

-Draft-
South Carolina
Lieutenant Governor's Office on Aging

STATE PLAN ON AGING



FFY 2013 – 2017

South Carolina State Plan on Aging 2013 -2017

The Honorable Glenn F. McConnell
Lieutenant Governor of South Carolina
State Constitutional Officer responsible for the
State Office on Aging

Mr. Tony Kester, Director
Lieutenant Governor's Office on Aging

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Table of Contents

Chapter 1: Introduction & Executive Summary

Letter to Constantinos I. Miskis
State Plan Assurances
Verification of Intent
Executive Summary

Chapter 2: Overview of South Carolina Aging Network

A. LGOA Mission, Vision and Values
B. Lieutenant Governor
C. Director of the Office on Aging (LGOA)
D. State Unit on Aging (Lieutenant Governor's Office on Aging)
E. Designation of Planning and Service Areas Overview (PSAs)
F. South Carolina Advisory Council on Aging
G. Advocates in the SC Aging Network
H. Aging Trends in SC
I. Funding Sources
J. Programs and Services

Chapter 3: State Data and Demographics

Chapter 4: Overview of the 2013 – 2017 State Plan

A. Improving Programs and Services
B. Modernization of Aging Services in South Carolina
C. Long Term Care Reform and Community Living Incentives
D. Senior Transportation
E. Geriatric Trained Professional Workforce
F. Evidenced-Based Research
G. Emergency Preparedness
H. Elder Rights
I. Volunteer and Employment Opportunities
J. Community Living Program (CLP) and Veteran Directed Home and Community Based Services (VDHCBS).
K. Affordable Care Act and Health Concerns
L. Education and Training
M. Resource Allocation
N. Coordination of the Title III with Title VI of the Older American's Act

Goals and Objectives

Appendix A – State Plan Assurances, Required Activities and Information
Appendix B – Intrastate Funding Formula
Appendix C – Issues, Outcomes and Strategies
Appendix D – Area Agency on Aging Listing
Appendix E – Acronyms/Abbreviations
Appendix F – Governor's Signature Explanation



State of South Carolina
Office of The Lieutenant Governor

Glenn F. McConnell
Lieutenant Governor

Office on Aging
Tony Kester
Director

July 1, 2012

Mr. Constantinos I. Miskis
Regional Administrator
U.S. Administration on Aging Region IV, DHHR
Atlanta Federal Center
71 Forsyth Street, SW, Suite 5M69
Atlanta, Georgia 30303-8099

Dear Mr. Miskis:

The State Plan on Aging is hereby submitted for the State of South Carolina for the period of October 1, 2012, through September 30, 2017.

The enclosed plan describes the values, resources, goals and strategies designed to achieve the State of South Carolina's objectives in providing services that allow our state's elderly citizens to remain active, healthy and independently at their homes for as long as possible. Included are required assurances and a description of programs and services under the provisions of the Older American's Act of 1965, as Amended.

As a State Unit, we are very pleased with the progress that has been made in providing elderly South Carolinians a wide array of services over the years. However, with this State Plan, it is our intent to continue our concerted efforts to improve the quality and capacity of long-term services and supports provided.

If you have any questions about the 2013 – 2017 State Plan, you may contact me at (803) 734-9910 or Gerry Dickinson at (803) 734-9867.

Sincerely,

A handwritten signature in cursive script, appearing to read "Tony Kester".

Tony Kester, Director
Lieutenant Governor's Office on Aging

State Plan Assurances

For

Older Americans Act of 1965, as amended, P.L. 89-73, 42. U.S.C. 3001, et seq.

I, undersigned affirm and give the assurances required by sections 305, 306, and 30 of the Older Americans Act, as amended in 2006 P.L. 89-73, 109-365 42 U.S.C 3001, et seq., 3025, 3026, and 3027.

I, the undersigned, affirm and give the assurances required by sections 305, 306, and 307 of the Older Americans Act, as amended in 2006 (P.L. 89-73, 109-365)

Mr. Tony Kester, Director
SC Lt. Governor's Office on Aging

Date

Glenn F. McConnell
Lt. Governor of South Carolina

Date

DRAFT

Verification of Intent

The Plan is hereby submitted for the State of South Carolina for the period October 1, 2012 through September 30, 2017. The Plan includes all assurances and activities to be conducted under Provision of the Act (as amended) during the period identified. The SUA has been given the authority to develop and administer the Plan in accordance with all requirements of the OAA, and is primarily responsible for the coordination of all state activities related to the purposes of the OAA, i.e., development of comprehensive and coordinated systems for the delivery of supportive services and to serve as the effective and visible advocate for older citizens in South Carolina.

This plan is hereby approved by the Lieutenant Governor and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary for Aging. The State Plan on Aging hereby submitted has been developed in accordance with all federal statutory requirements.

Date

Tony Kester, Director

I hereby approve this State Plan and submit it to the Assistant Secretary for Aging for approval.

Date

Glenn F. McConnell
Lieutenant Governor of South Carolina

D. Executive Summary

The Older Americans Act (OAA) of 1965 and as amended in 2006 requires that each state submit a State Plan on Aging (hereinafter referred to as the “Plan”) in order to be eligible for federal funding under the OAA. The Lieutenant Governor’s Office on Aging is the designated State Unit on Aging (SUA) for South Carolina, and as such is responsible for administering and carrying out requirements of the OAA.

The 2013 Plan provides a blueprint for how the SUA will manage OAA programs, services and other activities in South Carolina from October 1, 2012 through September 30, 2017. The Plan provides guidance on how the SUA will carry out its mission of enhancing the quality of life of all South Carolina older citizens, regardless of whether they participate in OAA programs. The four year plan incorporates major goals and objectives developed by the Lieutenant Governor’s Office on Aging through the submission of the FY 2010 – 2013 Area Plans drafted by the Area Agencies on Aging, as well as input from various needs assessments carried out throughout the state and from aging partners such as SC AARP, the Silver Haired Legislature, the SC Joint Legislative Committee on Aging, service waiting lists, and surveys conducted by the SUA.

The 2013 – 2017 State Plan, in the way of previously submitted plans will impact the many aging network partners and allies who work to improve the lives of older citizens in South Carolina. With the challenges of a growing senior population, future success is not possible without the support of Area Agencies on Aging (AAAs) and local contractors and sub-grantees. In addition, there must be cooperation, coordination and collaboration between the SUA and state agencies and private sector organizations if the goals of the Plan are to be met. The final component of success can be achieved by working with the many older citizens who volunteer their time to help others and who participate in advocacy groups and provide input and guidance to the SUA.

There has been considerable change since the 2008 – 2012 State Plan was submitted. Both the nation and state have experienced an economic downturn that has significantly affected resources for senior services. The loss of both federal and state funding has led to cuts in services and to increased waiting lists. The state has seen the senior population grow as baby boomers have begun to reach retirement age and as retirees choose to relocate to South Carolina. As the older population grows, the SUA will have to adapt and change the way it provides services to South Carolina seniors if it is to manage the dramatic growth in long term care costs. Today’s seniors want choice and the SUA must modernize its service delivery system to incorporate the citizens’ needs in a cost effective manner. The State Plan on Aging will describe how the State of South Carolina will continue to provide consumer choice, person centered and self-directed services over the next four years, as well as lay out a long term strategic plan that will attempt to address how the state will modernize its service delivery system in the future and work to seek alternative funding as traditional funding is cut or eliminated.

The period from 2008 to 2012 was a time of transition for the Lieutenant Governor's Office on Aging. During that time there were three Lt. Governors, two directors of the State Unit on Aging, staff reductions, state funding was cut by as much as 48 percent and the senior population continued to grow significantly. With the submission of a new State Plan for the years 2013 – 2017, the SUA will continue to face the challenges of serving a growing senior population with limited resources. But with challenges comes opportunity and the Office on Aging is working with its partners to begin measures such as cost sharing in order to better utilize its resources.

When Lt. Governor Glenn McConnell addressed the South Carolina Joint Legislative Committee on Aging on May 3, 2012 he told the legislators and other policy makers gathered about the serious issues facing the senior network in the state, such as a growing elderly population and declining budgets. He urged the committee to increase their commitment to serving seniors and asked everyone in South Carolina to begin a conversation on aging. McConnell stated to the committee, *“The best way to prepare for the Gray Tsunami that has already begun to reach our state is to start a long overdue conversation on the future of aging. While I am here today to speak, I am also here to listen, so let us use this opportunity to begin a frank conversation on the many challenges we face with aging in South Carolina.”*

This 2013 – 2017 State Plan is the start of the long overdue conversation on aging that Lt. Governor McConnell spoke about during his remarks to the Joint Legislative Committee on Aging. As written, this plan will be a renewal of the state's commitment to its seniors as the State Unit continues to modernize the senior network and improve services in South Carolina and prepares for the many challenges and successes ahead.

South Carolina continues to face the many challenges of the 21st century. These challenges include a growing senior population with a greater demand for aging services, declining numbers of nursing home beds, shrinking federal and state revenues, state, national, and global economies ravaged by recession. Several important grants with the Administration on Community Living end soon and the sustainability of these programs and services presents a challenge. However, the SUA will aggressively seek new sources of funding and innovative approaches in order to carry on the mission of the agency.

To successfully carry out the mission of the SUA, it is critical to establish priorities to ensure a comprehensive and coordinated plan that addresses the growing older population in South Carolina. South Carolina, like the nation faces critical challenges in the future with high unemployment, a high poverty rate, and state budget writers who continue to rank a growing senior population and senior services low as a funding priority.

Our state also has many less fortunate seniors who have not shared in the wealth of a growing economy and may face difficult years as they age. South Carolina has a high poverty rate among its older adults and ranks high for the number of older citizens who do not receive proper nutrition. In South Carolina, 1 in 11 seniors are at risk for hunger. Our state ranks in the top ten nationally with 9.66% of seniors (60+) at risk and 11.27%

of those ages 50 to 60 at risk. The risk for African Americans and Hispanics is twice that of whites.

Programs and services designed to meet the needs of the older population will continue to evolve within an ever-changing political and economic environment. South Carolina's approach to preparing for the aging of its population will continue to focus on helping its senior citizens maintain their independence and allowing choice in the services they receive. The SUA recognizes that with the significant growth in South Carolina's senior population there will not be adequate public resources to pay for significantly increased levels of long-term care and funding for other Home and Community Based Services will be limited. The SUA has already sounded the warning alarm and informed the AAAs and others in the senior network that alternative funds will be needed to carry on and supplement core functions in the future.

The goal of the SUA is to provide services that allow seniors who wish to remain independent and in their homes to do so safely. Throughout the past four years the SUA has increased its outreach and has sought to build public/private initiatives that help all of our seniors, while continuing to meet the needs of the frail and economically needy. In the next four years it is clear that public policy on aging issues must emphasize personal and family responsibility. As policy makers and service providers in a SUA, we must promote those behaviors and attitudes that prevent many of the negative outcomes often associated with older citizens.

Because aging services are evolving, the SUA is already working with the AAA/ADRCs to develop new needs assessments in order to serve those seniors with the greatest needs and has piloted with three regions, with the goal of expanding cost sharing measures statewide in order to attract new senior clients and to stretch limited aging service dollars.

This plan focuses on services provided with public funding but also addresses the critical need of involving private sector and faith-based communities in expanding the options available for older South Carolina citizens and their families. It builds upon the goals and mission of the US Administration on Aging and addresses how South Carolina as a state will meet the key goals of this plan.

- Goal 1: Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access existing health and long term care options. It is critical that the elderly be provided choices and options.
- Goal 2: Enable older South Carolinians to remain in their homes with a high quality of life for as long as possible through the provision of home and community-based services, including support for family caregivers.
- Goal 3: Empower older people to stay active and healthy through Older American Act services and other non-OAA services provided through the SUA.

- Goal 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation through the State Long Term Care Ombudsman and the services of State Adult Protective Services.
- Goal 5: Maintain effective and responsible management of OAA services offered through the SUA and within the ten service regions in South Carolina.

The Lieutenant Governor's Office on Aging, as the State Unit on Aging (SUA), hereby presents South Carolina's four year strategic plan for federal fiscal years (FFY) 2013 through 2017. The state plan provides leadership and guidance in the management of the SUA and the administering of aging programs authorized by the Older Americans Act (OAA), the Administration on Community Living (ACL), formerly the Administration on Aging (AoA) and the State of South Carolina. The plan documents the goals, objectives, and strategies that will be implemented to identify and address the needs of South Carolina's older adult and disabled adult populations. It addresses marketing, outreach, and advocacy issues as well as the development of initiatives geared towards promoting evidence-based, consumer-directed, and community-based long-term care services and supports.

Through its FFY 2013-2017 State Plan on Aging the SUA recognizes that it must lead in changing attitudes of the state's aging network and implement the initiatives that address the critical issues facing our state's elderly population, if we are to meet the aging challenges for the next four years of this plan.

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Chapter 2: Overview of Aging Network

A. Lieutenant Governor's Office on Aging's Mission, Vision, Values

The **mission** of the Lieutenant Governor's Office on Aging is to enhance the quality of life for seniors and / or adults with disabilities by providing leadership, advocacy and planning. We pledge the efficient use of resources in partnership with state and local governments, non-profits and the private sector.

While the Lieutenant Governor's Office on Aging is technically the "State Unit on Aging," for convenience this Plan will use the term "SUA," to refer to staff that perform daily operating functions. Enabling legislation for the SUA is found in Title 43 of the Code of Laws of South Carolina, 1976, as amended.

The Older Americans Act (OAA) intends that the SUA shall be the leader relative to all aging issues on behalf of all older persons in the state. This means that the SUA shall proactively carry out a wide range of functions, including advocacy, interagency linkages, monitoring and evaluation, information and referral, protection of older adults, information sharing, planning, and coordination.

These functions are designed to facilitate the development or enhancement of comprehensive and coordinated community-based systems serving communities throughout the state. These systems shall be designed to assist older persons in leading independent, meaningful, and dignified lives in their own homes and communities as long as possible.

The SUA shall designate Area Agencies on Aging (AAAs) for the purpose of carrying out, at the regional level, the mission described above for the SUA. The SUA shall designate as area agencies on aging only those sub-state agencies having the capacity and making the commitment to carry out fully the mission described for area agencies in the OAA. The SUA shall ensure that the resources made available to AAAs under the OAA are used to carry out the mission described for area agencies.

The SUA is responsible for oversight of home and community-based services funded through federal and state sources that are not specifically under the jurisdiction of another state agency. These include primarily programs funded through the federal OAA and various state-funded programs. The SUA has a streamlined organizational structure which provides an additional focus on the customer.

The **vision** of the Lieutenant Governor's Office on Aging is to provide leadership, advocacy and collaboration to assure a full spectrum of services so that South Carolina seniors and / or adults with disabilities can enjoy an enhanced quality of life, contribute to their communities, have economic security, and receive the support necessary to age with choice and dignity. This network will be highly visible, accessible, well-managed, accountable and transparent.

The **values** established for the LGOA put South Carolina seniors first and include outstanding customer service, excellence in government, person-centered care, teamwork, and research-based decision-making. Values include: A strong customer focus, accountability, transparency, and partnerships.

The mission, values and vision set for the LGOA allows for seniors to enjoy an enhanced quality of life, contribute to communities, have economic security, and receive supports necessary to age independently with choice and dignity.

B. Lieutenant Governor

On March 16, 2012, the Honorable Glenn F. McConnell became the state's new Lieutenant Governor after the resignation of Lt. Governor Ken Ard. The Lieutenant Governor of the State of South Carolina is the chief administrative officer of the SUA, and provides overall leadership for agency staff. This includes responsibilities for interpreting state and federal policies and ensuring the implementation of such policies and related procedures statewide.

C. Director

Tony Kester became the Interim Director of the Lieutenant Governor's Office on Aging in 2008 and was officially made the permanent director in 2010 by former Lt. Governor Andre Bauer. The current Lt. Governor, Glenn McConnell has asked Mr. Kester to remain in this post. The Director of the SUA is responsible for the overall administration of SUA policies, coordination and review of legislation, both federal and state, broad advocacy activities, liaison with public and private agencies and organizations, and representing the interests of the SUA to executive management.

D. The State Unit on Aging

The Lieutenant Governor is authorized under South Carolina State Code of Laws to head the State Unit on Aging in South Carolina. Between 2004 and 2009, the Lieutenant Governor was authorized by proviso to head the SUA, but that was made permanent in 2008 through legislation passed by the General Assembly and signed by Governor Mark Sanford. Prior to 2004, the SUA had been housed several times at the Office of the Governor, The South Carolina Department of Health and Human Services and as a stand-alone State Commission on Aging.

The LGOA is the federally designated SUA as required by the Older Americans Act. The OAA intends that the Lieutenant Governor's Office on Aging shall be the leader relative to all aging issues on behalf of all older persons in South Carolina. Enabling legislation for the LGOA is found in Title 43 of the Code of Laws of South Carolina, 1976, as amended.

From 2008 to 2012, the Lieutenant Governor's Office on Aging was in transition, as it had three administration changes and lost senior staff from within the agency to retirement. In addition, due to budget shortfalls, the agency was forced to consolidate positions, move to a smaller office suite, and restrict travel in order to better utilize its resources to serve the elderly. While this transition was occurring, the agency

continued to focus its employees and resources towards elderly consumers it serves throughout South Carolina.

With the transitions and limited budget resources, the agency was forced to reevaluate its organizational structure; reexamine its workforce plan; develop a staff succession plan, and rethink how it successfully captures and transfers knowledge from staff nearing retirement. Many of the staff members of the agency have been a part of the State Unit on Aging since before it was moved under the Lieutenant Governor's Office so additional retirements can be expected in the near future. As a result, knowledge transfer workforce planning will be an important component as the agency enacts the new State Plan.

Other Activities

When the SUA receives grants for special purposes, responsibility for the grant may be assigned to a temporary unit, or incorporated into an existing unit of the SUA.

E. Designation of Planning and Service Areas (PSAs)

Mandated by the federal OAA, area agencies on aging are organizations designated by the SUA to provide planning and administrative oversight for a multi-county planning and service area. It is the responsibility of the area agency on aging to assess and prioritize the needs of older adults within the planning and service area and to allocate federal and state funding to provide services that meet those needs. South Carolina has ten area agencies. Seven of the area agencies are public entities, housed within regional planning councils. The remaining three area agencies are private non-profit organizations: two are freestanding, and one is part of a community health organization. Area Agencies on Aging receive funding from the SUA through submission and approval of a two year Area Plan with annual updates, as well as through approval of specific grant applications. Each AAA contracts with providers of aging services.

Service providers receive federal and state funding through performance-based contracts, i.e., the provider agrees to provide a specified amount of a specific service at an agreed-upon unit rate. To earn funds, service must be provided. In addition to services provided through state and federal funds (many of which require local matching funds), most providers also receive funding through a variety of local sources; some of these include United Way contributions, church and civic donations, private donations, fees for non-federal programs, and funds generated through fund-raising activities.

South Carolina's ten AAAs have transitioned and now operate as Aging and Disability Resource Centers in order to improve services for the elderly and disabled in South Carolina.

The map of the AAA/ADRC regions is included below but a full listing of South Carolina's aging network is included elsewhere within the appendix.



The AAA's are responsible for:

- Assuring the supply of high quality services through contractual arrangements with service providers, and for monitoring their services;
- Local planning, program development and coordination, advocacy, monitoring;
- Developing the Area Plan on Aging and area plan administration, and resource development;
- Working with the community to develop a comprehensive coordinated service delivery system;
- Establishing and coordinating the activities of an advisory council, which will provide input on development and implementation of the area plan; assist in conducting public hearings; review and comment on all community policies, programs and actions affecting older persons in the area.

F. South Carolina Advisory Council on Aging

The SC Advisory Council on Aging's primary mission is to support and advise the Lieutenant Governor's Office on Aging with aging related issues in the State of South Carolina. Members are appointed by the Lieutenant Governor and must be citizens of the state and have an interest in and knowledge of the problems of a growing aging population. In making appointments, consideration must be given to assure that the council is composed of appointees who are diverse in age, who are able and disabled, and who are active leaders in organizations and institutions that represent different concerns of older citizens and their families. The Council is comprised of 15 members, ten representing the AAA regional areas and five appointed at-large. The Council meets quarterly.

G. Advocates in the Aging Network

South Carolina has a very strong aging network that advocates on behalf of the state's elderly. While the primary leaders of the network include the SUA, AAAs, and service providers, it also includes advocates, adult care centers, volunteers and older adults and their families and caregivers. The State Unit and AAAs partner with the SC Association of Area Agencies on Aging (SC4A), Council's on Aging, the SC Hospital

Association, AARP SC, the Alzheimer's Association SC Chapter, SC Nursing Homes Association, and local aging organizations throughout the state.

The aging network is working to increase the level of additional advocacy on behalf of South Carolina's elderly. Through AAAs, the Councils of Government (COG) and their partners, meetings are held for seniors to talk with and educate their elected officials. In addition, the LGOA works closely with legislators and Lt. Governor McConnell enjoys a strong working relationship with legislators after his 32 years in the Senate.

H. Aging Trends in South Carolina

The 2010 Census indicates that South Carolina's elderly population increased significantly from 2000 to 2010. This trend is expected to continue as South Carolina's elderly population is expected to double by the year 2030.

- South Carolina has experienced a significant growth in the number of senior citizens over the last few decades. The baby boom is having a dramatic impact and will continue to affect South Carolina's communities and institutions over the next twenty years.
- The SC senior population is among the fastest growing in the nation.
- Growth of Senior Population Between 2000 – 2010: SC's 60+ Population increased 40.5% from 651,482 to 912,429 for a 260,947 increase (Ranks 8th nationally for increase)
- SC's 65+ Population increased 30.19% from 485,333 to 631,874 for a 146,541 increase (Ranks 8th nationally)
- The state's senior population has grown from 286,272 persons aged 60 and over in 1970 to 917,000 in 2010 (a 319% increase in forty years).
- South Carolina ranks 17th in the nation for the highest percentage of age 60+ residents.
- The 85 to 94 age group is experiencing the fastest growth, 30 percent, while the 95+ age group increased 26 percent. At the same time, South Carolina nursing homes operate at nearly full capacity and unless you are Medicaid eligible or have funds to pay privately, Home and Community Based services are not an option.
- The population 60 years and over is projected to increase to 1,450,487 by the year 2030.
- Of the more than 917,000 over the age of 60, at least 42 percent have at least one disability which makes them more likely to live below the poverty level; 10.4% live below 100 percent poverty level (\$11,170/\$15,130; one in every five of those individuals age 65 and older survives on an average of \$7,500 a year; only 3 out of ten eligible seniors get SNAP (\$908 net = \$200 month).
- The LGOA had 27,880 clients in Fiscal Year 2010-11 and a conservative waiting list of over 8,522 seniors needing services.
- In addition, it should be noted that the 2010 Census counted 35,382 seniors in South Carolina over the age of 65 who are at risk because of self-care disabilities and difficulties.

- While the senior population is growing significantly, the LGOA only serves about 3% of the state's aging population. 97% of the senior population is not utilizing our services.
- 1 in 11 SC seniors are at risk for hunger. SC ranks in the top ten of states with 9.66% of seniors (60+) at risk and 11.27% of those ages 50 to 60 at risk. The risk for African Americans and Hispanics is twice that of whites.

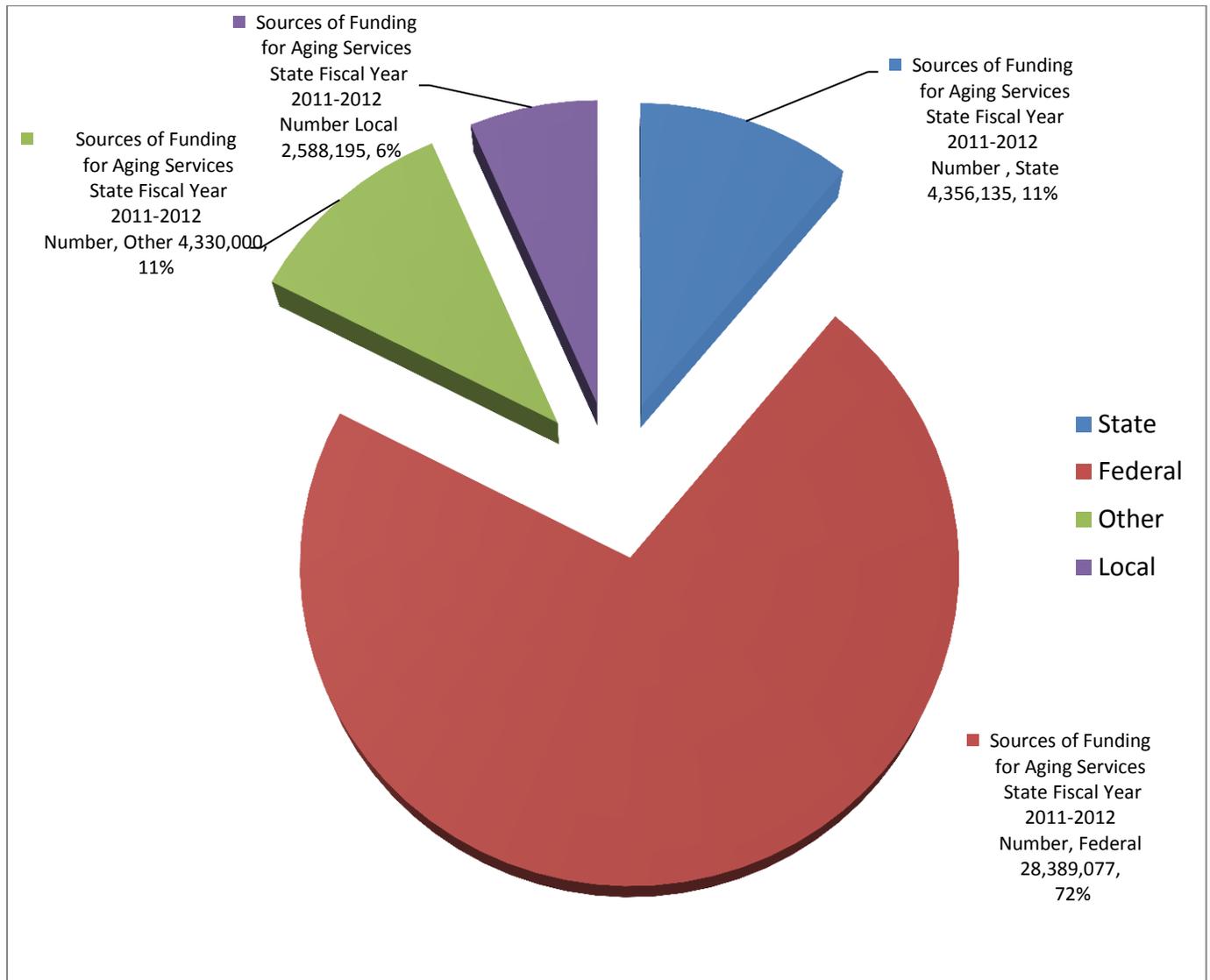
I. Funding Sources

The ACL makes annual allotments to South Carolina based on the state's ratio of the population aged 60 and older to the national population 60 and older. From these allotments under Title III, the SUA expends 5% to pay part of the costs of administration of the State Plan on Aging. South Carolina receives separate allotments for the following service programs (OAA 303):

- in-home and community-based services; (Title III-B)
- long term care ombudsman program; (Title III-B and Title VII)
- elder abuse prevention services; (Title VII)
- health insurance counseling and senior Medicare patrol; (ACL and CMS)
- congregate nutrition services; (Title III-C-1)
- home-delivered nutrition services; (Title III-C-2)
- nutrition services incentive program (USDA);
- disease prevention and health promotion services; (Title III-D)
- family caregiver support services; (Title III-E); and
- senior employment and training services. (Title V)

The SUA must use each allotment for the purpose for which it was authorized; however, limited transfers are permitted between nutrition services and support services. Except for 5% of Title III-B funds reserved for the long-term care ombudsman program, all social, nutrition, wellness, and caregiver service allotments shall be granted by formula to AAAs under approved area plans.

The chart below shows funding amounts in place for the State Fiscal Year 2011 – 2012.



J. Programs and Services

For the FY 2013 - 2017 Plan period, the SUA supports through federal and state funds the following services. The SUA may identify other sources of funds to support services where state and federal funds are not available.

Advance Directives Program - The Office on Aging is the lead agency for providing information on advance directives. South Carolina utilizes the Living Will, Health Care Power of Attorney and Five Wishes documents to assist its citizens in planning for end-of-life care. SC state statute requires Living Wills executed in hospitals or long term care facilities to be "witnessed by an ombudsman as designated by the State

Ombudsman, Office of the Governor.” The SUA oversees this program and trains and designates volunteers for the Living Will Witness program.

Adult Day Services: These services are offered from 4 to 14 hours daily in a community setting, to support and encourage personal independence and promote social, physical and emotional well-being. They are designed for adults who require partial or complete daytime supervision while their caregivers are employed or otherwise need a break from their caregiving responsibilities. Providers must be licensed and inspected by the SC Department of Health and Environmental Control.

The Aging and Disability Resource Center (ADRC): Grant Program, a cooperative effort of the ACL and the Centers for Medicare & Medicaid Services (CMS), assists states in their efforts to create a single, coordinated system of information and access for all persons seeking long term support to minimize confusion, enhance individual choice, and support informed decision-making.

Community Living Program (CLP) and Veteran Directed Home and Community Based Services (VDHCCBS): These services are designed to support independence and Choice in the Community for Seniors and Veterans who need nursing home level of care. Continued funding for VDHCCBS is entirely dependent on the VA allocating funds. The program currently is piloted in the Trident AAA Region and in Central Midlands at VA hospitals.

Disease Prevention and Health Promotion: These activities are designed to maintain and/or improve health status; reduce risk factors associated with illness, disability or disease; delay onset of disease; preserve functional status and manage chronic disease. Increasingly, programs that have been tested and proven to be successful through research are being introduced into the Network. These programs offer structured activities by trained leaders that address chronic disease management, nutrition, physical fitness and accident prevention. These activities occur in a variety of community settings, including senior centers.

The *Living Well* Program: A Chronic Disease Self-Management Program developed by medical researchers at Stanford University, is available in 6 of the 10 AAA regions at this time. Small group classes are held once a week for 2 1/2 hours over a six week period. By attending all six classes, participants gain the knowledge and skills needed to help them live a healthier life.

The *A Matter of Balance*: The A Matter of Balance program has also been proven to reduce the fear of falling in older adults. This fall prevention class is held twice a week for four weeks. Class locations can be found on the Lt. Governor’s Office on Aging website. Both Living Well and A Matter of Balance are partially funded through the Administration on Aging. Additionally, routine health screenings; nutritional assessment, counseling and follow-up are provided.

Group Dining: Provides a nutritionally balanced meal five days per week to older adults at a senior center or other designated place. The group dining setting offers the opportunity to provide evidence-based programming, nutrition education and other activities designed to promote health and wellness.

Eforms: Eforms are available online at www.scaccesshelp.org for **Medicaid Long Term Care** (Medicaid-eligible individuals interested in receiving services in their homes or those needing nursing home placement) and **GAPS** (the state-sponsored prescription coverage for seniors that helps “fill the gap” with their Medicare Part D drug coverage).

Elder Abuse Prevention: Through training and public awareness, coalescence with public agencies and private organizations, the SUA works to improve understanding of factors related to abuse, and to assist formal and informal caregivers of vulnerable elderly persons in developing appropriate preventive measures.

Employment Services: Title V of the OAA funds the Senior Community Service Employment Program. This program provides training to persons 55 and over who are low-income to assist them in entering the job market or transitioning to other types of employment. Enrollees receive training and experience by working for non-profit organizations. The SUA contracts with Experience Works and Goodwill of the Upstate and the Midlands, and there are two sub-grantees.

Homebound Support: These activities provide social contact with older persons who live alone or who are isolated. They are designed to provide an opportunity for socialization, as well as a means for checking on safety and well-being.

Home Care Services: Home Care Services address a broad range of activities based on the level of need of the client and the primary caregiver. Activities provided by a home care aide include: housekeeping, shopping, meal preparation, personal care assistance with activities of daily living (e.g., bathing, dressing, toileting) as well as temporary respite for caregivers.

Home-Delivered Meals: The home-delivered meal program ensures the provision of at least one nutritionally sound meal five days per week to persons in their own homes to maintain a maximum level of health and prevent institutionalization.

Information, Referral, and Assistance: Information and Referral is a system to link people in need of services to appropriate resources. An Area Plan must provide for a regional information and referral specialist to ensure that all older persons within the PSA have reasonably convenient access to the service. In areas in which a significant number of older persons do not speak English as their principal language, the AAA must provide access to information and referral services in the language spoken by the older persons. **SC Access**, www.scaccesshelp.org, is an Internet based information resource designed to assist seniors, adults with disabilities, and their caregivers in locating a variety of services in their area and provides educational material on

numerous issues. Ten regional Information and Referral Specialists, located at the AAAs, provide personal assistance by phone or in person.

Legal Services Development: This program ensures that legal services are available to seniors of greatest social and economic need in eleven priority areas, including income, health care, long term care, nutrition, housing, utilities, protective services, defense of guardianships, abuse, neglect, and age discrimination. These services identify and provide services that offer support to the older adult, including information on legal services and referral to appropriate agencies to deal with specific situations, information on and initiatives to address frauds and scams, advocacy, and interaction with other agencies to obtain services, thereby protecting the older person's dignity, rights, autonomy and financial security.

Long Term Care Ombudsman Program: This program provides a statewide system for protecting the dignity and rights of vulnerable adults in long term care facilities. Ombudsmen investigate and resolve complaints made by the resident or on behalf of the resident. Complaints include allegations of abuse, neglect and exploitation, and issues of quality of care and resident rights.

Respite Services: Respite services provide assistance and relief from caregiving responsibilities. Services may be provided for individual caregivers in the home, in group settings or, for overnight or more lengthy respite, in long term care facilities.

Senior Center Activities: Senior center activities include a broad range of group activities, designed to address the social, recreational, physical fitness and educational needs of a diverse older population. These are activities above and beyond the services specifically contracted by the area agency.

South Carolina Seniors' Cube: This is a nationally unique comprehensive statewide electronic database of the senior population's health care statistics and services, which integrates information from multiple data systems. Its quick query data analysis tool shows multiple relationship factors so researchers can examine cost-effective strategies for maintaining the health and well-being of the senior population to allow seniors to remain independent longer. Funding was discontinued in 2009, but SUA is entering into a new contract with the State Office of Research and Statistics to recapture the data in 2012.

State Health Insurance Program (SHIP) or I-CARE (Insurance Counseling and Referral for Elders): SHIP and I-CARE assists seniors and adults with disabilities by training personnel and volunteers to provide free counseling related to health insurance coverage, including Medicaid and Medicare Parts A, B, C and D, the new prescription drug program and long term care insurance.

Transportation: Older persons who do not have available transportation can travel to and from important activities via vehicles provided by the local aging service agency. Such activities include medical appointments, educational and social activities, shopping and travel to and from meal sites and social service agencies. The SUA has a

grant from the SC Department of Transportation to provide transportation for volunteers in the Santee Lynches Region.

Additional Related Activities:

The ElderCare Trust Fund: Contributions to the Trust Fund are awarded as grants to public and private non-profit agencies and organizations to establish and administer innovative programs and services that assist older persons to remain in their homes and communities with maximum independence and dignity.

Senior Center Permanent Improvement Project (PIP): The SUA, using state funds, awards up to \$350,000 during an annual funding cycle to grant applicants seeking to build or renovate senior centers. PIP also awards smaller Emergency Grants for senior centers with needs.

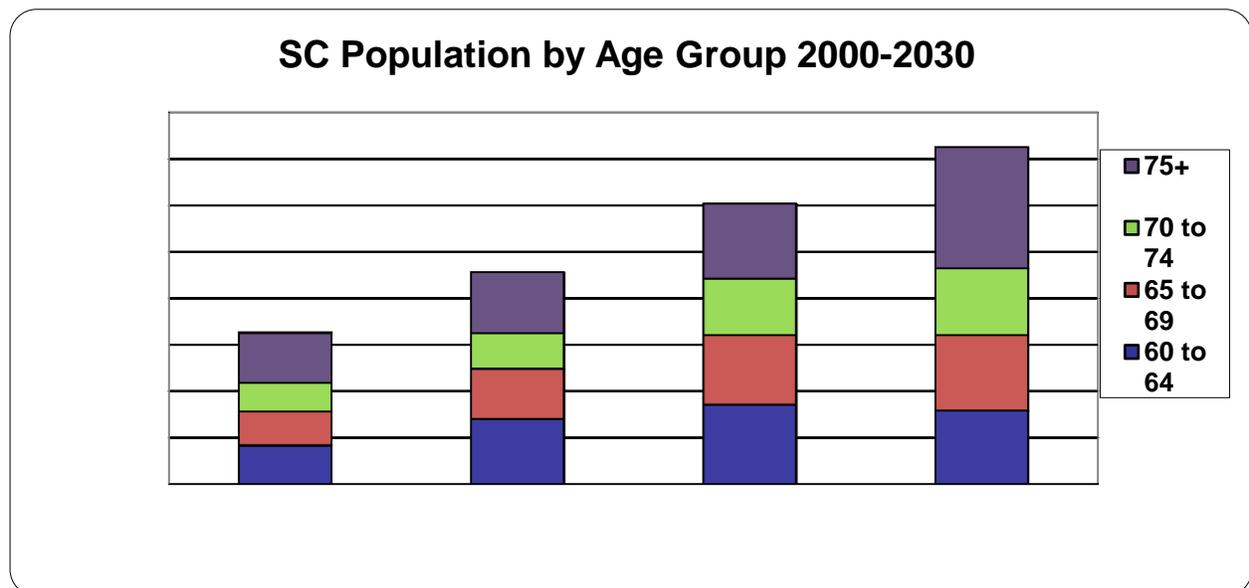
Alzheimer's Resource Coordination Center: Act 195 of 1993 directed the Joint Legislative Committee on Aging to form a Blue Ribbon Task Force to study the planning, coordination and delivery of services for individuals with Alzheimer's disease and related disorders, their families and caregivers. Following a recommendation of this Task Force and subsequent legislation, a statewide Alzheimer's Resource Coordination Center (ARCC) was established in the SUA under the direction of an Advisory Committee appointed by the Governor. The mission of the ARCC is to improve the quality of life for persons with Alzheimer's disease and related dementias through planning, education, coordination, advocacy, service system development and communication. Competitive respite and education grants are awarded annually to promote the delivery of services.

National Aging Program Information System: The ACL requires an annual report of services provided through the Older Americans Act. In South Carolina, the data for this report are collected and maintained through a computerized system known as the Advanced Information Manager (AIM).

CHAPTER 3: STATE DATA FOR SOUTH CAROLINA

Introduction

South Carolina has experienced a significant growth of seniors or mature adults over the last few decades. The baby boom has begun to have a dramatic impact and will continue to affect the nation and South Carolina's communities and institutions over the next twenty years. The state's population has grown from 286,272 persons aged 60 and over since 1970 to 912,429 in the year 2010. That is a gain of 626,157 seniors over the past forty years. Census projections have South Carolina's senior population doubling by the year 2030.



Source: 2000-2010" U.S. Census Bureau, Decennial Census 2000 and 2010. 2020-2030 Projections: US Census Bureau, Interim State Population Projections 2005.

The population 60 years and over is projected to increase to 1,450,487 by the year 2030, a 123% increase from 2000.

South Carolina Population by Age 2000-2030				
	2000	2010	2020	2030
50 to 54	262,543	326,662	309,755	302,530
55 to 59	206,762	303,240	339,621	305,344
60 to 64	166,149	280,555	332,083	316,028
65 to 69	145,599	215,561	289,980	325,913
70 to 74	124,449	153,482	232,716	286,921
75 to 84	165,016	192,114	244,666	380,339
Total 60+	651,482	912,429	1,198,333	1,450,487
Total 65+	485,333	631,874	866,250	1,134,459
Total 75+	215,285	262,831	343,554	521,625
Total 85+	50,269	70,717	98,888	141,286

Source: 2000-2010" US Census Bureau, Decennial Census 2000 and 2010. 2020-2030 Projections: US Census Bureau, Interim State Population Projections 2005.

The US Census Bureau predicts the 65 and older population will grow from one in eight Americans today to one in six by 2020. The mature adult population will total 53.7 million, representing a 53.8 percent increase over today's 34.9 million mature adults.

Nationally, South Carolina ranks 23rd with 12.60% of its population 65 and over in 2010. The population 65 and over is projected to reach 1,134,459 (22% of the population) in 2030."

Resident Population 65 Years and Over - Census 2010		
State	Percent	Rank
United States	13.0	(X)
Florida	17.3	1
West Virginia	16.0	2
Maine	15.9	3
Pennsylvania	15.4	4
Iowa	14.9	5
Montana	14.8	6
Vermont	14.6	7
North Dakota	14.5	8
Rhode Island	14.4	9
Arkansas	14.4	10
Delaware	14.4	11
Hawaii	14.3	12
South Dakota	14.3	13
Connecticut	14.2	14
Ohio	14.1	15
Missouri	14.0	16
Oregon	13.9	17
Arizona	13.8	18
Massachusetts	13.8	19
Michigan	13.8	20
Alabama	13.8	21
Wisconsin	13.7	22
South Carolina	13.7	23
New Hampshire	13.5	24
New York	13.5	25
Oklahoma	13.5	26
Nebraska	13.5	27
New Jersey	13.5	28
Tennessee	13.4	29
Kentucky	13.3	30
New Mexico	13.2	31
Kansas	13.2	32
Indiana	13.0	33
North Carolina	12.9	34
Minnesota	12.9	35
Mississippi	12.8	36
Illinois	12.5	37
Wyoming	12.4	38
Idaho	12.4	39
Washington	12.3	40
Louisiana	12.3	41
Maryland	12.3	42
Virginia	12.2	43
Nevada	12.0	44

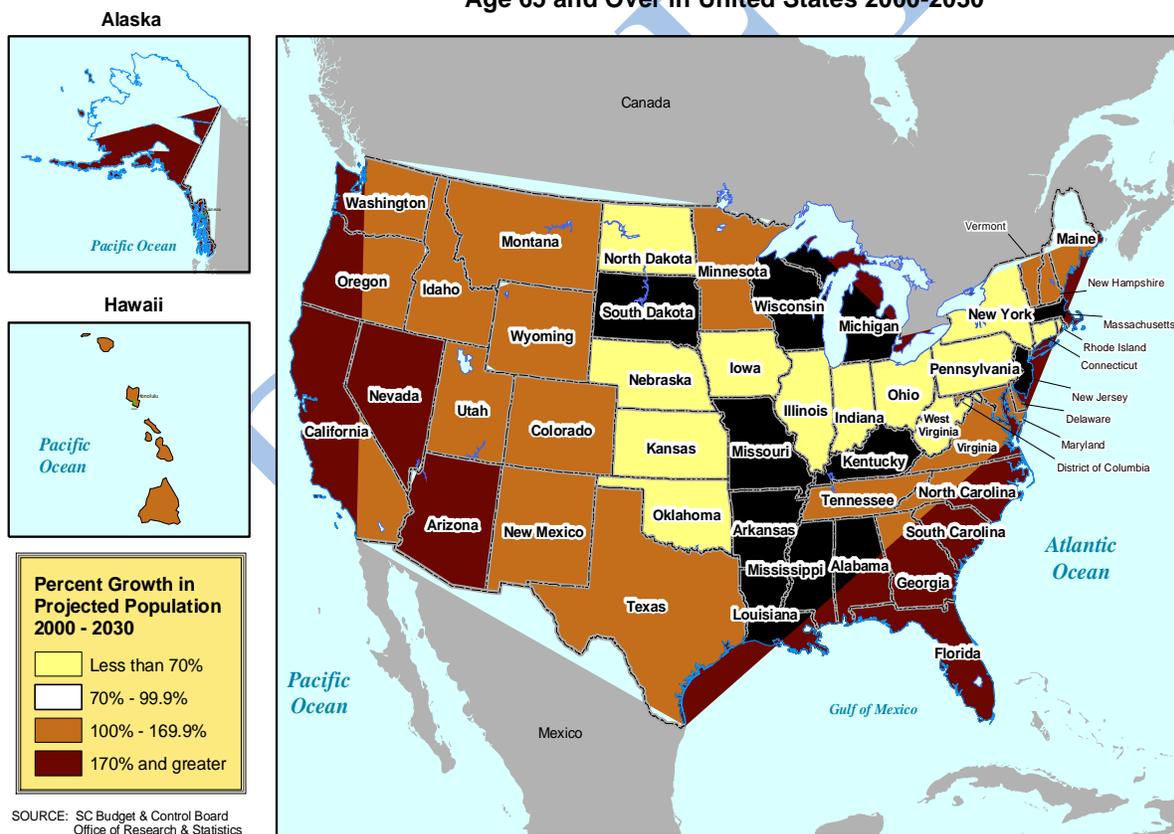
California	11.4	45
Colorado	10.9	46
Georgia	10.7	47
Texas	10.3	48
Utah	9.0	49
Alaska	7.7	50
District of Columbia	11.4	(X)

Source: U.S. Census Bureau: See Table 21, Statistical Abstract of the United States, 2012.

The map and table below show that from 2000 to 2030, South Carolina's growth rate ranked ninth in the nation with a 13.52% rate of growth of its 65+ population. Clearly, South Carolina has seen a significant growth in its senior population.

UNITED STATES PERCENT POPULATION CHANGE: AGE 65+

Percent Growth in Projected Population Age 65 and Over in United States 2000-2030



Source: SC Budget and Control Board, Office of Research and Statistics

PERCENT PROJECTED GROWTH UNITED STATES: AGE 65+

Percent Change - US Population 2000-2010				
Rank	State	Population Census 2000	Population Census 2010	% Growth
1	Alaska	35,699	54,938	53.89
2	Nevada	218,929	324,359	48.16
3	Idaho	145,916	194,668	33.41
4	Colorado	416,073	549,625	32.10
5	Arizona	667,839	881,831	32.04
6	Georgia	785,275	1,032,035	31.42
7	Utah	190,222	249,462	31.14
8	South Carolina	485,333	631,874	30.19
9	New Mexico	212,225	272,255	28.29
10	North Carolina	969,048	1,234,079	27.35
11	Delaware	101,726	129,277	27.08
12	Texas	2,072,532	2,601,886	25.54
13	Washington	662,148	827,677	25.00
14	Virginia	792,333	976,937	23.30
15	Oregon	438,177	533,533	21.76
16	Hawaii	160,601	195,138	21.50
17	Wyoming	57,693	70,090	21.49
18	Montana	120,949	146,742	21.33
19	Tennessee	703,311	853,462	21.35
20	New Hampshire	147,970	178,268	20.48
21	California	3,595,658	4,246,514	18.10
22	Maryland	599,307	707,642	18.08
23	Vermont	77,510	91,078	17.50
24	Florida	2,807,597	3,259,602	16.10
25	Maine	183,402	211,080	15.09
26	Minnesota	594,266	683,121	14.95
27	Kentucky	504,793	578,227	14.55
28	Alabama	579,798	657,792	13.45
29	Arkansas	374,019	419,981	12.29
30	Indiana	752,831	841,108	11.73
31	Michigan	1,219,018	1,361,530	11.69
32	Oklahoma	455,950	506,714	11.13
33	Missouri	755,379	838,294	10.98
34	Mississippi	343,523	380,407	10.74
35	Wisconsin	702,553	777,314	10.64
36	Louisiana	516,929	557,857	7.92
37	South Dakota	108,131	116,581	7.81
38	Connecticut	470,183	506,559	7.74
39	Ohio	1,507,757	1,622,015	7.58
40	West Virginia	276,895	297,404	7.41
41	Illinois	1,500,025	1,609,213	7.28

42	New York	2,448,352	2,617,943	6.93
43	New Jersey	1,113,136	1,185,993	6.55
44	Nebraska	232,195	246,677	6.24
45	Kansas	356,229	376,116	5.58
46	Massachusetts	860,162	902,724	4.95
47	Iowa	436,213	452,888	3.82
48	North Dakota	94,478	97,477	3.17
49	Pennsylvania	1,919,165	1,959,307	2.09
50	Rhode Island	152,402	151,881	-0.34
51	District of Columbia	69,898	68,809	-1.56

Source: U.S. Census Bureau, Census 2000, Table P30, and Census 2010, Table P34.

The table below shows the projected growth of the 65+ population nationally. South Carolina is projected to rank 14th by 2030 based on the 2010 census. South Carolina is projected to have an increase of 133.7% growth in the 65+ population by 2030.

Projected Change in Population 65 plus by State: 2000 to 2030								
Rank	State	% change	Rank	State	% change	Rank	State	% change
1	Nevada	264.1	18	Vermont	124.4	35	South Dakota	71.1
2	Alaska	256.3	19	North Carolina	124.3	36	Michigan	70.7
3	Arizona	255.1	20	Montana	122.9	37	Massachusetts	70.1
4	Florida	176.7	21	Maryland	106.2	38	Connecticut	69.0
5	New Mexico	161.6	22	Maine	103.9	39	Kansas	66.5
6	Texas	150.2	23	Hawaii	103.6	40	Oklahoma	66.1
7	Idaho	147.4	24	Tennessee	101.6	41	Indiana	63.6
8	Georgia	143.0	25	Oregon	101.3	42	Nebraska	61.9
9	Utah	142.1	26	Minnesota	100.8	43	Rhode Island	61.7
10	Wyoming	140.2	27	Wisconsin	86.8	44	North Dakota	61.3
11	New Hampshire	138.4	28	Mississippi	84.6	45	Illinois	60.8
12	Washington	136.2	29	Louisiana	82.7	46	New York	60.0
13	Delaware	133.8	30	Alabama	79.2	47	Ohio	56.3
14	South Carolina	133.7	31	Kentucky	79.0	48	West Virginia	54.0
15	Virginia	132.7	32	New Jersey	76.0	49	Iowa	52.0
16	California	130.5	33	Arkansas	75.5	50	Pennsylvania	50.6
17	Colorado	129.8	34	Missouri	72.3	51	District of Columbia	-16.7

Source: U.S. Census Bureau Interim State Population Projections, 2005.

Population Trends

The growth of South Carolina's 60 and over population will continue to increase significantly over the next eighteen years (2030). From 2000 to 2010 South Carolina's 60+ population increased by 257,906 individuals for a 39.4 percent change. Overall, persons 60 are anticipated to number 1,450,487 by 2030 for a 123% increase. The

fastest growing segments of our senior population will be in the 75+ and 85+ age categories.

For the population over 60, the fastest growing counties between 2000 and 2012 were Beaufort (78.7%), Horry (54.8%), Lancaster (67.2) and Berkeley (65.4%).

The PSA regions with the largest percentage change of persons 60+ were Lowcountry (61.2%), Waccamaw (54.6%), Catawba (50.4%) and Trident (46.1%).

Growth of 85+ Population

When looking at the 85 and over population from 1990 to 2010, we can see the significant rate of growth in this sector. All ages have increased significantly. When looking at growth from 2000 to 2010, we see the impact of the Baby Boomers on the state's population in the chart below:

SC Population Growth by Age Group		
	1990 - 2000	2000 - 2010
All ages	15.1%	15.3%
50 to 54 years	64.6%	24.4%
55 to 59 years	39.0%	46.7%
60 to 64 years	15.4%	68.9%
65 to 69 years	3.7%	48.1%
70 to 74 years	17.6%	23.3%
75 to 84 years	37.6%	16.4%
85 years and over	63.5%	40.7%

Source: US Census Bureau 1990, 2000, 2010 Decennial Census, Table P12

SOUTHEASTERN STATES PERCENT POPULATION CHANGE: AGE 65+

Percent Change - US Population Age 65 and over - 2000-2010

State	Population Census 1990	Population Census 2000	# Change 1990-2000	% Change 1990-2000	Population Census 2010	# Change 2000-2010	% Change 2000-2010
Alabama	522,989	579,798	56,809	10.9%	657,792	77,994	13.5%
Florida	2,369,431	2,807,597	438,166	18.5%	3,259,602	452,005	16.1%
Georgia	654,270	785,275	131,005	20.0%	1,032,035	246,760	31.4%
Kentucky	466,845	504,793	37,948	8.1%	578,227	73,434	14.6%
Mississippi	321,284	343,523	22,239	6.9%	380,407	36,884	10.7%
North Carolina	804,341	969,048	164,707	20.5%	1,234,079	265,031	27.4%
South Carolina	396,935	485,333	88,398	22.3%	631,874	146,541	30.2%
Tennessee	618,818	703,311	84,493	13.7%	853,462	150,151	21.4%

Source: 2010 U.S. Census, Decennial Census Table P12

***PERCENT CHANGE FOR SC COUNTIES IN 60+ POPULATION 2000 -2010

South Carolina Percent Change in Population 60 Plus by County and PSA: 2000-2010

County	2000	2010	# Change	% Change	County	2000	2010	# Change	% Change	County	2000	2010	# Change	% Change
Appalachia					Upper Savannah					Catawba				
Anderson	30,374	40,180	9,806	32.3%	Abbeville	5,013	5,999	986	19.7%	Chester	5,765	6,938	1,173	20.3%
Cherokee	8,710	10,792	2,082	23.9%	Edgefield	3,569	5,330	1,761	49.3%	Lancaster	10,140	16,954	6,814	67.2%
Greenville	59,857	82,486	22,629	37.8%	Greenwood	11,817	14,658	2,841	24.0%	Union	6,162	6,714	552	9.0%
Oconee	14,206	19,694	5,488	38.6%	Laurens	12,246	14,210	1,964	16.0%	York	23,572	38,043	14,471	61.4%
Pickens	17,135	22,572	5,437	31.7%	McCormick	2,306	3,483	1,177	51.0%	Regional Total	45,639	68,649	23,010	50.4%
Spartanburg	42,556	54,879	12,323	29.0%	Saluda	3,675	4,425	750	20.4%	Santee-Lynches				
Regional Total	172,838	230,603	57,765	33.4%	Regional Total	38,626	48,105	9,479	24.5%	Clarendon	6,222	8,436	2,214	35.6%
Central Midlands					Lower Savannah					Kershaw				
Fairfield	4,050	5,334	1,284	31.7%	Aiken	24,217	34,779	10,562	43.6%	Lee	3,260	3,789	529	16.2%
Lexington	30,447	47,417	16,970	55.7%	Allendale	1,850	2,054	204	11.0%	Sumter	15,878	19,547	3,669	23.1%
Newberry	6,910	8,448	1,538	22.3%	Bamberg	3,013	3,634	621	20.6%	Regional Total	34,496	44,674	10,178	29.5%
Richland	41,725	56,128	14,403	34.5%	Barnwell	3,854	4,597	743	19.3%	Trident				
Regional Total	83,132	117,327	34,195	41.1%	Calhoun	2,812	3,604	792	28.2%	Berkeley	16,460	27,219	10,759	65.4%
Pee Dee					Orangeburg					Charleston				
Chesterfield	6,949	9,370	2,421	34.8%	Regional Total	51,813	68,245	16,432	31.7%	Dorchester	12,423	21,153	8,730	70.3%
Darlington	11,129	14,311	3,182	28.6%	Waccamaw					Regional Total	77,725	113,580	35,855	46.1%
Dillon	4,780	6,014	1,234	25.8%	Georgetown	11,544	17,020	5,476	47.4%	Low Country				
Florence	20,031	26,331	6,300	31.5%	Horry	40,423	65,841	25,418	62.9%	Beaufort	25,351	45,305	19,954	78.7%
Marion	5,752	7,223	1,471	25.6%	Williamsburg	6,404	7,388	984	15.4%	Colleton	6,729	8,683	1,954	29.0%
Marlboro	4,671	5,586	915	19.6%	Regional Total	58,371	90,249	31,878	54.6%	Hampton	3,390	4,105	715	21.1%
Regional Total	53,312	68,835	15,523	29.1%						Jasper	3,101	4,069	968	31.2%
										Regional Total	38,571	62,162	23,591	61.2%
					<i>Source: U.S. Census Bureau - 2000 and 2010 Decennial Census, Table P12.</i>									
	2000	2010	# Change	% Change										
South Carolina	654,523	912,429	257,906	39.4%										

D. In-migration

Net in-migration to South Carolina has only become a positive force in the past two decades. From a net out-migration during the 1960's and 1970's, especially among blacks and rural residents, South Carolina has reversed this trend due mainly to its Sunbelt location and emphasis on tourism and business development. Continued in-migration is expected to provide additional impetus to the growth in the older adult population.

From 2000-2010 South Carolina had a net-migration of 61,969 individuals age 65 and over.

The areas that saw largest increase of in-migration correspond closely to major tourist destinations, reflecting the tendency of people to select areas for retirement where they have previously vacationed. Several characteristics of migrant retirees stand out. By and large, retirees coming from other states have higher incomes than indigenous retirees. (The net income is the difference between income brought into the state by in-migrants and income taken from the state by out-migrants.) A summary table by counties of in-migrants age 65 is as follows.

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Components of Population Change for Persons 65 Years and Older: 2000 - 2010						
Geographic Area	Census 2000 Population	Census 2010 Population	Total Population Change 2000-2010	Deaths	Natural Increase	Net Migration
South Carolina	485,333	631,874	146,541	288,339	84,572	61,969
Abbeville	3,842	4,203	361	2026	492	-131
Aiken	18,287	24,619	6,332	10,946	2,399	3,933
Allendale	1,421	1,375	-46	867	83	-129
Anderson	22,627	28,329	5,702	14,167	2,898	2804
Bamberg	2,314	2,565	251	1317	247	*
Barnwell	2,962	3,173	211	1758	298	-87
Beaufort	18,754	33,032	14,278	8,481	4,202	10,076
Berkeley	11,261	17,794	6,533	6,867	4,897	1,636
Calhoun	2,102	2,470	368	1198	468	-100
Charleston	36,858	44,721	7,863	20,976	5,909	1954
Cherokee	6,517	7,442	925	4,169	753	172
Chester	4,317	4,835	518	2,514	809	-291
Chesterfield	5,120	6,332	1,212	3,253	867	345
Clarendon	4,538	5,867	1,329	2,526	961	368
Colleton	4,928	6,078	1,150	3,087	879	271
Darlington	8,158	9,793	1,635	5,349	1,205	430
Dillon	3,545	4,159	614	2,389	301	313
Dorchester	8,791	13,849	5,058	5,572	2,722	2336
Edgefield	2,669	3,524	855	1597	560	295
Fairfield	3,094	3,565	471	2,090	120	351
Florence	14,837	18,017	3,180	9,880	1,690	1490
Georgetown	8,354	11,920	3,566	4,502	2,024	1,542
Greenville	44,573	57,581	13,008	26,183	8,283	4,725
Greenwood	9,075	10,544	1,469	5,398	675	794
Hampton	2,595	2,829	234	1576	231	*
Horry	29,470	46,070	16,600	16,017	6,173	10,427
Jasper	2,269	2,769	500	1220	636	-136
Kershaw	6,796	8,797	2,001	4,021	1,148	853
Lancaster	7,413	11,737	4,324	4,527	1,435	2889
Laurens	9,168	9,988	820	5,558	1,422	-602
Lee	2,504	2,596	92	1565	87	*
Lexington	21,989	32,111	10,122	13,928	5,748	4,374
McCormick	1,645	2,449	804	958	389	415
Marion	4,298	4,852	554	2,779	478	76
Marlboro	3,550	3,779	229	2,318	271	-42

SOUTH CAROLINA STATE PLAN 2013 - 2017

Newberry	5,323	5,959	636	3,165	398	238
Oconee	10,311	14,106	3,795	5,533	2,526	1269
Orangeburg	12,091	13,734	1,643	7,124	1,542	101
Pickens	12,616	15,993	3,377	7,261	2,476	901
Richland	31,475	37,541	6,066	18,897	4,656	1410
Saluda	2,778	3,195	417	1565	410	*
Spartanburg	31,740	38,227	6,487	19,666	4,543	1944
Sumter	11,760	13,921	2,161	6,980	1,718	443
Union	4,670	4,769	99	2,863	223	-124
Williamsburg	4,856	5,039	183	2,811	597	-414
York	17,072	25,626	8,554	10,895	3,723	4,831

Source: U.S. Census Bureau and SC Office of Research & Statistics.

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E. Socio-Economic Profile

As people grow older, they leave the workforce, and in many cases, their incomes decline. When reviewing South Carolina's senior population (those 60 +) for 2010, poverty or low income becomes a serious concern.

The following table shows the number of persons over 60 in poverty for each county in 2010.

County	Population 55 and older	Population 55 and older below poverty	Population 55 and older percent below poverty	Population 65 and older	Population 65 and older below poverty	Population 65 and older percent below poverty
Abbeville	6,869	1,202	17.5%	3,525	732	20.8%
Aiken	40,593	5,366	13.2%	21,732	3,059	14.1%
Allendale	2,228	714	32.0%	1,026	265	25.8%
Anderson	46,825	5,253	11.2%	24,880	2,668	10.7%
Bamberg	4,094	1,212	29.6%	2,127	656	30.8%
Barnwell	5,766	823	14.3%	3,049	386	12.7%
Beaufort	47,395	2,938	6.2%	27,565	1,775	6.4%
Berkeley	31,992	3,275	10.2%	14,847	1,743	11.7%
Calhoun	4,465	642	14.4%	2,204	397	18.0%
Charleston	79,590	8,667	10.9%	41,586	4,631	11.1%
Cherokee	13,102	1,766	13.5%	6,619	841	12.7%
Chester	8,512	1,396	16.4%	4,377	860	19.6%
Chesterfield	10,844	1,753	16.2%	5,456	953	17.5%
Clarendon	9,773	1,408	14.4%	5,233	873	16.7%
Colleton	10,606	2,139	20.2%	5,493	1,063	19.4%
Darlington	16,819	2,476	14.7%	8,366	1,284	15.3%
Dillon	7,110	1,586	22.3%	3,696	891	24.1%
Dorchester	24,728	2,361	9.5%	11,876	1,220	10.3%
Edgefield	5,410	849	15.7%	2,366	392	16.6%
Fairfield	6,314	1,269	20.1%	3,105	673	21.7%
Florence	31,446	4,051	12.9%	15,891	2,311	14.5%
Georgetown	19,456	2,690	13.8%	10,179	1,075	10.6%
Greenville	97,337	9,633	9.9%	49,898	4,955	9.9%
Greenwood	17,316	1,559	9.0%	9,519	908	9.5%
Hampton	4,950	857	17.3%	2,697	502	18.6%
Horry	75,750	6,799	9.0%	41,418	3,374	8.1%
Jasper	4,855	807	16.6%	2,576	367	14.2%
Kershaw	15,075	1,781	11.8%	7,759	937	12.1%
Lancaster	18,273	2,257	12.4%	9,208	1,192	12.9%
Laurens	17,852	2,523	14.1%	9,085	1,570	17.3%
Lee	4,596	984	21.4%	2,441	517	21.2%
Lexington	56,549	4,170	7.4%	27,958	2,459	8.8%

McCormick	3,933	403	10.2%	2,221	178	8.0%
Marion	8,517	1,545	18.1%	4,275	757	17.7%
Marlboro	6,674	1,251	18.7%	3,507	735	21.0%
Newberry	9,813	1,152	11.7%	5,095	571	11.2%
Oconee	22,482	2,472	11.0%	12,468	1,203	9.6%
Orangeburg	23,108	4,286	18.5%	12,338	2,386	19.3%
Pickens	27,135	2,369	8.7%	14,599	1,249	8.6%
Richland	67,385	6,661	9.9%	32,980	3,380	10.2%
Saluda	4,992	669	13.4%	2,728	422	15.5%
Spartanburg	67,145	7,239	10.8%	35,418	4,015	11.3%
Sumter	23,893	3,413	14.3%	13,031	1,987	15.2%
Union	7,720	1,186	15.4%	4,176	777	18.6%
Williamsburg	9,215	2,153	23.4%	4,806	1,261	26.2%
York	45,782	3,371	7.4%	23,312	1,983	8.5%
South Carolina	1,074,284	123,376	11.5%	558,711	66,433	11.9%

Source: American Community Survey, Data collected 2006 – 2010, Table 17001

Income: The percent below poverty varies from 6.3% in Beaufort County to 27% in Allendale County. Poverty is especially high among older women and blacks. Single women over age 60, most of whom are widowed, divorced, or separated, are the largest group of older persons. Most have never been employed, or worked in jobs where pensions were not provided. They live mainly on their husband's pension or Social Security "survivor's" benefits. Most elderly blacks live on Social Security only, due to the reduced employment opportunities available to them during their working years.

In addition to those living in poverty, many older South Carolinians earn incomes just above the poverty level. This "near poverty" population is at substantial risk of falling into poverty at the slightest adversity. Because the elderly have little or no protection against these adverse events, these events often become catastrophic and even life-threatening.

Sources of Income: When looking at sources of income for persons 65 and older, the SC Chapter of AARP states that 30% of income comes from Social Security, around 15% comes from asset income, and 18% comes from pensions, 28% from earnings and 3% from other.

The following table gives the number of those South Carolinians age 65 or older below selected poverty levels.

2010 Poverty Status for Person Over 65 Years			
	Estimated Number of Persons Age 65+	Margin of Error	Percent of Persons Age 65+
Number 65 years and over for whom poverty level was determined :	616,863	+/-1,915	100.0%
Less than 50% of poverty	12,072	+/-1,711	2.0%
50% to 99% of poverty	48,579	+/-3,461	7.9%

100% to 124% of poverty	37,581	+/-3,380	6.1%
125% to 199% of poverty	116,502	+/-5,250	18.9%
200% of poverty or higher	402,129	***	65.2%

Source: US Census Bureau, 2010 American Community Survey

Based upon latest Census statistics, 11.9% percent of all South Carolinians 65 and older live below the poverty level. A significant factor especially for persons 65 and older with low incomes and do not have adequate health insurance is that they may have to choose between purchasing expensive prescription medicines and food or housing.

2012 Health and Human Services Poverty Guidelines

	Annual Income for One-Person Household	Monthly Income for One-Person Household	Annual Income for Two-Person Household	Monthly Income for Two-Person Household
Living at 50% poverty	\$5,585	\$465.42	\$7,565	\$630
Living at 75% poverty	\$8,378	\$698.13	\$11,348	\$946
Living at 100% poverty	\$11,170	\$930.83	\$15,130	\$1,260.83
Living at 125% poverty	\$13,963	\$1,163.54	\$18,913	\$1,576.04
Living at 150% poverty	\$16,755	\$1,396.25	\$22,695	\$1,891.25
Living at 175% poverty	\$19,548	\$1,628.96	\$26,478	\$2,206.46
Living at 200% poverty	\$22,340	\$1,861.67	\$30,260	\$2,521.67

Source: US Department of Health and Human Services - 2012 Federal Poverty Guidelines

Race: The following table shows various groups by age, race and sex for South Carolina based upon 2010 Census statistics. The disparity in life expectancy between males and females, and whites and minorities is evident as they age.

SC Population by Age Group, Race and Sex 2010					
Age	Age 50+	50-64	65-74	75-84	85+
All races	1,542,331	910,457	369,043	192,114	70,717
Male	705,833	432,351	172,067	80,004	21,411
Female	836,498	478,106	196,976	112,110	49,306
White	1,144,847	648,854	287,170	152,852	55,971
Male	532,962	313,141	136,766	65,646	17,409
Female	611,885	335,713	150,404	87,206	38,562
Nonwhite	397,484	261,603	81,873	39,262	14,746
Male	172,871	119,210	35,301	14,358	4,002
Female	224,613	142,393	46,572	24,904	10,744

Source: US Census Bureau, 2010 Population Estimates

Education: Educational attainment varies greatly among older South Carolinians. As shown below, 26.2 percent of our 65 and older population have less than a high school education compared to 13.6 percent of our 45 to 64 year olds. The table below indicates that future generations of older adults are more likely to have at least a high school

education or higher. Education is a powerful predictor of health status and income. Educational attainment offers the hope of improved health status and quality of life.

2010 Estimated Educational Attainment by Age Group		
	South Carolina	
Total:	#	%
25 to 44 years:	1,192,330	100.0%
Less than High School Diploma	154,159	12.9%
High School Diploma or higher	1,038,171	87.1%
Bachelor's or higher	216,170	18.1%
Graduate or professional degree	96,025	8.1%
45 to 64 years:	1,247,097	100.0%
Less than High School Diploma	169,255	13.6%
High School Diploma or higher	1,077,842	86.4%
Bachelor's or higher	310,311	24.9%
Graduate or professional degree	119,022	9.5%
65 years and over:	634,930	100.0%
Less than High School Diploma	166,467	26.2%
High School Diploma or higher	468,463	73.8%
Bachelor's or higher	131,985	20.8%
Graduate or professional degree	55,103	8.7%

Source: US Census Bureau - 2010 American Community Survey. Single Year Estimates, Table C15001

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Employment: Employment continues to be an important, although not primary, source of income for older adults. Data for 2010 indicate that Social Security was a major source of income for South Carolina seniors with 30 percent of individuals age 65+ only having Social Security income. In 2010, 43.5% of those 60 to 64 were employed, 22.5% of those 65 to 69 were employed, 13.8% of those 70 to 74 were employed, and 5.0% of those 75+ were employed.

Despite the trend toward earlier retirement among those who can look forward to adequate income replacement, many older workers are strongly induced and/or are essentially forced out of their jobs. They subsequently have difficulty finding work with comparable wages and salaries. Pressures on older workers to leave the workplace have been growing during the past 15 to 20 years as employers have tried to reduce the costs of wages and employee benefits and to create labor force structures that can be readily altered at management discretion. With the impact of globalization and many employers reducing or eliminating pensions, many seniors will be impacted by job security and economic well-being and thus retirement planning. At the same time we are seeing many seniors who are healthier and want to continue to work after age 65 because they wish to or because they need to work to pay for on-going living expenses. Many employers will also face labor shortages and need to rethink work to accommodate their manpower needs and meet the needs of older workers who want to work part time in later years.

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SC Employment Status by Age Group - 2010

	Total for age group:	In labor force*:	Total employed	Percent of age group employed	Percent of labor force employed	Total unemployed	Percent of labor force unemployed	Total not in labor force
45 to 54 years:	658,778	514,432	459,483	69.7%	89.3%	53,908	10.5%	144,346
55 to 59 years:	305,410	210,483	193,109	63.2%	91.7%	17,262	8.2%	94,927
60 to 64 years:	282,909	137,299	122,957	43.5%	89.6%	14,342	10.4%	145,610
65 to 69 years:	213,262	53,876	48,083	22.5%	89.2%	5,793	10.8%	159,386
70 to 74 years:	161,730	25,332	22,258	13.8%	87.9%	3,074	12.1%	136,398
75+:	259,938	14,191	12,913	5.0%	91.0%	1,278	9.0%	245,747

* Includes Civilian and Military

Source: U.S. Census Bureau, 2010 American Community Survey Single-Year Estimate, Table 23001

Data are based on a sample and are subject to a sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables. Employment and unemployment estimates may vary from the official labor force data released by the Bureau of Labor Statistics because of differences in survey design and data collection. For guidance on differences in employment and unemployment estimates from different sources go to Labor Force Guidance.

Insurance: Health insurance is a very important component of economic security. As the population ages, it is especially important for security as acute, chronic and disabling conditions become more prevalent. Most older Americans and South Carolinians are covered by health insurance, primarily by Medicare. Most elderly, however, lack insurance coverage for long term care, leaving them especially vulnerable to the high cost of nursing home care.

As the population continues to age, it's critical to understand the health related issues and pre-existing conditions that non senior citizens have which will add to the state's burden when they become 65. A report by Families USA in 2010 showed that approximately 879,000 people under the age of 65—almost one in four (24.2 percent) of South Carolina's non-elderly population—have a diagnosed pre-existing condition that could lead to a denial of coverage in the individual health insurance market. The report shows that, while individuals in all age groups in South Carolina have pre-existing conditions, this is a problem that grows with age: Nearly two in five (38.2 percent of) adults aged 45 to 54 have a diagnosed pre-existing condition that could lead to a denial of coverage. In the 55 to 64 age group, the portion of adults with diagnosed pre-existing conditions climbs to nearly half (49.6 percent). 50 percent of South Carolina's uninsured are non-Hispanic white.

The elderly and disabled account for 23 percent of those covered with Medicaid, but they consume 62 percent of the resources.

Living Arrangements: As persons grow older or have chronic illnesses or conditions, the level of need for assistance raises the issue of living arrangement. Social and family supports are an important determinant of the well-being and continued independence of older adults. Furthermore, approximately 431,157 South Carolinians 65+ lived with at least one other related family member in a family household and 293,771 South Carolinians age 65+ lived in owner occupied housing.

As people age, they are increasingly likely to live alone: 166,356 of the state's 65+ year olds live alone. We may expect that the numbers of older adults living alone may increase as the baby boomers age; this cohort has been more likely to remain single and childless.

Other household types for the 65+ population are illustrated below.

Household Type for Population 65+ in South Carolina	
	Census 2010
Total Population	631,874
In family households	431,157
In Non-family households:	182,618
Male; Living alone	47,907
Male; Not living alone	4,424
Female; Living alone	118,449
Female; Not living alone	4,420
Nonrelatives	7,418
In group quarters	18,099

Source: US Census Bureau, SF2 Table PCT28

Aging adults living independently may become increasingly vulnerable to injury within the home. Inadequate home safety contributes to the number of in-home injuries among older people.

Institutional Care: There is a wide range of institutional facilities in South Carolina. They vary according to the level of care. The greatest level of care is provided in nursing facilities. Individuals requiring significantly less care may reside in a residential care facility (boarding home). Finally, individuals or couples may reside in a retirement home with varying degrees of assisted living that range from apartment style living to assisted living with congregate meals, to skilled care.

In South Carolina there are currently 194 nursing homes with 18,891 beds providing 24-hour skilled or intermediate nursing care and related services for persons with a wide range of physical and mental disabilities. In recent years the number of nursing home bed has decreased in South Carolina and there is one year + waiting list for beds.

South Carolina Nursing Home Joint Annual Report 2010	
Number of Nursing Homes (reporting)	191
Number of Beds Setup And Staffed	18,891
Admissions:	
Under age 65	3,764
65+	31,312
Total Admissions	35,076
Total Patient Days (P.D. = sum(Fac. P. D.))	6,264,896
Average Daily Census (ADC= sum(Fac. P.D. / Fac. Operating Days))	17,176
Total Facility days (=sum(Fac. Operating days))	69,675
ADC to Beds Differential	1,715
Percent Occupancy (=ADC/Beds)	91%
Percent of Nursing home Admissions Over Age 65	89.3%

Source: SC Budget & Control Board - Office of Research & Statistics - Health & Demographics Section

F. Health and Functional Status Profile

Mortality: The six major causes of mortality for older adults 65-74 in South Carolina are cancer (malignant neoplasms), diseases of the heart, chronic lower respiratory disease, cerebrovascular disease, diabetes mellitus and septicemia. For those persons 75 and older the six major causes of mortality are diseases of the heart, cancer (malignant neoplasms), cerebrovascular disease, Alzheimer's disease, chronic lower respiratory disease, and Nephritis, nephritic syndrome and nephritis.

South Carolina Mortality from Six Leading Causes of Death - 2010

Cause of Death	65 - 74					
	Total		White		Minority	
	Number	Percent	Number	Percent	Number	Percent
Cancer (Malignant neoplasms)	2,577	33.1%	1,928	34.5%	649	29.5%
Diseases of heart	1,722	22.1%	1,188	21.2%	534	24.3%
Chronic lower respiratory disease	615	7.9%	536	9.6%	79	3.6%
Cerebrovascular disease	386	5.0%	228	4.1%	158	7.2%
Diabetes mellitus	272	3.5%	148	2.6%	124	5.6%
Septicemia	167	2.1%	97	1.7%	70	3.2%
All other diseases	2,056	26.4%	1,470	26.3%	586	26.6%
All Causes	7,795	100.0%	5,595	100.0%	2,200	100.0%

Cause of Death	75 plus					
	Total		White		Minority	
	Number	Percent	Number	Percent	Number	Percent
Diseases of heart	4,876	23.7%	3,849	23.5%	1,027	24.4%
Cancer (Malignant neoplasms)	3,506	17.0%	2,761	16.9%	745	17.7%
Alzheimer's disease	1462	7.1%	1217	7.4%	245	5.8%
Cerebrovascular disease	1434	7.0%	1138	7.0%	296	7.0%
Chronic lower respiratory disease	1255	6.1%	1126	6.9%	129	3.1%
Nephritis, nephrotic syndrome and nephrosis	570	2.8%	387	2.4%	183	4.3%
All other diseases	7,472	36.3%	5,883	36.0%	1,589	37.7%
All Causes	20,575	100.0%	16,361	100.0%	4,214	100.0%

Source: SC Department of Health & Environmental Control, 2010 Vital and Morbidity Statistics

G. Limitations - Activities of Daily Living and Instrumental Activities of Daily Living.

As persons age, the number of limitations increase. Basic indices of a person's ability to function are shown by Activities of Daily Living (ADL), and by Instrumental Activities of Daily Living (IADL). The ADL includes basic self-care activities such as bathing, feeding, dressing and toileting. IADLs include activities related to home management such as shopping, preparing meals, and transportation.

The numbers of older South Carolinians 60+ who experience some ADL/IADL limitations are shown below.

PERSONS ASSESSED WITH AT LEAST ONE ACTIVITY OF DAILY LIVING OR INSTRUMENTAL ACTIVITY OF DAILY LIVING DIFFICULTY BY SELECTED CHARACTERISTICS BETWEEN 7/1/2010 AND 6/30/2011		
CHARACTERISTICS	NUMBER OF PERSONS SERVED	% ASSESSED WITH AT LEAST ONE DIFFICULTY
AGE (12,967 Assessed)		
55 – 64	1,555	8%
65 – 74	3,810	23%
75 – 84	4,859	32%
85 and Older	3,595	25%
HOUSEHOLD INCOME (11,460 Assessed)		
Poverty	5,800	41%
101 – 200% of Poverty	5,247	42%
201 – 300% of Poverty	592	5%
301+% of Poverty	197	2%
RACE (12,984 Assessed)		
White	4,296	27%
Non-White	10,085	63%
GENDER (12,984 Assessed)		
Male	4,897	24%
Female	12,279	64%
EDUCATIONAL LEVEL (10,964 Assessed)		
Less Than Third Grade	415	4%
3 rd through 8 th Grade	2,710	24%
Some High School	3,072	27%
High School Graduate	3,039	26%
Some College	1,178	10%
College Graduate	758	6%
LIVING ARRANGEMENT (12,186 Assessed)		
Live Alone	6,688	51%
Live with Others	5,536	42%
All Clients	14,408	92%
Source: AIM data Cluster 1 of NAPIS: Services: Personal Care, Homemaker, Home-Delivered Meals, Adult Day Care, and Care Management.		

The difficulty of performing ADL and IADL increases with age. ADL/IADL impairment is also inversely related to low income and education: The lower the income and

educational level, the greater the likelihood of impairment. This inverse relationship can be explained due to the better preventive care and health care received by higher income/educational groups as well as better ongoing management of chronic disease.

The number of persons 60+ with specific ADL/IADL limitations is shown in the table below. It also indicates that the need for assistance with these activities is often unmet.

PERSONS 60+ WITH ACTIVITIES OF DAILY LIVING (ADL) RECEIVING SERVICES BETWEEN 7/1/2010 AND 6/30/2011		
PROBLEM	% WITH PROBLEM	NUMBER OF PERSONS
Feeding	5%	653
Dressing	15%	2,226
Bathing	23%	3,334
Toileting	11%	1,655
Bladder/Bowel	10%	1,486
I/O of Bed	17%	2,422
Unduplicated Count with at least one ADL		5,980
Persons Indicating 3 or More ADL		2,740
Source: AIM data Cluster 1 of NAPIS Services (Above)		

PERSONS WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING (ADL) AGE 60 AND OVER Between 7/1/2010 and 6/30/2011		
PROBLEM	% WITH PROBLEM	NUMBER OF PERSONS
Normal Housework	63%	9,083
Cooking	61%	8,820
Phone	17%	2,411
Heavy Cleaning	75%	10,745
Shopping	64%	9,156
Medication	40%	5,773
Money Management	42%	6,042
Unduplicated Count of Persons with at least one IADL		14,529
Persons Indicating 3 or More Problems		11,141
Source: Source: AIM data Cluster 1 of NAPIS Services (Above)		

Looking at the numbers of persons with impairments raises the questions of who cares for these persons and where they receive their care. Informal caregivers, such as family and neighbors, provide approximately 78% of the care received. According to the Family Caregiver Alliance:

-
- 5.8 – 7 million people (family, friends and neighbors) provide care to persons 65+ who need assistance with everyday activities.
 - 29.2 million family caregivers provide personal assistance to adults (18+) with a disability or chronic illness
 - As the baby boomers age, the percent of persons with disabilities will increase from a low of 16.9% in 2025 to 18.9. % in 2045.

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CHAPTER 4: OVERVIEW OF THE 2013 – 2017 SOUTH CAROLINA STATE PLAN

This Chapter presents issues to be addressed through the Plan for the period October 1, 2012 through September 30, 2017 and beyond. These issues were identified through the submission of the FY 2010-2012 Area Plans, as well as input from our partners, various needs assessments carried out throughout the state and from many of our waiting lists and data collections. The SUA used data gathered from a variety of other sources, including the 2010 Census and the American Community Survey. The Plan discusses the graying of South Carolina, providing an overview of the diversity of its older adult population. Basic socio-economic, health, and functional status profiles are given. Census data show that the native over 60 population is disproportionately poor, with low formal education attainment.

With increases of frail, 65+ elderly, there will be increased need for acute care and long term care, both institutional and community-based. The numbers of persons suffering from dementia and Alzheimer's disease will grow dramatically over the next decade, with the cost of care increasing anywhere from four to seven times current costs. The demands on informal caregivers such as family and friends will increase.

The Plan outlines the major challenges that face us individually and collectively as South Carolina's population grows older. Implementation of the strategies will require partnerships among all state agencies and between public and private sectors. Individuals and families face the need to take on greater personal responsibility and accountability for their lives and life decisions to ensure that their later years are productive and healthy. The quality and vision of our public policy will have a significant impact on the changes caused by the aging of our population. It is for this purpose that the State Unit on Aging offers this plan.

With South Carolina's population aging, the SUA and AAAs will continue modernizing how we do business and how we serve the elderly. The SUA will look at cost sharing of services and lowering unit costs in order to better utilize funding resources. The SUA also plans to start using new assessment forms for OAA services in order to serve those seniors with the greatest needs. This plan lays out the key issues, goals, outcomes and strategies for the next four years and beyond on how we plan to accomplish our mandates from both the federal and state governments.

Key Outcomes and Strategies

A. Modernizing and Improving Programs and Services

The SUA has organized its issues and efforts into seven basic areas for the implementation of Choices for Independence. They are as follows:

1. Increased funds for home and community-based services
2. Maintaining and improving ADRC's statewide with a focus on improving a case management system
3. Information, Referral and Assistance, SC Access
4. Family Caregivers
5. State Health Insurance Program/I-CARE
6. Evidence-Based Prevention and Wellness programs
7. Long Term Care Training

Each of these issue/initiative areas focuses on enhancing personal choice and enhancing our older South Carolinians and their caregivers' ability to remain healthy and independent as long as possible. Increased funds on the state and federal level for home and community-based services help seniors remain independent and delay costly institutionalization which saps the resources of the individual and his or her family or results in public funding for these services. The implementation of Aging and Disability Resource Centers over the past four years, as a one-stop shop for senior services, and services for family caregivers and seniors also enhance independence and choice.

B. Modernization of Aging Services in South Carolina

As in the 2008 – 2012 State Plan, the SUA has organized its issues and efforts into basic areas for modernization of aging services in South Carolina. Many of these are in response to requirements of the Administration on Aging. Others are in response to the needs of South Carolina's seniors and their caregivers. They are as follows:

1. Collaboration with other state health and human services agencies to coordinate and maximize services to seniors, including the Affordable Care Act.
2. Meaningful Senior Centers: Senior Centers as the Town Square
3. Increased Competition/Cost control/cost sharing/Accountability
4. Information Technology
5. Expand and modernize nutrition services
6. Energizing the Alzheimer's Resource Coordination Center
7. New assessment forms for OAA services

South Carolina, as well as the nation, has recognized the need to modernize the service delivery system that was created under the Older Americans Act in 1965. With the aging of the "baby boomers" seniors' expectations have changed. They demand choice and will not use a system that fails to meet their expectations and needs.

The SUA has been working with the AAAs and service providers to update the client assessment procedures so that those seniors with the greatest needs are served first, focusing on rural, low income, and frail seniors. We are also directing our service providers to reevaluate their nutrition services by considering vouchers, frozen and shelf stable meals. In addition, pilot programs have been established in three AAAs to study cost sharing of services.

The Alzheimer's Resource Coordination Center is in the process of bringing in new advisory board members. Legislation has been drafted, and been approved by the Senate, that will give the Lt. Governor the authority to appoint members to the Alzheimer's Resource Coordination Council instead of the Governor. In 2009, an Alzheimer's State Plan was approved, which brought in new partners to leverage and consolidate the state's resources and to increase the visibility of Alzheimer's programs.

C. Long Term Care Reform and Community Living Incentives

South Carolina like the nation has recognized it will not have adequate resources to pay for the massive growth of the senior population over the next thirty years. South Carolina, likewise must craft a series of policies, initiatives, programs and services that move our service delivery system to one of providing choice, necessary information, guidance, prevention and wellness programs and incentives to help seniors remain independent as long as possible. With this also comes the recognition on the part of government that families and individuals must take personal responsibility for planning for their retirement and golden years. South Carolina must work with the federal and state government bodies to use the Medicaid and Medicare programs in the most

efficient manner possible within the state environment. South Carolina must also advocate to the federal government through the Centers for Medicare and Medicaid Services and the Administration on Aging for policies and initiatives that will work in South Carolina and benefit South Carolina's seniors and caregivers.

All of these initiatives will be focused on providing incentives for remaining in the community and reforming the Medicaid and Medicare programs to provide the greatest array of options possible for our seniors and their caregivers.

D. Senior Transportation

Transportation is critical for seniors and persons with disabilities, as well as low to moderate income members of South Carolina's population, to maintain their independence and remain at home. South Carolina like many other states lacks a coordinated and affordable transportation system that currently meets the needs of its population. The SUA is an active member of the SC Human Services Transportation Coordinating Committee as established by the Governor's Executive Order.

- The SUA will work with the SC Transportation Department and the Human Services Transportation Committee to draft a coordinated statewide transportation plan to build an affordable statewide system of public transportation to meet the needs of South Carolina's citizens.
- Provide adequate funding mechanisms to accomplish the Department of Transportation's statewide plan in the future.
- Provide a coordinated public transportation system to meet the needs of South Carolina's citizens.
- Seek funding opportunities such as the grant from the SC Department of Transportation to provide senior transportation such as has been established in the Santee Lynches region.

E. Geriatric Trained Professional Workforce

South Carolina was the first state in the nation to implement a geriatric physician loan program. This is the first step in a process to build incentives for building an adequate trained geriatric workforce of professionals in the state. This state plan will address how we plan to solve this growing shortage as our senior population grows.

F. Evidence-Based Research

South Carolina has been a national leader in the use of evidence-based research to improve its services and as a means to advocate for resources for the state's seniors. The Lieutenant Governor's Office on Aging also is administering health promotion/disease prevention evidence-based programs and collecting and analyzing data to determine to what degree the programs are working in community-based settings. Those programs to be analyzed include the Chronic Disease Self-Management Program (*Living Well* in SC), A Matter of Balance, a fall prevention program, and the Arthritis Foundation Exercise Program administered by the health department. Improving access to home and community-based services for individuals with Alzheimer's disease and related disorders (ADRD) by targeting underserved minority and rural populations is the focus of the ADSSP initiative. Expanded consumer choice and consumer-directed long term care support for caregivers is accomplished through the Aging and Disability Resource Centers (ADRC) and the Family Caregiver Support Program (FCSP).

G. Emergency Preparedness

In the past four years, the SUA has rewritten its Emergency Preparedness Plans and Policies to increase awareness and provide strategies for protecting the elderly during emergency situations and events (the SUA Emergency Plan is attached to this State Plan). SUA staff partners with the SC Division of Emergency Management and participate in drills and real life situations. The AAAs have established policies and procedures in their area plans and have been urged by the SUA to have strong working relationships with local emergency coordinators. The SUA also works with the SC Department of Health and Environmental Control on health emergencies such as Pandemic Flu. The Lieutenant Governor's Office on Aging has two major areas of concern with emergency preparedness: State Disaster Plan and State Pandemic Flu Plan

H. Elder Rights

The Lieutenant Governor's Office on Aging has addressed a number of issues concerning elder rights in the FY 2013-2017 State Plan on aging:

- Prevention of Abuse, Neglect and Exploitation
- Improvement of Quality of Care for Residents of Long Term Care Facilities
- Decisions Regarding Health Care and End-of-Life
- Legal Assistance Development
- Volunteer Program and Mental Health

The Lieutenant Governor's Office on Aging seeks to achieve the following goals in the area of Elder Rights:

- To reduce the prevalence of elder abuse, neglect and exploitation in home and institutional settings
- To improve the quality of care in facilities
- To empower residents to know and exercise their rights, voice their concerns and, to the extent possible, act on their own behalf or to seek outside assistance
- To identify and resolve resident problems relating to poor facility practices
- To identify and represent the interests of residents and seek appropriate

remedies

- To improve access to legal assistance services for older adults who have no other legal resources
- To increase awareness and promote the use of advance directives for health care planning in the community and long term care facilities through training and education
- To increase partnering and collaborative opportunities to increase knowledge of advance directives for health care providers
- To increase the awareness of the occurrence of mental illness and substance abuse in the older adult population
- Compile statistical information that documents and supports the need for the development of legal services or legislative initiatives to fill existing gaps
- Develop a complete system of centralized secure files and records to maintain comprehensive information on volunteers statewide
- Input information and compile statistical information that documents the visits made by Friendly Visitors

I. Volunteer and Employment Opportunities

As South Carolina's elderly population increases, available resources will continue to be a major concern for policymakers, providers of service, families, and individuals needing care and assistance. Funding will be stretched, and federal, state and local governments will not be able to provide for all needs of the aging population. The need for volunteers will be critical in the delivery of services for the elderly.

With limited resources, the SUA and AAAs must continue to utilize seniors in these activities, and seek ways to further utilize seniors' assets. Programs currently utilizing a sizeable number of volunteers are the home delivered meals program, State Health Insurance Program (SHIP), and the Friendly Visitor Program. The Lieutenant Governor's Office on Aging continues to build partnerships with community organizations and other parts of state government in order to increase volunteer efforts.

J. Community Living Program (CLP) and Veteran Directed Home and Community Based Services (VDHCBS).

The SUA will continue working with the ACL, U.S. Department of Veterans Affairs, and local Veterans Hospitals to strengthen and expand the Community Living Program (CLP) and Veteran Directed Home and Community Based Services (VDHCBS) in South Carolina as funding and resources are available. Currently the SUA has programs in the Trident AAA region through the Ralph H. Johnson VA Medical Center and it was recently expanded to the Dorn VA Medical Center in Columbia.

K. Affordable Health Care Act and Health Issues

In South Carolina, the Affordable Care Act is administered by the SC Department of Health and Human Services. All of the AAAs have been encouraged to partner with local hospitals for Care Transition funding through the Affordable Care Act. So far,

three AAAs (Waccamaw, Catawba and Appalachia) are working to receive Care Transition grants.

L. Education and Training

The rapid growth in the numbers of seniors in South Carolina heightens awareness of the expanding need for both institutional and home and community-based services. Preparation of personnel to work with older adults and caregivers is essential to ensuring an adequate supply of services now and in the future. Such preparation must include education and skills training specific to the services offered. Such training must address concerns regarding quality of care and accountability.

The SUA ensures that an orientation to aging services and programs is provided to new staff of the AAAs and AAA contractors. Training and continuing education opportunities are provided by the SUA at the state office and regionally in the field. Also, the SUA periodically conducts an assessment of statewide training needs to determine the types of training to be provided. The SUA cooperates with the ACL to ensure that state and regional staff attends training developed by the ACL. The AAA is responsible for conducting training needs assessments, and has responsibility for designing and implementing a regional education and training program.

M. Resource Allocation

The methods used by the SUA to allocate funds to the area agencies are described in Appendix B. OAA funds and most state funds, except when otherwise directed by law are allocated based on a multi-factored formula. The factors include an equal base, percent of population 60+ below poverty, percent of minority population 60+, percent of population who are moderately or severely impaired, and the percent of state rural population. An examination of the recipients of services through the Aging Network shows that those populations in greatest economic and social need and minorities are served in numbers greater than their general representation in the population. No further targeting measures are indicated at this time.

N. Coordination of Title III with Title VI of the Older Americans Act

South Carolina has one federally recognized Native American tribe, the Catawba Nation, in the region of the Catawba Area Agency on Aging. The AAA provides resources and information and assistance to the tribe and responds to other requests as they are received. The state assures that it will continue to assist the Catawba AAA in their efforts to coordinate Title III and Title VI programs in a way that will maximize services to the tribe and will share other resources as they become available. Additionally, the AAA has one member of the Catawba Nation as a member of its Advisory Board. South Carolina also has Native Americans in the Greenville and Pee Dee. The Lieutenant Governor's Office on Aging continues to reach out to these unrecognized tribes and provides services where possible. The SUA also is reacting to the growth of other minorities in South Carolina. With the growth in the Hispanic population, the SUA has developed informational materials in Spanish and SC Access works with Hispanics who need information in Spanish.

APPENDIX A
Assurances

DRAFT

FY 2013 State Plan Guidance**Appendix A****Listing of State Plan Assurances, Required Activities and Information Requirements****Older Americans Act, As Amended in 2006**

By signing this document, the authorized official commits the State Unit on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES**Sec. 305(a) - (c), ORGANIZATION**

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out,

directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall

- (I) identify the number of low income minority older individuals and older individuals residing in rural areas in the planning and service area;
- (II) describe the methods used to satisfy the service needs of such minority older individuals; and
- (III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on

- (I) older individuals residing in rural areas;
- (II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (IV) older individuals with severe disabilities;
- (V) older individuals with limited English proficiency;
- (VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- (VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:

in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including –

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

- (A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
- (B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that

- (i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
- (ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
- (iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long Term Care Ombudsman, a State Long Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--

- (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
- (ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for —

(A) public education to identify and prevent abuse of older individuals;

(B) receipt of reports of abuse of older individuals;

(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties referred; and

(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

- (A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
- (B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English speaking ability, then the State will require the area agency on aging for each such planning and service area—

- (A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English speaking ability; and
- (B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full time basis, whose responsibilities will include
 - (i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
 - (ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

- (A) identify individuals eligible for assistance under this Act, with special emphasis on—
 - (i) older individuals residing in rural areas;
 - (ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
 - (iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
 - (iv) older individuals with severe disabilities;
 - (v) older individuals with limited English-speaking ability; and
 - (vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- (B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular

attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community based, long term care services, pursuant to section 306(a)(7), for older individuals who -

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long term care facilities, but who can return to their homes if community based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall-

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made -

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

- (A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for
- (i) public education to identify and prevent elder abuse;
 - (ii) receipt of reports of elder abuse;
 - (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
 - (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
- (B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
- (C) all information gathered in the course of receiving reports and making referrals shall remain confidential except
- (i) if all parties to such complaint consent in writing to the release of such information;
 - (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
 - (iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

(1)(A) The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with

limited English proficiency, and older individuals residing in rural areas). Note: “Periodic” (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

Information Requirements

Section 102(19)(G) – (Required only if the State funds in-home services not already defined in Sec. 102 (19).

The term “in-home services” includes other in-home services as defined by the State Agency in the State plan submitted in accordance with Sec. 307.

The SUA is currently piloting Home and Community Based Services within several AAA's and cost-sharing is an essential part of the pilot.

Section 305(a)(2)(E)

Provide assurances that preference will be given to providing services to older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

The SUA recently revised its assessment form to ensure individuals with the greatest social need (low-income, limited English proficiency and rural residents) are being served. Priority scores are assigned and those with the highest scores are served first. Greater score variance was included in the new assessment. The new tool is currently under review by our Regional Administrator.

Section 306(a)(17)

Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and state governments and other institutions that have responsibility for disaster relief service delivery.

EMERGENCY PREPAREDNESS: *The “Disaster/Emergency Preparedness Manual” for the Lieutenant Governor’s Office on Aging (LGOA) was revised by the Emergency Preparedness Coordinator and approved by the Agency Director in February of 2012. The purpose of the plan is to improve the LGOA’s readiness for and response capability to emergency/disaster situations. In those situations, the role of the LGOA is three-fold:*

- 1. To ensure the capability of the State Office and Aging Network to continue/resume operations as quickly as possible following a disaster;*
- 2. To facilitate the coordination of disaster mitigation, preparedness, response, and recovery activities in the aging community where the disaster occurred; and*
- 3. To assist in the provision of mass care/shelter services before, during, and after a disaster.*

The LGOA plan includes Standard Operating Procedures for providing information and support, when needed, to the Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRC), Aging Network service providers and other agencies that work with senior adults. AAA’s and their contracted service providers are required to have their own emergency plans and mutual aid agreements. Each AAA is also required to compile and maintain a list of emergency contact information, and to supply the list to the LGOA. Severe weather alerts, situation reports regarding developing/potential disasters, and similar information is conveyed through these contacts.

The AAAs have been asked to partner with their local county Emergency Preparedness Office in order that all activities performed by the AAA are locally approved and coordinated with the local emergency officials.

By Executive Order of the Governor of South Carolina, the LGOA is mandated to perform a support role with regard to two emergency support functions in the State Emergency Operations Center (SEOC): ESF 6 (Mass Care) and ESF 11 (Food). To that end, a team of nine LGOA personnel, who attend appropriate trainings and participate in disaster exercises held by the SC Emergency Management Division

(SCEMD), have been designated to provide manpower and support to those functions in the SEOC when activated during a State of Emergency.

The LGOA Emergency Preparedness Coordinator is involved in the annual SCEMD reviews/revisions of the statewide plans for hurricanes, earthquakes, terrorist attacks, fixed nuclear facility accidents, pandemics, and other natural or man-made disasters. In addition, the Coordinator represents the LGOA on appropriate emergency-related committees and subcommittees, such as the Public Health and Human Services Committee, the SC Emergency Planning Committee for People with Functional Needs, the Shelter Subcommittee, the Assistive Technology Subcommittee, the SC Department of Health and Environmental Control's Community Preparedness Subcommittee, and others as needs are identified. Through these committees, essential connections have been made with emergency personnel in the SC Emergency Management Division and the county emergency preparedness offices, the SC Department of Social Services (the lead agency for ESF 6 - Mass Care), the SC Department of Health and Environmental Control, the American Red Cross, the Salvation Army, and numerous other agencies and organizations.

During the Long Term Care Ombudsmen visits to facilities, they review the disaster plan. All Long Term Care Ombudsmen will report changes to a facility's disaster plan to the Office of the State Long Term Care Ombudsman for update of the Master Disaster Relocation List.

Section 307(a)

(2) The Plan shall provide that the State will:

(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under Sections 306(C) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) (Note: Those categories are access, in-home, and legal assistance.) 1%

Section (307(a)(3)

The Plan Shall:

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); (Note: the "statement and demonstration" are numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)

(B) with respect to services for older individuals residing in rural areas;

(i) provide assurances the State Agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Section 307(a)(8) (Include in Plan if applicable)

(B) Regarding case management services, if the State Agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State Program, the plan may specify that such agency is allowed to continue to provide case management services.

Section 307(a)(10)

The plan shall provide assurances that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Section 307(a)(21)

The Plan Shall:

(B) provide assurances that the State Agency will pursue activities to increase access by older individuals who are Native American to all aging programs and benefits provided by the agency, including programs and benefits provided under this title (title III), if applicable, and specify the ways in which the State agency intends to implement the activities.

Several AAA's have tried to work with Native Americans in their areas. However, the Native Americans have no interest in working with the AAA's. The Catawba AAA is the only region with a recognized tribe.

Section 307(a)(28)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

The SUA has begun informing the Legislature of the increase in number of seniors and the dire results should no action be taken by the state. The new Lt. Governor was the former President Pro Tempore of the Senate and had been a member of the Senate 32 year before becoming Lt. Governor through Constitutional Ascension in March 2012. He is using his extensive contacts with the General Assembly and policy leaders throughout state government to make the case for increased funding for seniors.

The aging population who meet criteria for nursing home placement and are Medicaid eligible will have increased difficulty locating appropriate placement in facilities. This is resultant to the stagnant growth of adding facilities or Medicaid beds.

(B) Such assessment may include –**(i) the projected change in the number of older individuals in the State;**

SC ranks 17th in the nation for the highest percentage of age 60+ residents (917,000). From 2007 to 2030, the population of adults age 65 and older is projected to increase by 89%, more than four times as fast as the U.S. population as a whole.

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

Of the more than 917,000 South Carolinians over the age of 60, at least 42% have at least one disability which makes them more likely to live below the poverty level; 10.4% of seniors live below 100% poverty level (\$11,170/\$15,130); one in every 5 of those individuals age 65 and older survives on an average of \$7,500 a year; only 3 out of 10 eligible seniors get SNAP (\$908 net = \$200 month)

(iii) an analysis of how programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of Older individuals in the State; and

The SUA after years of budget cutbacks has recently reestablished a contract with the State Office of Research and Statistics to capture critical aging, hospital, emergency room and nursing home data to provide valuable insight to show how aging services are assisting South Carolina's seniors. This data is collected for the state's Senior Cube and it will be a key resource to provide the SUA with an accurate picture of seniors in South Carolina. Through the period of the State Plan, the SUA will be coordinating with the AAAs on how to better serve the elderly populations. The 2013 area plans will reflect the state's new aggressive approach to coordination and resource allocations during the next four years. The SUA hosts monthly meetings with the AAA directors and numerous other meetings with AAA programming staff monthly to follow trends and to ensure that everyone is following established guidelines and keeping true to their area plans. The SUA director, program directors and finance staff works closely with the AAAs in order to keep track of AAA resources in the event that resource levels have to be adjusted.

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

The 85 – 94 age group is experiencing the fastest growth – 30% while the 95+ age group increased 26%. Many of these seniors live below the poverty rate and it is critical that they receive supportive services.

Section 307(a)(29)

The plan shall include information detailing how the State will coordinate activities and develop long-range emergency preparedness plans, with area

agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief delivery. *Teams from the Office on Aging work in the state's Emergency Operation Center with other agencies responsible for emergency response. Aging representatives work with the Functional Needs cell to provide input on our target population. The LGOA plan includes Standard Operating Procedures for providing information and support, when needed, to the Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRC), Aging Network service providers and other agencies that work with senior adults. AAA's and their contracted service providers are required to have their own emergency plans and mutual aid agreements. Each AAA is also required to compile and maintain a list of emergency contact information, and to supply the list to the LGOA. In addition, the AAAs have been asked by the SUA to partner with their local emergency officials to coordinate emergency plans in order to ensure vulnerable seniors are protected locally. Severe weather alerts, situation reports regarding developing/potential disasters, and similar information is conveyed through these contacts.*

The AAAs have been asked to partner with their local county Emergency Preparedness Office in order that all activities performed by the AAA are locally approved and coordinated with the local emergency officials.

Section 307(a)(30)

The Plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

The director is directly involved in the coordination of emergency preparedness and in the event of an emergency will be in contact with the LGOA Emergency Coordinator and with the Lt. Governor to ensure that the emergency management plan established for the Lt. Governor's Office on Aging is properly activated and coordinated with staff and the AAAs. The "Disaster/Emergency Preparedness Manual" for the Lieutenant Governor's Office on Aging (LGOA) was revised by the Emergency Preparedness Coordinator and approved by the Agency Director in February of 2012. The purpose of the plan is to improve the LGOA's readiness for and response capability to emergency/disaster situations. The State Public Health Emergency Preparedness procedures are similar to the procedures established through the Disaster/Emergency Preparedness Manual, except the Department of Health and Human Services takes a lead role during the emergency.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State Plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraph (1) through (6). (Note: Paragraph (1) of through (6) of this section are listed below.

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State Plan submitted under section 307:

- (1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
- (2) an assurance that the State will hold public hearings; and use other means, to obtain the views of older individuals; area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
- (3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
- (4) an assurance that the State will use funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
- (5) an assurance that the State will place no restrictions, other than the required referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
- (6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3 –
 - (A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
 - (i) public education to identify and prevent elder abuse;
 - (ii) receipt of reports of elder abuses;
 - (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
 - (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
 - (B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
 - (C) all information gathered in the course of receiving reports and making referrals shall remain confidential except –
 - (i) if all parties to such complaint consent in writing to the release of such information;
 - (ii) if the release of such information is to a law enforcement agency, public protective service agency; licensing or certification agency, ombudsman program, or protection or advocacy system; or
 - (iii) upon court order.

The LGOA and the Office of the State Long Term Care Ombudsman have designated “seats” on the SC Adult Protection Coordinating Council. Membership on the Council insures consultation and collaboration with all agencies entrusted with protecting seniors and vulnerable adults. It also provides an alliance network for all adult protection entities to assist in strengthening laws and a body of experts to conduct public awareness and educational seminars regarding elder abuse, neglect and exploitation. The Long Term Care Ombudsmen will receive, evaluate, and investigate complaints or refer them to the appropriate entity. We will abide by the confidentiality laws and diligently work to protect the privacy of individuals (complainant and victim) involved in the complaint process.

Signature and Title of Authorized Official

Date

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APPENDIX B
Intrastate Funding Formula (IFF)

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Appendix B: Intrastate (IFF) Funding Formula

Each State IFF submittal must demonstrate that the requirements in Sections 305(a)(2) (C) have been met: OAA, Sec. 305(a)(2) “States shall,

(C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account (i) the geographical distribution of older individuals in the State; and (ii) the distribution among planning and service areas of older individuals with the greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older.

- For purposes of the IFF, “best available data” is the most recent census data (year 2000 or later), or more recent data of the equivalent quality available in the State.
- As required by Section 305(d) of the OAA, the IFF revision request includes: a description statement; a numerical statement; and a list of the data used by (by planning and service area).
- The request also includes information on how the proposed formula will affect funding to each planning and service area.
- States may use a base amount in their IFFs to ensure viable funding for each Area Agency but generally, a hold harmless provision is discouraged because it adversely affects those planning and service areas experiencing significant population growth.

Philosophy of the Intrastate Funding Formula

The guiding philosophy of the South Carolina Intrastate Funding Formula is to provide equitable funding to ensure quality services to persons age 60 and above, including those older persons with the greatest economic and social needs, low-income minority persons, and persons residing in rural areas.

Intrastate Funding Formula Assumptions and Goals

The Lieutenant Governor’s Office as the State Unit on Aging (SUA) utilizes the following factors to distribute Older American Act funds by Planning and Service Areas (PSA). The current formula provides specific weight for each of the following populations: persons age 60 years of age and older, Low-Income 60 and older population, Minority population 60 years and older, Proportion of State population 60 and older that is moderately or severely impaired (ADL), and proportion of state rural population.

- The Intrastate Funding Formula is intended to address the following goals:
- To satisfy requirements of the OAA and Title III regulations;

- To be simple and easy to apply;
- To ensure equal access to the system by eligible persons;
- To objectively apply all requirements;
- To correlate services with need; and
- To achieve balance between prevention and intervention in the allocation of resources.

The LGOA traditionally revises the funding formula decennially (every ten years) based upon demographic and population data changes from the Census. The LGOA will revise the IFF based on 2010 Census data for the older adult population. Future updates to the IFF will be based on population estimates provided by the Census.

Definitions for each population are indicated below.

60+ Population

The number of persons in the age group 60 and above.

Low-Income minority 60+ Population

Numbers of persons in the age groups 60 and above who are minorities (non-white) and are below the poverty level, as established by the Office of Management and Budget in directive 14 as the standard to be used by Federal agencies for statistical purposes. This factor represents “special attention to Low-Income minority older individuals” as required by the Older Americans Act.

Low-Income 60+ population

Numbers of persons in the age groups 60 and above who are below the poverty level as established by the Office of Management and Budget in Directive 14 as the standard to be used by Federal agencies for statistical purposes. This factor represents economic need as defined by the Older Americans Act.

Estimated rural 60+ population

An estimate of the numbers of persons in the age group 60 and above who reside in a rural area as defined by the U.S. Census Bureau. This factor represents the social need factor of “geographic isolation” as defined by the Older Americans Act.

Disabled 60+ population

Numbers of persons in the age group 60 and above who have a “mobility or self-care limitation” as defined by the Census Bureau. This factor represents the social need factor of “physical and mental disability” as defined by the Older Americans Act.

Intrastate Funding Formula Factors and Weights

Factors	Weights
Equal Funding Among all PSA Regions (AAA Regions)	50%
Population 60+	20%
Low-Income Minority 60+	10%
Low Income 60+	10%
Rural 60+ (estimate)	5%
Disabled 60+ (Moderately or Severely Impaired Population)	5%

Numerical Statement of the Formula

A = Planning and Service Area (PSA) Allocation
 T = Total Federal Funds Available for Allocations
 E = Equal Base; Weight 50%
 S = PSA Proportion of State 60 plus Populations; Weight 50%
 P = PSA Proportion of State 60 plus Population at are Below Poverty; Weight 10%
 M = PSA Proportion of State 60 plus Minority Population; Weight 10%
 I = PSA Proportion of State 60 plus Moderately or Severely Impaired Population, Weight 5%
 R = PSA Proportion of State Rural Population, Weight 5%

Therefore each planning and service area allocation is computed as follows:

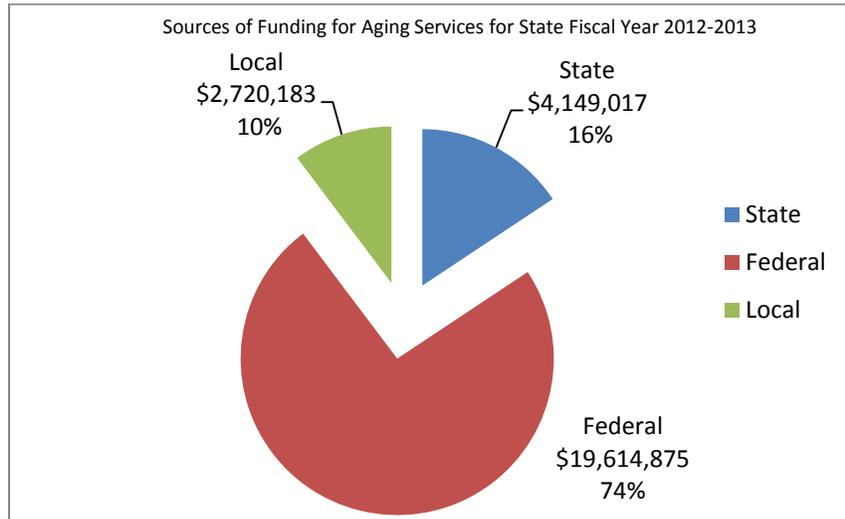
$$A = (.5E + .2S + .1P + .1M + .05I + .05R)T$$

The equal base is divided among the ten sub-state economic development and planning districts. If two or more of the designated planning and service areas (PSAs) merge, then the merged PSA shall receive 1/10 of the equal base for each sub-state economic development and planning district that is included in the new PSA.

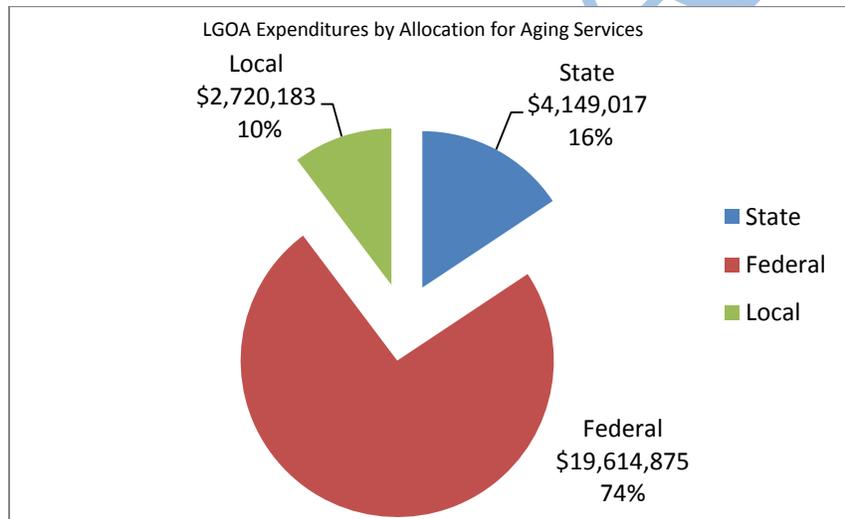
Lieutenant Governor's Office on Aging Program Expenditures

<u>Source</u>	<u>2012 - 2013</u>
Title VII, Chapter 2, Ombudsman	\$253,776
Title VII, Chapter 3, Abuse Prevention	\$74,605
Title III, expended by State, as Authorized in OAA, Sec.304 (d) (1)(B)	\$280,000
Title III provided at AAA Level	\$652,716
Other Federal	\$260,291
State Funds	0
Local (does not include "in-kind)	0
Total	\$1,521,388

LGOA (SUA) Total Budget for State Fiscal Year 2012 - 2013



LGOA Expenditure by Allocation Issuance



APPENDIX C
ISSUES, OUTCOMES, AND STRATEGIES

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Appendix C: ISSUES, OUTCOMES, AND STRATEGIES

As we review the key issues that face South Carolina over the next four years, it is apparent that state policy makers, providers of service and the public must carefully consider the trends facing the nation and the state as the population ages. The growth of the number of seniors needing long term care and related services, as well as the cost of providing such care will have a major impact on the nation and the state economy, local communities and families. This section provides information required by the Administration on Community Living (ACL), formally the Administration on Aging (AoA). Below are some of the issues and challenges that South Carolina and the nation will face over the next four years and for decades to come:

South Carolina Issues and Challenges

- **The dramatic growth of the senior population**
- **The growth of the number of persons with disabilities**
- **The increase of the number of persons with Alzheimer’s disease and related dementias**
- **The rising cost of health care and long term care services**
- **The serious resource limits for governmental services that will be outstripped by the growth in the need for health care and long term care services**
- **Consumers’ demand for increased choice and flexibility of services**
- **Consumers and caregivers needing increased information and assistance to make intelligent decisions and choices in order to assist their loved ones and maintain their independence for as long as possible.**

South Carolina has many needs and with a growing elderly population it will be imperative that legislators and policy makers are made aware of these critical challenges. With a new Lieutenant Governor, the SUA has stepped up its efforts to educate members of the General Assembly and policy makers in order to prepare for the significantly growing senior population that South Carolina will face during the next ten years. These leaders have been told about the consequences should no action be taken to prepare for the growing senior population.

Choices for Independence

Issue: Proposed Increased Funds for Home and Community-Based Services

From FY 2006 to 2009 the SUA was appropriated \$2.9 million in supplemental state funds for home and community-based services. However, the \$2.9 million was reduced to \$1.4 million recurring by 2012. This money funded a wide array of home and community-based services such as home delivered meals, group dining, transportation, home care, home modifications and respite, etc. All of these

programs are designed to help seniors remain at home. The program allows considerable flexibility for the Area Agencies on Aging and local service contractors to meet local service needs. As of 2012 there were 8,522 seniors on the waiting lists statewide, which the SUA believes is a conservative number since the 2010 Census identified 35,382 seniors over 65 who are at risk because of disabilities and difficulties. For the FY 2012 - 2013 state budget the SUA has requested an additional \$5 million in recurring funds for HCBS, but the budget will not be finalized until summer 2012. This will guarantee continuity of service for our state's seniors in the future. However, additional state funds are necessary if we are to serve all those on our waiting list. Although the SUA has asked for only \$5 million it would need at least \$10 million to serve the current waiting lists.

Goal

- **To obtain additional appropriated state funds on a recurring basis for the \$5 million requested for FY 2012 – 2013, and up to \$10 million to serve the persons on the current waiting list.**
- **To obtain additional state funds in the future to serve seniors in a cost effective manner to maintain choice and independence.**
- **To obtain a cost of living factor to be added to maintain current services in the future.**

Outcomes:

- The current population being served with limited state funding and those on the waiting list will be served within available resources.
- Research and outcome data will support current and future advocacy efforts to obtain funds to promote choice and independence, and to provide a cost effective mix of long term care services within South Carolina.
- South Carolina's seniors will be able to remain independent and in their homes if they so choose.

Strategies:

- Continue to collect research and outcome data to support recurring funding for home and community based services.
- Build and maintain partnerships with agencies and organizations concerned with the elderly and their caregivers to support senior friendly policies and services.
- Advocate with state policy makers in the future for resources for services that promote choice and independence and a balanced long term care system for the state.
- Provide cost effective services through competitive local service providers so that the maximum number of seniors are served with limited federal and state funding.

Issue: Statewide ADRC Implementation with Case Management

Since 2003, South Carolina has opened 10 Aging and Disability Resource Centers (ADRC), covering all counties that serve older adults and adults with disabilities.

It was the vision of the Administration on Aging that all Area Agencies on Aging in South Carolina would become Aging and Disability Resource Centers so that in every community there is a highly visible and trusted place where people can turn for information on the full range of long term support options.

ADRCs play an active role in helping the elderly and individuals with disabilities access public benefits for long term services and supports, making the application process easier and more seamless for consumers.

The SUA has piloted with three AAAs to create cost sharing in order to serve new clients and to stretch current funding. In addition, the SUA is working with AAAs to draft a new client assessment in order to ensure that the seniors in most need are the recipients of aging funds.

Goal

- **To have the ten Aging and Disability Resource Centers known in every community as a highly visible and trusted places where people of all incomes and ages can turn for information on the full range of long-term support options and a single point of entry for access to public long-term support programs and benefits.**
- **Assist consumers with completing financial applications for Medicaid, food stamps, LIS, and other public benefits.**
- **Have functional eligibility assessors within the ADRC**
- **Have financial eligibility assessors within the ADRC**

Outcomes:

- Consumers of LTC would have one single entry point into the system
- Seniors and caregivers will have choice and remain independent at home whenever possible.
- ADRCs could provide case management services for those in need if funding was available.

Strategies:

- Build on the strong existing networks for SC Aging Network (specifically I&R and Family Caregiving), I-CARE Programs and Independent Living Centers.
- Develop partnerships with local community and state service providers.
- Maintain and expand the statewide resource directory – SC Access.
- Complete “Bridges” project so consumers only have to tell their story once. Bridge is completed for SHIP and Family Caregivers. Working on the Benefits Bank.
- Have ADRC staff complete assessments and screenings (AIM, CLTC, etc.).
- Overcome the stigma associated with Medicaid by serving all income groups and across disabilities; ADRCs can assist a wide range of individuals, including family caregivers, in obtaining long term supports and services in the most desirable and appropriate setting.
- Have ADRCs intervene in critical pathways to long term services and supports, such as hospital discharge planners, physicians or other health professionals, or long term supports providers, through options counseling; ADRCs convey

the range of alternative services and settings available, as well as methods to pay so individuals can both plan ahead and make informed decisions about current needs.

- ADRCs are working with the SC Hospital Association, the Carolina's Center for Medical Excellence's Quality Information Organization (QIO) and local hospitals to develop Care Transitions Programs.
- Divert individuals from nursing facilities by conducting pre-admission screening through the ADRC.
- Work with General Assembly and policy leaders to pass legislation to enhance and expand ADRCs.

Issue: The Community Living Program (CLP) and Veteran Directed Home and Community Based Services

Supports Independence and Choice in the community for seniors and veterans who need nursing home level of care. The two year Community Living Program with the Veterans Directed Home and Community-Based Services (VDHCBS) option is being piloted in the Trident AAA Region (serving Berkeley, Charleston and Dorchester Counties). This grant allows the ADRC to serve individuals at highest risk of nursing home placement and spend-down to Medicaid with flexible services, including consumer direction. The VDHCBS option allows veterans who need nursing home level of care to continue living comfortably in their homes and out of nursing homes or to transition out of the nursing home and return to the community. In addition, to the Trident Regional ADRC, the Ralph H. Johnson VA Medical Center in Charleston is another key partner in this effort. Recently, the program was expanded to the Dorn VA Hospital in Columbia. (Funding for this pilot is slated to end unless new funding opportunities are found from ACL and VA.)

Goal

- **Provide seniors and veterans with independence and choice.**
- **Provide seniors the option of leaving nursing homes and to live safely and comfortably in the community in their own homes.**

Outcomes:

- To provide consumer choice to seniors and veterans.
- Provide options to have seniors and veterans live independently at home.
- To make this a statewide program.

Strategies:

- Build upon the successful pilot program and expand to other areas of South Carolina.
- Work with the ACL and the Department of Veterans Affairs to seek new funding and grant opportunities to expand the pilot. Continued funding for VDHCBS is entirely dependent on the VA allocating funds.

Issue: Information, Referral and Assistance, SC Access

The mission of SC Access is to help older adults, adults with disabilities, and those who care for them access useful information about long term support and needed senior care and health services. Through the use of a comprehensive web-based service directory, regional Information, Referral and Assistance Specialists (IR&A Specialists) and staff at the regional Aging and Disability Resource Centers (ADRCs), individuals find options for care throughout South Carolina.

SC Access has several components. The public side includes the service directory, personal care worker listing, community calendar, e-forms, and “Learn About”, an educational feature with both local and national information on a wide array of topics. References to SC Access from this point on will cover all of the components mentioned above. In addition to the public resource database, SC Access has a protected Client Intake/Case Management Module (On Line Support Assist-OLSA) used by the IR&A Specialists and ADRC staff to track clients and provide case management to those who contact them for assistance.

IR&A Specialists provide personal assistance in a “one stop shop” environment that enables older adults, people with disabilities, and their caregivers to access the services they need to live as independently as possible. IR&A Specialists are trained according to national standards (AIRS) in interviewing and screening techniques and referral skills. They are also trained on how to use the public side of SC Access and the protected OLSA module. They receive continuous training at monthly meetings to stay informed on current issues facing the constituents the IR&A Specialists serve.

Issues Facing SC Access:

In a system as large as SC Access, maintenance of the data contained within will always be an issue. Another issue SC Access faces is the constant need to improve and expand the information so that it remains at the forefront of providing answers in an ever changing system. SC Access needs to continuously be marketed through multiple avenues to ensure all South Carolinians know that SC Access is their map to services. OLSA needs to be enhanced to increase efficiency for the IR&A Specialists and improve client tracking. IR&A Specialists need effective continuous training to ensure that their knowledge and skills grow with the changing needs of the constituents they serve. Partnerships and information sharing among the aging network and other interested parties need to grow and develop into a strong two way communication network so the citizens of South Carolina are served in the most efficient and effective manner possible.

Goal

- **Ensure that information in SC Access remains current through annual review**
- **Add service providers to include services and groups not currently well represented.**
- **Build upon the success of SC Access to ensure that the number of online visitor to the site grows monthly and annually.**
- **Continue enhancing and promoting the Community Calendar**
- **Develop partnerships between the aging network and other**

community partners statewide to build a strong communications network.

- **Add state specific information to “Learn About” for seniors and adults with disabilities.**
- **Conduct training that will build the skills of the IR&A Specialists**

Outcomes:

- Consistent, accurate, up to date information will be available in all areas of SC Access
- Additional resources and service providers are added to the SC Access database
- South Carolinians will have access to information related to events in their local area related to aging or disabilities
- South Carolinians will know how to find information and resources in SC Access
- Data entered in OLSA will be more consistent and accurate, thereby making reporting more reliable
- IR&A Specialists will have the knowledge, skills, and ability needed to effectively and efficiently assist clients who contact them
- The aging network and its community partners will have open, effective communication that will identify resources, find solutions to problem areas, and improve overall services to older adults, adults with disabilities and their caregivers
- Information on long term care in South Carolina will be available in “Learn About”
- The number of new and regular site visitors will increase annually

Strategies:

- Constant development and implementation of policies and procedures that allow SC Access staff to effectively maintain accurate, consistent, and current information in the database
- Develop working partnerships with individuals, groups, and organizations that can assist in identifying resources for inclusion as well as provide outlets for marketing efforts
- Creative marketing that uses traditional venues and media, word of mouth, and any new way to get the information to the public that may present itself
- Develop training materials to be used for internal staff and the staff of our partners to ensure that more professionals who have an opportunity to assist an individual will know how to use SC Access
- Use new technology (Forms Builder) from VisionLink to upgrade OLSA
- More local South Carolina events will be posted to the Community Calendar
- Add new long term care planning information in “Learn About” based on questions and feedback received during presentations and long term care trainings
- Aggressively market SC Access through outreach at community events, senior expos, health fairs and screenings, meetings, and senior network partners

Issue: Family Caregiver Support Program

Eighty percent of all long term care services are provided in the home by unpaid family members. It is often this support that enables the older person to remain at home despite illness and disability, thus delaying or avoiding much more expensive care in an institution.

Latest data available shows that there are 770,000 family caregivers in South Carolina who provide 737,000,000 hours of care per year at an estimated value of over \$7.4 billion. Annually 15% of the workforce becomes full-time caregivers. When 1,500 caregivers stop working, \$22 million in purchasing power is lost to the SC economy. Without caregivers, 50% of care recipients would go to a nursing home and cost the state millions in state funds to provide Medicaid nursing home care for one year.

- Families provide care willingly but at great personal cost to the caregiver's health, financial stability and their longevity. The average caregiver foregoes \$659,139 in salary and retirement benefits over the course of a lifetime, which impacts the caregiver's ability to support one's own care needs in the future.
- The caregiver's own physical health is an influential factor in the decision to place an impaired relative in a long term care facility.
- Caregiver support services have been shown to mitigate costs.
- Respite decreases the risk to caregivers, reduces the risk of acute hospital admissions, and helps prevent or delay costly placements in assisted living or nursing homes.
- Caregiver counseling and support improves health outcomes and extends caregiving.
- National Family Caregiver Support Program – SC's Model is Consumer-Directed. Administered locally by the 10 Area Agencies on Aging (AAA), each AAA has a full-time Family Caregiver Advocate who works directly with family caregivers to help them work through the challenges of their own specific caregiver situation. Eligible caregivers may also obtain a mini-grant or budget to purchase services from the provider of their choice. Caregivers purchase the agreed upon services and are reimbursed later or they may access services through vouchers.

Goal

- **Family caregivers in all counties will be recognized and supported for their valuable role in the long term care system; have access to high quality information, referral, and assistance; be able to choose from a full array of service options; and have access to respite care and other supportive services in their communities throughout the caregiving experience.**
- **Educate policy makers about the need to provide more respite services to caregivers.**
- **The LGOA will continue supporting programs like Seniors Raising**

Children and Grandparents Raising Grandchildren.

Outcomes:

- Improve the quality and availability of information to families and caregivers, including those caring for persons with Alzheimer's disease and related disorders.
- Obtain more funding to provide the ever increasing number of family caregivers in the state with consumer-directed, flexible caregiver support services.
- Increase availability of support groups, caregiver training, respite, and peer support options.
- Increase Consumer Choice for the elderly and their family care givers.
- Family caregivers would be provided with more Respite services if new funding sources were found.

Strategies:

- Partner with ADRCs to demonstrate the positive impact of South Carolina's Family Caregiver Support Program and justify a request for additional funding.
- Continue development of a consumer-driven statewide service delivery system by conducting 6 technical assistance/training meetings annually with regional Family Caregiver Advocates.
- Keep the LGOA web site updated as a caregiver resource.
- Work with groups like the SC Advisory Council on Aging to educate policy makers on the need for new respite resources.

Issue: Elder Care

The ElderCare Trust Fund was established in 1992 by the SC General Assembly. Citizens are able to make a voluntary contribution to the fund through a check-off on state income tax forms or through direct contributions. The ElderCare Trust Fund enables the LGOA to support innovative programs that help older persons remain in their homes and communities, avoiding institutional care. All money provided by fund is distributed through grants. Since 1995, over \$300,000 in contributions have been granted to South Carolina's not-for-profit organizations. The Fund is administered by the LGOA and is guided by an advisory board comprised of citizen leaders.

Goal

- To increase the awareness of the ElderCare Trust Fund so that more South Carolinians contribute by checking-off on their state income tax forms, thereby providing more funds that support the elderly in remaining in their homes and communities and avoiding institutional care.

Outcomes:

- More state funding for senior programs.

Strategies:

- Education to inform taxpayers of this voluntary fund.

Issue: State Health Insurance Program (SHIP)

SHIP (State Health Insurance Information Program) is the gateway to accessing essential information and assistance regarding Medicare Part D and Medicare Advantage plans. The State Health Insurance Information Program aka Insurance Counseling Assistance and Referrals for Elders Program (I-CARE) is a counselor based program designed to provide unbiased Medicare enrollment and assistance to beneficiaries. The SHIP counselors at each of the state's ten regional ADRCs help consumers meet this goal.

Medicare Part D offers many prescription plan options to offset the cost of prescription drugs. Ten percent of beneficiaries in SC are enrolled in Medicare Advantage plans (MA) and many do not understand the benefits.

SHIP Provides:

- A searchable database for Medicare Part D drug plans and Medicare Advantage Plans.
- Trained counselors to provide objective and free information.
- The SHIP Program is co-sponsored by the SC Department of Insurance. To avoid any conflict of interest, the Department of Insurance screens potential counselors for insurance licensures. The SHIP grant prohibits agents from becoming counselors.
- The SHIP training modules are Medicare Part A thru D, Medicare Supplement, Medicaid Eligibility and Medicare fraud. Medicare counselors are required to become certified by obtaining a proficiency of 70 or more on a final examination. Broader Medicare training opportunities are provided at annual conferences hosted by CMS. There are 467 certified SHIP counselors in South Carolina and 102 new counselors were certified in 2012.
- Local help to learn about and/or enroll in Medicare programs.
- The SUA allocates funds to the AAA to provide assistance in the local communities. Grant funds are allocated using the intrastate formula and can be used to hire coordinators.
- Under Part D, Low-income Subsidies (LIS) are available based on low-income and resources. Some people will be automatically enrolled and others will be required to complete a lengthy application.
- People are enrolled in a Medicare Advantage plan that health care providers are not accepting. They are required to pay full cost of care if providers do not accept the plan for care.

Goal

- **Provide information and assistance to a greater number of beneficiaries unable to access other channels and who prefer locally based services.**
- **Enhance the SHIP counselors and equip them to be proficient in**

educating, assisting and enrolling consumers.

- **Increase targeted outreach to locate and enroll consumers eligible for Low-income subsidy.**

Outcomes:

- Seniors and adults with disabilities will be able to locate prescription drug coverage that meets their financial and health needs
- Consumers will be able to understand and access services in their local community
- Increase the number of beneficiaries contacting the SHIP program for assistance
- Increase outreach events to provide information about MA coverage and marketing policies
- Reduce the number of consumers misinformed about provider's acceptance of Medicare Advantage Plans

Strategies:

- Offer four Medicare basic and advanced trainings annually for counselors with regard to Medicare products.
- Offer educational and enrollment seminars to people in every region in South Carolina.
- Offer Medicare 101 to new Medicare beneficiaries to empower them to choose decisions that suit their needs.
- Collaborate closely with CMS, Social Security and ACL as an active partner to provide the most current and accurate information to beneficiaries and the public.
- Identify and partner with universities and colleges to use students to enroll low-income consumers eligible for LIS.
- Increase targeted outreach to reach consumers eligible for LIS.
- Partner with other community organizations such as the Benefits Bank to increase the number of individuals enrolled in LIS.

Issue: Senior Medicare Patrol (SMP)

South Carolina Senior Medicare Patrol' (SMP) purpose is to educate Medicare/Medicaid beneficiaries and caregivers about Medicare/Medicaid benefits in order to understand Medicare Statements such as Medicare Summary Notices (MSN), Medicare Part D Prescription Drug Plan (PDP) Explanations of Benefits (EOB) and other related health care statements. Through this knowledge, a person can identify, resolve and/or report possible billing errors, fraud, abuse and waste to the SMP.

Unfortunately, unscrupulous people take advantage of the Medicare program.

The SMP Project works in collaboration with national and state fraud control units to help beneficiaries resolve complaints. If a billing error or fraud complaint cannot be resolved with the provider, a certified SMP counselor can be reached at the Fraud TIPS Hotline.

Goal

- To provide the elderly and their caregivers with the tools to fight Medicare fraud and to ensure that they are educated consumers when making decisions about Medicare and Medicare Drug Coverage programs.

Outcomes:

- Ensure that seniors and their caregivers have the tools necessary to make informed decisions about Medicare benefits. Through this knowledge, a person can identify, resolve and/or report possible billing errors, fraud, abuse and waste to the SMP.
- Seniors will be empowered and know their Medicare rights.

Strategies:

- Inform seniors of the risks and provide them with the tools to protect themselves from Medicare fraud.
- Inform seniors to treat Medicare, Medicaid and Social Security numbers like a credit card number and to never give out account numbers or other personal information to strangers.
- Inform seniors that Medicare representatives do not make uninvited home visits or call to sell a drug or health plan.
- Provide seniors with a Medicare Prescription Drug Coverage Fraud pamphlet online.

Issue: Evidence-Based Prevention and Wellness Programs

Since August 2006 the LGOA has partnered with the SC Department of Health and Environmental Control (DHEC) to administer Evidence-Based Prevention and Wellness Programs. The funding was received with a grant from the Administration on Community Living (ACL) to introduce and expand evidence-based health promotion and disease prevention programs (EBP) in South Carolina. The programs are offered in all AAA regions statewide.

Organizations use the Stanford University Chronic Disease Self-Management Program, called *Better Choices Better Health* South Carolina; *A Matter of Balance*, a falls prevention program; and/or the Arthritis Foundation Self Need Program or the Arthritis Exercise Program. Training will continue to be provided by Master Trainers throughout the state including the LGOA or DHEC. The programs are also being offered outside of the aging network in such locales as housing complexes, faith based organizations, assisted living facilities and health care provider organizations.

The SUA continues to seek new funding opportunities through ACL for these programs, including funding to begin a Diabetes program.

Goal

- Have local contractors and AAAs identify evidence-based programs they would like to provide at their senior centers and meal sites.

- **Increase the number of participants in the program statewide.**
- **Continue to identify partners that can support the sustainability of the program either through financial support or contribution of resources.**
- **Continue to explore additional grants to support the program.**
- **Policy Makers will demonstrate support of evidence-based programming at the federal and state levels through allocation of additional resources and funding.**

Outcomes:

- Through evaluation, seniors will demonstrate a higher quality of life after completing the programs.
- New partnerships will be developed.
- Research will enable state and local providers to have adequate resources to provide cost effective prevention services to the elderly and their caregivers.
- EBP programs will enable the elderly and caregivers to have choices and remain safe and independent at home whenever possible.

Strategies:

- Complete research related to program outcomes of ACL grant, including qualitative program analysis and quantitative data provided by the USC School of Public Health evaluations and eventually by the SC Office of Research and Statistics once the SUA renews that contract.
- Disseminate findings of the evaluation efforts and compare with other states' data.
- Seek additional funding and/or resources for the sustainability and expansion of the EBP initiatives.

Issue: Long Term Care Planning

The need for long term care for seniors is probably the most catastrophic unexpected event that could happen. This is because the need for long-term care typically removes any level of security a senior may have. With the need for long term care the senior may lose his/her independence, experience a loss of good health and/or use up his/her remaining assets and income. No other late-life event can be as devastating to the lifestyle of a senior.

Although seniors are definitely concerned about the need for long term care it is not high on the list of concerns. It is human nature not to worry about an event until it happens. Certainly everyone is concerned about having his house burn down or having an accident or getting an illness or ending up in the hospital or needing long-term care but these things are typically beyond our control. But people do plan for the risk of loss and typically have set money aside or bought insurance or prepared written documents to cover the unexpected, except when it comes to long term care.

Over 60 percent of seniors over age 65 will require at least some type of long-term care services during their lifetime. Despite the need for long term care planning,

most Americans still do not carry any form of coverage and fewer than two in five (37%) adults report that they have developed a plan to pay for their long term care needs. Very few seniors spend money or time to plan for the event of long-term care.

Most Americans are unable to afford to carry long term care coverage after they pay for their monthly expenses such as shelter, food, prescriptions and medical. No one knows why people beyond age 65 are not more concerned about preparing for long-term care. Perhaps seniors prefer to ignore it rather than embrace the need for it as they mistakenly think the government will take care of them. Or they are assured that family and friends will provide the care when needed, but don't know how difficult it really is for loved ones to provide that care when the time actually comes. Whatever the case, without proper planning, the need for long-term care can result in the single greatest crisis in a senior's life.

This lack of planning will also have an adverse effect on the senior's family. It usually results in great sacrifice or financial cost on the part of the spouse or children. For those with no immediate family, long term care can be a burden to extended family members.

Why Plan Ahead for Long Term Care Needs

No one wants to think about when they might need long term care. It is natural that thinking about needing long term care and "planning ahead" is often postponed, sometimes until it is too late.

Most people learn about long term care the hard way – when they or a loved one needs care. However, long term care needs are best met when they are planned for. Planning ahead gives individuals time to talk with their family about preferences and concerns, to research care options in the community, and to give some thought to preferred types of services and providers. Furthermore, planning ahead gives individuals the time to plan for how they will pay for care, which can be very costly, in a way that does not deplete the financial resources available for a spouse or other family members.

Why People Do Not Plan Ahead

Even though there are important advantages to planning ahead, people still often do not do so. Even when people are aware of and acknowledge these advantages, there are still emotional and logistical barriers to planning ahead. Some factors are more important for certain people than others, but all play some part. They include:

- Lack of awareness of the risks of needing care
- Lack of awareness of the costs of care and who pays
- Realization that, if they need long term care for an extended time, it is most likely to be paid for out-of-pocket
- Denial
- Competing planning priorities
- Have difficulty in discussing long term care issues
- Misunderstanding the benefits of planning
- Not understanding how to plan

Goal

- **Increase the awareness of the need for long term care planning through trainings and public awareness campaigns.**

Outcomes:

- Increased public awareness of the need to plan for long term care needs.
- Reduced dependence on Medicaid for funding of long term care needs.
- Increased choices and control of care options.
- Improved quality of life and increased independence.
- Reduced caregiver burden.

Strategies:

- Provide educational opportunities to explain need to prepare for Long Term Care
- Provide additional trainings as requested
- Post training modules and other resource materials on the Lt. Governor's Office on Aging website and SC Access calendar

Issue: Nursing Home Bed Locator Website

The LGOA in partnership with the SC Department of Health and Human Services (DHHS) will establish a website that is updated daily with information regarding vacant or available nursing home beds in South Carolina. The nursing home operators will be provided an online tool to input the number of vacant beds they have available each day and the LGOA will maintain a website that provides that information to the public.

It should be noted that currently South Carolina is losing nursing home beds and there is a two year waiting list for Medicaid to place patients in nursing homes. The aging population who meet criteria for nursing home placement and are Medicaid eligible will have increased difficulty locating appropriate placement in facilities. Currently there is already a two year waiting list for Medicaid Beds in this state. This is resultant to the stagnant growth of adding facilities or Medicaid beds.

Goal

- **To provide seniors and their caregivers with a tool which provides a list of available nursing home beds, that is updated daily.**

Outcomes:

- Seniors and their caregivers will have the most comprehensive and accurate data available regarding available nursing home beds in South Carolina.

Strategies:

- Work with DHHS to ensure that all nursing home providers participate in the program and update their status each day.
- Educate the public about this valuable service so they know how to locate nursing home information.

Issue: Affordable Care Act

The Affordable Care Act (ACA) was passed by Congress in 2010 with the goal of ensuring that all Americans have access to quality, affordable health care and creation of the transformation within the health care system necessary to contain costs. The Patient Protection and Affordable Care Act contains nine titles, each addressing an essential component of reform:

- Quality, affordable health care for all Americans
- The role of public programs
- Improving the quality and efficiency of health care
- Prevention of chronic disease and improving public health
- Health care workforce
- Transparency and program integrity
- Improving access to innovative medical therapies
- Community living assistance services and supports
- Revenue provisions

The lead agency for the Affordable Care Act in South Carolina is the Department of Health and Human Services (DHHS). The Act has been controversial in South Carolina with the Governor and DHHS asking for waivers to be exempt from certain provisions of the Act. In addition, the State of South Carolina, through Attorney General Alan Wilson, has brought suit with other states against the Act to determine if specific mandates and provisions are constitutional. That suit is currently pending in the U.S. Supreme Court.

The SUA has encouraged AAAs to partner with local hospitals for Care Transition Funding through the Affordable Care Act. The Person-Centered Hospital Discharge Model Grant was built upon and piloted with one ADRC by providing targeted assistance to improve hospital discharge planning and lesson or eliminate hospital readmissions within thirty days. The HDM grant promotes the development and implementation of enhanced hospital discharge planning models that meaningfully engages seniors and individuals with disabilities and their informal caregivers; increases the capacity of ADRCs as a single entry point to provide critical linkages to available long-term care services in the community and much needed supports for informal caregivers themselves.

Goal

- **The SUA will continue working with the South Carolina Department of Health and Human Services, which is the lead agency in South Carolina in regards to the Affordable Care Act.**
- **The SUA will continue encouraging the AAAs/ADRCs to partner with the SC Hospital Association, State QIO, and local hospitals on Care Transition Funding through the Affordable Care Act.**

Outcomes:

- Care Transition Funding through the ACA, increase the capacity of the ADRCs as the single entry points to provide critical linkages to available long-term care

services in the community and much needed supports for informal caregivers themselves.

Strategies:

- Encourage the AAAs/ADRC to seek Care Transition Funding opportunities.

Modernization of Aging Services in South Carolina

Issue: Collaboration with other state health and human services agencies

As South Carolina continues implementing current initiatives and key elements in its FY 2013-2017 State Plan on Aging, it will be necessary to collaborate and build long term partnerships with a core group of state agencies to help South Carolina transition for the age wave that is doubling its senior population. The Lieutenant Governor's Office on Aging will need to work with those agencies concerning mental health, transportation, long term care, adult protective services and disabilities and special needs in order to build cost effective policies, programs and services that meet the needs of our senior population and caregivers within our resource limits. It will be critical that South Carolina enlist the collaboration and cooperation of related health and human services agencies to plan and implement those programs that will be particularly important to helping seniors remain independent and healthy.

Goal

- **Assemble a core group of state agencies to plan and implement cost effective programs for South Carolina's seniors and caregivers to meet their needs within limited resources. This core group could be the Aging Coordination Council of Agency Heads, which has been suspended for several state budget cycles due to a budget proviso.**
- **Work with the Long Term Care Council.**
- **Continue working collaboratively with the SC Department of Health and Human Services.**
- **Coordinate and maximize services to seniors and their caregivers so that the greatest number of seniors and caregivers may be served within available resources.**
- **Educate South Carolinians to take personal responsibility for their retirement years and to utilize available services and information responsibly.**

Outcomes:

- A state coordinating body of appropriate state health and human services agencies concerned with serving South Carolina's seniors and caregivers will be established and continue working with the Long Term Care Council.
- A statewide plan for these agencies will be developed and implemented.
- Services for seniors and their caregivers will be coordinated and cost effective to serve the maximum number of persons within available resource limits.

- South Carolina’s related agencies will establish mechanisms to educate seniors and their caregivers to take personal responsibility for their senior years and to responsibly utilize information and services to make wise choices.

Strategies:

- The SUA will work to create a statewide coordinating body through legislative proviso or through collaborative approaches of appropriate health and human services agencies.
- The Lieutenant Governor will serve as Chair of this body to guide Agency Heads and policy makers representing their organizations to address the needs of seniors.
- Key agencies in the coordinating body will be the SC Department of Health and Human Services, Department of Mental Health, Department of Transportation, Department of Social Services and the Department of Developmental Disabilities and Special Needs.

Work with the above agencies to develop an assessment of the status of South Carolina’s seniors and develop a coordinated plan to meet the needs of seniors and their caregivers.

Leverage this working relationship to maximize the availability of services to South Carolina’s seniors and their caregivers through cost effective service delivery and advocacy for resources on the state and federal levels.

Issue: Native American Tribes

South Carolina has one federally recognized Native American tribe, the Catawba Nation, in the region of the Catawba Area Agency on Aging. The AAA provides resources and information and assistance to the tribe and responds to other requests as they are received. The state assures that it will continue to assist the Catawba AAA in their efforts to coordinate Title III and Title VI programs in a way that will maximize services to the tribe and will share other resources as they become available. Additionally, the AAA has one member of the Catawba Nation as a member of its Advisory Board. South Carolina also has Native Americans in the Greenville and Pee Dee. The Lieutenant Governor's Office on Aging continues to reach out to these unrecognized tribes and provides services where possible. The SUA also is reacting to the growth of other minorities in South Carolina. With the growth in the Hispanic population, the SUA has developed informational materials in Spanish and SC Access works with Hispanics who need information in Spanish. Several of the AAAs have tried to work with Native Americans in their regions. However the Native Americans in South Carolina have not shown an interest in working with the AAAs.

Goal

- **To establish a closer working relationship with the one federally recognized Native American Tribe and other Native American groups in South Carolina to ensure they know about the aging services they are entitled to receive.**

Outcomes:

- Provide needed services to Native Americans

Strategies:

- The SUA and AAAs must reach out and provide education materials of services these individuals are eligible for through the aging providers.

Issue: Meaningful Senior Centers and Senior Centers as the Town Square

South Carolina, like the nation, is facing the task of modernizing its senior centers to make them more relevant to today's mature adults and senior needs. Many of our state's senior centers are little more than group dining sites that have minimal or no programming or other offerings that would make today's seniors want to use them and participate in their activities. The SUA will continue to focus on South Carolina senior centers and the current aging network practices and operation in the state in order to achieve our ideal center: that of a well-rounded and resourceful facility that attracts mature adults. Currently there are approximately 80 active senior centers and 73 group dining sites according to data provided to the SUA by the AAAs through SC Access (this does not reflect independent sites that do not provide data and have chosen not to be included). Since 2009, all Permanent Improvement Project Grant Recipients have been required to abide by the National Council on Aging's national senior center standards.

Changing the image of the traditional senior center and the perception that the community has of the facility is an important aspect to the transition, and acceptance of a "village square" senior center and an aging friendly community is at the forefront of focus. It is widely known that today's seniors and the "Baby Boomers" tend to avoid centers that operate as congregate meal sites as they are perceived to be for the less fortunate and low income seniors. Today's seniors and "the Boomers" seek activities, choices, and input into the programming and services that interest them and meet their needs.

It is imperative that our state aging network redirect the focus of the senior center from a nutrition site (meal provider) to a community focal point by promoting awareness, training, knowledge and resourcefulness. Our vision is to incorporate the National Council on Aging established senior center standards and, along with modeling our senior centers after their best practice facilities, to result in accredited and successful senior centers. This, in conjunction with a strong collaborative effort throughout the aging network should assist in creating effective centers that are the "village square" for their communities.

Goals

- **The SUA serves as the catalyst/guide to modernize senior centers and make them vital resourceful centers synonymous with the services and programming that the elderly can benefit from and use.**
- **Implement the vision of the model senior center, incorporating the National Council on Aging established senior center standards.**

Modeling our senior centers after their best practice facilities will result in accredited and successful senior centers. All new senior centers using PIP funds must comply with National Council on Aging's established senior center standards.

- **To have an evolution of change and move our state to be the best in the nation in senior services, programs, and resources.**

Outcomes:

- Seniors have well-rounded and resourceful senior centers that attract mature adults by providing a broad range of activities, programs, and services.
- Continue encouraging senior centers to use the National Council on Aging's established senior center standards and modeling our senior centers after their best practice facilities to result in accredited and successful senior centers.
- State and local governments, civic, philanthropic, and faith-based communities collaborate with the senior center and aging network community to provide adequate funding/volunteers to build, maintain and operate the best practice centers.

Strategies:

- Statewide friendly visits are conducted by SUA staff for a "hands-on" assessment of facilities and a "snapshot" of centers' operations in terms of the LGOA vision for the centers.
- AAAs will visit sites to ensure services and activities are being provided.
- Maintain a current and accurate database of contact and address information.
- Enforce state and federal guidelines and an accountability process to assure the practices are being conducted each day in the centers.
- Maintain effective partnerships with aging network and local communities. By partnering with Area Agencies, service providers, faith-based communities, and organizations, joint efforts and cooperation will move our state's focus to better serve mature adults and promote new opportunities, ideas and concepts to be implemented.
- The SUA will provide technical and financial assistance to aging partners.
- The SUA will build public awareness through marketing of senior centers and programs.
- Require the AAAs to keep accurate records of senior center status using LGOA classifications and provide that data to the SUA.
- Best Practices will be recognized and the National Council on Aging accreditation will be encouraged. All new senior centers built using PIP funds must comply with National Council on Aging standards.

Issue: Increased Competition, Cost Control and Accountability

The SUA lets the AAAs and service providers know that costs must be kept to the fair market value and that seniors now demand choices of services. As the demographic section of this State Plan illustrates, the in-migration of older adults to

South Carolina, the increasing longevity of all individuals over age 60, and the need to provide community based services to older adults will expand exponentially over the next decade. The issue is three part: a) how to assure there will be enough service providers to handle the increased demand for consumer choice; b) how to control the cost of critical services; and c) how to determine the positive outcomes of those service expenditures. In 2011 – 2012 the SUA created a pilot program with three AAAs to establish cost sharing as a means to better utilize resources and to serve seniors not currently being served.

The SUA has been working with the ADRCs to rewrite the Assessment Forms for OAA services and Caregiver programs in order to ensure that those seniors with the greatest needs are being served.

Goals

- **Increase the awareness of seniors and caregivers of the aging and disability resource centers that are operating throughout the state.**
- **Expand services by using cost sharing measures.**
- **Increase competition so that consumers have more choices.**
- **Through comprehensive planning and resource coordination at the state level, focus statewide human service agencies to address both the preventive and care-providing services required to control long term care costs.**
- **Develop new assessment forms for OAA services and the caregiver program that provide accurate data and ensures that those individuals with the greatest need are being served.**
- **Actively partner with SC Office of Research and Statistics to promote reporting client data through the Senior Cube to document specific outcomes of this coordinated effort.**
- **Generate economic support from both the public and private sector based on documented outcomes.**

Outcomes:

- Increase consumer choice and competition in delivery of services to elderly South Carolinians.
- Enact effective strategies to build working relationships with entities providing goods and services to older consumers.
- Determine the fair market value for services and develop strategies to keep costs within the ranges. Make Unit Costs reflect the fair market value.
- Expand the cost sharing pilot to other AAA regions throughout the state.
- Provide case coordination at the regional level.
- Ensure that those individuals with the greatest social and economic needs are being served.

Strategies:

- The SUA coordinates with Area Agencies on Aging to improve the process for procurement of services in order to increase competition and allow for consumer choice where multiple providers are available.
- The SUA works with Area Agencies on Aging to develop effective strategies to build working relationships with the human service organizations, service providers, and businesses focused on older consumers throughout the State.
- The SUA reviews data and research to determine fair market value for home and community based services and develop strategies for the AAA to use to keep costs of subsidized services within those ranges in each region.
- Develop resources to provide case management at the regional level based on the proven effectiveness in the Medicaid Waiver Community Long Term Care Medicaid Waiver model.
- Develop new assessment forms and tools for OAA services and caregiver programs.

Issue: Information Technology

Technology is critical in providing services to South Carolina's seniors. Bridges have been built between OLSA, Caregivers and SHIP and still working on e-forms through the Benefits Bank. Two challenges that we have identified are 1) staff has to re-enter the same data multiple times in various databases (duplicate data entry) and 2) the public is not aware that the e-form technology exists to help them. One problem brought to the attention of the SUA by the AAAs is that Information and Referral Specialists and other staff (ADRC) are still entering the same client data multiple times in multiple systems. These include Caregiver, SHIP, AIM and RouteMatch. Ombudsman is unique in the information it collects and in privacy issues and therefore is not a part of the Bridges plan.

In this age of technology it is also critical that steps be taken to protect the integrity of the data collected and to make sure client data is stored safely without threat of private information being accessed or stolen.

Goal

- **To fine tune the system so that there is only one central point for entry of client data that can then be shared with other applications as needed. The system uses a mechanism to check for existing clients so as not to duplicate clients and a mechanism for deciding which client data is the most current. It is critical that this data be safely stored so there is no threat of confidential client information being accessed or stolen.**

Outcomes:

- Information and Referral Specialists and ADRC staff would enter client data one time but could share information among other applications as necessary.
- Client data could be modified by various staff, with checks and balances in place, to ensure changes are valid.

- Protect the integrity of personal client data by the SUA and AAA to ensure that no data can be illegally accessed or stolen.

Strategies:

- Ensure that staff is fully trained and has the best technology and software tools available with the limited resources available to the SUA and AAAs.
- Create one central client intake screen.
- Establish system to verify if the client already exists in one of the systems.
- Establish security guidelines in the SUA and AAAs that strictly adhere to state and federal laws regarding data collection and warehousing.

Issue: E-Forms

Built on the web-based system SC Access, the SUA uses a web-based consumer data collection and electronic forms management process to enable consumers to apply directly for Medicaid long term care services. All ADRCs have been trained in the use of the Benefit Bank. This unique technology enables consumers to enter personal information only once to apply for multiple programming. The system guides the consumer through a series of questions (similar to the way TurboTax operates), gathering needed information. Once completed, the information added by the consumer populates the “official” form. Consumers can store their information and return later and edit forms, or apply for additional services if needed, without entering the same information again. The consumer can save the form, send some forms electronically (some have to be followed up with a signature page), or print and mail the application for processing.

Goal

- **Make applying for benefits and services as easy as possible for seniors and adults with disabilities by having to enter common information once for all applications.**

Outcomes:

- Ensure that eforms are available for seniors and adults with disabilities so they can apply for a variety of services and programs without having to duplicate the same information on every application.

Strategies:

- Market the eforms to increase the number of individuals using the forms in order to contain costs.

Issue: Expand and modernize nutrition services

Today’s seniors want consumer choice. Many states are looking at new ways to attract younger seniors to their facilities by providing more consumer choice and additional activities to keep seniors healthier longer. The SUA is piloting with three ADRCs in a cost sharing project with the goal of expanding it statewide once the data is reviewed.

Goal

- To modernize the ACL nutrition program in South Carolina and revitalize senior centers to make them the focal point of the community.
- Increase the number of seniors who use senior centers by providing more choices, cost-sharing and activities that appeal to today's seniors.

Outcomes:

- Increased attendance at meal sites and senior centers.
- Make available more evidence-based activities for adults at senior centers.
- Senior center directors are more adept at marketing and outreach strategies.
- More competition in the procurement of meals from vendors.
- Seniors who are more involved in the nutrition program/senior center planning process.

Strategies:

- Develop an incentive program for senior centers to participate in the NCOA Senior Center Accreditation Program
- Provide marketing training to senior center directors and key staff
- Solicit meal vendors from other states to increase competition among meal vendors
- Explore a state level meal contract
- Promote the use of affordable frozen meals versus hot meals, including total unit cost
- Reward organizations that actively recruit seniors as evidenced by revitalization of senior centers and meal sites
- Hold focus groups of consumers in at least four regions of the state.

Issue: Building Upon the Success of the Alzheimer's Resource Coordination Center

In 1994, legislation was enacted (SC Code of Laws 44-36-310) creating the Alzheimer's Resource Coordination Center (ARCC). The ARCC receives \$150,000 annually through state appropriations for its activities. These funds also serve as matching funds for the Family Caregiver Support Program. The ARCC was tasked to provide specific services as outlined in the following goals. According to the *2012 Alzheimer's Disease Facts and Figures*, published by the Alzheimer's Association, South Carolina had 80,000 people with Alzheimer's Disease or Related Disorders (ADRD). This number is projected to reach 100,000 by 2025. Additionally, in 2011 there were more than 283,000 caregivers providing assistance to family or friends with ADRD. This represents more than 322,853,918 hours of unpaid care per year, with an economic value of more than \$1.4 billion. These statistics indicate the need for outreach, education, and collaboration between the

public and private sectors to provide comprehensive services and resources to those directly impacted by ADRD.

Goal

- **Improved statewide coordination through the Alzheimer's State Plan**
- **Service system development**
- **Information and referral**
- **Caregiving support services to individual with ADRD, their families and caregivers**
- **Continuing oversight of a grant program to assist communities and other entities in addressing problems relative to ADRD through education and respite programs**

Outcomes:

- More seniors and their families access resources through the ARCC and Alzheimer's Association
- More organizations apply for ARCC grants
- More funding made available for Alzheimer's support programs and their caregivers
- Increased collaboration and coordination between the private and public sectors

Strategies:

- The ARCC and SUA will work to expand the scope and mission as written in legislation
- The ARCC and SUA will follow the strategies and goals of the Alzheimer's State Plan and monitor implementation
- Continue providing seed grants for education and/or respite programs, targeting underserved communities
- Collaborate with the SC Alzheimer's Association to enact the recommendations of the state plan and develop future strategies based on a global perspective of stakeholders
- Collaborate with the Family Caregiver Support Program to obtain a comprehensive view of the need for assistance for caregivers specifically dealing with Alzheimer's disease
- Collaborate with Aging and Disability Resource Centers (ADRC's) to coordinate centralized service delivery for persons with Alzheimer's disease and their caregivers

Long Term Care and Community Living Incentive Issues

Issue: Protect Medicare/Medicaid and provide choice and personal incentives

As healthcare reform was debated over the past four years, South Carolina, like the nation is moving toward a serious recognition that there will not be adequate resources to pay for the massive growth of the senior population over the next thirty years. SC likewise must craft a series of policies, initiatives, programs and services that move our service delivery system to one of providing choice, necessary information, guidance, prevention and wellness programs and incentives to help seniors remain independent as long as possible. With this also comes the recognition on the part of government that families and individuals must take personal responsibility for planning for their retirement and golden years. South Carolina must work with the federal and state government bodies to use the Medicaid and Medicare programs in the most efficient manner possible within the state environment. South Carolina must also advocate to the federal government through the Centers for Medicare and Medicaid Services and the Administration on Aging on policies and initiatives that will work in South Carolina and benefit our state's seniors and caregivers.

Goal

- **Use the available options under Medicare/Medicaid to reform the state's system to maximize choice and independence for seniors and caregivers, and to provide cost efficient approaches to utilizing limited available resources.**

Outcomes:

- Our state will obtain an adequate balance of institutional and home and community-based services that helps to meet the needs and resource limits of South Carolina.
- Seniors will have choice of services, information and incentives to help them plan for their retirement years.
- South Carolina will have an efficient working relationship with other state and federal agencies to meet the needs of South Carolina's elderly and caregivers.

Strategies:

- The SUA will work with other state health and human services agencies to implement the Long Term Care Partnership.
- Educate the Governor and the General Assembly on the need to provide tax incentive programs for purchasing long term care insurance.
- Educate the Governor and the General Assembly on the need to enact tax incentives for Family Caregivers.
- Work with other state and federal agencies and policymakers to provide payments to caregivers.
- Work with South Carolina's citizens to educate them on incentives, options for community living and reverse mortgages.
- DHHS is contracting with the LGOA for Money Follows the Person (MFP). The LGOA will need to work with DHHS on getting Medicaid funding for eligible services which the ADRCs provide.

Issue: Implement Long Term Partnership

Medicaid is currently the largest source of funding for long term care expenses. Publicly funded long term care under Medicaid and Medicare is primarily financed on a pay-as-you-go basis. Because of the lack of advance funding, demographic changes will significantly strain the financing of these programs. A parallel growth of long term care insurance coverage could mitigate this effect. To the extent that long term care insurance becomes a significant source of long term care, then Medicaid will be able to better target its expenditures to those in greatest need, providing better care and avoiding or minimizing current and future funding crises.

Long Term Care Partnerships in South Carolina must be enacted by the SC Department of Health and Human Services (DHHS). The SUA has asked DHHS to work in partnership with them but DHHS has been reluctant to pursue Long Term Care Partnerships.

Goal
<ul style="list-style-type: none">• Support the state’s efforts to develop, implement, and market a Long Term Care Partnership Program in South Carolina.• Encourage the development of reciprocal agreements with other states that have Long Term Care Partnership programs.• Continue providing consumer training regarding long term care planning.• Support passage of state legislation that would provide tax incentives to individuals purchasing long term care insurance.

Outcomes:

- The state’s risk for future unexpected and uncontrolled expenditures would be minimized, while the availability and quality of care for those in greatest need would be maximized.
- The purchase of long term care insurance would be more attractive, as well as offer more options and choices for those individuals participating in the program.
- Seniors and/or their families would be more informed and would have increased awareness and understanding of their long term care needs and options for financing their care.
- The cost to the consumer of long term care insurance policies would be reduced, making it more likely that such policies would be purchased.

Strategies:

- Encourage SCDHHS to amend the state’s Medicaid plan to allow implementation of the Long Term Care Partnership Program.
- Work with advocacy groups for passage of this proposed amendment.

Issue: Tax Incentives

With the growth in the number of seniors, South Carolina will be facing a potential crisis with the number of seniors requiring long term care. One of the measures that the Lieutenant Governor's Office on Aging is considering is the use of tax incentives through credits or deductions in the state income tax as a means to create incentives for individuals and families to take additional personal responsibility for planning for their retirement and the need for long term care. Family caregivers also face problems of stress and negative financial outlooks for their assuming responsibility for a loved one. Tax incentives are one means to help them serve as a caregiver and not suffer severe financial hardships when they retire.

Tax Incentives for Long Term Care

The SUA is concerned about the potential crisis resulting from large numbers of senior citizens needing Long Term Care in the very near future. With the Baby Boomers already retiring, policy makers stress that innovative measures must be taken so that senior citizens can be allowed to age gracefully and with dignity. At the current rate, government institutions and programs will be unable to keep pace with the limited resources available. Many of the Baby Boomers have not saved for retirement nor have they purchased Long Term Care Insurance Policies – thinking instead the government will provide a safety net when Long Term Care is needed.

The bottom line is that with shrinking resources, the government cannot be counted on in the future to provide long term care. The Office on Aging believes one of the possible solutions to this impending crisis is to provide tax incentives for long term care.

Goal

- **To provide everyone with the resources and tools necessary to age with dignity while taking the steps needed to solve the pending long term care crisis**
- **South Carolina will reduce its long term care liability for Medicaid to manageable levels in the future**

Outcomes:

- By providing tax incentives, working South Carolinians would have the ability to plan for their futures by purchasing long term care insurance
- South Carolinians will be able to afford long term care insurance through the benefits of tax savings
- Tax savings/incentives would provide much needed motivation and encouragement for taxpayers to plan for their futures so that government would not be overwhelmed with expensive long term care expenditures when seniors retire or need long term care

Strategies:

- Ensure that Office on Aging staff is well educated on the latest trends in long term care insurance
- Establish a meaningful relationship with members of the General Assembly who are interested in senior financial issues so that legislators can make decisions for the future on long term care insurance tax incentives
- Continue educating the public on the need for and best types of long term care insurance to meet their individual and family needs

Tax Incentives for Caregivers

As South Carolina's senior population grows, consideration must be given to providing tax incentives for caregivers. As healthcare and long term care costs skyrocket a large number of senior citizens will be unable to afford institutional care resulting in seniors remaining at home longer. The seniors who remain home will need caregivers, but many caregivers will not be able to afford retiring early or taking a less responsible job in order to serve as a caregiver. There is also a significant cost savings realized when a senior is able to age in place rather than utilizing an expensive facility.

Family caregivers are a key bulwark for maintaining the ability of a senior to remain at home and avoid institutionalization. Many caregivers are forced to retire early and are not able to purchase affordable health insurance. One possible solution to this *aging-at-home* issue will be tax credits for caregivers.

The SUA plans to aggressively address the issue of caregiving and how changes in the law and State Code can improve care for seniors. One of the innovative approaches to caregiving is to provide tax incentives. Other states already have tax incentives in place.

Goal

- **To enact meaningful policy so that South Carolina becomes an innovative leader in tax incentives for caregiving – while protecting and serving the needs of the state's senior population.**
- **To provide tax incentives to caregivers to enable them to help their loved ones remain at home and also to provide some tangible recognition of their efforts.**

Outcomes:

- By providing tax incentives, many South Carolina seniors would be able to continue to *Age in Place* with the grace and dignity they deserve.
- Caregivers would be able to continue in their role of helping their loved ones and not suffer the potential consequences of lost income and retirement benefits.
- Caregivers may be more able to purchase health insurance due to tax incentives being available.

Strategies:

- Educate members of the General Assembly who are interested in senior financial issues so that legislators can make decisions for the future on assisting caregivers through tax incentives.
- Educate the public on caregiving and available benefits and services to meet their individual and family needs.
- Work with the members of the General Assembly to provide tax incentives to caregivers in the future.

Issue: Payments for Family Caregivers

Family caregivers keep families together, often preventing or delaying institutionalization.

The critical role of families, especially women, in providing care to elderly relatives (as well as relatives with disabilities) is well established. The challenges of family care are an increasing reality of daily life for America's families. Most seniors with long term care needs rely exclusively on family and friends to provide assistance. Care provided by family and friends can determine whether seniors can remain at home.

The need to strengthen families in their caregiving role and to sustain them as the backbone of our long-term care system is a central issue in our aging society. At both Federal and state levels, debate is mounting about policy choices to support family and informal care and increase the capacity of families and friends to provide such care. Families often undertake caregiving willingly and as a source of great personal satisfaction. However, caregiving can exact a high cost. Families commonly face health risks, financial burdens, emotional strain, mental health problems, workplace issues, retirement insecurity and lost opportunities. Research shows that support services effectively reduce the burdens, strain and depression of caregiving responsibilities and allow family caregivers to remain in the workforce and can even delay institutionalization.

Caregiving has short and long term financial consequences.

The financial aspects of caregiving are likely to affect the caregivers' present and future well-being if caregivers discontinue or limit their workforce participation. Although men participate in caring for relatives, the bulk of caregiving is provided by female relatives. Women live longer than men, tend to outlive their spouses, and have less access to retirement savings such as pensions. Time away from the workforce limits their ability to support themselves especially if they are not compensated, however minimally, for work they are doing. In addition, caregivers who leave the workforce are unable to accumulate retirement savings, contribute to Social Security, and earn Social Security work credits. Caregivers who return to full-time employment after caregiving are more likely to earn lower wages, have a benefit-poor job, and/or receive reduced retirement benefits.

Goal

- **Compensate family caregivers as a way of recognizing and supporting them in their role caregiving role.**

Outcomes:

- More seniors will be able to remain at home or delay costly institutionalization.
- Increased satisfaction and choice for the care recipient.
- Help families remain together with their loved ones, thus avoiding more costly institutionalization.
- Make it easier for family members to make a commitment to their role as a caregiver by decreasing the financial penalty associated with it.

Strategies:

- Encourage SCDHHS to amend the state’s waiver family caregiver policy to allow legally responsible family members to be paid for providing “extraordinary” care.
- Work with advocacy groups to promote assistance for family caregivers.

Issue: Reverse Mortgages

Reverse Mortgages have become very popular in recent years as the population ages. The SUA has followed this trend and is aware that as the popularity of Reverse Mortgages has grown, the opportunity for the elderly to be targets of scams or exploitation has grown.

Reverse Mortgages are currently addressed in the State Code under Chapter Four, Section 29-4-10. The State Code provides detailed rules on governing reverse mortgage loans. However, the Office on Aging will work in the future to ensure that the public continues to be educated so that seniors can make decisions on what is in the best interests of their future and their families’ futures. If necessary, the Office on Aging will work with the General Assembly to amend the State Code in order to better serve and protect seniors.

State Code Section 43-21-150 directs the Division on Aging to cooperate with the Long Term Care Council and the SC Department of Insurance to develop and implement a program on the availability of home equity conversion alternatives, such as reverse annuity mortgages, in this state and the risks and benefits of these alternatives.

The SUA believes that Reverse Mortgages can be an excellent tool which allows senior citizens to “age-in-place” at the family home they love so much. Many of the seniors who utilize the Reverse Mortgage concept benefit from having money in the bank and the security of knowing they can live comfortably without incurring debt. It provides seniors a safety net by utilizing their own hard earned equity.

Goal

- **The ultimate goal of the SUA is for South Carolina to have the best Reverse Mortgage laws and regulations in the nation.**
- **It is the intent of the SUA to keep the Reverse Mortgage industry in South Carolina on the cutting edge of industry trends nationally.**

Outcomes:

- South Carolina’s elderly will be protected.

- Our state's elderly will have the tools to do what is in their best interest financially.

Strategies:

- The SUA will follow national trends to ensure that South Carolina's senior citizens are not targeted by the Reverse Mortgage industry.
- Continue working with the Department of Insurance and the Long Term Care Council to ensure that SUA staff is well educated on the latest trends in the Reverse Mortgage Industry.
- Continue establishing dialogue with policy makers and legislators who are interested in senior financial issues.

Senior Transportation

Issue: Transportation

Transportation is critical for people of all ages to be able to access goods, services, and social activities. Unfortunately, as people age, they undergo physical, mental and, often, financial changes that can restrict or even completely eliminate access to their usual method of transportation. The inability of seniors to get where they need to go can quickly lead to poor nutrition, diminished mental and physical health, and a general disengagement from their community.

The SUA has secured the South Carolina Department of Transportation to develop and implement a volunteer transportation program in an ADRC region and were just awarded additional funds to expand to two other regions.

Seniors, individuals with disabilities, and low income individuals have critical transportation needs. South Carolina like many other states lacks a coordinated and affordable transportation system that currently meets the needs of its population. This system will be significantly lacking in the future as the state's population ages. There is a mix of transportation systems in South Carolina: large urban areas have public bus systems that are significantly under-funded and under-utilized. Each region of the state has a RTA (Regional Transportation Authority) and over 60 separately funded systems that are program related. Many of them act as silos and are not coordinated with one another to take advantage of cost efficiencies and economies of scale. The two major transportation systems that serve the state's seniors and persons with disabilities are the Older Americans Act funded transportation services provided by the state's local contract providers and the state's new Medicaid brokerage system. During FY 2010-2011, 5,147 seniors in South Carolina received transportation services. This involved 1,800,858 trips for 10,805,148 miles. These transportation services primarily provide trips to group dining sites with some other services for shopping and medical facilities. As South Carolina ages, many seniors will not be able to drive and will require transportation to remain independent. Many will be able to pay for this service with options like cost sharing.

Transportation funding for human service agencies/organizations has grown at a much slower rate than the demand for the services and this trend is unlikely to change in the near future. In order to meet these needs, particularly as the baby-boomer generation ages, alternatives must be explored, implemented and

evaluated and coordination among different types of transportation service providers is essential.

The SUA is working with the SC Department of Transportation as a member of the Human Services Transportation Coordinating Committee. The Committee was established by executive order and all state human services agencies were brought together to develop a plan to coordinate transportation in order to provide service where there is no service and to improve efficiency. Various services and funding streams will be coordinated to provide cost efficient transportation services that meet the needs of a maximum number of citizens within available resources. The committee will make recommendations to the governor and General Assembly.

Goal

- **Provide a coordinated public transportation system to meet the needs of South Carolina's citizens**
- **Develop a coordinated statewide transportation plan to build an affordable statewide system of public transportation to meet the needs of South Carolina's citizens.**
- **Provide adequate funding mechanisms to accomplish the statewide plan in the future.**

Outcomes:

- South Carolinians of all ages have an adequate and affordable transportation system to meet their work, social or human services, and recreation needs.
- South Carolina's seniors and persons with disabilities are able to utilize a transportation system that provides choice and options to maintain their independence.
- Various services and funding streams are coordinated to provide cost efficient transportation services that reach the maximum number of citizens within available resources.

Strategies:

- Monitor additional funding sources from federal, state and other grant sources.
- Review Medicaid brokerage and service provision processes to mitigate any negative impact that the new South Carolina Medicaid brokerage system may have in current coordination efforts throughout the state.
- Amend conflicting policies and procedures which is part of efforts to mitigate the programmatic and pragmatic challenges associated with mixing varied funding sources
- Better understanding of trip origins and destinations to address service overlap with other regions as well as how trips are made in each region to better determine common destinations.
- Education and staff development to address professional skill building and improve the delivery of resources.
- Address access to medical services (for preventative health care measures)
- Address access to non-medical services to avoid isolation of seniors without transportation.

- Consider expanding the pilot program in Santee Lynches that uses SC Department of Transportation funding for volunteer drivers to other areas of the state.

Geriatric Trained Professional Workforce

Issue: Geriatric Loan Forgiveness Program

In 2005, South Carolina took steps to address the anticipated shortfall in fellowship-trained geriatric physicians and gero-psychiatrists by creating a grant program that offers these specialists up to \$35,000 in student loan repayments in exchange for a five year commitment to practice in the state.

The State Geriatric Loan Repayment Program has begun paying dividends already, with 16 geriatricians having received a total of 18 awards since the program was started.

To qualify for the program, applicants must be enrolled in, or have recently completed, a fellowship program in geriatric medicine. Successful applicants must agree to establish a practice in South Carolina and stay for at least five years in exchange for up to \$35,000 towards repaying student loan debt incurred during their medical school training.

Goal

- To ensure an adequate supply of trained geriatricians and other health professionals trained in geriatrics or gerontology in order to better serve the health care needs of older adults in South Carolina.

Outcomes:

- Increase the number of fellowship trained geriatricians and geropsychiatrists in SC providing services to older adults.
- Increase the number of other allied health professionals with advanced training in geriatrics or gerontology.
- Obtain adequate funding to recruit and retain geriatric specialists to serve the ever increasing number of older adults in the state.

Strategies:

- Use the Geriatric Loan Forgiveness Advisory Board, including representatives of other health professions, to draft legislation to expand the scope of the current legislation to include grants to other health disciplines.
- Develop a plan to introduce legislation and to request additional funding.

Evidence-Based Research

Issue: South Carolina's Seniors' Cube

The Seniors' Cube was started in 2005 with a grant from the Duke Endowment Fund. In 2009, because of budget cutbacks the Cube was no longer funded by the SUA, although the SUA continued to provide data to the State Office of Research and Statistics. The SUA plans to reestablish a contract with ORS in 2012 in order

for the SUA to collect Cube data from other health and human services agencies that contribute to ORS.

The South Carolina Seniors' Cube is a nationally unique comprehensive web-based database of the senior population's health care statistics and services integrating information from multiple data systems. The database provides a cross-sectional analysis of data from the state's all payer hospital system, Medicaid, Medicare acute and non-acute services, as well as Aging data, Alzheimer's disease and Vital Records data. Eventually, Medicaid waiver services and other agency data will be added. This quick query data analysis tool shows multiple relationship factors that affect outcomes and that allow for policy development and research in a wide area of programs, services, and diseases that affect seniors. If you think of the Rubik's Cube, it is possible to visualize a three-dimensional health care database that can be accessed by program staff and researchers to instantaneously sort through millions of pieces of data that relate to demographic and health statistics. It allows South Carolina to look for patterns of diseases and illnesses that affect seniors and to look for disparities within different population groups. South Carolina will be able to look at trends of chronic diseases in order to consider the most cost effective use of OAA services and resources in the future.

Goal

- **Reestablish a contract with ORS to maintain and expand the South Carolina Seniors' Cube through annual updates of current information and addition of new program and demographic data on seniors in the future.**
- **Establish a partnership with the major colleges and universities to conduct research to drive state and national policy concerning senior services.**
- **Seek grants to continue research to enhance the lives of seniors and to develop cost effective policies and programs to wisely use limited state and federal resources**
- **Obtain additional state and federal resources through advocacy efforts resulting from use of the South Carolina Seniors' Cube.**
- **South Carolina invests in Data Warehouse (Senior Cube) to determine where problems and successes are found. The Senior Cube would help state agencies be most efficient in service delivery.**

Outcomes:

- With limited state and federal resources, as well as a growing elderly population, this research will enable state and local providers to document the need for and justify having adequate resources to provide cost effective prevention services to seniors and their caregivers.
- Policy makers will support home and community-based services and reallocate institutional service resources

- Use Senior Cube to provide SUA with data and statistics which will enable seniors and caregivers to have choice and remain independent at home whenever possible
- Research will enable state and local providers to document the need for and justify having adequate resources to provide cost effective prevention services to seniors and their caregivers.
- South Carolina will be recognized as a national leader in evidence-based research for seniors' healthcare.

Strategies:

- Negotiate with the Office of Research and Statistics for on-going maintenance and expansion agreement for the South Carolina Seniors' Cube.
- Develop final access/use protocols to allow public/private use of the South Carolina Seniors' Cube.
- Develop partnerships with South Carolina's major colleges and universities to use the SC Seniors' Cube for research and policy development.
- Request adequate resources through grants and internal funds to continue to develop the SC Seniors' Cube in order to fully utilize SC data capabilities.

Issue: Prevention and Wellness Evidence-Based Research

The SUA continues to expand its health promotion/disease prevention evidence-based programs and collect and analyze data to determine to what degree the programs are working in community-based settings. Those programs to be analyzed include the Chronic Disease Self-Management Program (*Better Choices Better Health SC*), A Matter of Balance, a falls prevention program, and the Arthritis Foundation Exercise Program and a Arthritis self-help program administered by the SC Department of Health and Environmental Control (DHEC). Data from these programs will be entered in to the unique Senior Cube that is part of the Office of Research and Statistics to research the impact of the programs on hospitalizations and health care utilization. Data from these evidence-based programs will be analyzed by appropriate LGOA staff, USC and Office of Research and Statistics staff to determine the impact of these programs on reducing health care utilization and costs and to determine the impact and cost benefit factor in helping South Carolina's seniors remain independent and have choice in their senior years. The South Carolina Seniors' Cube will be utilized to help obtain further grants to conduct additional evidence-based studies and to use positive findings to obtain additional resources for prevention and wellness programs and services in South Carolina. In 2012, the SUA is seeking a grant opportunity that would add a new evidence-based program to address diabetes and other evidence based issues.

Goal

- **Conduct evidence-based research projects that will build support for home and community-based services**
- **Conduct evidence-based research projects to enhance the lives of seniors and their caregivers**
- **Provide evidence to national and state policy makers to guide them**

in resource allocation decisions

Outcomes:

- Policy makers will demonstrate support of evidence-based programming at the federal and state levels through allocation of additional resources and funding.
- Research will enable state and local providers to have adequate resources to provide cost effective prevention services to seniors and their caregivers.
- Through evaluation, seniors will demonstrate a higher quality of life after completing the programs, as health care utilization decreases.

Strategies:

- Complete research related to program outcomes of ACL and other grants, including qualitative program analysis using Office of Research and Statistics (ORS) data and the Senior Cube.
- Disseminate findings of the evaluation efforts and compare with other states' data.
- Recruit partners for Partnership for Healthy Aging and carry out its mission and goals within the next four years.
- Seek additional funding and/or resources for the sustainability and expansion of the evidence-based program initiatives.
- Disseminate findings from the research efforts.
- Request adequate resources through grants and internal funds to continue to develop the SC Seniors' Cube in order to fully utilize SC data capabilities.

Issue: (ADSSP) Alzheimer's Disease Supportive Services Program

This grant ends in September 2012. It is collaborative project with the overarching goal of improving access to home and community-based services for individuals with Alzheimer's disease and other related dementia by targeting underserved minority and rural populations. The objectives are to implement strategies that build familiarity and trust among underserved minority populations; provide outreach and screening through mobile ADRC in the Trident Region; provide outreach and screening through family consultants who are congregants of local churches; provide medical screening by MUSC-ADCCRG; and provide vouchers that allow increased services through the SCAA, the ADRC, and the Family Caregiver Support Program. The targeted population is within a three county area in the South Carolina Lowcountry.

Goal

- To improve the quality of life for individuals with Alzheimer's and related dementia disorders, by targeting underserved minority and rural populations.
- Expand consumer choice and consumer-directed long term care support for caregivers through the Aging and Disability Resource Centers (ADRC), the Family Caregiver Support Program (FCSP), and the SC Alzheimer's Association to effect systems change.

Outcomes:

- Increased access to needed services and information
- Increased consumer control
- Increased trust, familiarity and willingness to use services
- Effectiveness of interventions in meeting outcomes

Strategies:

- Educate potential patients and caregivers about the early symptoms of Alzheimer's disease and available therapies.
- Utilize members of the congregations as Family Consultants to bridge the divide between the minority population and service providers.
- Expand consumer choice by use of vouchers to select services from an expanded list of providers.

Emergency Preparedness

Issue: The LGOA Emergency Preparedness Manual and Program

The "Disaster/Emergency Preparedness Manual" for the Lieutenant Governor's Office on Aging (LGOA) was revised by the Emergency Preparedness Coordinator and approved by the Agency Director in February of 2012. The purpose of the plan is to improve the LGOA's readiness for and response capability to emergency/disaster situations. In those situations, the role of the LGOA is three-fold:

1. To ensure the capability of the State Office and Aging Network to continue/resume operations as quickly as possible following a disaster;
2. To facilitate the coordination of disaster mitigation, preparedness, response, and recovery activities in the aging community where the disaster occurred; and
3. To assist in the provision of mass care/shelter services before, during, and after a disaster.

The SUA's plan includes Standard Operating Procedures for providing information and support, when needed, to the Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRC), Aging Network service providers and other agencies that work with senior adults. AAA's/ADRC's and their contracted service providers are required to have their own emergency plans and mutual aid agreements. The AAAs/ADRCs have been asked by the SUA to reach out to their local emergency coordinators in their regions to coordinate emergency services for the elderly and individuals with disabilities. Each AAA/ADRC is also required to compile and maintain a list of emergency contact information, and to supply the list to the LGOA. Severe weather alerts, situation reports regarding developing/potential disasters, and similar information is conveyed through these contacts.

In addition, when Long Term Care Ombudsmen visit nursing home and assisted living facilities, they review their disaster plan. All Long Term Care Ombudsmen will report changes to a facility's disaster plan to the Office of the State Long Term Care Ombudsman for update of the Master Disaster Relocation Plan.

By Executive Order of the Governor of South Carolina, the LGOA is mandated to perform a support role with regard to two emergency support functions in the State Emergency Operations Center (SEOC): ESF 6 (Mass Care) and ESF 11 (Food). To that end, a team of nine LGOA personnel, who attend appropriate trainings and participate in disaster exercises held by the SC Emergency Management Division (SCEMD), have been designated to provide manpower and support to those functions in the SEOC when activated.

The LGOA Emergency Preparedness Coordinator is involved in the annual SCEMD reviews/revisions of the statewide plans for hurricanes, earthquakes, terrorist attacks, fixed nuclear facility accidents, pandemics, and other natural or man-made disasters. In addition, the Coordinator represents the LGOA on appropriate emergency-related committees and subcommittees, such as the Public Health and Human Services Committee, the SC Emergency Planning Committee for People with Functional Needs, the Shelter Subcommittee, the Assistive Technology Subcommittee, the SC Department of Health and Environmental Control's Community Preparedness Subcommittee, and others as needs are identified. Through these committees, essential connections have been made with emergency personnel in the SC Emergency Management Division and the county emergency preparedness offices, the SC Department of Social Services (the lead agency for ESF 6 - Mass Care), the SC Department of Health and Environmental Control, the American Red Cross, the Salvation Army, and numerous other agencies and organizations. *The LGOA's Emergency Plan is attached to the State Plan.*

Goal

- **Maintain and keep updated an emergency preparedness program that reflects both federal and state plans with requests for assistance working through the Aging Network from the bottom up.**
- **Require selected SUA staff to participate in state level training exercises so that staff will be familiar with plans and procedures.**
- **Encourage AAAs/ADRCs and COAs to keep contact with their regional and county emergency management directors so that their needs and resources can be coordinated prior to an actual emergency or disaster.**
- **Encourage AAAs/ADRCs and COAs to participate in county and state level training exercises so that staff will be familiar with plans and procedures.**
- **Encourage AAAs/ADRCs and COAs to create and reaffirm mutual aid agreements with each other to make the process of requesting and rendering assistance as simple as possible.**

Outcomes:

- The emergency preparedness program will be more consistent with standardized emergency management programs in South Carolina. Under the new program, COAs and AAAs/ADRCs would backfill each other providing the

support necessary where possible to help an impacted area get back on its feet and return to normal status.

- COAs and county emergency managers would have a relationship established prior to a cry for assistance during an emergency.
- AAAs/ADRCs and Regional Emergency Managers would have a relationship established prior to a cry for assistance during an emergency.
- COAs and AAAs/ADRCs would be familiar with plans, personnel and procedures prior to a disaster or emergency allowing them to better deal with their responses.
- Mutual aid agreements would allow for those that already know how to work in a COA or AAA/ADRCs to go in and get the system up and running rather than sending down staff from the LGOA to struggle through something with which others are already familiar. Barriers such as liability and reimbursement would have already been addressed at least on a basic level allowing a faster response to seniors needing help. The LGOA would also be able to concentrate on their task of interacting with state and federal partners to insure that COAs and AAAs/ADRCs get the help they need in a timely manner.

Strategies:

- Maintain an emergency preparedness plan that is updated when needed that reflects the bottom up approach to response operations.
- Meet with SCEMD when needed to review and make recommendations on changes to the LGOA emergency preparedness program.
- Encourage participation in training and exercises at the county and regional level.

Issue: Pandemic Flu and Continuity of Operations at the SUA

The threat of an outbreak of pandemic flu is an issue of great concern at both the state and national level. In relation to the SUA the primary concern will be continuity of operations and the health and safety of the seniors that we serve. The Department of Health and Environmental Control (DHEC) holds the lead on primary responsibility for the development of a plan for pandemic flu preparedness and response, and the LGOA is responsible for providing input on the senior aspect of the plan. The SUA's Pandemic Flu preparedness is similar to that of the planning for a natural emergency or disaster as detailed in the LGOA Emergency Plan.

Goal

- **Maintain a plan for the SUA that is updated when needed in regards to continuity of operations during an outbreak of pandemic flu.**
- **Continue working with DHEC to insure that the SUA is in line with the overall state plan on pandemic flu.**
- **Work with DHEC on educating seniors as to the dangers of pandemic flu to the vulnerable senior population.**
- **Encourage AAAs/ADRCs and COAs to consider developing their own policies and plans for an outbreak of pandemic flu.**
- **Encourage AAAs/ADRCs and COAs to work with DHEC regions to insure that they are in line with the overall response to pandemic flu.**

Outcomes:

- The LGOA will be able to continue daily operations serving seniors during an outbreak of pandemic flu.
- The LGOA will be informed and compliant to pandemic flu plans developed by DHEC.
- Seniors will be educated as to how they can best lessen the impact of pandemic flu.
- AAAs/ADRCs and COAs will be able to continue daily operations serving seniors during an outbreak of pandemic flu.
- AAAs/ADRCs and COAs will develop a relationship with DHEC regions to insure they are getting information on the preparedness and response to an outbreak of pandemic flu.

Strategies:

- Maintain a plan as to how the LGOA will maintain regular operations during an outbreak of pandemic flu. The plan should potentially include the option for staff to work in non-traditional settings such as through telecommuting rather than working out of the main office.
- The risk of exposure and cross contamination is increased through the close quarters contact of a traditional office environment, consequently management should monitor the health of staff members and encourage them to take sick leave if they are symptomatic and telecommute during the period of time that they are or could be contagious after exposure to pandemic flu.
- Require AAAs/ADRCs and COAs to make contact with their DHEC regions to assist them in monitoring potential outbreaks of pandemic flu and how they can best protect the seniors they serve and maintain their daily operations without risking further exposure to seniors through daily activities such as congregate feeding and home meal delivery.

Elder Rights and Related Issues

America's growing elderly population affects every segment of the social, political, and economic landscape. As individuals age, there are often changes in their living patterns and conditions which sometimes contribute to the deterioration of their rights. Issues surrounding the changing needs of the elderly in this country age 60 years and over have heightened national awareness and concern. It is no surprise that elderly people with physical and mental frailties are more likely to be vulnerable to abusive behavior from those whom they depend upon to provide care and support. Especially vulnerable to abuse, neglect, and exploitation are elderly persons unable to care for themselves. State and local organizations must mobilize to recognize these potential problems and provide support. Given the large number of incidents of abuse and neglect that are reported, service providers, caregivers, and all citizens who relate to seniors need to be alerted to the problem of abuse and neglect, taught to recognize it, and encouraged to report it. As a result, public policies relating to issues such as health care, health care insurance, retirement,

affordable long term care, and quality of life are changing to meet the unique needs of the aging population.

Under Section 307(a) the State Plan will (C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out Part B that will be expended (in the absence of a waiver under Sections 306(C) or 316) by such area agency on aging to provide each of the categories or services specified in section 306 (a)(2) (Note: those categories are access, in-home, and legal assistance.) The AAAs will expend One Percent of the funds for access, in-home, and legal assistance.

Issues for Elder Rights and Related Issues:

Prevention of Abuse, Neglect and Exploitation:

The increasing number of frail and impaired older persons suggests a situation that is ripe for increased incidences of abuse, neglect, exploitation and other crimes against these vulnerable persons. In South Carolina, “vulnerable adult” is defined as a person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection. A resident of any long-term care facility is a vulnerable adult. The South Carolina Omnibus Adult Protection Act defines abuse, neglect, and exploitation and encourages the collaboration of organizations and agencies involved with adult protective issues to help prevent/reduce the incidence of abuse, neglect, and exploitation.

Mistreatment or abuse can be physical, psychological or both. It occurs in both the community and in long-term care settings. Nationally, studies indicate elder abuse is grossly underreported in the community. Statistics show as few as one in four cases of abuse are ever reported to the proper authorities. Although long-term care facilities are heavily regulated and monitored by both federal and state statutes, abuse can also occur in this setting. Residents of long-term care facilities may be extremely frail, cognitively impaired and totally dependent on caregivers for their needs. Because of these conditions they may be at risk for abuse. Nationally, and in South Carolina, physical abuse is the most common type of abuse reported in long term care facilities. The highest risk factor may be the presence of dementia. Residents with dementia, especially if they have disruptive or violent behaviors, may have an increased risk for being abused.

Physical abuse. Intentionally inflicting or allowing to be inflicted any physical injury on a vulnerable adult by an act or failure to act. It also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment except a therapeutic procedure prescribed by a licensed physician or other qualified professional.

Psychological abuse. Deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

Neglect. The failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult is likely to increase with the growing numbers of the age 80+ population. *Self-neglect* includes

the inability of a vulnerable adult without a caregiver to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death. The situation is aggravated when the older person lives alone, often without family or friends to observe the deterioration in functioning or to be available to intervene. Given the concomitance of Alzheimer's disease with advanced age, the probability of increased numbers of elders requiring a caregiver becomes a more realistic specter for the future.

Exploitation. This is defined as causing or requiring a vulnerable adult to engage in improper or illegal activity or labor against their wishes. It is an improper, illegal, or unauthorized use of funds, assets, property, power of attorney, guardianship or conservatorship of a vulnerable adult by a person for the profit or advantage of that person or another person. Frailty, mental confusion or disorientation, and lack of social supports leave the older adult vulnerable to scam artists and other exploiters. A growing number of private sector services and products are targeted to older consumers. Fraud and exploitation occurs in the marketing of insurance, retirement housing, investment and financial planning, private care management, home equity, health, home care and medical services and supplies.

Improvement of Quality of Care for Residents of Long Term Care Facilities:

Many seniors and family members find it a challenge to select a facility and to ensure appropriate care will be provided. Generally, a nursing home or residential care facility offers daily assistance to individuals who are physically or mentally unable to live independently. The aging population who meet the criteria for nursing home placement and are Medicaid eligible will have increased difficulty locating appropriate placement in facilities. This is a result of the stagnant growth of additional facilities or nursing home beds. Currently, South Carolina is losing nursing home beds and there is a waiting list for nursing homes that could be as long as two years.

The long-term care system is complex and sometimes difficult to understand. There are many different agencies responsible for helping to ensure good care for long-term care residents. The Long Term Care Ombudsman Program is responsible for assisting individuals in understanding long term care issues.

In South Carolina, unlike most other states, the Long Term Care Ombudsman Program has two distinct roles. The first role is to be an advocate for residents in long-term care facilities as required by the federal Older Americans Act. The second role as defined under the South Carolina Omnibus Adult Protection Act is to be the mandated investigator for abuse, neglect and exploitation in facilities. In contrast to regulators, whose role is to apply laws and regulations, ombudsmen seek to identify and resolve problems on behalf of residents before intervention is needed by the regulatory agency. The Ombudsman program does not have direct enforcement authority and cannot sanction facilities for violations; however, it does have the authority to refer cases to the proper regulatory agencies for enforcement action, and refer all cases of abuse, neglect, and exploitation to local law enforcement or to the Attorney General's Office for investigation and prosecution. In 2006, the Omnibus Adult Protection Act was amended and all abuse, neglect and exploitation complaints in facilities operated or contracted for operation by the

Departments of Mental Health and Disabilities and Special Needs must be reported directly to the Vulnerable Adult Investigative Unit (VAIU) at the State Law Enforcement Division. The VAIU vets the complaints and refers all “non-criminal” abuse, neglect and exploitation complaints to the Long Term Care Ombudsman Program for investigation.

The LGOA and the State Long Term Care Ombudsman have designated “seats” on the SC Adult Protection Coordinating Council. Membership on the Council insures consultation and collaboration with all agencies entrusted with protecting seniors and vulnerable adults. It also provides an alliance network for all adult protection entities to assist in strengthening laws and a body of experts to conduct public awareness and educational seminars regarding elder abuse, neglect, and exploitation. The Long Term Care Ombudsman receive, evaluate, and investigate complaints or refer them to the appropriate entity. They abide by the confidentiality laws and diligently work to protect the privacy of individuals (complainant and victim) involved in the complaint process.

The State Long Term Care Ombudsman Program, located in the SUA, has the responsibility for directing the program and oversees the investigation of complaints by its ten (10) Regional Programs. While the Ombudsmen do not have direct authority to require action by a facility, they have the responsibility to negotiate on the resident’s behalf and to work with other state agencies for effective enforcement. The ten Regional Ombudsman Programs are located throughout the state and there are 16 ombudsman and 2 clerical workers supporting the program. The administration of these regional programs is through the local Area Agency on Aging and they investigate complaints and provide assistance to all nursing home and residential care facility residents.

Seniors who need long term care have more choices today and many more are able to stay in their homes and receive the care they need. This is attributed to the rapid growth in home health care as well as advances in medical technology that permit people to postpone institutional care and opt for less costly home-based alternatives. However, nursing homes remain a critical component of health care and are essential for those who need intensive, 24-hour medical care.

In FY 2010 - 2011, the Ombudsman Program investigated 7,410 complaints. Often a single complaint affects more than one resident. For example, complaints regarding lack of staff to assist with meals could reasonably affect a single resident or the entire facility depending on the circumstances. This information is tracked over the reporting year to yield the number of people the ombudsman affects by conducting complaint investigations. The majority of the complaints to the ombudsman come from facility staff or families and friends of the resident.

However, in addition to investigating complaints and advocating on behalf of residents, Ombudsmen also serve as a valuable resource for residents, families, facility staff and community members. Ombudsmen are able to provide education

on residents' rights, provide information or assistance with family and resident councils, share information about community groups and activities available to improve life and care for nursing home residents, offer advice about how to select a nursing home and answer questions about long term care.

Data also suggest approximately 60% of the residents in nursing facilities do not have visitors, thus increasing the feeling of loneliness and boredom. To counter these feelings and provide residents with volunteer visitors from the community, the LTCOP has implemented The Friendly Visitor Program.

Decisions Regarding Health Care and End-of-Life:

The right to receive quality health care, to refuse care, and to execute advance directives regarding desired health care continues to grow in importance as the older population increases and as medical technology makes it increasingly possible to extend life. The SUA has partnered with members of the Carolinas Center for Hospice and End of Life Care to better understand and increase public awareness about end-of-life issues.

Research indicates less than 20% of South Carolinians have executed an advance directive. Research also indicates, 1) 37% of persons in South Carolina have primary end of life concerns about pain, comfort and dignity, 2) 38% of the nursing home residents have adequate advance health care planning, 3) 60% of African Americans and other minorities in SC want more information on advance care planning. The data also suggest that when advance health care planning is conducted, the patient's wishes about end of life care are frequently ignored (e.g. the patient's desire to have CPR withheld is followed only 50% of the time). Reasons for this include lack of communication between the patient, family and physician prior to the health care incident that would invoke the use of an advance directive type document.

Legal Services:

The increased complexity of a highly technological and impersonal society combined with the increased frailty and advanced age of older adults sets the stage for the erosion of elder rights. Many older persons who lose their autonomy and their financial, legal, or personal rights are often outside the formal legal system. Family members, caregivers and medical and social service providers often assume power and control over the older person's choices and resources, both through quasi-legal transfers of authority and through failure to fully inform elders. In growing numbers, older persons lose their rights often with no due process safeguards. Exploitation and criminal abuses abound. Public guardianship programs are non-existent and conservatorship or legal guardianship may be awarded with little or no consideration of alternative services or how to limit the scope of the orders. The availability of training, support services, guardians and courts is limited. Guardian reporting is not reviewed and courts have little capacity to exercise oversight.

The SUA is an advocate for Elder Rights in the areas of legal services, legislation/legislative initiatives, and financial exploitation/scam and fraud protection. Legal issues that seniors and other vulnerable adults face run the gamut from financial exploitation to predatory lending practices, from contract disputes to disagreements over real estate, from estate issues and family conflict to treasury and banking issues, and from domestic violence to physical, mental, and emotional abuse.

Legal services are expensive and for people on limited income, their ability to obtain quality representation and advocacy is restricted. State resources that provide these services are also severely limited. Significant eligibility restrictions for the availability of services exist, based on income levels and financial qualifications. While the need for such resources and protection is extensive, even limited resources place many vulnerable adults above the threshold requirements for assistance, and the excessive cost of paid legal services make these services unavailable. Additionally, when seniors and vulnerable adults lose capacity and need someone else to make legal decisions for them, there is no public guardianship program available to step into the gap.

Legislation that affects the quality of life and the ability of vulnerable adults to obtain services is proposed annually. The need for advocates who understand the issues and who can advocate for the interests of these individuals is far-reaching.

The Lieutenant Governor's Office on Aging provides referrals to seniors for obtaining legal resources through the South Carolina Center for Equal Justice, the National Elder Law Foundation, and the South Carolina Bar Association. General information and documents for Living Wills and Health Care Powers of Attorney are provided on the website and educational sessions are offered to all interested organizations throughout South Carolina. The SUA has taken the lead to protect seniors from exploitation and fraud. Participation on the South Carolina Elderlaw Committee provides better oversight of legislation that targets issues that affect seniors and vulnerable adults. Guardianship initiatives are being developed in conjunction with organizations such as the Junior League and efforts of the Bar to establish a pilot program to provide pro bono guardianship in Lexington County.

Volunteer Program:

The SC Lieutenant Governor's Office on Aging (LGOA) has a Volunteer Ombudsman Program (Friendly Visitor Program). “The Friendly Visitor Program” is the contact point for seniors and vulnerable adults who lack friends and family or other visitors within the long term care environment.

The program is met with challenges because facilities view “Volunteer Ombudsmen” as “junior Ombudsmen” and perceived that these workers lack neutrality, focusing on finding even the smallest flaws within the long term care facilities.

Mental Health:

Data has shown that the prevalence of mental illness among the elderly is approximately 20%. Suicide is a leading cause of injury or death among adults 65 and older in South Carolina. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) older individuals experience serious mental health and/or substance abuse (MH/SA) problems that affect their quality of life as well as their ability to function independently in the community. The incidence rates vary among older adults', however, studies suggest that older adults experience high rates of depression and anxiety disorders, as well as alcohol abuse and dependence. As the Baby Boomers age and this population group increases, it will become increasingly imperative to insure both the clinical and policy communities are well informed as to the nature and effectiveness of different service delivery models for treating MH/SA problems.

Program Goals for Elder Rights and Related Issues:

- Reduce the prevalence of elder abuse, neglect and exploitation in home and institutional settings
- Improve the quality of care in facilities through increased participation in the Advancing Excellence and Culture Change programs.
- Empower residents to know and exercise their rights, voice their concerns and, to the extent possible, act on their own behalf or to seek outside assistance
- Identify and resolve resident problems relating to poor facility practices
- Identify and represent the interests of residents and seek appropriate remedies
- Improve access to legal assistance services for older adults who have no other legal resources
- Increase awareness and promote the use of advance directives for health care planning in the community and long term care facilities through training and education
- Increase partnering and collaborative opportunities to increase knowledge of advance directives for health care providers
- Increase the awareness of the occurrence of mental illness and substance abuse in the older adult population
- Create process maps of Adult Protective Services Providers' services for vulnerable adults to include legal services information
- Develop a gap analysis of services including legal support available for and needed by vulnerable adults
- Compile statistical information that documents and supports the need for the development of legal services or legislative initiatives to fill existing gaps
- Develop partnerships with organizations such as the Junior League to create programs for vulnerable adults who lack capacity
- Develop partnerships with organizations such as AARP to recruit volunteers on an ongoing basis
- Utilize partnerships to create a dynamic base of volunteers to provide an ongoing pool of visitors for residents of long term care facilities
- Develop a complete system of centralized secure files and records to maintain comprehensive information on volunteers statewide

- Input information and compile statistical information that documents the visits made by Friendly Visitors
- Solicit facilities to participate in the program with a goal of 60% participation within three years

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Strategies for Elder Rights and Related Issues:

- Increase public awareness about issues of elder abuse, neglect and exploitation including causes, profiles of victims and perpetrators, warning signs, reporting, and strategies for prevention through work with member agencies of the Adult Protection Coordinating Council
- Increase professional understanding of physicians and other health care and social service professionals and educate them about the Omnibus Adult Protection Act through work with member agencies of the Adult Protection Coordinating Council
- Develop methods for standardized collection, reporting, and coordination of data related to adult abuse, neglect and exploitation through work with member agencies of the Adult Protection Coordinating Council
- Improve the coordination with law enforcement, solicitors and the judicial system to increase prosecution of adult abuse, neglect and exploitation through the work of the Adult Protection Coordinating Council
- Ensure timely and responsive access to the services of the long term care ombudsman program for all residents in long term care facilities
- Support the statewide Long Term Care Ombudsman program through training and technical assistance
- Expand the advocacy capacity of the ombudsman program by increasing the number of community outreach connections, increasing the profile and visibility of the ombudsman program, and by improving effective networking
- Develop and nurture effective self-advocacy of nursing home residents by supporting the development of family councils through collaboration with the long term care ombudsman program
- Ensure the health, safety, welfare and rights of residents by working more vigorously with long term care providers and related health and human services agencies toward a level of care that is responsive, individualized, and of high quality
- Provide collective and analytical data concerning complaints, trends, patterns and condition of residents in long term care facilities and identify and present essential information to appropriate public policymakers
- Provide ongoing training and public information about advance directives for the public and professionals who serve older adults
- Support the network of trained volunteers to provide ombudsman witness services to persons who are in hospitals and long term care facilities
- Identify the services provided by various agencies that target the needs of vulnerable adults and disseminate the information to agencies throughout South Carolina
- Identify the resources available to meet specific support requirements and create

a needs assessment that establishes service gaps

- Compile findings from latest surveys and program initiatives nationally and in South Carolina and disseminate findings from statistical research to the Bar Association and members of the Adult Protection Coordinating Council as well as to the Joint Legislative Committee on Aging
- Develop partnerships with resources within South Carolina for financial and legislative support of issues involving vulnerable adults
- Use AARP mailings; public presentations at fraternal, community, and religious organizations; mass media; participation in wellness events, health fairs, senior events, and other public gatherings to solicit participation in the program
- Establish centralized confidential files on program participants and recruitment efforts
- Regional staff will require and retain visit records from all participants and enter the data in the Ombudsman database system
- Create and employ a strategic plan of facility solicitation, including meetings with directors of facilities and officials of the South Carolina Health Care Association

Desired Outcomes for Elder Rights and Related Issues:

- Reports will be produced on a regular basis identifying unduplicated crimes of abuse, neglect and exploitation of vulnerable adults through the Adult Protection Coordinating Council.
- Public awareness of factors related to abuse, neglect and exploitation will result in increased reporting.
- Residents, families and agencies contact the ombudsman program for information and assistance to resolve problems with long term care facilities.
- Residents and families initiate and participate in resident and family councils.
- Complaints are analyzed to identify major issues impacting residents and strategies are developed based on identified issues.
- Needed regulatory and law enforcement actions are initiated.
- Citizen groups and other advocates push the long term care ombudsman's advocacy agenda.
- Consumers' quality of care and quality of life are improved.
- Residents, families and the public understand the need for systems change, make comments and provide testimony on legislative and regulatory proposals.
- Knowledge and public understanding of advance directives will increase.
- Partnership with the Dept. of Mental Health, PAMI and substance abuse organizations will result in increased awareness and resultant policy changes and increased services to older adults.
- Agencies, police authorities, and groups that serve vulnerable adults will be able to quickly ascertain where support services can be located. Clients, consumers, and their caregivers will be referred to the appropriate services to enhance their quality of life.
- Document the need for expanded services for vulnerable adults
- Justify having adequate resources for the provision of cost effective protective services for vulnerable adults and their caregivers.

- Establish a public guardianship program for vulnerable adults who lack capacity.
- Older adults will have more pro bono or sliding fee scale legal assistance services available.
- The Friendly Visitor program will become dynamic in nature, so that new volunteers are always entering the program as experienced volunteers retire from service. This will prevent service gaps in the participating facilities.
- Centralized documentation provides much needed documentation of participant credibility and will also allow long term tracking of program effectiveness and results, as well as help in establishing challenges to program success.
- Friendly Visitor data meets some of the mandated statistical requirements placed on the agency by funding sources.
- Establish greater outreach to residents and improve quality of life in facilities.

Volunteer and Employment Opportunities

As South Carolina's population ages dramatically, future, available resources will continue to be a major concern for policymakers, providers of services, families, and individuals needing care and assistance. Funding will be stretched, and federal, state and local governments will not be able to provide for all needs of the aging population. Seniors currently living in South Carolina and seniors moving to South Carolina offer a wealth of knowledge, skills and abilities. Through volunteerism and employment, these older adults contribute to quality of life for other seniors and to their communities.

Early retirement had been a major trend among seniors but the economic downturn of the past four years has created new and critical challenges for South Carolina's elderly population. Many of South Carolina's lifelong residents have lived in rural communities with below-the-national-average income levels. Many native South Carolina seniors are ineligible for federal financial assistance, and with skyrocketing health care costs, must continue to work in order to afford the basics.

Thus the goals of our state's senior population are reflected in both a greater need for additional income for many, while others look for volunteer services for a type of enrichment and satisfaction that previous employment may not have permitted. The SUA and the Aging Network are committed to both assisting seniors needing additional income and utilizing the skills and abilities of those who wish to volunteer.

The State of South Carolina currently uses senior volunteers and Title V workers in many activities throughout the state. With limited resources, the SUA must continue to utilize seniors in these activities, and seek ways to further utilize seniors' assets. Many of these opportunities have been presented through Federal funding made available through a partnership of local aging services providers, Area Agencies on Aging, and the State Unit on Aging.

Education and Training

South Carolina's elderly population is increasing significantly which heightens awareness of the growing need for both institutional and home and community-based services. Preparation of personnel to work with older adults and caregivers is essential to ensuring an adequate supply of services now and in the future. Such preparation must include education and skills training specific to the services offered. Such training must address concerns regarding quality of care and accountability.

The SUA ensures that an orientation to aging services and programs is provided new staff of the AAAs and AAA contractors. Training and continuing education occur throughout the year at the local level and at the SUA. In addition, the SUA, with the assistance of the AAAs, periodically conducts an assessment of statewide training needs to determine the types of training to be provided. The SUA cooperates with the ACL to ensure that state and regional staff attends training developed by the ACL. The AAA is responsible for conducting training needs assessments, and has responsibility for designing and implementing a regional education and training program.

Issue: Senior Community Service Employment Program (SCSEP)

The purpose of the Senior Community Service Employment Program (SCSEP) is to enhance older worker employment services by improving coordination among organizations engaged in older worker activities.

The SCSEP program fosters and promotes useful part-time training opportunities in community service organizations for unemployed low-income persons who are 55 years of age or older and who have poor employment prospects. Additionally, SCSEP promotes individual economic self-sufficiency and increases the number of persons who may enjoy the benefits of unsubsidized employment in both the public and private sectors by providing individuals with appropriate training for targeted jobs in the community. New regulations have strengthened the role of the State Unit on Aging (SUA) in ensuring that seniors receive services in a more coordinated manner. The SUA contracts with Experience Works, Inc. and Goodwill, Inc. of the Midlands/Upstate, and has two sub-grantees.

Goal

- To provide employment services and opportunities to adults 55 years of age or older and who may have poor employment prospects.

Outcomes:

Provide employment services for adults 55 years of age or older, and who may have poor employment prospects.

Strategies:

Work with Experience Works and the ADRCs to ensure seniors needing employment options are aware of the program.

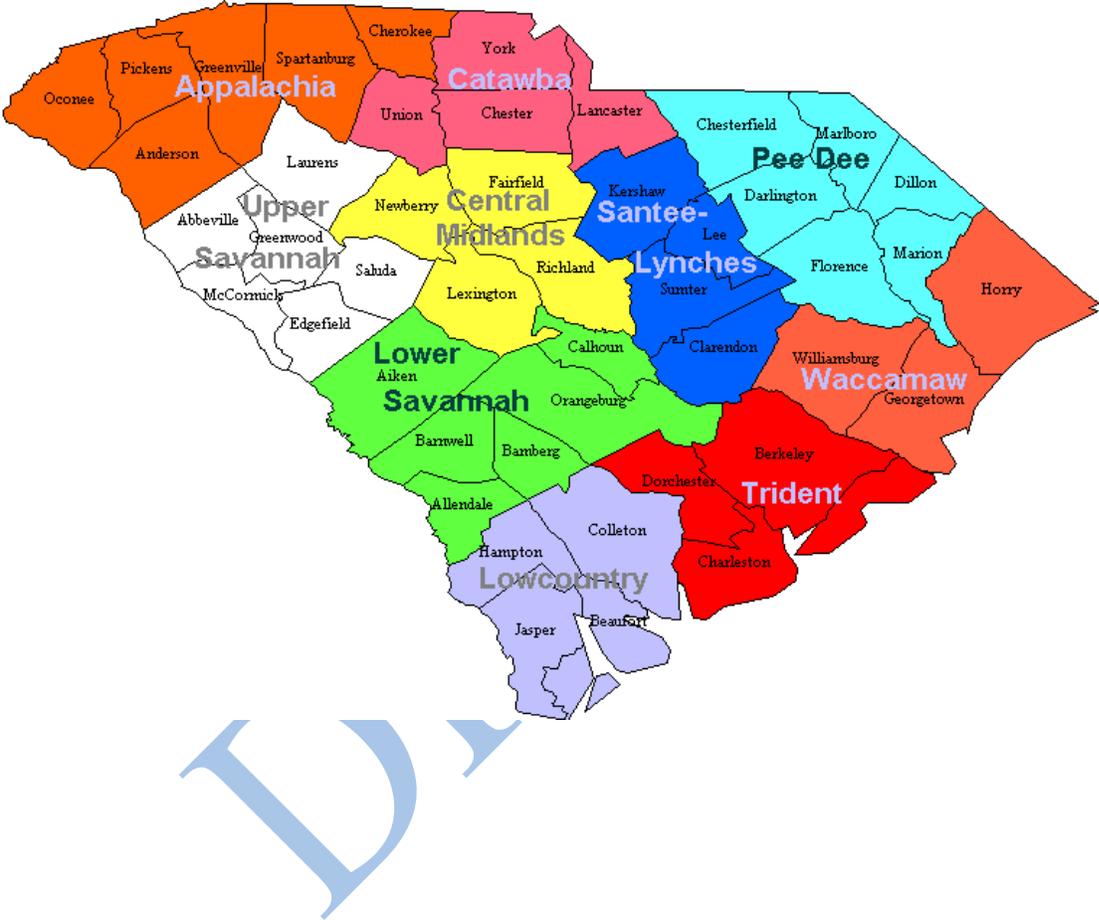
Resource Allocation

The methods used by the SUA to allocate funds to the area agencies are described in the Intrastate Funding Formula found in Appendix B. OAA funds and most state funds, except when otherwise directed by law are allocated based on a multi-factored formula. The factors include an equal base, percent of population 60+ below poverty, percent of minority population 60+, percent of population who are moderately or severely impaired, and the percent of state rural population. An examination of the recipients of services through the Aging Network shows that those populations in greatest economic and social need and minorities are served in numbers greater than their general representation in the population. No further targeting measures are indicated at this time.

DRAFT

APPENDIX D
South Carolina Planning Service Areas
(PSA)

Appendix D: South Carolina Planning and Service Areas



AGING & DISABILITY RESOURCE CENTERS AND SERVICE PROVIDERS

REGION I - APPALACHIA

MR. STEVE PELISSIER, Executive Director

MS. BEVERLY ALLEN, Aging Unit Director

South Carolina Appalachian Council of Governments

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Gen. E-Mail: adrc@scacog.org

COUNTIES SERVED: Anderson, Cherokee, Greenville, Oconee, Pickens, and Spartanburg

REGIONAL OMBUDSMAN: Sandy Dunagan, Nancy Hawkins, Jessica Winters,
Jamie Guay, Tiwanda Simpkins, and Kim Bridges

REGIONAL I/R&A SPECIALIST: Tim Womack **E-mail:** twomack@scacog.org
Toll Free Number: 1-800-434-4036

REGIONAL I-CARE COORDINATOR: Shirley Hayes **E-Mail:** shayes@scacog.org

REGIONAL FAMILY CAREGIVER ADVOCATE: Debra L. Brown **E-Mail:** brown@scacog.org
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Mr. Doug Wright

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101 Perry Avenue

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Ms. Kimberly Snide

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DRAFT

APPENDIX D
South Carolina Aging Acronyms

DRAFT

South Carolina Aging Acronyms

A

AA	Alcoholics Anonymous
AAA	Area Agency on Aging
AAFES	Army and Air Force Exchange Services
AAHSA	American Association of Homes & Services for the Aging
AAIDD	American Association on Intellectual and Developmental Disabilities
AAMD	American Association of Mental Deficiency (now AAIDD)
AAMR	American Association on Mental Retardation (formerly AAIDD)
AAPD	American Association of People with Disabilities
AARP	American Association of Retired Persons
ABA	Architectural Barriers Act or American Bar Association
ABC	Advocates for Better Child Care (SC)
ABD	Aged, Blind & Disabled
ABN	Advanced Beneficiary Notice
ABS	Annual Beneficiary Summary
AC	Actual Charge or Allowable Cost
ACA	Affordable Care Act
ACB	American Council of the Blind
ACCH	Association for the Care of Children's Health (under DHHS)
ACE	Alternative Care for the Elderly
ACF	Administration for Children & Families (HHS)
ACLD	Association for Children with Learning Disabilities
ACLU	American Civil Liberties Union
ACOA	Adult Children of Alcoholics
ACP	Advanced Care Planning
ACS	American Cancer Society or Army Community Services
ACYF	Administration on Children, Youth and Families (DHHS)
ADA	Americans with Disabilities Act or Age Discrimination Act
ADAAG	Americans with Disabilities Act Accessibility Guidelines
ADAPT	Americans Disabled for Attendant Programs Today
ADC	Aid to Dependent Children (now TANF) or Adult Day Care
ADD	Administration on Developmental Disabilities (ACF, HHS)
ADH	Adult Day Health

ADJ	Adjusted Claim
ADL	Activities of Daily Living (toileting, bathing, eating, transferring, etc.)
ADMC	Advance Determination of Medicare Coverage
ADP	Advance Planning Document
ADRC	Aging and Disability Resource Center
ADRD	Alzheimer's Disease and Related Disorders
ADSSP	Alzheimer's Disease Supportive Services Program
ADVP	Adult Developmental Vocational Program
AE	Age Equivalent
AEP	Annual Coordinated Election Period
AFAS	Air Force Aid Society
AFB	American Foundation for the Blind or American Federation for the Blind or Air Force Base
AFDC	Aid to Families with Dependent Children (now TANF in SC)
AGI	Adjusted Gross Income
AHA	American Heart or Hospital Association
AHCA	American Health Care Association
AIM	Advanced Information Management (SC)
AKA	Also Known As
ALANON	Alcoholics Anonymous (for family members of AA)
ALF	Assisted Living Facility
ALFA	Assisted Living Federation of America
ALJ	Administrative Law Judge
ALOS	Average Length of Stay
ALS	Advanced Life Support
ALT	Average Length of Treatment
AMA	American Medical Association
AMI	Alliance for the Mentally Ill
ANA	American Nurses Association
ANE	Abuse, Neglect and Exploitation
AoA	Administration on Aging (HHS)
APA	American Psychological Association or American Psychiatric Association
APD	Advanced Planning Documents
APH	American Printing House for the Blind
APHA	American Public Health Association
APS	Adult Protective Services

APWA	American Public Welfare Association
ARC	Advocates for the Rights of Citizens with Disabilities (formerly Association of Retarded Citizens) or American Red Cross
ARCC	Alzheimer's Resource Coordination Center (SC)
ARCH	Access to Respite Care and Help
ARRA	American Recovery and Reinvestment Act
ASA	Autism Society of America
ASL	American Sign Language
AT	Assistive Technology
ATA	Alliance for Technology Access
ATBCB	Architecture and Transportation Barriers Compliance Board
ATI	Assistive Technology Initiative
ATP	Assistive Technology Project (SC)

B

BBA	Balanced Budget Act
BC/BS	Blue Cross/Blue Shield
BDOD	Beneficiary Date of Death
BSW	Bachelor of Social Work
BX	Base Exchange (military)

C

CA	Chronological Age
CAD	Computer Assisted Drawing
CAI	Computer Assisted Instruction
CAP	Client Assistance Program (SC) or Community Alternatives Program or Corrective Action Plan
CAPH	Citizens for the Advancement of the Physically Handicapped (SC)
CARF	Commission on the Accreditation of Rehabilitation Facilities
CAST	Center for Applied Special Technologies
CAT Scan	Computerized Axial Tomography (same as CT scan)
CCF	Continuing Care Facility
CCP	Crippled Children's Program (in SC, called CRS)
CCRC	Continuing Care Retirement Community
CCRS	Children's Case Resolution System (SC)

CD	Consumer Directed
CDB	Childhood Disability Benefit
CDBG	Community Development Block Grant
CDC	Centers for Disease Control and Prevention (HHS) or Child Development Center
CDD	Center for Developmental Disabilities (SC – same as CDR)
CDDC	Consortium of Developmental Disabilities Councils
CDF	Children’s Defense Fund
CDM	Consumer Directed Model
CDR	Continuing Disability Review or Center for Disability Resources (SC – formerly CDD)
CDSMP	Chronic Disease Self Management Program
CEC	Council for Exceptional Children (Division of CEC)
CETA	Comprehensive Employment Training Act
CFB	Commission for the Blind (SC)
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFSAN	Center for Food Safety and Applied Nutrition (FDA, HHS)
CHADD	Children and Adults with Attention Deficit Disorder
CHAMPUS	Civilian Health & Medical Programs of the Uniformed Services (Now Tri-Care)
CHAMPVA	Civilian Health & Medical Program of the Veterans Administration (Now Tri-Care)
CHIP	Children’s Health Insurance Program
CHIPRA	Children’s Health Insurance Program Reauthorization Act
CHSPR	Center for Health Services and Policy Research (SC)
CIL	Centers for Independent Living
CIO	Chief Information Officer
CIP	Crisis Intervention Program
CITA	Center for Information Technology Accommodations
CLASS	Community Living Assistance Supports and Services
CLP	Community Living Program
CLTC	Community Long Term Care (SC)
CMS	Centers for Medicare and Medicaid Services (formerly HCFA) or Children’s Medical Services
CMHS	Center for Mental Health Services (SAMHSA, HHS)
CMSO	Center for Medicaid and State Options
CAN	Certified Nursing Assistant
CNCS	Corporation for National and Community Services

COA	Council on Aging (SC)
COBRA	Consolidated Omnibus Budget Reconciliation Act
COG	Council of Governments (SC)
COLA	Cost of Living Adjustment
CON	Certificate of Need
COTA	Certified Occupational Therapist
CPAP	Continuous Positive Airway Pressure
CPS	Child Protective Services
CQI	Continuous Quality Improvement
CQMR	Carrier Quarterly Medical Review
CRCF	Community Residential Care Facilities
CRD	Chronic Renal Disease (ESRD (preferred))
CRF	Change Request Form
CRIPA	Civil Rights of Institutionalized Persons Act
CRS	Children's Rehabilitative Services (SC)
CSO	Community Service Organization
CSRS	Civil Service Retirement System
CUFAN	Clemson University Forestry and Agriculture Network (SC)
CWLA	Child Welfare League of America
CY	Calendar Year

D

D&E	Diagnosis and Evaluation
DAC	Disability Action Center (SC)
DAODAS	Department of Alcohol and Other Drug Abuse Services (SC)
DAV	Disabled American Veterans
Db	Decibel
DBTAC	Disability Technical Assistance Center
DD	Developmental Disability
DDC	Developmental Disabilities Council
DDD	Disability Determination Division (Vocational Rehabilitation Dept. in SC)
DDPC	Developmental Disabilities Planning Council
DDSN	Department of Disabilities and Special Needs (SC – formerly DMR)
DDSNB	Department of Disabilities and Special Needs Board (SC)
DDST	Denver Developmental Screening Tool

DEC	Division for Early Childhood (Division of CEC) or Developmental Evaluation Clinic
DEERS	Defense Enrollment Eligibility Reporting System (Military)
DEW	Department of Employment and Workforce
DHEC	Department of Health and Environmental Control (SC)
DHHS	Department of Health and Human Services
DJJ	Department of Juvenile Justice (SC)
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DMH	Department of Mental Health (SC)
DMR	Department of Mental Retardation (SC – now DDSN)
DMV	Department of Motor Vehicles (SC)
DNR	Do Not Resuscitate
DOA	Division of Aging
DOB	Date of Birth
DOC	Department of Commerce (U.S.) or Days of Care
DOD	Department of Defense (U.S.) or Date of Death
DOE	Department of Education (U.S.) or Date of Entitlement
DOEH	Date of Entitlement to Hospital Insurance (Medicare Part A)
DOES	Date of Entitlement to Supplementary Medical Insurance
DO-IT	Disabilities, Opportunities, Internetworking and Technology
DOJ	Department of Justice (U.S.)
DOL	Department of Labor (U.S.)
DOL VETS	Department of Labor Veterans' Employment and Training Services
DOST	Date of Suspension or Termination
DOT	Department of Transportation (U.S.)
DOTH	Date of Termination of Hospital Insurance
DOTS	Date of Termination of Supplementary Medical Insurance
DPOA	Durable Power of Attorney
DRA	Deficit Reduction Act
DRACH	Disability Rights Action Coalition in Housing
DSM	Diagnostic & Statistical Manual
DSN	Disabilities and Special Needs (SC)
DSS	Department of Social Services (SC)

DTAP	Disabled Transition Assistance Program
DVA	Department of Veterans Affairs (VA)
DVAAP	Disabled Veterans Affirmative Action Program
DVOP	Disabled Veterans Outreach Program
DVR	Department of Vocational Rehabilitation (SC)
DWB	Disabled Widow's Benefits
Dx	Diagnosis

E

EASI	Equal Access to Software and Information
EBNE	Eligible But Not Enrolled
EBP	Evidence-based Program
EC	Early Childhood
ECF	Extended Care Facility
EDGAR	Education Department General Administrative Regulations
EDPP	Evaluation, Diagnosis and Prescriptive Program
EEG	Electroencephalogram
EEOC	Equal Employment Opportunity Commission
EFA	Epilepsy Foundation of America or Education Finance Act
EFMP	Exceptional Family Member Program (Military)
EHA	Education for all Handicapped Children Act
EHD	Early Head Start
EI	Early Intervention
EIA	Education Improvement Act
EIB	Employer Insured Beneficiary
EIN	Employee/Employer Identification Number
EITAC	Early Intervention Technical Assistance Collaborative (SC)
EMB	Eligible Medicare Beneficiary
EMD	Emergency Management Division (SC)
ENT	Ears, Nose and Throat
EOC	Economic Opportunity Commission (SC)
EOMB	Executive Office of Management & Budget
EPD	Emergency Preparedness Division
EPMS	Employee Performance Management System
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ERIC	Educational Resources Information Center

ERISA	Employee Retirement Income Security Act
ESC	Employment Security Commission (SC) – now DEW
ESEA	Elementary and Secondary Education Act
ESRD	End Stage Renal Disease
ESY	Extended School Year

F

F2F HIC	Family to Family Health Information Center
FA	Fiscal Agent
FAPE	Free Appropriate Public Education or Families
FCC	Federal Communications Commission (U.S.)
FCSP	Family Caregiver Support Program (Title III of OAA)
FDOEH	First Date of Entitlement to Hospital Insurance (Part A)
FDOES	First Date of Entitlement to Supplementary Medical Insurance (Part B)
FEMA	Federal Emergency Management Agency
FERPA	Family Educational Rights and Privacy Act
FES	Functional Electrical Stimulation
FFATA	Federal Funding Accountability and Transparency Act
FFP	Federal Financial Participation
FGP	Foster Grandparent Program
FHA	Federal Housing Administration
FHAA	Fair Housing Amendments Act
FI	Family Independence (SC – formerly AFDC) or Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FMAP	Federal Medical Assistance Percentage
FMS	Financial Management Service
FNS	Food & Nutrition Service
FOIA	Freedom of Information Act
FQHC	Federally Qualified Health Centers
FR	Federal Register
FSA	Flexible Savings Account
FSP	Family Support Plan
FUTA	Federal Unemployment Tax Act
FY	Fiscal Year
FYE	Fiscal Year End or Ending
FYTD	Fiscal Year to Date

G

GA	Graduate Student
GAL	Guardian Ad Litem (SC)
GAO	Government Accounting Office
GRI	Grant Related Income
GSA	General Services Administration

H

HAL	Handicapped Assistance Loans (SBA)
HASCI	Head and Spinal Cord Injury (SC – Division of DDSN)
HCBS	Home and Community Based Services
HCBWP	Home & Community Based Waiver Program
HCCBG	Home and Community Care Block Grant
HCFA	Health Care Financing Administration (U.S.) (now – Centers for Medicare and Medicaid Services)
HCPOA	Health Care Power of Attorney
HEW	Dept. of Health, Education and Welfare (now DHHS)
HH	Home Health
HHA	Home Health Agency
HHS	Health and Human Services
HHSCC	Health and Human Services Coordinating Council (SC)
HHSFC	Health and Human Services Finance Commission (SC)
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Program
HMO	Health Maintenance Organization
HRSA	Health Resources & Services Administration (formerly HRA and PHS)
HS	Head Start
HSA	Health Savings Account or Health Service Area
HUD	Housing and Urban Development
Hx	History

I

I & O	Intake and Output
I & A	Information and Assistance
I & R	Information and Referral
I & R/A	Information, Referral and Assistance

IAC	Interagency Advisory Committee
IADL	Instrumental Activities of Daily Living (shopping, cooking, bill paying, etc.)
I-CARE	Insurance Counseling, Assistance and Referral for the Elderly
ICC	Interagency Coordinating Council
ICD-9	International Classification of Diseases
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility for the Mentally Retarded
ICU	Intensive Care Unit
IDC	Institute on Disability Culture
IDEA	Individuals with Disabilities Education Act
IDT	Interdepartmental Transfer (SC)
IEE	Independent Educational Evaluation
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IHE	Institutions of Higher Education
IHP	Individualized Habilitation Plan
IHSS	In-home Supportive Services
IL	Independent Living
ILC	Independent Living Center/Council
ILRU	Independent Living Research Utilization
IPE	Individualized Plan for Employment
IPP	Individualized Program Plan
IQ	Intelligence Quotient
IRC	Interagency Resource Committee
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IRWE	Impairment Related Work Expense
ISO	Intermediary Service Organization
ISP	Individualized Service Plan
IT	Information Technology
ITP	Individualized Transition Plan
IWRP	Individualized Written Rehabilitation Plan
J	
JAN	Job Accommodation Network
JCAHCO	Joint Commission on Accreditation of Health Care Organizations

JTPA Job Training Partnership Act

L

LAC Local Advisory Committee
LBPH Library for the Blind and Physically Handicapped
LDA Learning Disabilities Association
LEA Local or Lead Education Agency (School District)
LEAA Law Enforcement Assistance Administration
LGOA Lt. Governor's Office on Aging (SC)
LIHEAP Low Income Home Energy Assistance Program
LIS Low-Income Subsidy (Medicare Beneficiary)
LISW Licensed Independent Social Worker
LOC Level of Care
LPN Licensed Practical Nurse
LRADAC Lexington/Richland Alcohol and Drug Abuse Commission (SC)
LRD Lifetime Reserve Days (Medicare Beneficiary)
LRE Least Restrictive Environment
LSP Local Service Provider
LTC Long Term Care
LTCF Long Term Care Facility
LVER Local Veterans Employment Representative (DEW)

M

M+CO Medicare + Choice Organization
MA Mental Age
MAO Medical Assistance Only
MAP Medication Assistance Program
MA-PD Medicare Advantage Prescription Drug Plans
MBA Monthly Benefit Amount (SSA)
MCFN Military, Family, and Community Network
MCH Maternal and Child Health
MCI Medicare Claims Inquiry
MCO Managed Care Organization
MDS Minimal Data Set
MDT Multidisciplinary Team
MEDICAID Medical Aid (State administered health insurance program)

MEDIGAP	Medicare Gap (Medicare complementary insurance program)
MFP	Money Follows the Person
MGRAD	Minimum Guidelines & Requirements for Accessible Design
MH	Mental Health
MHLP	Mental Health Law Project (formerly The Bazelon Center)
MIAF/MIAP	Medically Indigent Assistance Fund/Program
MICH	Maternal, Infant and Child Health
MICHC	Maternal, Infant and Child Health Council (SC)
MIPPA	Medicare Improvements for Patients and Providers Act
MIS	Management Information System
MMA	Medicare Modernization Act
MMIS	Medicaid Management Information System
MMO	Materials Management Office
MOA	Memorandum of Agreement
MOB	Matter of Balance
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MR	Mental Retardation
MR/DD	Mental Retardation and other Developmental Disabilities
MRI	Magnetic Resonance Imaging
MRRC	Mental Retardation Research Center
MSN	Medicare Summary Notice
MSP	Medicare Savings Plan
MSW	Master's Degree in Social Work
MTF	Military Treatment Facility
MUMS	Mothers United for Moral Support
MUSC	Medical University of South Carolina (SC)
MWR	Morale, Welfare and Recreation (military)

N

N4A	National Association of Area Agencies on Aging
NA	Narcotics Anonymous or Not Applicable
NACHRI	National Association of Children's Hospitals and Related Institutions
NADS	National Association for Down Syndrome
NADSA	National Adult Day Services Association
NAEYC	National Association for the Education of Young Children

NAGC	National Association for Gifted Children
NAHC	National Association for Home Care
NAMI	National Alliance for the Mentally Ill
NAPIS	National Aging Program Information System
NAPVI	National Association for Parents of Visually Impaired
NARF	National Association of Rehabilitation Facilities
NARIC	National Rehabilitation Information Center
NASLTCOP	National Association of Long Term Care Ombudsman Program
NASMD	National Association of State Medicaid Directors
NASOP	National Association of State Ombudsman Programs
NASUA	National Association of State Units on Aging (now NASUAD)
NASUAD	National Association of States United for Aging and Disabilities (formerly NASUA)
NAVH	National Association for Visually Handicapped
NCAL	National Coalition for Assisted Living
NCAM	National Center for Accessible Media
NCCA	National Center for Child Advocacy
NCCAN	National Center on Child Abuse and Neglect
NCCNHR	National Citizen's Coalition for Nursing Home Reform
NCD	National Council on Disabilities
NCDRR	National Center for Disability Dissemination Research
NCHS	National Center for Health Statistics
NCIL	National Council on Independent Living
NCIP	National Center to Improve Practice
NCNHR	National Coalition on Nursing Home Reform
NCOA	National Council on Aging
NCSC	National Council (or Center) of Senior Citizens
NDSC	National Down Syndrome Congress
NDSS	National Down Syndrome Society
NDT	Neurodevelopmental Treatment
NEA	National Education Association
NEC*TAS	National Early Childhood Technical Assistance Systems
NET	National Employment Team
NF	Nursing Facility
NFB	National Federation of the Blind
NFCSP	National Family Caregiver Support Program
NGA	Notification of Grant Award

NHO	National Hospice Organization
NIA	National Institute on Aging
NICCYD	National Information Center for Children and Youth with Disabilities
NICHCY	National Information Center for Handicapped Children and Youth (now NICCYD)
NICU	Neonatal Intensive Care Unit
NIDRR	National Institute on Disability and Rehabilitation Research (US Dept. of Educ.)
NIH	National Institutes of Health
NII	National Institute of Immunology
NILP	National Institute on Life Planning
NLE	National Library of Education
NLS	National Library Services for the Blind and Physically Handicapped
NLT	National Leadership Team
NOA	Notice of Award
NOD	National Organization on Disabilities
NORD	National Organization for Rare Disorders
NP	Nurse Practitioner
NPIN	National Parent Information Network
NPND	National Parent Network on Disabilities
NPO	Nothing by Mouth
NPPIS	National Parent to Parent Support & Information Systems, Inc.
NRC	National Resource Center
NRHA	National Rural Health Association
NRIC	National Rehabilitation Information Center
NRT	Norm Referenced Test
NSCLC	National Senior Citizens Law Center
NSIP	Nutrition Services Incentive Program
NTIA	National Telecommunications and Information Administration

O

O & M	Orientation and Mobility
OAA	Older Americans Act
OASB	Old Age & Survivors Benefits
OASDHI	Old Age, Survivors, Disability & Health Insurance

OASDI	Old Age, Survivors & Disability Insurance
OASI	Old Age & Survivors Insurance
OBRA	Omnibus Budget Reconciliation Act
OCR	Office of Civil Rights (U.S. Department of Education)
OCWI	Optional Coverage for Women, Infants and Children
OD	Office on Disability (U.S.)
OEF	Operation Enduring Freedom (war in Afghanistan)
OFCCP	Office of Federal Contract Compliance Programs
OHCDs	Organized Health Care Delivery Systems
OHDS	Office of Human Development Services (U.S.)
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget (U.S.)
OMB & BS	Office of Medicaid Eligibility and Beneficiary Services
OMRDD	Office of Mental Retardation and Developmental Disabilities
OOA	Office on Aging (SC)
OPEC	Office of Programs for Exceptional Children (SC Dept. of Education)
OPH	Office of Programs for the Handicapped (SC Dept. of Education – now OPEC)
ORHP	Office of Rural Health Policy (HRSA)
ORSI	Office of Retirement & Survivors Insurance
OSEP	Office of Special Education Programs (U.S. Dept. of Education)
OSERS	Office of Special Education and Rehabilitation Services (U.S. Dept. of Educ.)
OSHA	Occupational Safety and Health Administration
OSS	Optional State Supplement
OT	Occupational Therapy
OWL	Older Women's League

P

P & A	Protection and Advocacy System for Individuals with Disabilities
PACE	Program of All-Inclusive for the Elderly
PAND	Public Access Network Directory
PAS	Personal Assistance Services
PASARR	Pre-Admission Screen/Annual Resident Review
PASS	Plan for Achieving Self Support

PCA	Personal Care Aid
PCEPD	President's Committee on the Employment of People with Disabilities
PCP	Person Centered Planning
PD	Position Description
PDR	Prescriptive Drug Reference or Physician's Desk Reference
PE	Physical Education
PEP	Parent Educator Partnership
PERS	Personal Emergency Response System
PHAC	Preschool Handicapped Advisory Committee
PHC	Partners for Healthy Children
PHN	Public Health Nurse
PHRMA	Pharmaceutical Manufacturers and Researchers of America
PIA	Programs for Individuals with Autism
PIN	Personal Identification Number
PIP	Permanent Improvement Program (SC)
PL	Public Law
PL105-15	Individuals with Disabilities Education Act of 1997 (formerly PL101-476)
PL105-476	Individuals with Disabilities Education Act of 1990
PL94-142	Education of Handicapped Children's Act of 1975 (now PL 101-476)
PL99-457	Education of the Handicapped Amendment of 1986 (now PL101-476)
PM & R	Physical Medicine and Rehabilitation
PNA	Personal Needs Allowance
PO	Purchase Order
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PRN	Pro Re Nata (Latin for "as the situation demands")
PRT	Parks, Recreation and Tourism (SC)
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PSA	Public Service Announcement
PSO	Provider Sponsored Organization
PT	Physical Therapy
PTI	Parent Training and Information Center
PTSD	Post-Traumatic Stress Disorder

PX Post Exchange (military)

Q

Q&A Questions & Answers

QA Quality Assurance

QMB Qualified Medicare Beneficiary

QWDI Qualified Working Disabled Individual

R

RAAC Regional Aging Advisory Committee

RAP Relatives as Parents

RC Rehabilitation Councils

RCF Residential Care Facility

RCP Residential Care Program

RD Registered Dietician

RFA Request for Application

RFB Recordings for the Blind

RFI Request for Information

RFP Request for Proposal

RN Registered Nurse

ROM Range of Motion

RRC Regional Resource Center

RSA Rehabilitation Services Administration (U.S. Dept. of Educ.)

RSDI Retirement, Survivors, & Disability Insurance

RSVP Retired Senior Volunteer Program

RT Recreational Therapist

RTA Regional Transit Authority

Rx Prescription

S

SAMHSA Substance Abuse & Mental Health Services Administration

SART Semi-Annual Report Tool

SBA Spina Bifida Association or Small Business Administration

SBE State Board of Education

SC4A SC Association of Area Agencies on Aging

SCABA South Carolina Association for Blind Athletes

SCACAD	SC Association of Council on Aging Directors
SCAD	South Carolina Association for the Deaf
SCAN	Suspected Child Abuse and Neglect
SCATP	SC Assistive Technology Program
SCCB	South Carolina Commission for the Blind
SCDDC	South Carolina Developmental Disabilities Council
SCDDSN	South Carolina Department of Disabilities and Special Needs
SCDEW	South Carolina Department of Employment and Workforce (formerly Employment Security Commission – ESC)
SCDHEC	South Carolina Department of Health and Environmental Control
SCDHHS	South Carolina Department of Health and Human Services
SCDMH	South Carolina Department of Mental Health
SCDSNB	South Carolina Department of Disabilities and Special Needs Board
SCDSS	South Carolina Department of Social Services
SCDVR	South Carolina Department of Vocational Rehabilitation
SCFOA	South Carolina Federation for Older Americans
SCHIP	State Children’s Health Insurance Program
SCILC	South Carolina Independent Living Council
SCP	Senior Companion Program
SCP & A	South Carolina Protection and Advocacy
SCSDB	South Carolina School for the Deaf and the Blind
SCSEP	Senior Community Service Employment Program (Title V)
SD	Standard Deviation
SDE	State Department of Education (SC)
SEA	State Education Agency or Act
SEP	Service Entry Point or Single Entry Point
SES	Socioeconomic Status
SGA	Substantial Gainful Employment
SHHH	Self Help for Hard of Hearing
SHHSFC	State Health and Human Services Finance Commission
SHIP	State Health Insurance Program (what SC calls I-CARE)
SI	Sensory Integration
SIB	Self Injurious Behavior
SILC	Statewide Independent Living Council
SL	Speech/Language

SLMB	Specified Low Income Medicare Beneficiary
SLP	Speech Language Pathologist
SLT	Speech Language Therapist
SMP	Senior Medicare Patrol (Medicare Fraud)
SN	Special Needs
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SOBRA	Sixth Omnibus Budget Reconciliation Act
SOP	State Operated Program or Standard Operating Procedure
SPE	Single Point of Entry
SPED	Special Education or Special Education Teacher
SPIL	State Plan for Independent Living
SPRANS	Special Projects of Regional and National Significance
SS	Social Security
SSA	Social Security Administration or Social Security Act
SSBG	Social Services Block Grant
SSDI	Social Security Disability Income
SSG	Summer School of Gerontology (SC)
SSI	Supplemental Security Income
SSN	Social Security Number
SSP	State Supplemental Payment
ST	Speech Therapy
SUA	State Unit on Aging
SUTA	State Unemployment Taxes
SW	Social Worker

T

TA	Technical Assistance
TAAC	Telecommunications Access Advisory Committee
TANF	Temporary Assistance for Needy Families
TAP	Transition Assistance Program
TASH	The Association for the Severely Handicapped
TC	Total Communication
TCM	Targeted Case Management
TDD	Telecommunications Device for the Deaf
TDP	Transportation Development Plan
Tech Act	Technology Related Assistance for Individuals with Disabilities Act

TEDP	Telecommunication Equipment Distribution Program (SC)
TEFRA	Tax Equity and Fiscal Responsibility Act
TIIAP	Telecommunications and Information Infrastructure Assistance Program
TIRR	The Institute for Rehabilitation and Research
Title III	OAA Grants for State and Community Programs on Aging (funds for supportive and nutrition services, family caregiver support, and disease prevention and health promotion activities)
Title III-B	OAA - Funds for support services such as in-home and other community supportive services
Title III-C-1	OAA - Funds for congregate nutrition services for older adults
Title III-C-2	OAA - Funds for Home-Delivered nutrition services for older adults
Title III-D	OAA - Funds for health, wellness and disease prevention services
Title III-E	OAA - Funds for Family Caregiver Support Program
Title IV	OAA – Research, Training and Demonstration grants
Title V	OAA - Senior Community Service Employment Program
Title VI	OAA - Native American Programs
Title VII	OAA – Vulnerable Elder Rights Protection (Ombudsman, Legal Assistance)
Title XIX	Medicaid Home and Community Based Waiver Services for the Elderly
Title XVIII	Medicare – Health Insurance for the Aged and Disabled – Social Security Administrators
Title XX	SSBG (Social Services Block Grants) Social Security Administrators
TJTC	Targeted Job Tax Credit
TPR	Termination of Parental Rights
TRICARE	Military Health Benefits Program
TT	Text Telephone
TTY	Text Teletype (for the Deaf)
TWWIIA	Ticket to Work and Work Incentives Improvement Act
Tx	Treatment

U

UAF	University Affiliated Facility (same as UAP)
UAP	University Affiliated Programs (formerly UAF)

UCE	University Centers for Excellence (formerly UAP's)
UCP	United Cerebral Palsy Association
UFAS	Uniform Federal Accessibility Standards
USABA	United States Association for Blind Athletes
USC	University of South Carolina
USDA	United States Department of Agriculture
USERRA	Uniformed Services Employment and Reemployment Rights Act

V

VA	Veteran's Administration
VAMC	VA Medical Center
VAVS	Department of Veterans Affairs Voluntary Service
VDHCBS	Veteran's Directed Home and Community Based Services
VE	Vocational Education
VETS	Veterans' Employment and Training Service
VFA	Veteran's Families of America
VFW	Veterans of Foreign Wars
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VNA	Visiting Nurses Association
VR	Vocational Rehabilitation
VR&E	Vocational Rehabilitation and Employment
VS	Vital Signs

W

W3C	World Wide Web Consortium
WAI	Web Access Initiative
WAIS-R	Weschler Adult Intelligence Scale - Revised
Waivers	1915 (c) waiver - Medicaid home and community-based services waivers
WHCOA	White House Conference on Aging
WIC	Women, Infants and Children
WID	World Institute on Disability
WIIA	Work Incentives Improvement Act
WISC-R	Weschler Intelligence Scale for Children - Revised
WS	Waivered Services
WSHPI	William S. Hall Psychiatric Institute (SC)
WT	Warriors in Transition

Y
YTD Year To Date

DRAFT

APPENDIX F

DRAFT

Appendix F
Governor's Office Signatory Requirement

Email from former Governor Mark Sanford's Chief of Staff (Swati Patel, referenced in English's email below, serves as General Counsel for current Governor Nikki Haley.)

From: Scott English [mailto:senglish@gov.sc.gov]
Sent: Thursday, July 24, 2008 1:16 PM
To: Dickinson, Gerry
Cc: Swati Patel
Subject: State Plan on Aging

Gerry --

Thank you for sending the State Plan for the Office on Aging to us.

As you know, the previous state plan required the Governor's approval because it was developed by the South Carolina Department of Health and Human Services (SCDHHS), which is in the Governor's Cabinet.

The Office was transferred at approximately the same time from SCDHHS to the Lieutenant Governor's office via temporary proviso in the FY 2004-2005 Appropriations Act and remained in subsequent budgets until the FY 2008-2009 Appropriations Act.

Just this year, the General Assembly passed S. 530 to codify certain budget provisos, including the transfer Office on Aging (See Part 25 of the bill). The bill became law on 17 June 2008 and the effective date of this provision was 1 July 2008.

Based on that permanent law change and a review of the Older Americans Act, our legal counsel has indicated that the Lieutenant Governor would be the appropriate officer to sign and submit the State Plan to the U.S. Administration on Aging (AOA) and the Governor's signature would no longer be necessary.

If your office or AOA need additional information you can contact me or Swati Patel, our Chief Legal Counsel.

Scott D. English
Chief of Staff
Governor Mark Sanford
PO Box 12267
Columbia, SC 29211