place is increasingly determined by whether a connected set of enabling conditions exists—stable household finances, safe housing, reliable transportation, accessible food and care, caregiver capacity, and the ability to navigate (and trust) complex systems.

The implications below are meant to be strategic—recapping what the assessment suggests USA will be asked to "carry" in the next several years, and offering a set of practical directions to consider as the organization prioritizes, partners, and plans.

01

Plan for compounding demand—and design for scalability, not just service delivery.

The Upper Shore's senior population is growing in ways that will steadily increase demand for nearly every service domain covered in this report. That growth will not be evenly distributed across needs; it will concentrate in higher-acuity cohorts (older seniors, seniors living alone, and seniors living with disabilities), where support requirements tend to be more intensive and time-sensitive.

Strategically, this argues for an operating posture that treats USAInc. as both a direct service provider and a capacity-builder for the broader aging network. A core question becomes: "What can USA standardize, streamline, or systematize so the region can absorb more demand without simply adding more strain?" This can include repeatable intake and triage tools, consistent cross-county navigation protocols, and clear referral pathways that reduce handoffs and duplication.

02

Treat "aging in place" as infrastructure—and align programs around the few constraints that drive most crises.

Across sections—housing, transportation, nutrition, disability, isolation—the report shows that the most serious breakdowns often happen when two or three constraints stack at once (for example: limited transportation plus a disability plus living alone). That suggests a strategic shift from viewing services as separate program lines to organizing around a small set of "system stabilizers" that keep seniors safe at home: reliable access to food and medical care, safe and functional housing, consistent transportation, and effective navigation/case coordination. The implication is not that USA should do everything directly, but that USA may be most impactful when it deliberately strengthens the connective tissue among these stabilizers—so a transportation barrier doesn't become a nutrition crisis, and a housing issue doesn't become a hospital discharge failure.

03

Make navigation the front door—and deepen "no wrong door" coordination across the three counties.

The report's MAC Center section reinforces a central lesson: even strong programs can underperform if the pathway between them is hard to access or confusing. In the Upper Shore context, where services vary by county and providers are dispersed, navigation capacity becomes one of the most strategic assets USA can invest in—especially through Maryland Access Point (MAP) and related coordinated-entry functions.

A strategic implication is to treat MAP not only as a helpful service, but as the organizing "front door" for the region's aging network: a consistent intake experience, shared triage logic, warm handoffs, and clearer cross-county pathways (including when programs are administered differently across counties). The operational goal is reduced fragmentation—fewer repeated stories, fewer missed referrals, fewer delays that convert manageable needs into crises.

04

Financial fragility is not a "poverty-only" issue—USA's strategy must account for ALICE households and near-poor instability.

The financial vulnerability section shows why a narrow focus on "poverty threshold" will miss a meaningful share of older adults who are still financially unstable (including seniors who may not qualify for certain supports, but routinely have to choose among housing, utilities, food, and transportation).

Strategically, this means USA's role as an advocate and stabilizer may need to expand its toolkit for "financial shock absorption": benefits navigation, budgeting and application support, emergency assistance partnerships, and—critically—service models that reduce friction and costs (for example, bundling transportation with nutrition access, or aligning outreach with benefit enrollment cycles). This also reinforces why partnerships with agencies that touch energy assistance, SNAP enrollment, and public benefits administration matter as much as traditional "aging services" partners.

05

Food access is a health strategy—and food insecurity will increasingly show up through rural barriers, not just income.

The report underscores both need and scale: older adults face gaps that are driven by income and rural access constraints, and the regional food-support ecosystem spans pantries, SNAP reliance, and large-scale distribution networks. In rural counties, "food availability" can still translate into "food inaccessibility" if transportation and mobility are unreliable.

Strategically, this points toward deeper integration: positioning food access as part of care coordination (screening, referral, follow-up), and considering how USAInc. can help align food supports with transportation and in-home service networks so that seniors are not simply told where help exists, but can realistically reach it. In practice, the strategy is less about adding a new program and more about reducing failure points between programs that already exist.

06

Social connection should be treated as core infrastructure—because it drives health risk, service utilization, and aging-in-place stability.

The isolation section makes a direct case that social disconnection is not a "soft" issue; it is a measurable risk factor with downstream consequences (emergency utilization, earlier institutionalization, and weakened adherence to basic health routines). The report also notes the scale of seniors living alone across the three counties.

Strategically, USAInc. may want to elevate social connection from an important program outcome to a cross-cutting design principle: embedding routine social contact into nutrition, transportation, and case management pathways (rather than isolating it as a standalone service domain). This also opens a larger strategy question: where can volunteer engagement, faith community partnerships, and "light-touch" check-in models safely expand reach without overextending staff capacity?

07

Disability overlap will increase complexity—and USA's strategy should prioritize integrated pathways that prevent "predictable" institutionalization.

The disability section is one of the clearest signals in the report: a large share of older adults in each county experiences disability, and the region should plan for growth in the number of seniors living with disability. The report explicitly frames this as not a single-program challenge, but a need for connected pathways across housing, transportation, caregiver support, and case management.

Strategically, this suggests USA should continue strengthening (and possibly formalizing) integrated "stability pathways" for seniors with disabilities—pathways that are designed to keep manageable limitations from becoming the trigger for institutional placement. This may include stronger home-modification referral loops, more deliberate transportation alignment, and case coordination that anticipates predictable escalation points (post-hospital discharge, caregiver burnout, loss of mobility, or benefit disruptions).

08

Digital readiness is now an access requirement—and the strategy should pair digital inclusion with consumer protection.

The technology readiness section frames technology as the "front door" to healthcare, benefits, and even basic communication—while also showing uneven adoption among older adults and likely senior-specific gaps that are masked by countywide broadband averages. The implication in the report is straightforward: without training, device access, and ongoing support, digital tools will not reach the seniors who most need them.

At the same time, the scams section reinforces that increased online participation also increases exposure risk, particularly for older adults navigating new platforms or financial transactions. Strategically, this supports an integrated approach: digital inclusion efforts that also build confidence and safety—trusted help desks, hands-on navigation support for portals and telehealth, and scam-prevention education embedded in regular touchpoints (rather than as a one-time workshop).

09

Caregiver capacity is a system constraint—and supporting the "sandwich generation" may be one of the most effective ways to keep seniors at home.

The sandwich generation section ties together the report's major themes: family caregivers increasingly carry the daily work of aging in place, and rural barriers (distance, limited transit, uneven digital access) intensify the load.

The report's implications emphasize that small system breakdowns can quickly become household crises, accelerating institutionalization.

Strategically, this means caregiver support should be viewed as a high-leverage investment, not an auxiliary service. Strengthening respite pathways, simplifying navigation for caregivers, and tightening referral loops can function as a "pressure release valve" for the entire aging network.

10

Long-term care bottlenecks and federal policy volatility require scenario planning—not just program planning.

The Medicaid-accepting nursing home section describes limited local availability and the compounding risk created when waitlists exist alongside constrained placement options. The federal policy section then raises a broader strategic risk: Medicaid/Medicare volatility, eligibility churn, and funding uncertainty, with particular consequences for rural systems that operate close to capacity.

Strategically, this suggests USA should treat policy uncertainty as an operational reality: building contingency plans for benefit disruptions, anticipating increased need for enrollment/redetermination support, and strengthening partnerships with hospitals and discharge planners so seniors do not face avoidable placement crises when options are scarce. It also supports a broader diversification mindset—expanding non-federal funding partnerships and strengthening local coordination so that the regional aging network is less fragile when external policy shifts occur.

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