



AREA PLAN

APPALACHIAN AREA AGENCY ON AGING

FY 2014-2017

Appalachian Area Agency on Aging/Aging Disability Resource
Center: Area Plan 2014-2017

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SECTION I INTRODUCTION

This is the presentation of the 2014-2017 Area Plan for the Appalachian Council of Governments/Aging Disability Resource Center and Area Agency on Aging (ACOG ADRC/AAA) to the Lieutenant Governor's Office on Aging (LGOA).

The Appalachian Area Agency on Aging is housed in the Appalachian Council of Governments. The office, located in Greenville, South Carolina, serves the six northwestern counties of: Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg. The agency is governed by a Board of Directors made up of: Legislative Delegation members, County Council members, Mayors/Council members of Cities, Citizen Members and Minority members. The Area Agency on Aging has existed since the early 1970's and has experience in planning, administering and delivering services to the elderly and disabled population in the region. A projected staff of fifteen (15) will comprise the AAA, operating on a budget of approximately \$3,339,096.

The Area Plan guides the work of the local Area Agency on Aging and Aging Disability Resource Center (AAA/ADRC) for the next four years. The document reflects the needs as a community and highlights the goals for maintaining and creating elder and disabled friendly communities. The major goals address basic needs, the improvement of health and well-being and assisting older adults and persons with disabilities to remain independent and living within their homes and community. The goals will also address the needs for caregivers of this population, as well as, those seniors that are raising their grandchildren.

The Older Americans Act (OAA) requires the AAA to establish a Regional Aging Advisory Committee (RAAC) to assist in identifying unmet needs, advisement on needed services, and advocate for policies and programs that promote quality of life and independence to keep from entering long term care facilities. As required by the OAA, the plan incorporates suggestions from the RAAC as well as numerous partners in the community. A statewide needs assessment completed in 2012 will also address the needs of this service population in the region. The agency also engages regional consumers in several activities to better understand the local needs.

There are key trends in the aging population:

- In 2010, 40 million are 65 years of age and older making up 13% of the population
- By 2030, it is projected that 72 million will be over 65 making up almost 20% of the population
- Percentage of the elderly living below poverty has dropped from 15 to 9% from 1974 to 2010
- Percentage of the elderly with low income has dropped from 35 to 26% from 1974 to 2010
- Baby Boomers continue to work longer than previous generations
- Diabetes in on the rise for all elderly, ethnic groups and both sexes

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- In 2009, 41% of those over 65 and on Medicare, had reported at least one functional limitation in their daily living
- 12% of those reported they had difficulty with one or more Instrumental Activities of Daily Living (IADLs)
- 25% of those reported they had difficulty with at least one Activity of Daily Living (ADLs)
- Majority of the senior population remains living in their communities than in institutionalized settings
- The cost of home and community based services continues to remain much lower than that of cost for institutional care

The Area Plan will address some of the above stated trends and the intent to provide services and programs to the current senior and disabled population. The document will also address the needs for the future of this population with plans for expansion of funding to combine with the current funding levels from the state, federal and local resources. The document will summarize the funding resources and service plans for the fiscal years of 2014-2017.

A. Purpose

The purpose of the Area Plan is to direct the ADRC and AAA in developing a community that promotes quality of life, independence, and choices for older people, caregivers and adults with disabilities in the Appalachian region.

B. Verification of Intent – See Appendices

C. Verification of AoA and LGOA Assurances – See Appendices

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Section II Executive Summary

In accordance with its responsibilities under the Older Americans Act, the South Carolina Appalachian Council of Governments' Area Agency on Aging has prepared and submits this Regional Area Plan for FY 2014-2017 to the Lieutenant Governor's Office on Aging. The region is comprised of the following counties: Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg.

In reviewing the pertinent issues facing the aging and disabled population of the region and the state, it is clear that all of the people involved must continue to evaluate the trends, needs and funding sources to adequately provide services to this ever expanding service population. The people involved in making these decisions and policies should always include state policy makers, regional staff, service providers and the public that has a vested interest by either providing or receiving the services. The growth of the Baby Boomer generation that began reaching the age of 65 in this last decade means changes are coming. All the players will have to be constantly on top of the changing trends to serve as many as possible, and not always with the same traditional services as were served in previous years.

With the constant changes in the funding for these programs, the AAA will continue to focus on the population that is rural, minority, and with the greatest need and socio-economic status. The trends also show that the AAA's begin looking into business practices to serve the middle and upper class that are able to pay for some of their desired services.

The socio-demographic trends impacting the Appalachian region are as follows:

- 60+ - 224,029
- 75+ - 67,894
- 85+ - 17,665
- The 60+ of the region make up 25% of the aging population in the state
- The percentage of change of this population from 2000-2010 was the highest in Oconee County at 26%, followed by Anderson County at 21%. Cherokee, Pickens and Spartanburg Counties saw an increase of 19% with Greenville County increasing its senior population at 18%. The region's average increase is 20.34%.
- The average senior with an income below poverty level was at 9.8% with Cherokee County at the highest (12.5%) and Spartanburg County at 11.2%, both of which are at a higher percentage than the state average.
- The region is 29% rural and 20% of the population is made up of minorities. Greenville County has the highest percentage of Hispanics in the state.
- There are at least 13% of this population suffering from Alzheimer's disease and related disorders.

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With the increasing need of support services for seniors, their caregivers and the disabled population, the AAA is moving toward the development of a seamless long term care support services system that is flexible and meets the needs of consumers by offering them more choice. The flexibility of consumer-directed choices permits a mix of private and agency provided services, allows the consumer to find workers when agencies have a short supply, and provides services when needed rather than at fixed times.

PLANNING, ADVOCACY AND PROGRAM COORDINATION

The System Wide Solutions, Inc. conducted a Statewide Needs Assessment in the October, 2012. The Appalachian region was included in this process. The following information was provided in the final report for the Appalachian region:

As might be expected, the population in need is more poor, more African-American, more female, less likely to have a spouse, older and with fewer social supports than the general senior population in the region. These demographic characteristics are often connected.

Overall, respondents viewed Information, Referral, and Assistance to be the service most important to helping them stay where they are, followed by I-CARE (Insurance Counseling), caregiver services, senior center activities, services to help them maintain independence, and personal and home care. The most important service to caregivers is respite care, followed by monetary assistance in obtaining services. Within senior center activities, respondents viewed exercise and counseling (having someone to talk to) to be the most valuable. Services to help in maintaining independence came in fifth, with the most important services being those of the Ombudsman. Monetary assistance is only slightly more than a little important, with the most important being help with payments for medical care and prescriptions or prescription drug coverage. Personal and home care is viewed to be the least important, with the most important of these being transportation for errands and home repairs and modifications (for both upkeep and for safety).

However, these are generalizations. There is a great deal of variation within categories. For example, service needs of caregivers vary depending upon whom they are caring for and what the age of the person(s) they are caring for is. Personal and home care, which is viewed as the least important to seniors who are already receiving services, is viewed as very important to caregivers and persons with disabilities. Needs within categories vary according to age, race and gender. Mean scores, therefore, for the sample as a whole, are not necessarily a good guide for planning. Rather, the needs perceived by each group should be examined separately and in detail. This is a segmented market and should be approached as one, as Region 1 is doing. It is strongly recommended that the Service Needs by Targeted Group sections of this report be

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carefully reviewed by the staff and policy makers of Region 1 rather than an attempt be made to produce a single list of needs in order of priority.

In this report, SWS presents the needs as reported by the respondents to the needs assessment survey by target group, demographic clusters and the two combined. It has further divided the needs by the types of services provided and has provided an additional breakdown for caregivers. This information is provided in written and in graphic form. This information can be utilized as a rich source for in-depth planning for services in the Region.

While partners believe they have a good relationship with the AAA, they believe they have little interaction with the AAA on the planning process, have little knowledge of the plan, do not understand how priorities are set for which clients receive services and have very little knowledge of the strategic plan or the planning process. In short, the partners feel that they are a strong part of service provision and a small part of planning and prioritizing. This may or may not be an important issue, but should be explored.

Per the information provided by this survey, the providers need and want to be part of the planning process for services in the region. This will begin to be accomplished by the providers being required to attend the Regional Aging Advisory Council meetings. They will be required to give status reports on the services and programs they deliver, as well as, give input to the planning process and all aging issues on the local, state and national levels.

The Appalachian AAA plans to monitoring the providers very closely on the new assessment process to ensure that the forms are being completed, processed and data submitted into AIM as required. This will take place after the AAA staff has been trained by the LGOA so that the AAA in turn can adequately train the service providers in this new process.

Due to the variation of services needed by the separate categories as shown above, the AAA will plan with each service program to strongly attempt to meet those specific needs. With the Nutrition Program, the AAA and service providers are striving to correct some issues as brought forth by the LGOA to better serve the neediest of those at a greater nutritional risk. The AAA and service providers also believe that by serving these nutritious meals, the nutrition score will come down as time passes.

Challenging times heighten the need to think creatively and strengthen partnerships. It also affords the opportunity for advocacy and advocacy coalition building aimed at all levels of elected officials from the local municipality to the U.S. Congress. The AAA will focus increased efforts to facilitate planning, collaboration, partnering and advocacy across the spectrum of human service providers and their constituencies.

PROGRAM DEVELOPMENT

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The Appalachian AAA has hosted the annual I-CARE training and had an average of 30 participants. These new volunteers will greatly assist the AAA staff during the Open Enrollment of Medicare Part D and other Medicare counseling as needed and required.

The Care Transitions contract awarded to the region by CMS for this program has been implemented and is beginning to show signs of success with the four hospitals involved in the program. Those four hospitals include: Spartanburg Regional Hospital, Mary Black Memorial Hospital, Wallace-Thompson Hospital and Upstate Carolina Medical Center. The counties represented for this collaboration are Cherokee, Spartanburg and Union Counties. Even though Union County is not served by this region, many of the persons utilizing that hospital in turn use the hospitals in Spartanburg County. The contract was awarded for 2 years and after all goes well, the AAA hopes to receive the (3) 1-year contract extensions. The Care Transitions Coaches are providing the care management/transition process to assist hospital discharge patients from recurring readmissions.

The AAA continues to collaborate with the publication of “All About Seniors” that is a resource and referral directory for the Upstate. AAA staff submit updated information and articles of interest to the consumers that receive this magazine. The magazine is published by Striped Rock: Senior Network Marketing and Media Solutions on a quarterly basis. In the Summer 2013 issue, the I-CARE staff submitted an article on the Medicare Update, Health Exchanges, Medigap Policies, Senior Medicare Patrol and Older Americans Month. The AAA submits advertisements providing information on the agency, the ADRC website and upcoming events.

The AAA will continue to work with all of its partners and the LGOA to make needed changes to some of the service programs. A team effort approach is most necessary to make these changes as painless as possible for all affected, while continuing to provide quality services to those eligible for the programs. This AAA applauds the efforts being made by the LGOA and the direction for which it wants to take the future of aging services in South Carolina. It is going to take time and much needed effort and support of all the team players to accomplish these goals to the advantage of the population that is now and will be served.

SECTION III OVERVIEW OF THE AAA/ADRC

A. Mission Statement

To assist seniors, their caregivers and those with disabilities in maintaining dignity and independence in their homes and communities. The Appalachian Council of Governments Area Agency on Aging is the designated regional lead agency for the development of a comprehensive, coordinated and cost effective long term care system.

B. Vision for the FY 2014-2017 Planning Cycle

- Continue to work with all aging service partners to provide quality services to maintain the service population in their homes and communities;

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- Meet the challenges to changing funding, programs, policies and needs of the service population;
- Work with the service providers and Regional Aging Advisory Council in planning and providing the desired services to the population;
- Keep all aging service partners abreast of changes in all aging issues on local, state and federal levels;
- Plan, develop new programs, educate the public, advocate with legislators and provide services that include the involvement of the service population and aging service partners;
- Promote a comprehensive long term care system; and,
- Support intergenerational partnering, planning and policy development.

C. Organizational Structure

The South Carolina Appalachian Council of Governments Area Agency on Aging (SCACOG AAA) is a public, non-profit organization. The Older Americans' Act charges the SCACOG AAA with being the leader for aging issues on behalf of older persons and their caregivers in the Appalachian region. As the designated regional focal point for aging, the SCACOG AAA proactively carries out a wide range of functions related to planning, advocacy, program development, contract management, service delivery, training, technical assistance, service delivery and resource development in the region.

The AAA is a division of the South Carolina Appalachian Council of Governments. SCACOG is a voluntary organization of local governments in Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg Counties in Upstate South Carolina. Created in 1971, the Council of Governments has become a valuable resource for area local governments in the areas of public administration, planning, information systems and technology, grants, workforce development and services to the elderly population. While assistance to local government remains as the Council's first priority, the private sector also benefits from services designed to enhance the region's economic environment. These efforts include public/private partnerships in support of economic development, economic research and analysis, and small business lending programs.

The services to the elderly population are provided through the Appalachian Area Agency on Aging (AAA). The AAA is the largest division within the organization, with staff dedicated solely to the operations of the AAA. The SCACOG Executive Director certifies that the division functions as the AAA/ADRC for the purpose of carrying out all functions as specified in the Older Americans Act of 1965, as amended in 2006.

D. Staff Experience & Qualifications

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The current AAA Director, Karen Carter, joined the agency in May, 2013. Ms. Carter brings 22 years of experience in the aging field at different levels of service. Ms. Carter holds a Masters Degree in Gerontology and has worked with AAAs in Georgia and Kentucky for a total of 12 years.

Nutrition Coordinator: Glenda Manigault – Responsible for nutrition site monitoring and ordering congregate and home-delivered meals and works with the AIM database; has staffed the Aging unit for 24 years.

Finance Officer: Carolyn Breeze, Accountant - Responsible for the finance activities of the Aging Program; has worked in the Finance Division of the COG for 27 years.

The biggest transition of the FY 2014 will be for the new AAA Director in settling into her new role, learning the policies, procedures and program structures for the region and state. The lead Long Term Care Ombudsman will be retiring and two positions within that program will need to be filled. The current staff is made up of persons that have worked in the field for several years and also promotions within the organization. Overall, the staff is truly dedicated to serving the seniors, caregivers and disabled persons in the region.

E. Regional Aging Advisory Committee (RAAC)

The duties of the Committee are to:

- Advise the SCACOG Area Agency on Aging on matters relating to the development of the regional area plan.
- Promote and encourage local communities to recognize the needs and promote the establishment of programs for older adults or person with disabilities.
- Support and advocate on behalf of programs and services for older adults and persons with disabilities.
- Establish service and program priorities based upon the needs of the local communities and the region.
- Provide assistance in conducting public hearings to solicit local community input regarding the needs of older persons and persons with disabilities.

The RAAC members are appointed by the Council of Governments Board, serve in an advisory capacity to the Council in its role as the Area Agency on Aging. Ex-officio members of this committee include those members of the Board of the Lt. Governor's Office on Aging who reside in the Appalachian region. The Chairman of the Regional Aging Advisory Committee is also a member of the Council of Governments Board.

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The Committee takes recommendations concerning administration of Older Americans Act programs, reviews and makes recommendations on the awarding of funds to local organizations, and monitors local contracts. At least fifty (50) percent of the Committee is composed of older persons. The Committee also includes representation by minorities, service recipients, and persons with greatest economic and social need.

The RAAC Bylaws are an attachment of this document. The Bylaws are in need of review and revision. This will be accomplished in the new fiscal year and submitted to the LGOA when complete.

F. Current Funding Resources for the AAA/ADRC Operations

Program/Fund Source	Federal	State	Total Fed/State
Title III P&A	252,781		252,781
Title III E P&A	35,532		35,532
Arthritis- Evid. Base	2,407		2,407
Title IIIB Supportive Services	63,000	3,706	66,706
Title IIID Medication Mngt	7,575	446	8,021
Title IIIE Caregiver Staff	134,000		134,000
Title IIIB Ombudsman	170,359	10,021	180,380
Title VII Elder Abuse	19,472		19,472
Title VII Ombudsman	66,235		66,235
Ombudsman - State		67,937	67,937
State Grant (Hospital D/C)		15,000	15,000

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I-CARE (July - March)	65,128		65,128
I-CARE (April-June)	16,045		16,045
MIPPA	19,429		19,429
SMP	15,815		15,815
SMP - Expansion	16,027		16,027
In-House Service Funds			
Title III E Caregiver Services	169,983		169,983
HCBS (Trans. & Minor Hm Rpr)		108,640	108,640
Other Funding Sources			
DOT Rural (Asst Rides)	2,654		2,654
DOT Urban (Asst Rides)	6,036		6,036
Upstate Transitions Coalition (In-house)	41,700		41,700
Upstate Transitions Coalition (Pass through)	79,275		
			1,389,203
TOTAL	1,183,453	205,750	
Flow Through Funding	Federal	State Match	Local Match Total
Title IIIB	801,477	47,146	94,291 942,914
Title III C-1	7,990	470	940 9,400
Title III C-1	599,032	35,237	70,474 704,743
Title III C-2	5,404	318	636 6,358
Title III C-2	455,657	26,803	53,607 536,067

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Title IID Preventive Health	38,076	2,240	4,480	44,796
				41,517
NSIP (July-Sept 2012)	41,517			
NSIP (Oct-June 2013)	105,597			105,597
In-Home & Comm Svcs		503,564		503,564
ACE Bingo				114,954
Total	2,054,750	615,778	224,428	3,009,910

The Executive Director of the SCACOG certifies that the AAA/ADRC shall not use funds received under the Older Americans Act to pay any part of a cost incurred to carry out a contract or commercial relationship that is not necessary to implement Older Americans Act requirements.

All funding sources received by the AAA/ADRC have a distinct population in which it serves. All programs use the age limit of 60 and over, with the exception of the Grandparents raising Grandchildren program where the age requirement is 55 years of age or older. Consistent with the language of the Older Americans Act Amendments of 2006, the AAA/ADRC targets older persons with greatest social need (i.e., older persons who are without formal or informal support), older individuals with greatest economic need (i.e., those who are unable to meet their basic needs), and older individuals at risk of institutional placement (i.e., those who are frail and/or having difficulty living independently).

The information for assurance that each funding source serves its distinct population can be gathered from AIM reports for staff to monitor.

The SCACOG has several policies and protocols in place to certify the fiscal integrity for the AAA/ADRC and its service providers. They are as follows:

- Annual Audits;
- Fraud Prevention Policies;
- Financial Policies;
- Separation of duties with checks and balances;
- Budget goes through the Board Finance Committee for review, then submitted to the full Board of Directors for Approval; and,

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- A Cost Allocation Plan was submitted and approved to the Appalachian Regional Commission in 1993. ARC does not require the SCACOG to update the plan.

G. Written Procedures

The Procedures Manual of the S. C. Appalachian Council of Governments (as the Area Agency on Aging) sets forth the procedures and policies for administration and delivery of services under Title III of the Older Americans Act of 1965, as amended, funds appropriated by the S. C. State Legislature, and functions as prescribed by the policies and procedures set forth by the Lieutenant Governor's Office on Aging. The AAA/ADRC Policies and Procedures Manual is currently in the process of being reviewed and revised per the new manual authored by the LGOA that goes into effect July 1, 2013.

The manual's purpose is to assist local Older Americans Act contractors under the Appalachian Area Plan for the Aging in carrying out federal and state requirements for administering services to older people.

H. Sign-In Sheets

The group dining and home delivered meal providers will use the Report LG 94 form approved sign-in sheet to record clients utilizing daily nutrition services. These forms will be kept on file and provided to the LGOA and AAA upon request for a minimum of three (3) years. Formal monitoring by AAA staff will take place on a quarterly basis to ensure that this form is being utilized and kept on file as required.

To validate quality assurance that providers are providing home delivered meals in accordance with the 2013 LGOA Policies and Procedures Manual, the AAA Director, or designated staff, shall personally deliver three (3) home delivered meals on three (3) different routes on a monthly basis. A monthly report of these visits shall be provided to LGOA during the monthly AAA/ARDC Directors' meeting. Any issues that arise will be corrected within three (3) business days.

The home delivered meal providers will submit to the AAA a signed and dated by the driver copy of the delivery route. This will in turn be submitted to LGOA with the MUSR invoices to provide accountability.

I. Activity Calendars

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Each group dining site will submit copies of the site activity calendars monthly for approval. These calendars will then be submitted, via email, to the LGOA Policy and Planning Manager in the Program Services Division. The AAA staff will ensure that activities on the monthly calendars are being performed during scheduled monitoring and un-scheduled visits to the group dining sites.

J. Service Units Earned

In the Request for Proposals (RFP) for Service Deliveries, the service providers are given the service unit definition (i.e. one meal, one mile, one hour, etc.) as part of the service definitions. This is also monitored on the monthly reports and verified through AIM reports and AAA monitoring.

K. Reimbursement for Services

The process for which the AAA/ADRC verifies the providers' unit costs comes from the Budget and Unit Cost Calculations form that is utilized in the RFP. This is an Excel spreadsheet that covers Service Delivery Costs, Management (Indirect/Overhead) Costs and Case Management/Assessments Costs. These sections ask for information on the personnel salaries, fringe benefits, travel, training, building cost, utilities, equipment, insurance, supplies and raw food cost (for nutrition services only). The form also addresses matching requirements for cash or in-kind which must be provided with detail.

In the monitoring process conducted by the AAA staff, each provider's files and records will be monitored to ensure that service delivery units are being documented and then entered into AIM correctly.

L. Client Data Collection

The AAA/ADRC and the regional service providers will input client service data into the appropriate client data tracking systems including: AIM, OLSA, Ombudsman Innovative Data System and SHIP Talk. The data will be entered into each system by the 10th of each month. All AAA/ADRC and provider staff have registered employees that have access to the appropriate systems with clearance, access and passwords.

Data is entered daily with most reports being generated on a monthly, quarterly and annual basis for reported as required. The reported data from the systems is analyzed for accuracy, accountability and all planning purposes. Data from all programs shall be reviewed on a scheduled and as needed basis for reporting and analyzing specific information as needed for quality assurance.

M. Client Assessments

All new assessments and reassessments being conducted on and after July 1, 2013 will utilize the new form as required by the LGOA. The providers shall complete this form

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on new and current clients. For those services delivered out of the AAA, AAA staff will utilize this new form. The providers shall be completing assessments/reassessments and providing services. The AAA shall be in charge of setting the client's priority to enter into services at the provider level.

Each provider contract shall state that the provider staff has the responsibility to reassess all service clients no less than annually and with particular interest to those older individuals who are low income minority, have limited English proficiency, reside in rural communities and are eligible under the Older Americans Act.

The AAA staff which holds the responsibility for the providers monitoring shall monitor files on a quarterly basis at the provider location. The AIM report (LG 97c) will be run on a monthly basis to also serve as a check and balance on the dates of reassessment. If any providers' reassessments are out of date, the service units for that particular client will not be reimbursed to the provider. Each provider will be notified of this specific situation. The service units will not be paid for until the reassessment has occurred and the data submitted to the AAA and in AIM.

During monitoring and review of the LG 97c report, AAA staff shall review charts and information to ensure that the providers are delivering service to those clients with the greatest need. This can be determined by prioritization and NSI scores as brought forth during the assessment/reassessment process.

When clients must be terminated due to low priority scores, the client shall receive notice of a 30-day discharge from the service program. The client will be given the option to private pay for the service, as well as, receive resources for services in the community to meet their current needs. If local funding resources are available, the client may be able to partial pay for service if they so desire.

N. General Fiscal Issues

The Appalachian AAA/ADRC will expend all prior year funds before expending any new funds. All planning and administrative funds for Title III-B, III C-1 and III-E will be expended before any program development or Title III-E service funds are expended. All invoices from the Appalachian AAA/ADRC will be submitted in the format requested by the LGOA and will have the breakdown of the contractors' unit cost and verification of the units earned. The Appalachian AAA/ADRC keeps the following documentation on file for all payment requests: drawn down request, MUSR, Appalachian Recap Sheet, our internal earnings spreadsheet with YTD units less GRI units which is calculated against the federal and state portion of the unit rate for each service. We pay each

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contractor no more than 1/12 each of their Title III-C earnings to date in order to ensure that we have enough money at the end of the SFY to pay the caterer's bill. All payment for internal and flow-through expenditures will be submitted monthly. The Appalachian AAA/ADRC is audited by a procured outside auditing firm each year. A copy of our audit is submitted to the LGOA each year.

O. General Provisions for the AAA/ADRC in the Area Plan

The Appalachian AAA/ADRC will comply with all applicable Federal and State laws, regulations, and guidelines, as well as, the LGOA policies and procedures. The Appalachian AAA/ADRC will include in the monitoring tool the format to check for the provider's compliance with the LGOA policies and procedures and any Program Instructions received during the fiscal year. The Appalachian AAA/ADRC utilizes the GIS mapping department of the COG to determine if the OAA targeted client populations are being served in the region. These maps shall show service deliveries of each county with the emphasis on those populations the AAA is required to serve under the OAA. The Appalachian AAA/ADRC, and those with whom we contract, will ensure that persons with Limited English Proficiency receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the grant award. The agency utilizes the Language Line Services, an over-the-phone interpretation service, to assist these persons.

P. High-Risk Providers/Contractors and Corrective Action Plans (CAPs)

A provider will be considered "high risk" if the Appalachian AAA determines that it:

- Has a history of unsatisfactory performance;
- Is not financially stable;
- Has a management system that does not meet the standards in 45 CFR Part 92 or Part 74, as applicable;
- Has not conformed to terms and conditions of previous awards;
- Is otherwise irresponsible and unresponsive to fulfilling LGOA and Appalachian AAA/ADRC data collection policies and procedures;
- Has misrepresented material facts regarding funding reimbursements or service units earned; or
- Has engaged in unethical, immoral, or illegal behaviors or activities.

The Appalachian AAA/ADRC has identified the steps to be taken with the high risk providers with Corrective Action Plans.

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- The “high risk” provider staff and Board Chair shall receive written notification of the deficiencies for which they are non-compliant and request a Corrective Action Plan with a timeline to comply with policies and procedures on those issues.
- If the provider fails to come into compliance, then the agency will be notified that they are now at “High Risk Status” and have a shorter timeline to correct the deficiencies. If necessary, the Appalachian AAA/ADRC staff will meet with the provider staff and Board Chair to determine if the deficiencies can be corrected or if the agency has the capability for corrective action.
- If the provider still can’t complete the corrective action plan, then the Appalachian AAA/ADRC will take the steps necessary to de-designate the provider. This provider will also be notified that they may not bid on or receive contracts unless the issues which necessitated the high-risk designation have been resolved to the satisfaction of the LGOA and the Appalachian AAA/ADRC.
- AAA/ARDC will run the appropriate reports to determine the number of clients receiving services, their addresses and directions to their homes, and if any assessments are in need of being completed. The provider would need to produce all original client files, equipment/supplies used for the services, current employee information, Bylaws, list of Board members, and all other applicable information, paperwork, etc. that has been utilized for any and all services provided through the agency.
- The Appalachian AAA/ADRC will then begin the process of seeking a new provider in the immediate area/adjacent county that would be capable of taking over the services as needed. If a provider is not found immediately, then the AAA/ADRC would request a waiver from the LGOA to operate the provider’s services until at such time an appropriate provider can adequately take over the responsibilities and services for that area.
- An example of the need for a Corrective Action Plan with a provider would be when the AAA/ADRC has received several complaints that the quality and/or quantity of food delivered by the catering provider is not adequate or in compliance with the certified menus. The AAA/ADRC staff would correspond with the provider regarding the specific complaints and a timeline to fix the problems within the corrective action plan. If the provider is unable to comply, then the AAA/ADRC will begin the process to de-designate the provider and replace with one that is capable of providing the service as required. The AAA/ADRC will provide any and all technical assistance to providers in need in hopes of not having to de-designate or make them a high risk provider.

Section IV: Overview of the Planning & Service Area Region

A. Service Delivery Area

The Appalachian Council of Governments region is comprised of six counties: Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg. The counties contain a total area of 3,834 square miles and are part of the geographic region known as the Foothills of the Blue Ridge Mountains. The ACOG is the only region in South Carolina that is part of the Appalachian Regional Commission. The region supports a major airport in the Greenville/Spartanburg area and has major industry such as the BMW plant. The major waterways are the Reedy River, Saluda River and the three Tyger Rivers. The region has two interstates (I26 and I85) with the I385 from Greenville to Clinton. The major national highways are US 25, US 29, US 176, US 123, US 178 and US 221.

The AAA/ADRC provides and purchases services for the cities of the region including:

Anderson County

- Anderson
- Belton
- Honea Path
- Iva
- Pelzer
- Pendleton
- Starr
- West Pelzer
- Williamston

Cherokee County

- Blacksburg
- Gaffney

Greenville County

- Fountain Inn
- Greenville
- Greer
- Mauldin

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- Simpsonville
- Travelers Rest

Oconee County

- Salem
- Seneca
- Walhalla
- Westminster
- West Union

Pickens County

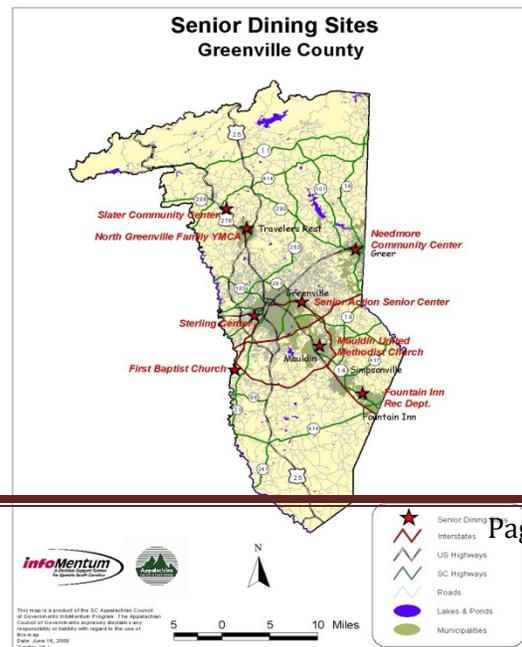
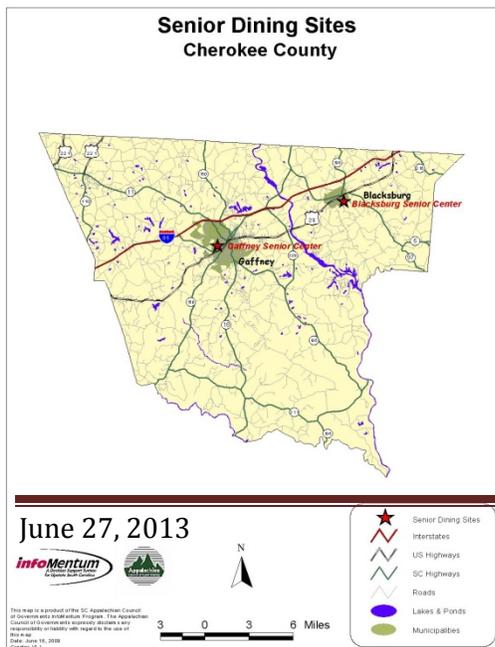
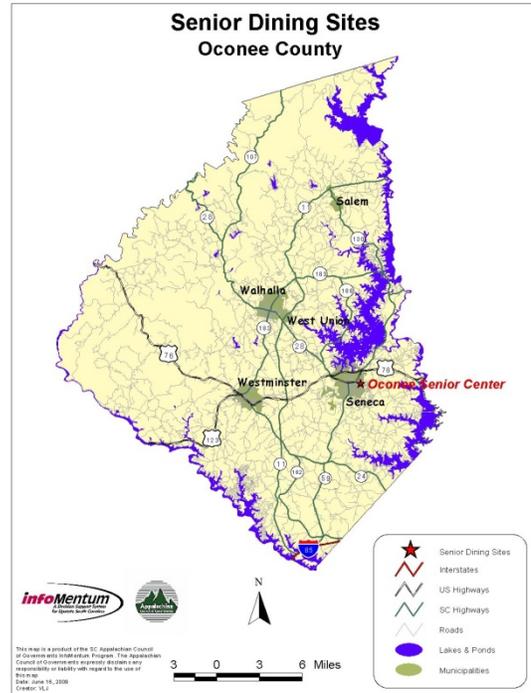
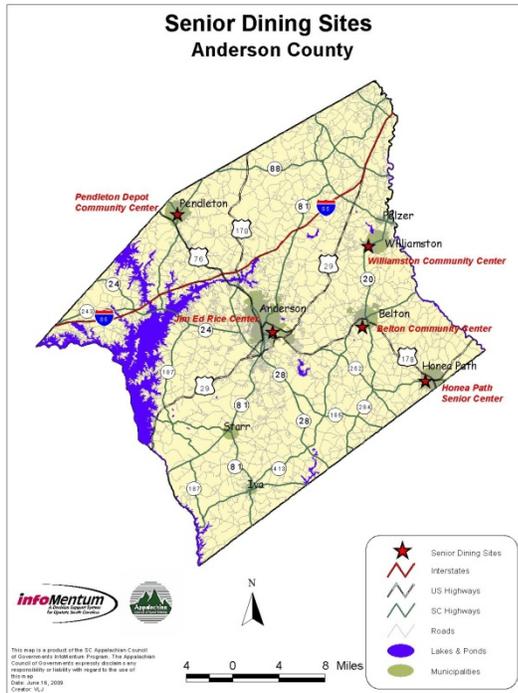
- Central
- Clemson
- Easley
- Liberty
- Norris
- Pickens
- Six Mile

Spartanburg County

- Campobello
- Central Pacolet
- Chesnee
- Cowpens
- Duncan
- Inman
- Landrum
- Lyman
- Pacolet
- Reidville
- Spartanburg
- Wellford
- Woodruff

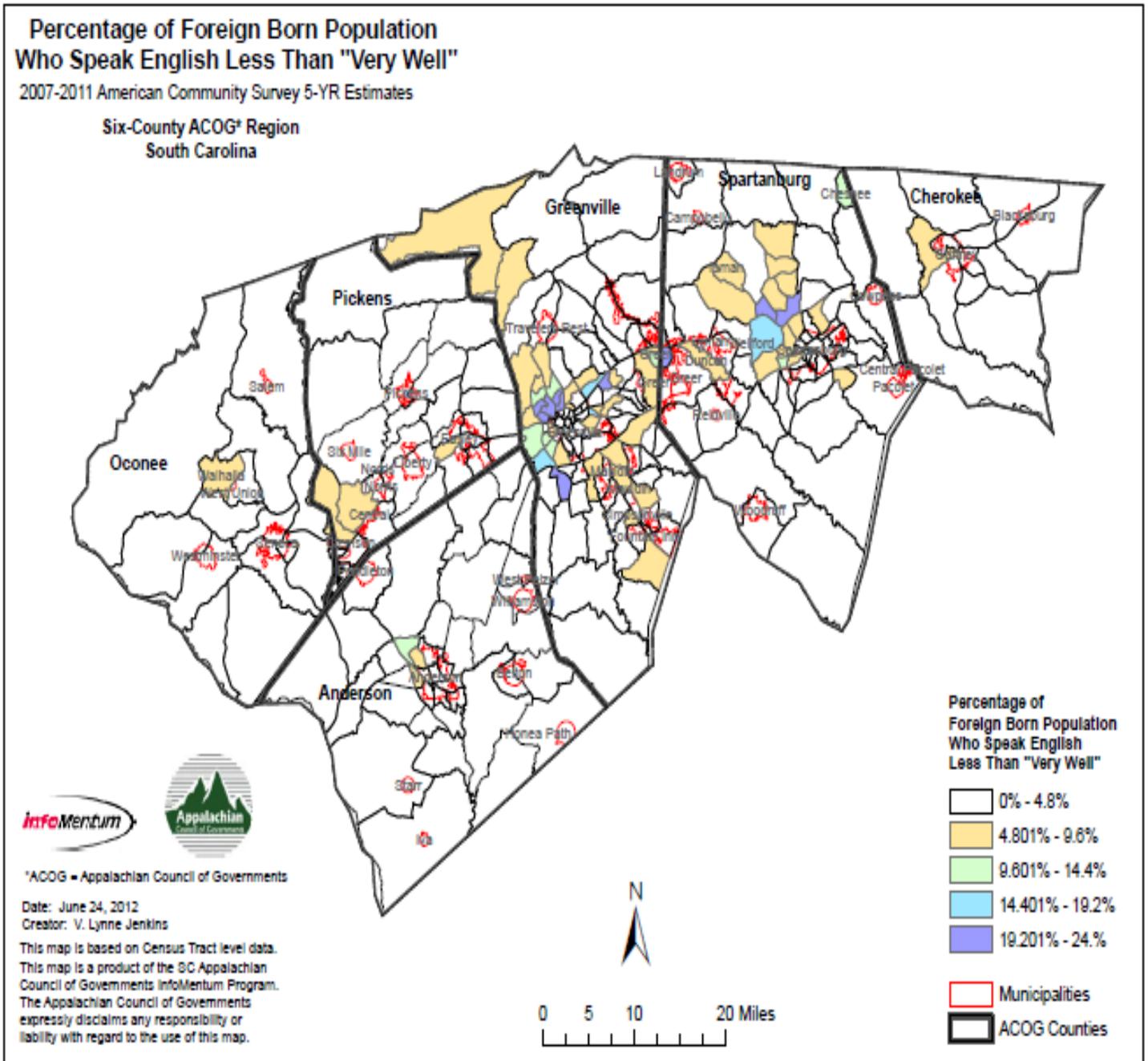
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SENIOR DINING SITES IN ACOG REGION



Appalachian Area Agency on Aging/Aging Disability Resource
Center: Area Plan 2014-2017

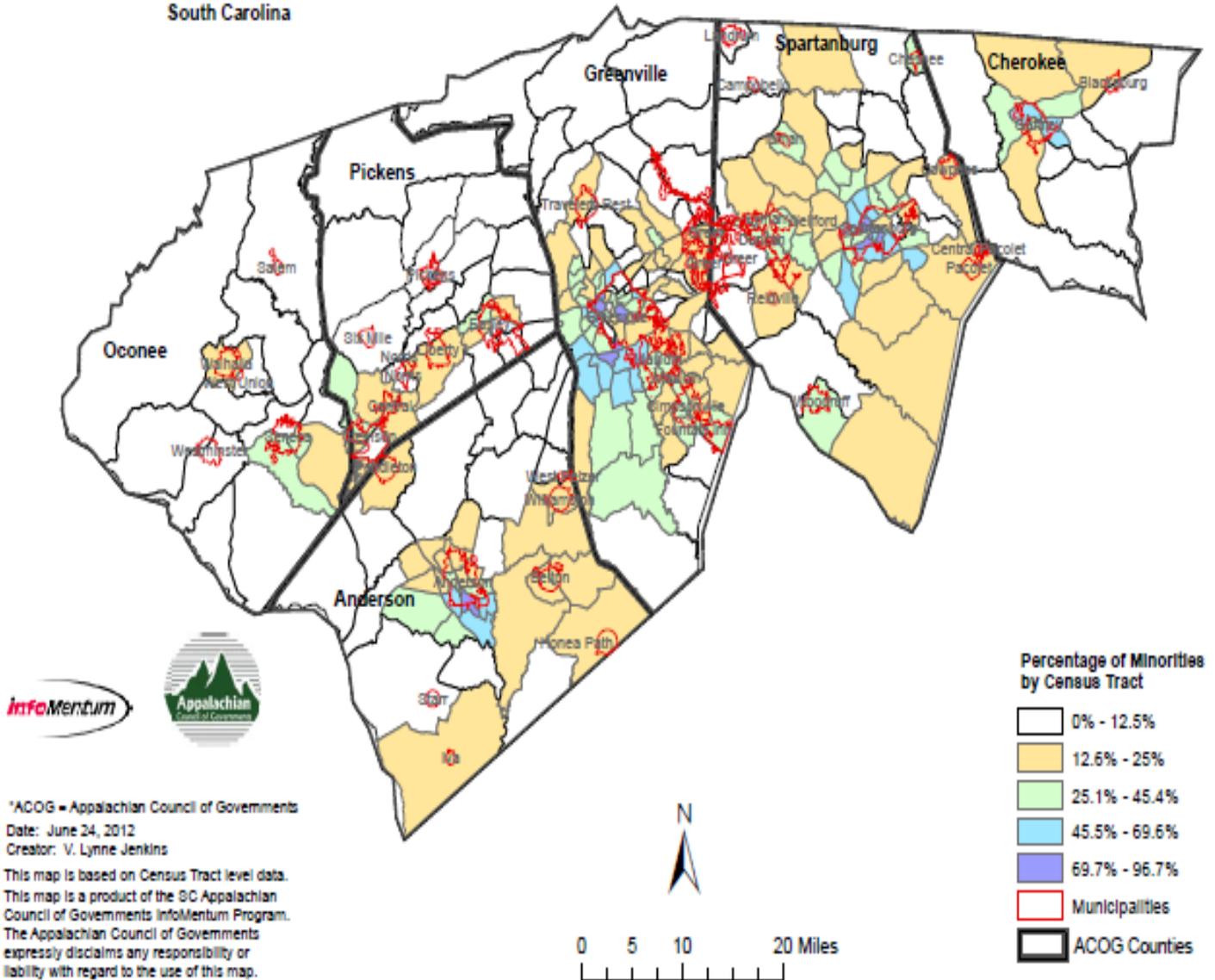
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Percentage of Minority Population by Census Tract

American Community Survey, 2007-2011 5-YR Estimates
Six-County ACOG* Region
South Carolina

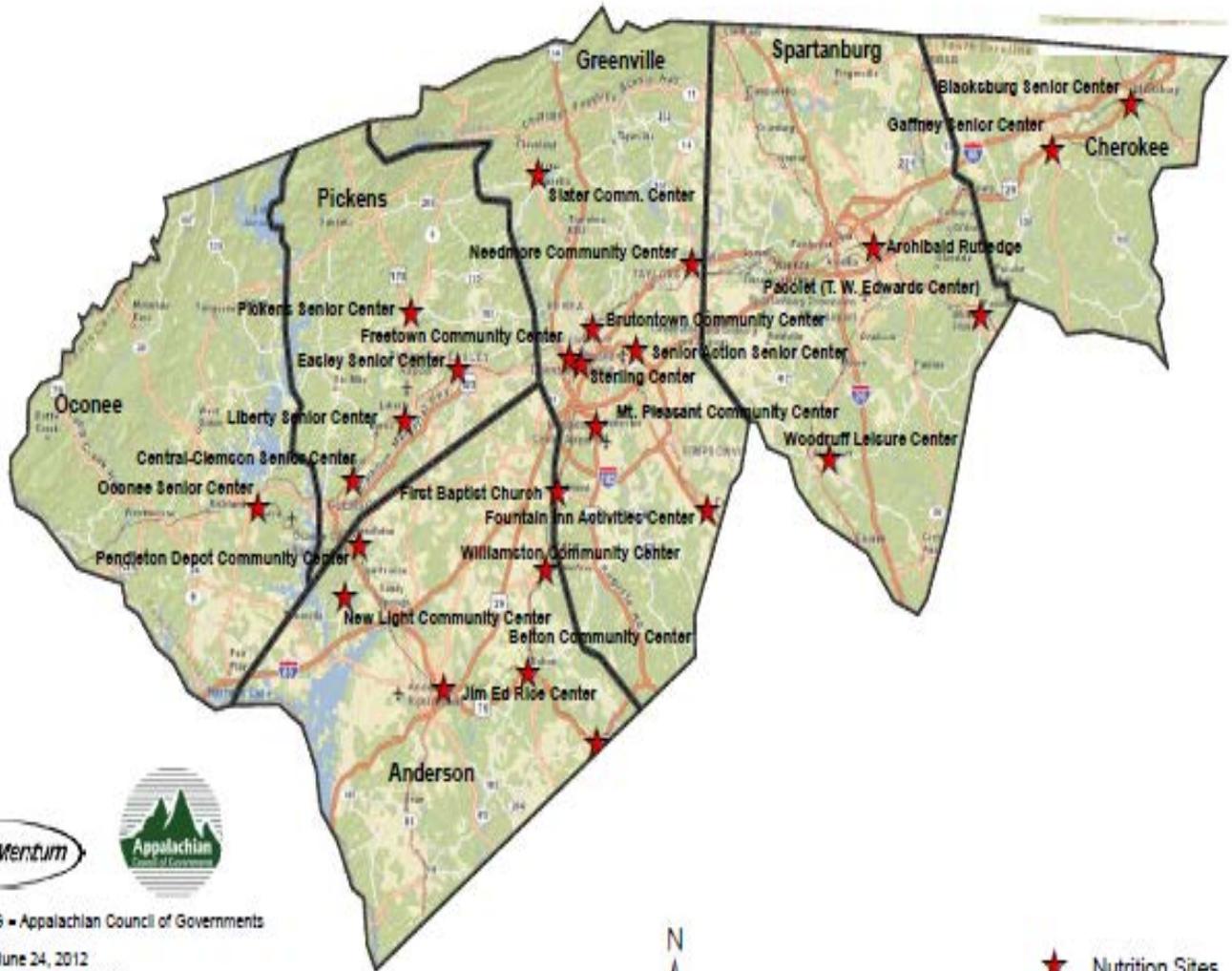


*ACOG = Appalachian Council of Governments
Date: June 24, 2012
Creator: V. Lynne Jenkins
This map is based on Census Tract level data.
This map is a product of the SC Appalachian Council of Governments InfoMentum Program.
The Appalachian Council of Governments expressly disclaims any responsibility or liability with regard to the use of this map.

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Nutrition Sites

Six-County ACOG* Region
South Carolina



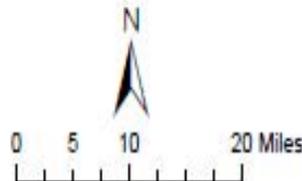
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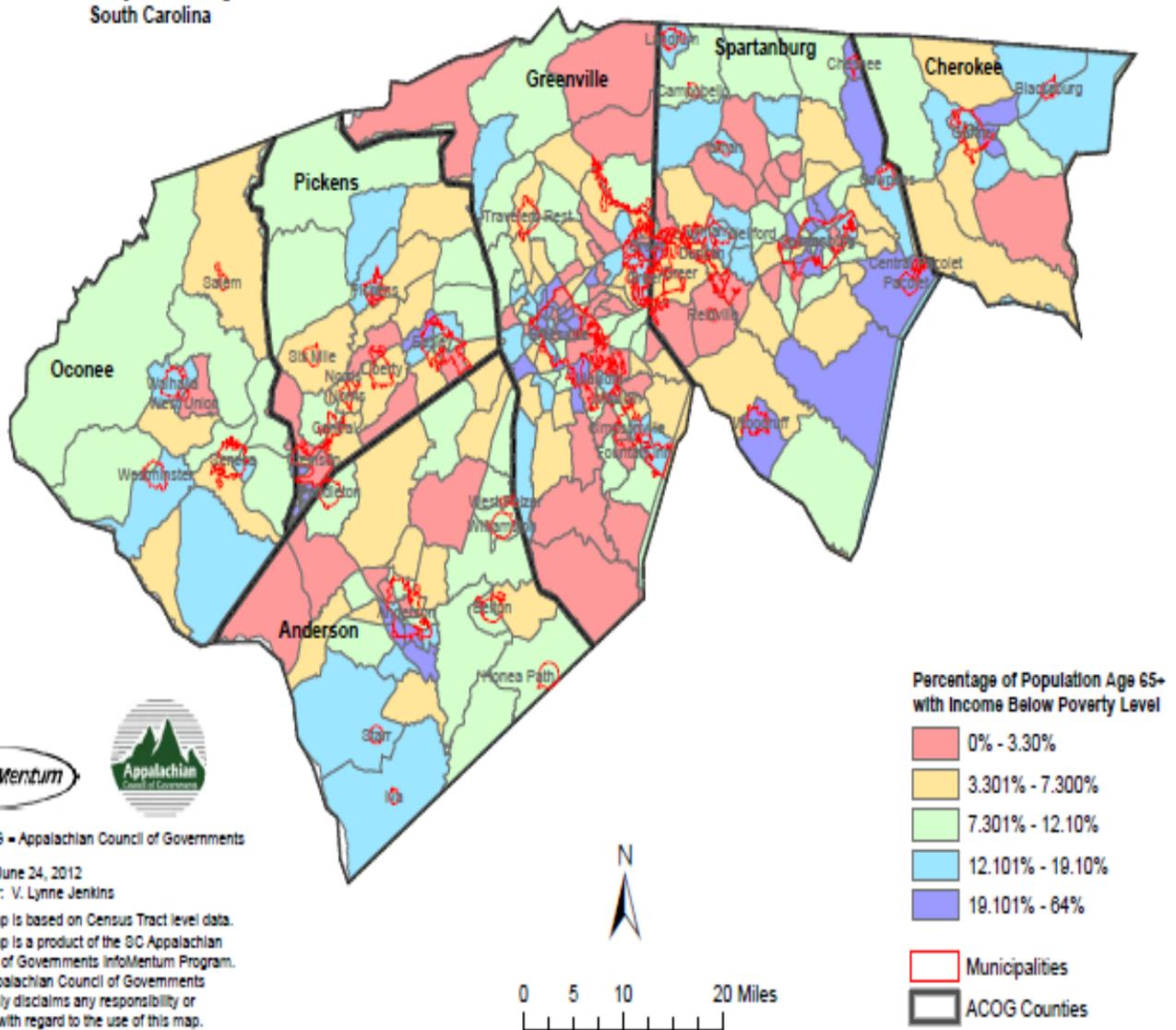
★ Nutrition Sites



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**Percentage of Population Age 65+
with Income Below Poverty Level**
2007-2011 American Community Survey 5-YR Estimates

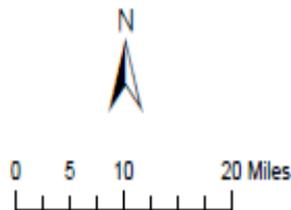
**Six-County ACOG* Region
South Carolina**



*ACOG = Appalachian Council of Governments

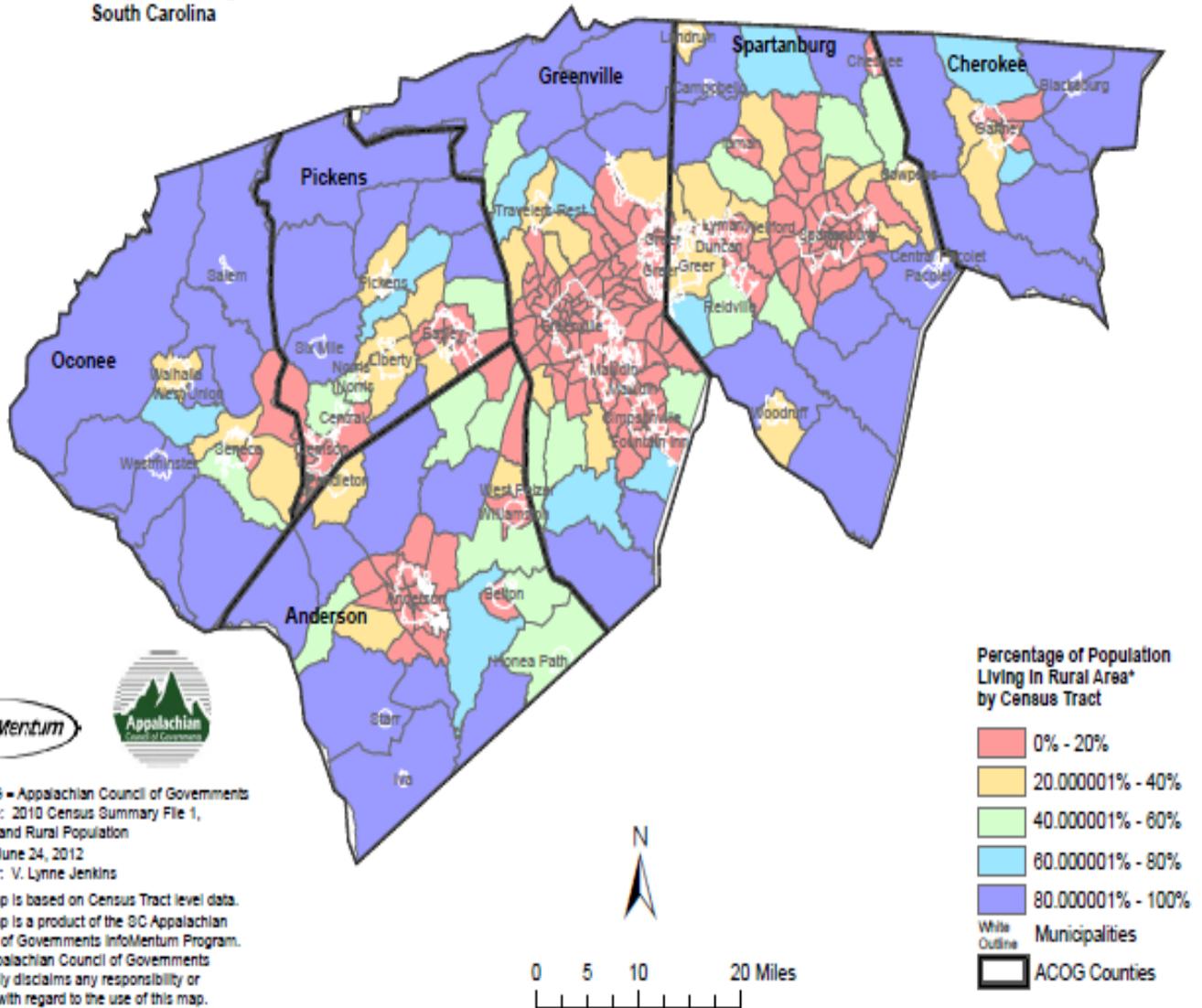
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**Percentage of Population
Living in Rural Area
by Census Tract
Six-County ACOG* Region
South Carolina**



B. Objectives and Methods for Services to OAA Targeted Populations

The socio-demographic trends impacting the ACOG region are as follows:

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- The ACOG region has the highest percentage of individuals over the age of 60, as well as, the largest overall populated section of the state.
- The ACOG has the highest percentage of Hispanics in the state, 36% of the Greenville County population.
- The ACOG has an average of 39% rural in the region, mostly in Cherokee and Oconee Counties. Greenville County has the highest urban population.
- Cherokee County (12.5%) and Spartanburg County (11.2%) have the highest percentages of those over 65 and living below the poverty level. The state percentage is 10.9% and the ACOG overall percentage is 9.8%.
- Per the American Community Survey of 2009-2011, the estimates for those with disabilities over age 65 in the region is 39.4%.
- Minority percentages for the region are as follows:

Black/African American – 14.86
American Indian/Native American – less than 1%
Asian – 1.24%
Native Hawaiian/Pacific Islander – less than 1%
Other – 2.36%
Two or more races – 1.59%
Hispanic/Latino – 4.69%

The overall minority statistics show that the white population is at 80% and the minority population estimates at 20% for the region.

Consistent with the language of the Older Americans Act Amendments of 2006, the ACOG targets older persons with greatest social need, greatest economic need, those at risk of institutional placement and those with Limited English proficiency.

C. Ten Year Forecast for the Appalachian Planning & Service Region

The Appalachian AAA/ADRC has identified four issues that will have a great impact on the service population in the region over the next ten years.

1. Changes in Regulations and Priority

Since the Older Americans Act began in 1965, the nation and regions have slowly increased the types of services delivered as new needs were addressed and funding has increased. The longevity of the nation's seniors has also put a strain on service delivery due to more services needed and not enough funding to provide for all. There are waiting lists all over the nation for almost all of the services that are funded through the area agencies on aging. The AAAs have played such an important role in providing for this population and the caregivers,

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even though most of the nation has no idea that the agency even exists. But even though the senior and disabled populations are growing, the AAAs only try to serve those that are in need of services. More seniors are working longer and are getting better preventative care. So, the amount of clients to be served is small in the overall population.

Due to the updated LGOA Aging Policies and Procedures that go into effect on July 1, 2013, the AAA/ADRC will begin to prioritize all clients to receive services. As this practice has been being completed at the provider level, due to changes in regulations, the AAA is now in charge of this task. A new AAA staff member will be hired as the Client Services Specialist.

Another task that the AAA will be assisting with and also completing in-house is the updated assessment. The AAA shall provide training to the service providers and receive training from the LGOA staff on completing this form and submitting the data into the AIM system. The AAA staff and service providers shall be monitored for compliance on this new task for accuracy and completeness.

Due to changes to scoring eligibility for congregate and home delivered meals, the AAA will utilize the GIS to search for those areas that are underserved so that the service providers will be able to better serve those in need. When clients become ineligible for service, the AAA and provider staff will provide all applicable and necessary resources to those clients to still maintain their independence in the community.

2. Monitoring of Service Providers

The AAA is in the process of updating the monitoring policies of all service providers. Due to updated LGOA Policies and Procedures manual, this document will be provided to the service providers to assist them in providing the required and regulated services per the document. The AAA shall update its own Policies and Procedures manual to be provided to the service providers to allow them to follow all regulations as required by LGOA, AoA/ACL and the Older Americans Act.

The updated monitoring process shall entail a quarterly desktop monitoring in-house. Each program that provides direct service within the region will receive this monitoring with records kept in the office for review. This monitoring will be completed by the AAA Aging Director. The monitoring of the service providers shall be completed on an annual basis with reports submitted to the LGOA office. Due to the recent changes in the manual as stated above, the AAA staff will be conducting monitoring on a smaller scale within the first three quarters of the year. These smaller undertakings are to assist the providers with transitions of new policies, procedures and regulations. This monitoring shall

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assist the AAA in holding the service providers more fiscally and programmatically accountable.

3. Per the Needs Survey completed by System Wide Solutions, Inc. in October, 2012, the region has some specific needs to be addressed.
 - a. Information & Referral/Assistance is a great need in the region, along with the I-CARE program. Clients call on a daily basis just for information on the services available and any assistance needed for their Medicare and other medical insurance needs. The AAA provides outreach information through community events, presentations, and providing AAA materials on both these and all other AAA programs. The volume of calls has greatly increased over the past several years, especially due to the AAAs having the task of assisting with the Medicare Part D annual Open Enrollment. New volunteers have been trained that will assist the AAA with this process in the fall of each year.
 - b. Caregiver needs for the region are respite and monetary assistance for receiving services. At this time, the AAA expends all caregiver funding for these types of services. This process shall continue until the caregivers show a greater need in another service area.
 - c. Senior Center activities that are needed are exercise and counseling. The participants have been receiving exercises that greatly improve their health and independence. Due to changes with the OAA Title IIID requirements, more evidence-based health programs are being introduced and present results that these new programs are assisting participants in a greater sense of health and well-being. Counseling for participants is not always needed with center staff, but also with other participants. Center staff can assist with issues of concern such as health and resources. Other participants can provide the socialization that is greatly needed to discuss health issues, family and past memories that this cohort of the population has in common.
 - d. Personal and home services seem to be of the least importance for some and most important for others. Transportation for errands and home/repair modifications are on the rise as an important need to this service population. Often times, agencies will need to coordinate and collaborate with community organizations and companies in providing for the needs of the clients' homes. Transportation has always been one of the greatest needs for this population, especially for the rural and low-income. At this time, the region is providing this service as needed with no waiting list. In the next fiscal years, the AAA will have to begin to prioritize this service as funding decreases. With assistance from the collaborations of other agencies, the AAA shall plan to keep providing this service to the fullest of our ability.
 - e. The needs survey results also noted that service needs vary across the segments of age, race and gender. The needs are perceived differently by the individual groups of seniors, disabled persons and caregivers. These needs shall continue to be addressed separately and in detail.

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- f. Service providers stated that there is a good relationship between them and the AAA, but would like to be included in aging issues on all levels and of the planning for the region. The new fiscal year will begin new relationships with the service providers and the Regional Aging Advisory Council. Both of these have a vested interest in the service delivery population of the region and both shall be part of the planning and reporting on needs and concerns within their counties to be reported to the AAA. This new relationship will also be enhanced as the AAA Director will provide all with information on aging issues from the local, regional, state and national levels.

4. Senior Center Development

A trend has begun in the region and is beginning to take off at a great speed. The senior centers are now starting to collaborate more with other agencies in their communities so as to provide a greater variety of services with different funding. The centers are collaborating with parks and recreation departments, local hospitals, fitness agencies and schools. The centers are able to provide a variety of intergenerational activities as well. We all know that the seniors and children of this nation are greatly underserved and can gather so much from each other. The children can assist seniors with the future and the seniors can teach the children about the past. It has been shown in several areas of the region that is a collaboration of the future and will enhance lives across the age spectrum, including those people who are providing the services. These centers are asking their participants to pay a small annual fee for the services. This also looks to the future for a growing business in serving the middle and upper income senior population.

D. Emergency Preparedness

The AAA collaborates with Federal, State and local entities that have an interest or role in meeting the needs of older individuals in planning for, during, and after natural, civil defense, and/or man-made disasters.

- 1) Procedures. The AAA employs specific procedures that include, but are not limited to, the following:
 - a) Notifying the Lieutenant Governor's Office on Aging of its need to provide emergency management activities, when a disaster occurs.
 - b) Providing information to the LGOA regarding the impact of the disaster on the older population in its service area, provide emergency management

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services in accordance with current AoA disaster relief guidelines, and collecting pertinent data necessary to submit reimbursement requests for disaster services.

- c) Communicating with county Emergency Preparedness office for guidance.
- d) Participating in planning activities with other entities and organizations that are charged with meeting the needs of disaster victims in emergency situations.
- e) Contractually stipulating that service providers develop plans for emergency management and that plan is integrated into the respective county emergency preparedness plan for both staff and their clients.
- f) Providing technical assistance to service provider staff regarding emergency management activities.
- g) Maintain up to date contact information for Emergency Preparedness offices, American Red Cross, etc. in each service delivery area.
- h) During on-site visits, the Ombudsman staff will check on each long term care facility's emergency preparedness plan to keep track of their relocations plans in the event of a disaster.
- i) Each AAA staff member will be placed on a telephone tree as to who will contact each member in the case of a disaster. The disaster plan will comprise of activities that each staff member will complete. The plan shall include the contact information for all emergency preparedness agencies and the providers of each county.

ACCESS INFORMATION FOR EMERGENCY PREPAREDNESS ACTIVITIES

REGION: I – APPALACHIA	FISCAL YEAR 2013-2014
ANY CHANGES TO THIS INFORMATION MUST BE REPORTED TO THE AAA, EPO, AND LGOA WITHIN TEN WORKING DAYS	

COORDINATING AGENCIES	EMERGENCY CONTACT STAFF	CONTACT NUMBER
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(Agency Name & Street Address)	(Names and Job Titles)	After Business Hours
Area Agency on Aging		
S.C. Appalachian COG/AAA	Karen Carter, AAA Director Carolyn Breeze, Aging Finance Nancy Hawkins, Long Term Care Ombudsman Supv Glenda Manigault	864-277-1587;606-224-7055 cell 864-848-0426 864-269-9454;864-616-7347 cell 864-963-0963;864-430-9314 cell
Area Agency Contractors		
Senior Action, Inc., 50 Directors Dr., Greenville, SC 29615	Andrea Smith, CEO	864-801-1351;864-303-5974
Senior Solutions, 3420 Clemson Blvd., Anderson, SC 29621	Doug Wright, CEO	864-226-3401;864-933-0929 cell
Senior Centers of Cherokee, 499 West Rutledge Ave., Gaffney, SC 29340	Amy Turner, Director	864-487-4238
Senior Centers of Spartanburg, 142 S. Dean Street, Spartanburg, SC 29302	Sandra Owensby, Executive Director	828-286-8777;864-580-1554 cell
Pickens County Seniors Unlimited 114 Pumpkintown Hwy, Pickens, SC 29671	Sharon Marling	864-878-9025
S. C. Legal Services 701 South Main Street, Greenville, SC	Kimaka Nichols-Graham, Interim Managing Attorney	864-679-3259I
Sr. Catering, Newberry Kitchen	Donnie Edwards	800-768-8922;803-276-7350 (H)

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Sr. Catering, Seneca Kitchen	David Chellam	800-756-8720;864-332-4244 (H)
Emergency Preparedness Offices		
Anderson County	Taylor Jones	864-332-5751
Cherokee County	Rick Peterson	864-487-2590
Greenville County	Damon Hubber	864-467-2680
Oconee County	Scott Krein	864-638-4200
Pickens County	Chuck Haynes	864-898-5945
Spartanburg County	Doug Bryson	864-596-5366
Volunteer Organizations Active in Disasters		
American Red Cross Western Carolinas Chapter	Ann Wright	864-271-8222
American Red Cross Oconee Chapter	Kathy Rogers	864-638-5919
American Red Cross Piedmont Chapter	Jane Morris	864-583-8000
Lt. Gov's Office on Aging	Ron Ralph	803-734-9895

E. Holiday Closings

Below is the holiday closing schedule for the ACOG for the FY 2014. The fiscal year shall have a total of 250 serving days. The document is to be posted in each of the senior centers in the region.

Thursday, July 4	Independence Day
Monday, September 2	Labor Day
Thursday, November 28	Thanksgiving Day
Friday, November 29	Day after Thanksgiving
Tuesday, December 24	Christmas Eve
Wednesday, December 25	Christmas Day

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Wednesday, January 1	New Year's Day
Monday, January 20	Martin Luther King Jr. Day
Friday, April 18	Good Friday
Monday, April 21	Easter Monday (optional)
Monday, May 26	Memorial Day

V. AAA/ADRC Operational Functions and Needs

A. Assessment of Regional Needs

In October, 2012, the System Wide Solutions, Inc. provided the AAA with the results of their Aging Needs assessment performed for this region. The population in need is more poor, more African-American, more women, less likely to have a spouse, older and with fewer social supports than the general senior population in the region.

Information, Referral and Assistance was viewed as the most important service to help them remain in place. This was followed by I-CARE, caregiver services, senior center activities, services to help them maintain independence and personal and home care.

For caregivers, the most important services were respite and monetary assistance with obtaining services (such as help with medical payments, prescriptions or prescription drug coverage).

Senior center activities that were most important were exercise and counseling.

Services to help maintain independence viewed the Ombudsman program as the service of most importance.

Under the heading of personal and home care, the most important services listed were transportation for errands and home repairs/modifications.

B. Program Development

Program development is an ongoing activity to meet the ever-changing needs of the service population. The current ongoing project is a contract with CMS for care transitions services.

The Appalachian Council of Governments is the Community Based Organization (CBO) along with four area hospitals in three counties who applied for and received approval for a Community-based Care Transitions Program (CCTP). The CCTP was created by

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Section 3026 of the Affordable Care Act to tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

This program includes four hospitals, a company who provides coordinated care services and the Area Agency on Aging working together. There is also a community partnership within this program that currently includes five regional Skilled Nursing Facilities (SNF) and three Home Health Agencies (HHA). The community partnership is expected to grow as other Skilled Nursing Facilities or Home Health Agencies are identified.

Patients who have Medicare FFS Parts A and B or Dual Eligible are included per the guidelines of the CCTP. The program chose four high risk diagnoses including Heart Failure, Acute Myocardial Infarction, Pneumonia and COPD based on the root cause analysis. A coach will guide a patient's transition for 30 days using the Care Transitions Intervention (CTI). The program also includes a short term supplemental package for those who are identified as needing transportation, nutrition or home-care. These services will be arranged and provided by the AAA as part of the program.

The program received approval from CMS on January 17, 2013 and went live April 15, 2013. The approval is a two year program with possible opportunities to add additional years annually up to five years based on the success of the program.

Currently there are three coaches. One coach is the lead and works closely with the AAA regarding billing, data collection and end of program surveys, which are all requirements of the program. The lead is also working closely with the Directors of Case Management at the hospitals and the Program Manager at the AAA to build processes and education for the program.

The program started April 15 with two of the four hospitals referring patients. In the coming weeks, more coaches will be hired and the other two hospitals will start referring patients. The program is accepting Medicare FFS or Dual Eligible patients with one of the four diagnoses who are discharged home from an in-patient stay.

In the coming months, patients who are discharged to partnering SNFs or HHAs will be added to the referrals. An education program has been developed and processes are being developed for partnering facilities. Once additional coaches are hired and the SNFs and HHAs are educated, these patients will be referred to the program. The program will phase in HHAs first and then phase in SNFs.

Currently, minor hurdles or barriers that have been encountered are minimal and have been overcome by the team. As the program adds referrals from the community partners,

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it is anticipated that the program will continue to ramp up to meet the goals submitted on the budget. The expectation from CMS is for all programs approved to increase their target goals over the length of the program. The success of the program including a reduction in readmissions at the four partnering hospitals throughout the two years will determine approval for additional years and if partnering hospitals are interested in continuing with the program.

C. Program Coordination

The ACOG ADRC/AAA will be revitalizing their relationship with the service providers of the region. Meetings and trainings are to be planned so that the service provider staff and AAA staff can provide technical assistance, information on aging issues, and work together to provide quality services on the region. There shall also be more quality assurances in the service delivery for both the service providers and AAA. Monitoring will be intense in the first year of the new planning cycle to ensure compliance with new regulations, policies and procedures. Any and all technical assistance will be provided by the AAA to the service providers to ensure a smooth transition into the new planning cycle. The AAA will ask for assistance from the LGOA and other regional AAAs of the state for technical assistance as needed.

D. ADRC and Long Term Care

ADRC Functions embedded in PSA

- Efficient and simplified access to a wide range of public/private resources/benefits/services for an array of consumers through diverse entry points
- Key partner in the provision of information/referral/assistance and coordination of resources
- One on one benefits counseling and education on available long term care options
- Streamlined intake and assessments
- Established and recognized in the PSA; the value of the ADRC mission and philosophy valued as worthwhile and needed
- Person centered, holistic approach to addressing individual and family needs
- Strengthening and promoting strategic partnerships; coordinating closely with informal and formal providers, caregivers and consumers
- Advocating for and implementing policies to protect consumer privacy and facilitate data sharing at the state, regional and local level

Lessons Learned

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- Establish relationships with new partners and advisory committee members early and educate them about the purpose of the ADRC; the integration of services/resources to be offered
- Identify champions in partnering organizations and work closely with those who best understand and support the ADRC mission
- Set clear and realistic expectations for ADRC staff by providing cross training on integrating services/programs and a more person centered approach
- Keep marketing approaches simple and appropriate for the diverse populations to be served: i.e.: cultural differences and literacy levels

The ADRC has opened up the AAA to the aging and disabled person's community. Even though the agency is geared toward serving those over 60 years of age, there has been a vast increase in call volume from the disabled population in need of services. In most cases, the callers are referred to SHIP for benefits counseling, Department of Social Services and the Department of Disabilities and Special Needs. If there are available services and resources within the AAA service programs, then appropriate referrals are made to those particular resources. The ADRC has increased the AAA staff knowledge of the available resources in the community. The ADRC website that began in 2010 has seen an increased usage of this internet resource.

Over the next planning cycle, the website will be on a schedule for updating all resources to keep the information current. Information that is currently not available will be placed on the site to enhance the information provided. There is a link provided on the website to South Carolina Access.

E. Advocacy

The AAA will continue to review and comment on public policy issues that impact older adults and their caregivers. This will include efforts at both the local, state and Federal levels. The AAA will continue to staff the Appalachian Caucus of the Silver Haired Legislature. Updates on key legislative issues are provided at Regional Aging Advisory Committee (RAAC) meetings and e-mailed to advocates and contractors in the region.

For this planning period, RAAC members will be given an opportunity to review key issues identified for their county in the needs assessment process. This information will be shared and compiled for the group so the committee can identify two to three issues where they will focus their efforts.

F. Priority Services

The AAA uses a funding formula to satisfy requirements of the Older Americans Act (OAA) and Title III regulations. It is intended to be simple and easy to apply; to

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

G. Priority Service Contractors

The AAA utilizes regional service providers and ensures that they provide quality, required and regulated services. Service reports are run out of AIM on a monthly basis to address accountability of the services and eligibility of clients.

The OAA Title IIIB funds for information/referral, access and legal services are determined first before a county distribution of funds to the service providers. The services the AAA contracts for are determined by past performance and execution of funds for those specific services. Next, the AAA utilizes funds to meet the needs as addressed by the regional needs survey. Issues of waiting lists in particular counties regarding specific services are also addressed.

In the RFP process, a Bid Review Committee is made up of RAAC members to review all bid proposals submitted. The committee members use a scoring sheet for determining the viability of each proposal. The final task of the committee was to make the decision on which bid proposals to accept for the AAA to contract with. The Bid Review Committee then makes this recommendation to the full RAAC. Once this recommendation is passed, the RFP committee's recommendations go to the ACOG Board of Directors for a final vote.

H. Transportation

Transportation is fundamental to assuring elders are able to meet their basic needs and age in place in their communities. For those unable to travel due to health issues or affordability, travel opportunities can be extremely difficult to come by without community based services and supports. Whether going to the grocery store or the doctor, elders need access to safe transportation. Inadequate transportation, as individuals deal with limited mobility, can put an older person at higher risk of poor health, isolation and loneliness.

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In order to address this need, the AAA receives requests for transportation throughout the region and makes the appropriate referrals to service providers. For the service providers, transportation is provided for non-emergency, medical, errands and trips to the congregate meal sites. One of the service providers contract with a local hospital for the trips, while other providers own and maintain their own fleet of vehicles. For medical transportation only in Greenville County, the AAA staff takes the requests, completes the assessment and makes referrals to one of two available providers. This service was taken over in September, 2012 when a service provider could no longer provide the service. AAA staff goes over billing units to ensure accountability and accuracy before payment.

There are currently no waiting lists for transportation at this time.

I. Nutrition Services

Both congregate and home delivered meals are provided in the Appalachian region, with 26 group dining sites located throughout the region. The region also has the Meals on Wheels organization that provides home delivered meals in Greenville, Cherokee, Pickens Counties and a portion of Anderson County. Mobile Meals delivers meals in Spartanburg County. In comparing days of operation, 3 sites have added 2 more days per week. One site in Anderson County was added that is open 2 days per week. There are two new centers in Spartanburg County that are open three days per week. Greenville County has 4 new centers that open 3 days per week (3 sites) and another open all through the week.

In comparing the level of infirmity of all clients from FY 2010 to FY 2013, the following changes were noted:

- Serving 8,462 clients in FY 10, only 7,161 in FY 13
- Nutritionally High Risk at 23% in FY 13 versus 21% in FY 10
- Rural served at 38% in FY 13 versus 35% in FY 13

In comparing unduplicated client count and service units from FY 2010 to FY 2013 (11 months), the following changes were noted:

- Both years compared show a drop in units and people served (only 11 months for FY 13)
- Due to increase in all costs associated with meals
- Congregate Meals: 155,091 in FY 10; 144,258 for 11 months in FY 13

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- Home Delivered Meals: 181,993 in FY 10; 130,514 for 11 months in FY 13

In comparing hours of operation of the congregate dining sites from FY 2010 to FY 2013, the following changes were noted (all centers are open the minimum of four hours per day):

- 26 congregate sites in FY 13 compared to 21 in FY 10
- 4 of the new sites are serving three days per week
- 2 of the new sites are serving 5 days per week
- 3 of the current sites went from serving 3 days per week to five days

It has been discovered that there are several sites that do not serve the minimum of 25 meals per day to the congregate participants. The process has begun to combine centers in some areas to resolve this issue. More of this will be taking place in the upcoming fiscal year.

The ACOG/AAA has in place the monitoring measures to validate and support data that service providers submit for reimbursement. When invoices are received, the AAA staff runs specific reports out of the AIM system to cross check the units that are being billed. Clients that are not eligible have their units removed and the billing is adjusted for the correct amount of units. This process takes place on all the invoices submitted to the AAA.

All dining sites are required to submit their monthly activity calendars with their monthly reports. The calendars are submitted prior to the month that billing is being reported. AAA has the responsibility to review all calendars making sure that they meet the requirements for the 4 hours of activity as required by the OAA and LGOA. If the calendar is not approved, the AAA staff will work with each provider on revising the calendars until they meet the standards.

The AAA ensures that the agency and service providers will serve older adults as written in the Older Americans Act. These requirements are as follows for individuals over 60 years of age and/or:

- Rural;
- With greatest economic need;
- With greatest social need;
- With severe disabilities;
- With limited English-speaking ability; and
- With Alzheimer's Disease and related disorders.

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These minimum requirements for services are all noted in the contracts with the service providers, LGOA and AAA Policies & Procedures, the Older Americans Act and the Request for Proposals. The new assessment form as required by the LGOA, has identified questions in the form to capture all this data to be reviewed in each file and through AIM reports.

In the coming fiscal year, the AAA staff will be responsible for the prioritization of clients to receive services. The service providers will be responsible for completing the assessment and providing services. The AAA has plans to hire a new staff person to carry out the prioritization process.

In the procurement process to take place in the fall of 2013, the RFP will require the proposing service provider utilizing state funds to describe their efforts for private pay and cost sharing programs for services. This will include marketing, policies and procedures that the AAA will monitor. GIS mapping will be provided to the service providers to assist them in serving the above mentioned populations in the service areas.

The AAA staff, nutrition provider staff, catering nutritionist and LGOA nutrition program staff meets on a quarterly basis to discuss and review the menus. Menus are provided to the centers for participant feedback. All menus are to be posted in each dining site as a requirement and will be included as part of the monitoring. Any substitutions to the approved menus will be sent to AAA staff for prior approval.

J. Training and Technical Assistance

The AAA will provide training on federal, state and regional fiscal and programmatic requirements, including reporting to new service providers or when there is a change in key staff with a contractor. Once training has been provided to any new providers, the AAA will conduct frequent on-site visits to insure compliance. The AAA provides training opportunities and technical assistance to consumers, caregivers and professional regularly.

SCACOG AAA provides regional training for contracted service provider agencies. Topics and training format are determined each year by the agency directors and the AAA. Per the newly updated LGOA Aging Policies and Procedures manual, the AAA will incorporate all training topics as required on a quarterly basis.

The AAA has identified specific areas of training needed by the service providers. This training will include, but not be limited to: AIM, assessment, LGOA and AAA Policies and Procedures, Center Director Training. The AAA and ACOG staff will

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coordinate to provide this and all other necessary training in the next fiscal year. As new policies, procedures, regulations and funding changes, more training will be provided.

K. Monitoring

The AAA will utilize the following monitoring mechanisms: 1) review and approve annual program planning documents; 2) RFP and grant agreement; 3) reviewing reports; 4) reviewing and approving expenditure reports including reimbursement requests, unit verification, and funds utilization; 5) perform on-site visits (announced & unannounced) to observe delivery of services, review record keeping and client eligibility and process, interview staff and program participants. The AAA will follow up on deficiencies and non-compliance as well as highlight significant accomplishments. A review of past non-compliance deficiencies will be monitored to determine if the situation has improved.

The AAA conducts annual fiscal and program monitoring of each program area. The visit is followed up with a written report. Any concerns are noted with a required written Corrective Action Plan due within a specific time period. The plan of action is monitored, with additional follow up as needed.

The monitoring visit will include the following:

- a. The Area Agency will notify the contracting agency in writing of scheduled visits and send the monitoring form for completion.
- b. Each component agency will have completed the appropriate quarterly monitoring forms.
- c. Area Agency staff will discuss the completed forms in detail with appropriate component staff.
- d. In order to verify units and persons served, the Area Agency staff will conduct a program audit of at least one Title III-B service and the Title III-C program.
- e. A fiscal monitoring will be conducted by the fiscal staff of the Area Agency.
- f. The executive director of the component agency will be informed in writing of the results of the monitoring visit within 30 working days.

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- g. Questions and comments regarding the monitoring visit and any exceptions to the monitoring letter may be made in writing to the Aging Unit Director.
- h. Results of the monitoring visit will be provided to the Area Agency's Advisory Committee on Aging and, when requested, to members of the Council of Governments Board of Directors and the Lt. Governor's Office on Aging.

The AAA will make all programmatic and fiscal records, as well as those of the service providers, available for review to LGOA staff, GOA staff, State Auditor, State Attorney General's Office, the US Department of Health and Human Services and/or any staff of the above.

L. Contract Management

Each year when the ACOG AAA looks at contract extension we will look at a variety of things: (1) did the contractor submit all requested information to the AAA, (2) how was the overall contract performance, (3) was the contractor identified as a high risk contractor and (4) was the contractor responsive to the request of the AAA. If the AAA feels like it is in the best interest of the county(s) and/or region we reserve the right to terminate the contractor's contract.

The ACOG AAA/ADRC will require each contractor to submit the following reports by the fifth day of each month: order, delivered and service report form with vouchers from the approved meal vendor shall be submitted to the AAA/ADRC; scanned or copies of the home delivered meal route sheets which have been signed and dated by the driver and the Executive Director to assure that meals have been delivered; signed ACOG Recap Sheet; and signed ACOG AAA Provider Certification with the following reports AIM MUSR, HHS18, HHS25b, LG97c (for each funded service) submitted to the AAA/ADRC.

We require that all units of service are to be entered in AIM by the 5th day of the following month of service. The AAA/ADRC will run the following reports out of AIM each month: LG45d and SC36a. Monthly congregate meal activity calendars must be submitted to the appropriate AAA staff member by the 5th day of the month before the calendar is effective. Once the calendars are approved they will be submitted to the LGOA by the last day of the month. Each month a nutrition

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contractor will be notified to turn in the sign-in sheets for a particular site when they submit their monthly request for payment. The Executive Director of the agency will be notified by the 1st day of the month. The monthly sign-in sheets will be reviewed to verify that each congregate meal was served.

The ACOG AAA/ADRC will notify each contractor by the beginning for each month when the AAA/ADRC will be out to conduct home delivered meal routes and visit senior centers in their county. The AAA/ADRC will deliver home delivered meals from three (3) different routes and visit three (3) different congregate meal sites in the region each month. The AAA/ADRC will continue to conduct announced and unannounced visit throughout the contract year.

The ACOG AAA/ADRC will provide electronic copies of procurement contracts and all amendments within thirty (30) days of execution. The ACOG AAA/ADRC assures that contractors for procurement of services or goods that are supported with financial assistance through the LGOA will adhere to the applicable Federal and State procurement codes (COG: OMB Circulars A102 and A87) ((PN-P: OMB Circulars A110 and A-122).

M. Grievance Procedures

At this time, a poster outlining the grievance procedures is posted at all group dining sites of contractors. This obviously does not reach many service recipients, especially if receiving services in the home. Identifying additional methods to communicate with service recipients will need to be addressed before year end 09-10.

General Guidelines – Any older individual who feels he/she has been discriminated against for any of the reasons listed below in “Concerns of Grievance” may file a verbal or written complaint with the SCACOG/AAA. Prior to agreeing to accept the complaint, SCACOG/AAA will ensure that the complaint has followed the contractor’s grievance procedures and all potential remedies have been exhausted. Complainants who indicate dissatisfaction with the disposition of their complaint shall be referred immediately by the contractor to the SCACOG/AAA.

Concerns of Grievance:

- Residency or citizenship imposed as a condition for provision of service.
- By reason of handicap, be excluded from participation in, be denied benefits of, or be discriminated against under any program or activity.
- On the basis of race, color, national origin, sex or sexual orientation be excluded from participation in, be denied benefits or, be discriminated against under any program or activity.

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- Person's receipt of services limited or denied based upon non-payment of fees for service used as a condition (all persons will be offered an opportunity to freely and voluntarily contribute to the cost of the service) unless it is a cost shared service or private pay service.

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Area Agency on Aging Responsibilities:

- Acceptance of the complaint and acknowledged in writing within three working days of receipt of the complaint.
- Immediate contact with the named contractor requesting a written summary of their involvement with the complaint. This summary to be provided within three working days of the request.
- Make follow-up or investigative contacts with all parties involved, including on-site review of the case file of the contractor, as deemed appropriate.
- Schedule the complaint review, advising complainant, subject and contractor. This will be accomplished within forty-five (45) days of receipt of the complaint. Notify all parties of the decision on the complaint; inform all parties of their recourse, if not satisfied with the resolution—such notification to be in writing within three working days.
- Advise the State Office on Aging of the complaint when deemed appropriate by the AAA. Advise the State Office on Aging of the specific resolution through copy
- Maintain documentation of concerns of grievance in a confidential file for no less than three years.

N. Performance Outcome Measures

In the new fiscal year, new performance outcome measures will be put into place. These measures will consist of soliciting the opinions of the participants and services providers on all issues concerning services delivered and service delivery. The measures will include surveys for the following programs:

- Senior Center Activities
- Congregate Meals
- Home Delivered Meals
- Homecare
- Family Caregiver
- SHIP
- Transportation
- Long Term Care Ombudsman
- Legal Services

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The results of the surveys will be addressed with the AAA staff, service providers and RAAC. These agencies and committee will make educated planning decisions on how to better serve the clients in the region.

O. Resource Development

In the past, the ACOG has been instrumental in assisting service providers in the region with grant writing and grant procurement. Anytime the AAA Director is made aware of appropriate grants for aging services, this information will be passed along to the service providers. The AAA shall utilize all coordination available from ACOG staff to assist in finding other funding sources available to the agency and the service providers. The AAA will also continue the discussion with service providers regarding cost sharing and private pay options.

P. Cost Sharing and Voluntary Contributions

The Older Americans Act (OAA) limits cost sharing for its programs. Currently, the Appalachian AAA is not utilizing a cost-sharing practice for any OAA service. The AAA is planning in the future to establish cost-sharing for transportation and the Family Caregiver Support Program based on current poverty guidelines.

Voluntary contributions are reported as Grant Related Income (GRI) on the monthly MUSRs submitted to the AAA. These contributions are used to purchase more units for the service for which they have been collected. The AAA financial staff monitors the service providers regarding the contributions annually.

Q. Confidential Assurances

The issue of confidentiality is addressed in all service provider contracts with the ACOG AAA. As part of the provider monitoring, it will be noted that each service provider has a confidentiality policy and notice of HIPPA compliance. All ACOG employees are required to sign HIPPA compliance forms at the beginning of their employment.

V. AAA/ADRC Direct Service Delivery Functions

A. Staff Experience and Qualifications

1. Nancy Hawkins, Regional Long Term Care Ombudsman & LTCO Supervisor with 14 years at the AAA

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2. Sandy Dunagan, Long Term Care Ombudsman (certified) with 14 years at the AAA
3. Jessica Winters, Intake Long Term Care Ombudsman (certified) with 8 years at the AAA
4. Tiwanda Simpkins, (MSW, CIR-A) Long Term Care Ombudsman (certified) for one year at the AAA (has also served in the position of I&R and is certified in I-CARE)
5. Barbara Jardno, M.Ed., Family Caregiver Advocate for 18 months, was previously in I&R and Hospital Discharge Grant and is also a SHIP counselor
6. Kim Bridges, Family Caregiver Advocate for over 4 years, has 20 years experience in the field
7. Kim Reyes, I-CARE Coordinator for 1 year, has over 8 years experience with aging service in the community
8. Marques Wideman, Benefits Counselor, AIRS certified with agency for over 3 years
9. Tim Womack, I&R/A Specialist, AIRS Certified with almost 2 years at the agency, many years spent as a volunteer in aging services with fundraising and case management

During the first fiscal year of the planning period, the biggest transition will be a new Aging Unit Director for the agency. Although the staff person has worked within an AAA and within the aging network, there remains a learning curve in the new role. The regional Long Term Care Ombudsman will be retiring at the end of the summer. Another LTCO has left for a new position, and the Volunteer Coordinator will also be taking a new position elsewhere. Two of the staff will be getting AIRS certification in August.

B. Long Term Care Ombudsman Program

The Regional Ombudsman is supervisor of both the Ombudsman Program and the Friendly Visitor Program. Three Ombudsman staff members devote 100 percent of their work hours to their assigned Ombudsman job responsibilities. The Volunteer Coordinator's time is divided between assigned Ombudsman responsibilities and her work as the Volunteer Coordinator.

There is anticipated turnover in the Ombudsman program with at least two staff members leaving and one retiring in the new fiscal year. There would be a possible promotion within the program and the hiring of one regional LTCO, a LTCO and a Volunteer Coordinator.

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The Long Term Care Ombudsman investigates complaints made by or on behalf of residents living in nursing homes, residential care/assisted living facilities, special needs and disabilities facilities, sub-acute units in hospitals, psychiatric hospitals, clients of mental health centers and hospice homes.

Ombudsman staff are also responsible for advocating for residents, providing mediation, consultations, and presentations in the community about the Ombudsman Program; doing “Friendly Visits” in facilities and providing training programs in facilities to help educate staff about various issues, i.e., Laws regarding Abuse, Neglect and Exploitation and Residents Rights.

Local law enforcement agencies are offered the opportunity to participate in training programs provided by the Ombudsman Program concerning Abuse/Neglect/Exploitation and the Laws regarding vulnerable adults.

During on-site visits to the facilities, Ombudsman staff will be checking on the facilities’ Emergency Preparedness plans and will keep a current record of relocation plans.

The long range goals of this program are to provide all of the above services in a timely and efficient manner that is most beneficial to the residents living in the facilities.

Major strengths of the Ombudsman Program include:

- Improved working relationship with facilities. Each of the Ombudsman staff strives to work with facility staff in promoting open communication and encouraging efforts be made that will be most beneficial to the resident. In recent years the program has seen the number of consultations more than double and the number of complaints/cases decline.
- The number of mediations has increased and Ombudsman staff members have been able to have both the facility and the family sit down and work together toward finding ways to resolve issues of concern.
- The Ombudsman program has a Friendly Visitor Program in which volunteers are assigned to a facility that they visit weekly. During the volunteers’ weekly visits, they strive to build a relationship with the residents. The volunteer also works closely with staff members, offering encouragement and support for their efforts. While visiting, the volunteer is able to monitor the residents’ care and activities. If there are issues of concern, they are able to advocate on the residents’ behalf and work with staff members to resolve the issues. This program has been very successful in that those facilities who are currently participating have shown a decrease in the number of complaints reported to the Ombudsman program.

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Weaknesses of the Ombudsman Program include:

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- The lack of sufficient number of staff to complete all assigned job tasks in a timely manner. Due to the loss of one position, all staff members have had to take on additional responsibilities. Each Ombudsman who investigates complaints has an average of 20-25 open cases at all times.
- An on-going backlog of cases to be investigated.

The Ombudsman Program does not have the opportunity to attend Resident Council meetings very often due to the fact that we must be invited in order to attend. In an effort to become more involved in these meetings, the Ombudsman staff will meet with the resident council president during our on-site visits to facilities and offer to provide a presentation concerning advocacy for residents or request to have permission to attend one of their meetings.

This program is also looking at the possibility of additional cuts in the State Budget in the upcoming year. Because of cuts to this program, efforts are going to have to be made to increase the number of volunteers working with the program.

C. Information & Referral/Assistance Services

Information, Referral and Assistance services for the Appalachian Council of Governments is provided to all six counties in the region through one specialist housed within the AAA in Greenville. This service provides personal assistance in a “one stop shop” environment to older adults, people with disabilities and their caregivers. All pertinent aspects of the individual’s situation are reviewed to ensure that the most appropriate referrals are made to meet their needs. An evaluation is made of: financial resources, age, diagnoses, current insurance coverage, activities of daily living, transportation, family supports, rent/mortgage, nutrition, advance directive/legal needs and physical/mental well-being. All of these factors assist in determining qualifications for obtaining assistance to their request. Persons are primarily supported through phone conversations, but they may also be seen in the home or where they are currently residing, or through emails.

Community resources are constantly updated through networking, attending interagency meetings, utilizing SC Access, United Way portals, the Internet and word of mouth. Communication with those councils on aging that have case managers is helpful. Our intra-agency teamwork with the Family Caregiver, I-Care/SHIP, Ombudsman and Healthy Connection programs has brought added resources to light and benefits all involved.

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In addition to the Information, Referral & Assistance responsibilities, the specialist also complements the I-Care and SHIP Counselor activities and is a Resource Coordinator for the Aging and Disability Resource Center. The current specialist is nationally certified in Information & Referral and as a SHIP counselor.

Through the Information, Referral & Assistance process, the specialist at the Appalachian Council of Governments strives to utilize its process to provide the identified resource information that will give the maximum quality of life, safety and independence to the individual or caregiver.

Current trends

Referrals have consistently run from 75-100+ each month, with no particular pattern towards a particular need except during open enrollment periods for Medicare programs. The latest needs assessment notes that persons requesting insurance counseling prefer to have it done on a one-on-one basis, which the ACOG has been able to provide. Unfortunately, this year has seen the SC GAPS insurance take a plunge, funding only 10 percent of eligible seniors during the gap period. The future of this program's ability to assist seniors is strictly wait and see.

With the downturn of the economy, there has been a slight increase in the requests for mortgage assistance but not to the extent that one would think. Basic needs assistance remains constant, while providers are finding it more difficult to fulfill those requests. Community Long Term Care has fluctuated its services with the various State cuts. While it has returned many of its former announced cuts to their previous levels, the waiting lists remain long to obtain in-home services needed to keep persons in their homes. As more employment is being lost, caregivers are requesting reimbursement possibilities in order to take care of that loved one.

Transportation for non-medical purposes continues to be an ongoing problem. Elderly and handicapped individuals must rely on neighbors, relatives or non-accessible public transportation to purchase the basic essentials for living. With fluctuating fuel prices, the altruistic ways of the community are diminishing.

Future Needs

It is difficult to assess what the next several years will look like for the aging population in the Appalachian region. With one of the fastest growing aging groups in the State, we know that the resources that are currently in place are lacking. While there has always been a prideful generosity in the region, it will take the coordination of all agencies—State and local—to weather the current economy crisis.

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The Information, Referral & Assistance Specialist will need to continue to stay abreast of any and all resources that may assist the individual/family/caregiver. Coordination of services with the I-Care and Family Caregiver programs is indispensable to positive outcomes. The specialist will encourage the expansion and participation of all resources to SC Access so that accurate referral information is available to agencies, caregivers, both local and in other states, and individuals.

It is imperative that the specialist remain on top of the guidelines for State funding for Medicaid eligibility, both for nursing home, assisted living placement and Community Long Term Care. Families are seeking more ways to maximize their financial resources. As family financial resources diminish, there is the potential for abuse of the powers of attorney. Continued coordination with the Appalachian Ombudsman program is essential.

Referrals to programs that can empower the individual to make better medical, nutritional and health decisions such as the Living Well programs should be continued. Identification of community case managers needs to be made as there is only one specialist for the entire region, making initial return calls and follow ups are slower than ideal. This program can encourage the development of additional congregational nurses, nursing ministries and the use of vehicles from the faith-based communities to promote additional transportation to the community.

D. Insurance Counseling & Referral Services and Senior Medicare Patrol (I-CARE & SMP)

The Medicare State Health Insurance Program (SHIP), known in South Carolina as the I-CARE (Insurance Counseling Assistance and Referral Program for Elders), is a counselor-based program designed to assist Medicare beneficiaries and caregivers with information on Medicare and prescription drug coverage. The program strives to provide:

- (1) Information and assistance to beneficiaries and caregivers regarding Medicare and prescription drug programs;
- (2) Educate consumers regarding Medicare, targeting new enrollees;
- (3) Outreach to assist beneficiaries with extra help applications and Medicare savings programs; and
- (4) Educate consumers on methods to prevent Medicare waste, fraud and abuse.

Counseling is usually provided by phone, and this effort is supplemented by on-site enrollment events in each county during the Medicare open enrollment period, and individual appointments are made as needed. Topics during the open enrollment period relate more to plan selection. During the year, consumer issues ranged from beneficiaries

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accessing benefits, coverage in the gap, Medicare advantage plans, to LIS (low income subsidy) information, and Medigap plans.

During the open enrollment period of October 15 – December 7, service provider staff and volunteers are utilized on site in all counties to expand services offered. Staff is available to answer calls daily and enrollment events are scheduled in each county of the region.

The Appalachia AAA is fortunate to have volunteer counselors in every county and has been able to maintain this effort. There are not any bi-lingual counselors at this time but there have also been very few requests from ESL (English as a second language) consumers. The AAA utilizes the Language Line as needed for these situations. With plans to coordinate with Upper Savannah COG to offer annual I-CARE training in the Upstate, we hope to increase the number of volunteers available in each county.

Outreach efforts during open enrollment will include the distribution of a calendar designed by CMS that provides Medicare and/or fraud messages monthly to consumers. Calendar distribution will target housing complexes, senior centers and community health centers in each county. Distribution of 2000 calendars will keep the contact info of the AAA readily available throughout the year. Quarterly information highlighting all services of the AAA, including I-CARE, is advertised in a senior directory, “All About Seniors.” This directory is distributed throughout the region with circulation of over 30,000.

Key partnerships are with agencies where there is an ongoing need to share client information – Department of Health and Human Services and Social Security Administration. Other partnerships have developed through outreach efforts at county housing authorities, community centers, faith congregations, local councils on aging, mental health centers, home health agencies, pharmacies, Disability Action Center and home-delivered meal providers. With the Medicare Advantage plans entering the market, hospital discharge planners regularly seek assistance for patients needing to return to original Medicare. AAA staff work with the Medical University in conjunction with Greenville Health System. We are providing training to hospital discharge staff on resources available through community programs, as well as, Medicare and Medicaid.

During sign up for the SFMNP (Senior Farmers Market Nutrition Program), Medicare information and fraud tips will be made available. Traditional forums of health fairs, expos and agency presentations will always be utilized. Information is reviewed regularly for continuous improvements to better reach the consumer.

E. Family Caregiver Support Program

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In 2000 the Family Caregiver Support Program (FCSP) was given the honor of being the new concept program of the Older Americans Act. With a purposely loosely structured law, we were asked to create a flexible, consumer-directed program through which we could offer support and assistance to caregivers, who provide approximately 80 percent of long term care in our state, and who do so in an informal setting. The advocates of the FCSP began creating a program that was essentially opposite from everything then in existence, geared to the caregivers rather than the care recipients.

In 2009, we had the advantage of hindsight and had experienced some changes in our responsibilities. Informal caregivers still provide the majority of long term care in our state. We now support: caregivers of adults over 60, who have at least two activities of daily living (ADLs) they cannot accomplish alone, kin caregivers (SRC) over the age of 55 caring for grandkids under the age of 18, adult caregivers caring for loved ones with early-onset Alzheimer's or related dementias, and adults who are caring for an adult relative ages 19 to 59 with severe disabilities.

The Appalachian region has two full-time caregiver advocates and one part-time administrative assistant. With this staff, we have managed to serve an ever increasing number of people. Our primary responsibility has been one-on-one work with caregivers in our region. In order to support our clients, it requires significant investments of time by phone and through correspondence to provide the services and support needed. Both advocates have taken every opportunity to speak to groups in the region to advance the use of our program by diverse groups from faith based, to medical communities, also any non-profits, corporate, municipal or county government entities in our area. Brochures are routinely mailed to anyone requesting information regarding our program.

Some of the weaknesses we see with the current staffing level are a lack of time to maintain support groups badly needed in our region; also, more interaction with local groups of all types would be beneficial for the advocates.

More funding could always be used to serve our clients; however, again, the time it takes to interview, process and maintain records also grows with more assets

It is critical that volunteers in our region who might be willing to assist with support groups or other efforts to collaborate with our program have our guidance and input. The advocates have been most fortunate in having other staff within the ACOG/AAA who have been willing to help us in any way they are able. Collaboration with the Information and Referral Specialists, the Ombudsmen and the I-CARE Specialists have provided us with more depth in assisting our clients. The addition of the ADRC Unit and the CMS grant have also served to provide further one-on-one contact with clients we might otherwise have been unable to see. More home visits in our region would be

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advantageous. As it stands now, due to time constraints, home visits are often done by social workers or employees with related expertise from other agencies (i.e., licensed social workers). In the Appalachian region, the affirmation by a third party of all activities of daily living has been key to helping us resolve and serve the number of clients we currently have on file. We serve well over 400 people per year with respite, supplemental and Seniors Raising Children services. The advocates also provide benefits counseling as part of the services. This year, the advocates provided services to over 60% new clients, as opposed to past clients.

In the coming months, we will be asked to dovetail with the CMS representative in order to assist in the transition of many of our clients from hospital to home setting. The value of our program for some time has been our ability to move quickly to provide limited but critical services to the caregiver. In the case of someone coming out of the hospital, the chances are extremely good that without such support the patient will wind up back in the hospital prematurely, and that benefits no one.

The FCSP looks forward to having an even more outstanding track record as we move forward to determine how best to meet the needs of our clients and the demands of our program. We have an excellent team willing to be adaptable to the situations and needs of our region. We look forward to the productive execution of our plan in the future. We are able to fund services in real time to avoid waiting lists.

Long Term Goals:

- Form and maintain additional support groups for:
 - Male caregivers
 - Grandchildren Caregivers
 - General Caregivers of Adults
- Increase Educational opportunities for our aging population in the areas of:
 - Alzheimer's Impact on the Caregiver
 - Medicare
 - Medicaid
 - Caregiving techniques
 - Disease/Health Management
 - Legal Issues and Rights of Seniors

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- Promote accessibility to Family Caregiver Advocates
- Increase visibility of the program in the community at large
- Continue to search for resources as directed by consumer's wishes

F. Disease Prevention/Health Promotion

The programs available in the region from service providers for disease prevention/health promotion are:

- Better Choices/Better Health (a 6-week, 2.5 hour a week class on Chronic Disease self-help teachings created by Stanford University)
- Arthritis Exercise
- Both classes are evidence based with proven results for up to 4 years into the future of those who participate
- Future plans are to coordinate with DHEC of South Carolina for funding of training leaders and other expenses for the Better Choices/Better Health classes
- Also, the provider receives some funding for the arthritis class from the Arthritis Foundation
- Providers are beginning to collaborate with community resources on continue health promotion classes and activities
- Providers distribute information on disease prevention on chronic diseases most common with the elderly

VII. Changing Demographics Impact on AAA/ADRCs Efforts

A. Intervention vs. Prevention

We all know that in 2011, the large baby boom generation will began to turn 65. The focus will shift from individuals aging to us as a society. This demographic shift shall impact many areas, as noted in the 10-year forecast section of this plan. Recognizing that many resources are quite limited at this time, the time is now for the AAA to help agencies to begin redirecting efforts toward prevention and reduce dependence on government-funded services. As a role of the ADRC, the agency will focus more on long term care planning. Plans are to offer the Long Term Care Planning sessions on an annual basis in the region. The "New to Medicare" sessions that will be offered to target workers that are new to Medicare. Efforts will be made to market this program to employers as well as identifying the AAA as a resource for retirement planning information. Another potential contact with employers is with eldercare issues. The

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Family Caregiver Program with the COG staff will explore ways to better identify the AAA as a resource for eldercare issues with local governments in the region.

Promoting good health is another key component of this shift. Evidence-based disease prevention and health promotion will be a primary focus with funding being directed to only evidence based programs.

B. Senior Center Development and Increased Use

The AAA has always been supportive of senior centers, seeking ways to assist in the promotion of their programs. The AAA plans to work with senior centers/group dining sites in the service area to offer at a minimum quarterly training to enhance programming efforts. Efforts are currently being made by the service providers to maximize the usage of the dining sites to meet the 25 per day requirement.

At this time, Spartanburg and Greenville county has two providers that have identified plans for senior center projects. These provides have applied for the PIP grant and are awaiting notice of awards.. Staff within the AAA and COG have provided grant assistance as needed.

C. Alzheimer's Disease

The agency has always coordinated with local Alzheimer's chapters; that role has strengthened with the expanded role of the Family Caregiver Support Program (FCSP) to caregivers of adults with Alzheimer's disease and with the expansion of the ADRC. The coordination role has taken on specific roles for the AAA as identified in the provision of services to individuals with Alzheimer's disease, their families and caregivers.

To create a single point of entry for persons seeking assistance with Alzheimer's related needs complements the main focus of the ADRC – a single point of entry to access public long term support services. The ADRC provides personal assistance in a “one stop shop” environment to older adults, people with disabilities and their caregivers. All pertinent aspects of the individual's situation are reviewed to ensure that the most appropriate referrals are made to meet their needs. An evaluation is made of: financial resources, age, diagnoses, current insurance coverage, activities of daily living, transportation, family supports, rent/mortgage, nutrition, advance directive/legal needs and physical/mental wellbeing. All of these factors assist in making appropriate referrals.

Providing the caregiver with the option of selecting services that best meet their needs, especially home and community based services, is the philosophy of the FCSP but is also the focus of the staff of the ADRC assisting caregivers. The agency is a strong advocate

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of consumer-directed services and has been quick to offer such options to its clients. Currently, consumers may self-direct the caregiver respite voucher through the FCSP.

D. Legal Assistance Services

The RFP criteria for legal services targeted access to the judicial system through advocacy, advice and representation in order to protect the dignity, rights, autonomy and financial security of persons 60+, caregivers and their families, particularly those who are economically needy. The requirements specified that legal assistance services must be provided in one or more priority areas identified in the Older Americans Act, including entitlement, health care, long term care, housing, utilities, protective services, and defense of guardianship, abuse, neglect, and age discrimination.

The AAA will contract with S.C. Legal Services for legal services in the region. The agency has a tri-part approach to help seniors with legal problems: (1) one-on-one representation, (2) education of seniors, and (3) outreach to seniors. If consumers needing services are immobile and unable to reach an office to see an attorney, the attorney visits the homebound clients. For clients in outlying counties where staff attorney/client may encounter difficulty in maintaining contact, the client may be referred to a private attorney in the applicant's area. Costs are paid by the law firm under its Private Attorney Involvement Program or to the S.C. Bar Pro Bono Program so that one way or another the client's needs are met. Elder law, housing, maintenance of income and public benefits are some of the priorities identified for the agency. These agency priorities are in accordance with the requirements of Section 307 (a)(11)(e).

VIII. Region Specific Initiatives

A. Community-based Care Transitions Program (CCTP)

The Appalachian Council of Governments is the Community Based Organization (CBO) along with four area hospitals in three counties who applied for and received approval for a Community-based Care Transitions Program (CCTP). The CCTP was created by Section 3026 of the Affordable Care Act to test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

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This program includes four hospitals, a company who provides coordinated care services and the Area Agency on Aging working together. There is also a community partnership within this program that currently includes five area Skilled Nursing Facilities (SNF) and three Home Health Agencies (HHA). The community partnership is expected to grow as other Skilled Nursing Facilities or Home Health Agencies are identified.

Patients who have Medicare FFS Parts A and B or Dual Eligible are included per the guidelines of the CCTP. The program chose four high risk diagnoses including Heart Failure, Acute Myocardial Infarction, Pneumonia and COPD based on the root cause analysis. A coach will guide a patient's transition for 30 days using the Care Transitions Intervention (CTI). The program also includes a short term supplemental package for those who are identified as needing transportation, nutrition or home-care. These services will be arranged and provided by the AAA as part of the program.

The program received approval from CMS on January 17, 2013 and went live April 15, 2013. The approval is a two year program with possible opportunities to add additional years annually up to five years based on the success of the program .

Currently there are three coaches. One coach is the lead and works closely with the AAA regarding billing, data collection and end of program surveys, which are all requirements of the program. The lead is also working closely with the Directors of Case Management at the hospitals and the Program Manager at the AAA to build processes and education for the program.

The program started April 15 with two of the four hospitals referring patients. In the coming weeks, more coaches will be hired and the other two hospitals will start referring patients. The program is accepting Medicare FFS or Dual Eligible patients with one of the four diagnoses who are discharged home from an in-patient stay.

In the coming months, patients who are discharged to partnering SNFs or HHAs will be added to the referrals. An education program has been developed and processes are being developed for partnering facilities. Once additional coaches are hired and the SNFs and HHAs are educated, these patients will be referred to the program. The program will phase in HHAs first and then phase in SNFs.

Currently, minor hurdles or barriers that have been encountered are minimal and have been overcome by the team. As the program adds referrals from the community partners, it is anticipated that the program will continue to ramp up to meet the goals submitted on the budget. The expectation from CMS is for all programs approved to increase their target goals over the length of the program. The success of the program including a reduction in readmissions at the four partnering hospitals throughout the two years will determine approval for additional years and if partnering hospitals are interested in continuing with the program.

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B. Area Agency on Aging

With the new AAA Director, the region specific initiatives are vague at this point, but there are a few plans and short term goals for the ACOG region.

- AAA Policies & Procedures manual revision
- Providers involved with the RAAC
- Providers more involved in aging planning for the region
- More partnerships and collaborations in the region
- Looking into more business practices with community resources for services
- Looking into more private pay options for AAA and providers
- Researching through GIS to target those most in need of services to meet service requirements
- More extensive quarterly and annual monitoring of providers for service compliance
- Collaborate and coordinate with service providers for establishing and providing new various activities at the dining sites
- Revitalize the relationship of coordination and collaboration with the LGOA and the all state AAAs

IX. Area Plan Appendices

- A. PSA/AAA/ADRC Organizational Chart
- B. Regional Needs Assessment
- C. Long Term Care Ombudsman Service Report
- D. Information & Referral/Assistance Report (SART)

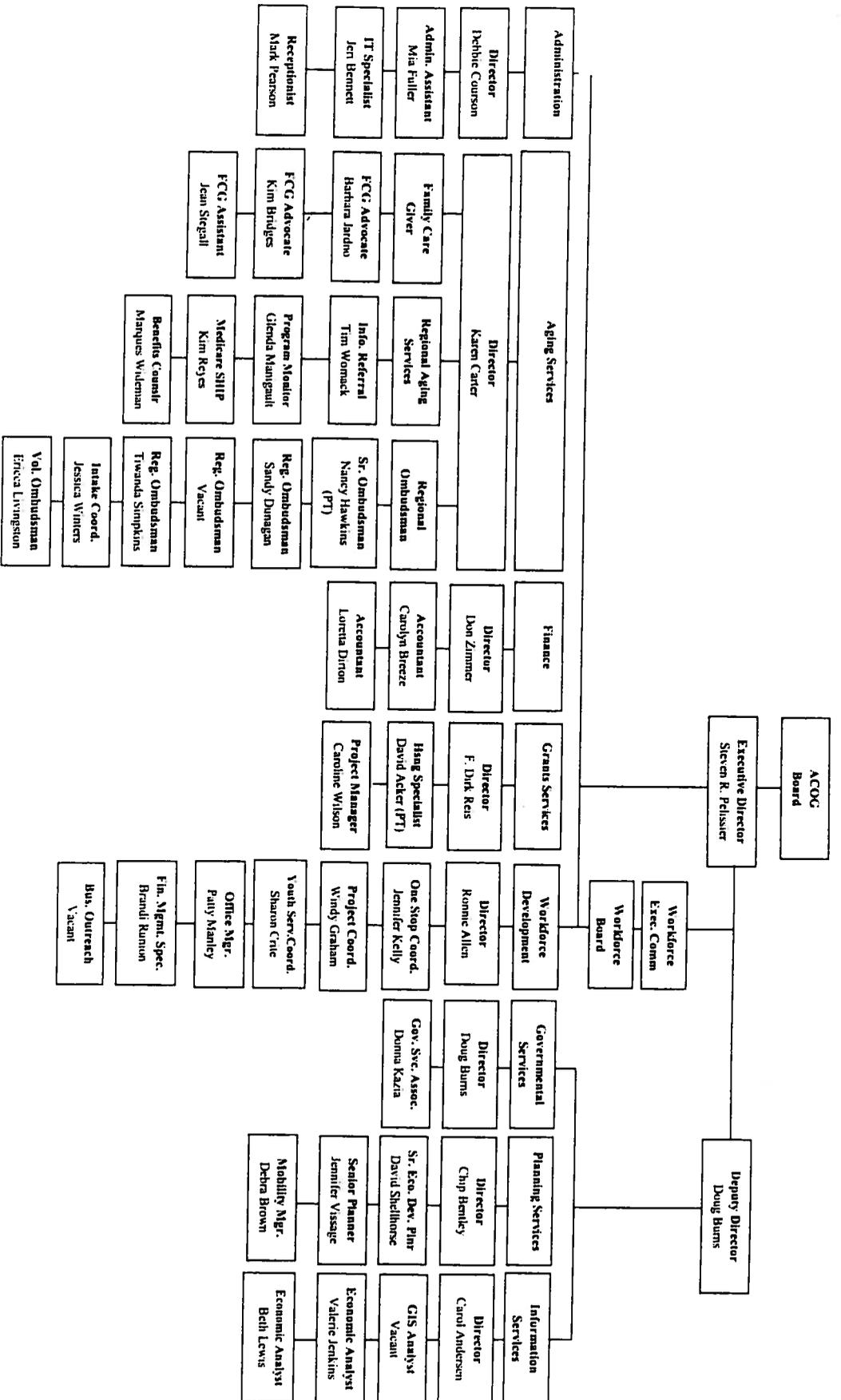
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- E. SHIP Midterm Report
- F. SMP Report
- G. Family Caregiver Report
- H. RAAC Bylaws
- I. Reports Review and Reimbursement Procedures
- J. Verification of Intent
- K. Verification of AoA and LGOA Assurances



APPENDICES
TO
AREA PLAN

APPALACHIAN COUNCIL OF GOVERNMENTS ORGANIZATIONAL CHART



**A STATEWIDE
AREA AGENCY ON AGING
REGION SPECIFIC NEEDS ASSESSMENT
FOR NINE REGIONS
IN THE STATE OF SOUTH CAROLINA**

**PREPARED BY
SYSTEM WIDE SOLUTIONS, INC.**

**Malia Howell
Sarah Meadows, MSW
Jessica Norton
Tiffany Powell
George W. Appenzeller, MSW**

October 15, 2012

EXECUTIVE SUMMARY

The Older Americans Act requires that a multi-year comprehensive area plan be developed for the planning and service area covered by each Area Agency on Aging (AAA) and submitted to the state organization designated as the state unit on aging (the Lieutenant Governor's Office on Aging in the case of South Carolina). This needs assessment is an essential part of that process. Nine of the ten Area Agencies in South Carolina joined together "To conduct a statewide region specific needs assessment in 9 of 10 regions in the state to determine the needs of seniors." System Wide Solutions, Inc. of Columbia, SC was chosen to carry out the needs assessment.

Different regions requested different configurations of populations to be assessed. The primary populations assessed were seniors (ages 55 and older), seniors receiving services from the AAA, caregivers, partners/professionals, and people seeking assistance through the Aging and Disabilities Resource Center (ADRC). Four regions also requested assistance in conducting focus groups with the public and aging persons receiving services and one region requested an interview schedule for persons in nursing facilities.

SWS centralized the methodology to allow for the burden to be shared by the AAA's and for a more cost-efficient implementation. The methodology was broken into five parts. The first part utilized a needs assessment survey instrument administered to seniors and persons with disabilities not in nursing facilities, and caregivers. The second part was interviews with partners/professionals. The third was interviews with persons in nursing facilities. The fourth part is a protocol and training for focus groups. In the fifth and final part, the data gathered and developed was written into a report and distributed to the AAA's.

Of the 4,773 surveys completed, 3,401 (71.3%) were categorized as a senior receiving services, 824 (17.3%) were categorized as a senior not receiving services, 1,181 (24.7%) were categorized as being a caregiver, and 2,940 (61.6%) were categorized as an individual with a disability. On the whole, the sample of both seniors and persons with disabilities is older, more likely to be below the poverty line, more likely to be female, more likely to be African American, and more likely to be without a spouse than the senior population as a whole. This is reflective of the population served by the AAA's/ADRC's.

The market for these services is segmented and this report approached the needs assessment in that manner, the same manner as it is being approached by the aging network. Seniors receiving services, seniors not receiving services, persons with disabilities and caregivers all prioritize the need for services differently. In addition, different demographic groups prioritize services differently.

To assure that the segmentation of the population is fairly represented, SWS conducted three statistical analyses before analyzing the responses to the needs assessment instrument. First, a principle components factor analysis was conducted to determine items on the instrument fell into categories. The solution identified five clear components, which we identified as Personal and Home Care, Senior Center Activities, Maintaining Independence, Information Referral and

Assistance, and Monetary Assistance. Second, we reclassified the respondents into mutually exclusive groups, so that no one was double counted as, for example, both a senior receiving services and a caregiver. Third, we used cluster analysis to identify demographic groupings.

In this report, SWS presents the needs as reported by the respondents by target group, demographic clusters, and the two combined. It has further divided the needs by the five service components and the service components by the services within those components. We have also provided an additional breakdown for caregivers. This information is presented in written and graphic form. This information can be utilized as a rich source for in-depth planning for services in the State of South Carolina.

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INTRODUCTION

The Purposes of the Needs Assessment

The Older Americans Act requires that a multi-year comprehensive area plan be developed for the planning and service area covered by each Area Agency on Aging (AAA) and submitted to the state organization designated as the state unit on aging (the Lieutenant Governor's Office on Aging in the case of South Carolina). Census data, needs assessment surveys, service delivery waiting lists and current service levels are used to project the needs for service. The Area Plan also requires that staff coordinate with other service organizations, engage in program development when needed, provide training and technical assistance to service providers and serve as the quality assurance component for contracted services. A public hearing is conducted and the AAA Board approves the final document. The area plan is updated annually each spring. This year (2012) is a year in which a new plan is to be developed. This needs assessment is an essential part of that process. Nine of the ten Area Agencies in South Carolina joined together "To conduct a statewide region specific needs assessment in 9 of 10 regions in the state to determine the needs of seniors." System Wide Solutions, Inc. of Columbia, SC was chosen to carry out the needs assessment.

The Goal of the Needs Assessment

The goal of the needs assessment is to determine the service needs at the state level and the regional level for:

- seniors age 60 or older (currently receiving services under the Older Americans Act),
- people seeking assistance through the Aging and Disabilities Resource Center (ADRC)

Needs were determined by surveying a representative group of people in the following groups:

- seniors age 60 or older
- seniors age 60 or older who are currently receiving services under the Older Americans Act
- people seeking assistance through the Aging and Disabilities Resource Center (ADRC)
- caregivers of seniors and persons with disabilities
- ADRC partners/Aging Professionals

Additional Goal

In addition to the needs assessment, the project team at System Wide Solutions prepared a focus group protocol for AAA's that wished to conduct focus groups to enrich their knowledge of needs in their communities. SWS trained focus group leaders on the use of the protocol. It also prepared an instrument for use by one AAA to use with the nursing facility population. The focus group protocol can be found in Appendix Two.

METHODOLOGY

Different regions requested different configurations of populations to be assessed. The primary populations assessed were seniors (ages 55 and older), seniors receiving services from the AAA, caregivers, partners/professionals, and people seeking assistance through the Aging and Disabilities Resource Center (ADRC). The specific populations requested by each region can be found in Table 1 below. Four regions also requested assistance in conducting focus groups with the public and aging persons receiving services and one region requested an interview schedule for persons in nursing facilities.

This mix of targets created a rather complex methodological problem to solve in an economical way. SWS chose to do so by centralizing the methodology to the greatest degree possible. This allowed for the burden to be shared by the AAA's and for a more cost-efficient implementation. The methodology was broken into five parts. The first part utilized a needs assessment survey instrument administered to seniors and persons with disabilities not in nursing facilities, and caregivers. The second part was interviews with partners/professionals. The third was interviews with persons in nursing facilities. The fourth part is a protocol and training for focus groups. In the fifth and final part, the data gathered and developed was written into a report and distributed to the AAA's.

Part 1: Survey of Targeted Populations to Determine Needs

The needs assessment survey was conducted by joint efforts of SWS and the AAA's. SWS developed the survey and protocols, administered the survey by mail and telephone, developed a method to complete the survey on the web, prepared the data, and conducted the data analysis. Each AAA administered the survey through convenience sampling methods and promoted the survey to service recipients/caregivers in their region to encourage their completing mailed surveys and surveys on the web. The eight steps in assessing the needs of the targeted populations were:

- Developing the survey instrument and its different versions (mail, telephone, etc.)
- Developing the protocols
- Reviewing the plan with the Regions
- Survey administration by mail and telephone
- Survey administration through convenience sampling methods
- Promotion of the survey to service recipients/caregivers
- Preparation of the data
- Conducting the data analysis

Developing the Survey Instruments

The development of the survey instruments began with a meeting with the Regional Directors on July 18, 2012 to discuss the specifics of the questions the regions wished answered. Survey

instruments were then developed using a review of the literature, analysis of existing data and previous needs assessments, and through telephone and email communications with each of the Area Agencies. The final instrument was coded for electronic scanning capability. A website was developed so that the public could complete the survey online. The survey instrument may be found in Appendix One.

Developing the Protocols

Protocols were developed for the follow-up telephone calls and convenience sampling processes that were conducted during the project. These protocols state exactly how, when and where the process was to occur. SWS furnished these protocols to the Area Agencies and trained them on their use. An online portal was developed through which the AAA's could access copies of the survey, protocols, recorded webinars and view a live report on the return rate for their region. The protocols may be found in Appendix One.

Reviewing the Plan with the Regions

The goal of the data gathering was to produce between 150 and 200 responses in each Region from each subsample of the following targets: seniors not receiving services, seniors receiving services, persons seeking assistance through the ADRC, and caregivers. The specific number for each subsample was based upon obtaining a scientifically valid sample using a targeted seven point confidence interval at a 95% confidence level for each subsample and a four point confidence interval at a 95% confidence level for the total. The total number of needs assessment surveys to be completed for each region varied depending upon what populations the region has requested be surveyed and the size of each population (see Table 1).

TABLE 1: POPULATIONS TO BE ASSESSED

REGION	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	ADRC	Population of Seniors Receiving Services	Total Senior Population	Total Needs Assessment Surveys to be Completed
1	X	X	X	X	12,000	161,178	725
2	X	X	X	X	2,500	48,105	725
3	X	X	X	X	2,500	68,649	725
4	X	X		X	10,330	117,327	540
5	X	X	X	X	2,625	68,248	725
6	X		X	X	1,792	44,674	540
8	X		X	X	2,322	87,900	540
9	X		X	X	3,700	113,580	540
10	X		X	X	1,020	62,162	540
All	9	5	8	9	38,789	771,823	5,600

On July 30 and 31, the plan for administering the survey was presented to the regional directors and their staff via online webinar. SWS presented the finalized instruments and protocols as well

as discussed ways to do convenience sampling. SWS provided the regions with the URL for the online version of the AAA mail survey so it could be used for promoting the survey and a link to print out hard copy surveys for distribution. The Webinar was posted to the AAA web portal so that it could be later viewed by persons who were unable to attend the live training. SWS also conducted short recorded Webinar trainings on each of the sections in the AAA web portal, and those were posted online as well.

Survey Administration by Mail and Telephone

Each region provided contact information for clients, caregivers, and individuals who have sought assistance through the ADRC. An additional sample was purchased from a commercial direct mail list. These lists were randomly sampled and stratified according to the subsamples requested and presented previously in Table 1. For example, regions with larger populations such as Region 1, Region 4, and Region 9, had slightly larger samples selected than regions with smaller populations. Furthermore, the sample was stratified by the populations requested. For regions that requested targeting of seniors receiving services, seniors not receiving services, caregivers, and recipients of ADRC services, the sample size was divided equally among these four groups; whereas the sample size for regions that requested only three of those groups was divided equally among those three. When there was not a sufficient number of individuals in a particular group on the list provided, the client list was over-sampled so that the appropriate number of surveys were mailed to that region.

SWS administered the survey by mail to the four targeted populations with the goal of obtaining at least 60% of the "Total Needs Assessment Surveys to be Completed." On August 7, 2012, 11,922 surveys were mailed to individuals residing in or who had been served by the nine regions. A letter on the SC Association of Area Agencies on Aging letterhead that explained the purpose of the survey and a self-addressed postage-paid envelope was included with the survey. A total of 1,478 surveys were returned by mail, which is a response rate of 12.4%.

Telephone surveys were conducted as follow up to ensure the appropriate number of surveys in each subsample in each region. Twenty four telephone surveys were completed by SWS after making 146 valid attempts, which is a response rate on the telephone surveys of 16.4%. One additional telephone survey was completed by one of the Area Agencies.

Administration of the Survey through Hard Copy Convenience Sampling

The survey was administered by the AAA's through hard copy distribution methods with a target of 20% of the "Total Needs Assessment Surveys to be Completed." Each Region could, at their sole expense and discretion, distribute the hard copy survey at community events, senior centers, churches, community centers, government offices and businesses. The Area Agency was responsible for printing and administering the survey and providing the completed hard copy surveys to SWS within agreed-upon deadlines. SWS was responsible for scanning and importing the hard copy surveys into the database. SWS provided at no cost training on protocols for

distributing hard copy surveys and sending to SWS. Training was provided via Webinar and posted to the Internet for viewing at any time.

The Area Agencies distributed approximately 4,000 surveys to senior centers, service providers who distributed them to their clients, churches, support groups, residential facilities, recreation centers, county government offices, and at community events. Of those distributed, 3,119 convenience sample surveys were collected, which is a response rate of approximately 78%.

Promotion of the Survey to Service Recipients/Caregivers

The survey was also administered online with a target of 10% of the "Total Needs Assessment Surveys to be Completed." The online survey was developed and maintained by SWS. Each Region could, at their sole expense and discretion, promote the online survey through their website, in region-specific newspapers and newsletters, at community events and community centers, and to current service recipients through existing communication mechanisms. Methods for communicating the web site address were developed individually with each Region. SWS provided at no cost training on protocols for promoting the online survey. Training was provided via Webinar and posted to the Internet for viewing at any time. One hundred and fifty one surveys were completed online.

Preparation of the Data for Analysis

The survey database was developed in SQL Server 2008. Surveys completed online were entered automatically into the database. Possible duplicate responses to the online survey were removed. Hard copy surveys returned to SWS were visually inspected and scanned into the database through optical scanning software. The survey data was validated to ensure the integrity of the data.

A total of 4,773 needs assessment surveys were completed, of which 1,478 (31%) were mail surveys, 25 (0.5%) were telephone surveys, 3,119 (65.3%) were convenience sample surveys, and 151 (3.2%) were online surveys. The quantitative data was then exported to the Statistical Package for the Social Sciences (SPSS).

Analysis of the Survey Data

Responses to the needs assessment survey were analyzed statewide and separately for each region. Within each of these sections, findings are reported in four steps. The first step identifies the extent to which respondents represent the population of individuals in the state/region. The second step is a tabulation of responses by county. In the third step, subgroups of the respondents who were similar both demographically and in their responses to the items on the survey are identified and the services they needed most are reported. The fourth and final step includes rankings of priority of needs identified by service and by county.

Demographics of individuals who reported that they were over 55 and the demographics reported by caregivers (caregivers were asked to report on the demographics of the individual for whom they were a caregiver) were compared to the demographics of individuals residing in the service areas. Service area population demographics were obtained from the 2010 Decennial Census and the 2010 American Community Survey. Information on these data sets can be found on the web at www.factfinder.census.gov.

Poverty status for the survey sample was determined by comparing the individuals responses to questions regarding income and number of people supported by the income to the U.S. Census Bureau chart of Poverty Thresholds for 2010 by Size of Family and Number of Related Children Under 18 Years. Although the groupings used in the survey did not match exactly to the thresholds used by the Census, and the number of individuals supported by the respondent's income who are under 18 are unknown, utilization of the respondent's marital status helped to mitigate this factor. As such, these figures may only be utilized as estimates of the poverty status of the survey sample and not actual figures.

Responses to the survey were analyzed in five steps. The first three steps were conducted using the statewide dataset. First, a principle components factor analysis was conducted to determine items on the instrument fell into categories. The solution identified five clear components, which we identified as Personal and Home Care, Senior Center Activities, Maintaining Independence, Information Referral and Assistance, and Monetary Assistance. Second, respondents were reclassified into mutually exclusive groups, so that no one was double counted as, for example, both a senior receiving services and a caregiver. Third, a cluster analysis was used to identify demographic groupings. In the fourth and fifth steps, regional analyses were conducted which compared needs for services for the five components and caregiver services among the mutually exclusive groups and demographic groupings and variables.

Part 2: Interviews with Partners/Professionals

The partners/professionals survey was administered exclusively online. The interview schedule, protocol, and online instrumentation were developed by SWS. SWS was also responsible for managing the database and analyzing the data. Each Region could, at their sole expense and discretion, conduct the interviews with their partners.

Developing the Instrument, Interview Schedule and Protocol

The partner and professional survey, interview schedule and protocol were developed by SWS and provided to each Area Agency. The survey included several multiple choice questions and two open ended questions. Each Region could, at their sole expense and discretion, collect survey data from partners and professionals by mail, telephone, email, or online survey. SWS furnished the interview schedule and protocol to the Area Agencies and trained them on their use. The interview schedule and protocol may be found in Appendix Two.

The sample of professionals and partners was obtained by the AAA's and collected through a "snowball" method. The AAA's were responsible for administering the professional/partner survey as well as for entering any mail, telephone, or email surveys into the survey database via the online survey portal. All professional and partner surveys completed online were automatically entered into the database.

Analysis of the Survey Data

The survey database was developed in SQL Server 2008. Surveys completed online were entered automatically into the database. Possible duplicate responses to the online survey were removed. The quantitative data was then exported to the Statistical Package for the Social Sciences (SPSS). The data analysis includes rankings of priority of needs identified, opinions of the partners/professionals on their relationship with the AAA, and an analysis of two open ended questions. The findings were then reviewed by the team and confirmed.

Part 3: Interviews with Persons in Nursing Facilities

Due to the cost of providing this service, individual interviews with persons in nursing facilities were removed from the SWS work plan. However, information gathered in this manner may be helpful to the Area Agencies in informing policy decisions and adding depth to data gathered through the survey methodology. Therefore, SWS developed and provided to the Area Agencies long term care facility interview schedules and protocols. With this information, each Area Agency could, at its sole expense and discretion, conduct the interviews of persons living in LTC facilities. Persons interviewed in long term care facilities were volunteers selected by the AAA's and the ombudsmen. SWS provided at no cost training on protocols for conducting individual interviews and entering survey data through the online portal. Training was provided via Webinar and posted to the Internet for viewing at any time. The protocol may be found in Appendix Two.

The Area Agency was responsible for administering the survey as well as for entering the surveys into the survey database via the online survey portal. Qualitative data from the individual interviews was reduced to scales. Analyses were conducted by SWS to determine the priority of needs for individuals in long term care facilities and this information was included in the overall assessment of needs by region.

Only one region conducted the LTC interviews prior to the completion of this report. However, all of the Area Agencies have been provided this information and may utilize the schedule and protocol to conduct the interviews in the future.

Santee-Lynches received permission from the facilities to interview the participants. A signed consent from each participant interviewed was also obtained. These consent forms (that contain client names) are being maintained in the AAA/ADRC office in a locked file separate from the completed interview survey forms (that do not contain client names).

Part 4: Protocol and Training for Focus Groups

Due to the cost of providing this service, focus groups were removed from the SWS work plan. However, information gathered in this manner may be helpful to the Area Agencies in informing policy decisions and adding depth to data gathered through the survey methodology. Therefore, SWS developed and provided focus group schedules and protocols to the Area Agencies. With this information, each Area Agency may, at its sole expense and discretion, conduct the focus groups at any point in the future. Persons to take part in focus groups will be volunteers selected by the AAA's.

The focus group schedule and protocol includes a series of open ended questions and methods for obtaining information from participants. The Area Agency will be responsible for summarizing the information obtained through focus groups according to the protocol and entering the key points into a database. SWS provided at no cost training on protocols for conducting focus groups. Training was provided via Webinar.

Part 5: Preparation of the Report

Subsequent to the analysis of the data, a series of discussions were held among the team members. The discussions centered around the interpretation of the findings of the needs assessment to determine what seniors' needs are in each Region and the state. Upon the completion of these discussions, a report was completed with the following elements: executive summary, introduction, methodology, a presentation of the findings for each region, a presentation of the findings for the State, conclusions based on the findings, services proposed/recommended to address the needs identified and a timeline for implementation.

In addition to the written report described above, SWS prepared a Power Point presentation that summarizes the key points of the study for the state and for each region that may be used to disseminate the findings. The presentation was furnished electronically (on a CD) subsequent to the written report. The regions were also given the opportunity for Webinar presentations of the findings.

Limitations of the Study

By randomly selecting individuals from the targeted populations to survey by mail, the study aimed to determine if the responses are representative of the population by comparing the sample demographics to the population demographics. However, the response rate to the mail survey was 12.4%, which is considerably lower than the anticipated 30% usually achieved in a one-time mail survey without additional follow-up.

The low response rate may be a result of outdated or incorrect address lists. As part of the mail survey process, the mail distribution list was processed through the National Change of Address (NCOA) registry. Of the 11,972 processed, 50 (0.4%) were deleted as being invalid addresses

and 408 (3.4%) were updated to a new address. After the mailing, an additional nine were returned as bad addresses, and nine were returned with a note from the sender that the addressee was deceased. This rate of invalid mailing addresses (4%) is acceptable; however, follow up telephone calls exposed other potential problems.

When conducting the telephone surveys, SWS made calls to 161 different telephone numbers provided by the Area Agencies. Of these, 51 (31.7%) numbers were disconnected or were the wrong number, and for six (3.7%) of the numbers, the individual was deceased, leaving 104 (64.6%) potentially valid telephone numbers. The telephone survey calls from client and/or caregiver lists were made primarily to Regions 1, 2, and 10, with a few conducted in Region 8. In comparison, the commercial data list yielded 42 out of 53 valid telephone numbers (79.2%), and the response rate from the commercial data list was much higher (23.8% compared to the 13.5% response rate from the client/caregiver list).

During the telephone surveying process, a common observation was that telephone respondents initially did not identify themselves as receiving any services through their local Area Agency on Aging, even though the interviewer explained at the beginning what types of services are provided, such as Meals on Wheels, transportation and Senior Centers. The AAA name did not stimulate name recognition, even when it was spelled out and explained. However, when answering the detailed survey questions, these same individuals stated that they frequently use a particular service or that they could not get by without it. The interviewer then explained that the service is provided through the AAA in their area. This experience indicates that consumers are often not aware of who is responsible for providing the services they receive and rely on. This lack of awareness of AAA as a crucial coordinator of services for seniors and person with disabilities was prevalent in all of the areas to which calls were made.

Some variation among the different regions in the receptiveness of individuals who were called was also noted. When asked to participate in the telephone survey, individuals in most areas were cooperative and forthcoming, whereas individuals in a few other areas were particularly cautious and reluctant to talk to anyone about their needs or affairs, even when assured of confidentiality. This variation may reflect traditional geographic and social difference within the state. These differences may have impacted the response rate as well as the way in which individuals responded to the survey itself.

Another impact on the response rate is the design of the survey itself. In an effort to meet the cost restraints of the project, the survey was printed double-sided which caused some survey respondents to complete only one side of the survey.

A high rate of non-response creates a high probability of non-response error and statistical bias (Hager, Mark A., et al 2003). Often in the case of customer satisfaction surveys, the individuals who respond are more likely to be satisfied with their services (Kelley, Kate, et al 2003). Therefore, those who responded may be more motivated to respond due to greater interest in the services; whereas those who did not respond may feel that they do not need the services, are not satisfied with their services or are not interested in receiving assistance.

In an attempt to combat the low response rate by mail survey, the Area Agencies increased their efforts on the convenience sampling method. Convenience sampling may or may not represent the population since the respondents are usually those to whom the Area Agencies had the easiest access. Therefore, this further increases the sampling error when attempting to compare the respondents to the population of seniors and persons with disabilities in the regions.

Therefore, it is possible that the sample does not represent the population of seniors and persons with disabilities in South Carolina and the particular region. It is more likely that the sample represents the population of seniors and persons with disabilities who are interested in or who have already received services. As a result of the convenience sampling, these individuals are also those who are more likely to identify with the AAA or with one of the partnering organizations.

STATEWIDE FINDINGS

Representation of the Population

A total of 4,773 surveys were completed. Respondents were asked a series of questions to determine if the respondent is a senior receiving services, a senior not receiving services, a caregiver, or an individual with a disability (the ADRC target population). The categories are not mutually exclusive and an individual could fall into more than one of these categories or none at all. Of the 4,773 surveys completed, 3,401 (71.3%) were categorized as a senior receiving services, 824 (17.3%) were categorized as a senior not receiving services, 1,181 (24.7%) were categorized as being a caregiver, and 2,940 (61.6%) were categorized as an individual with a disability.

Population sizes for seniors receiving services, caregivers, and the ADRC target population were determined using the number of individuals in the contact lists provided by the Area Agencies. The population size for seniors not receiving services was determined by subtracting the number of seniors receiving services from the population of individuals in the area over the age of 55 as measured by the 2010 Decennial Census. Information on this data set can be found on the web at www.factfinder.census.gov.

For the state as a whole, the confidence interval for the sample of seniors receiving services is 1.64 points at a 95% confidence level assuming 50% agreement on the item in question. For items where there is greater agreement, the likelihood that the responses are representative of the population increases. Therefore, there is a very high probability that the findings represent the responses that can be expected from seniors receiving services (plus or minus 1.64 points). The confidence interval for seniors not receiving services is somewhat higher (3.4 points at a 95% confidence level assuming 50% agreement), which indicates somewhat less representation of the population of seniors not receiving services. The representation of caregivers is very good (1.62 points at a 95% confidence level assuming 50% agreement), as is the representation of individuals with a disability who have received services through the ADRC (2.8 points at a 95% confidence level assuming 50% agreement). (See Table 2.)

TABLE 2: SAMPLE REPRESENTATION OF POPULATION

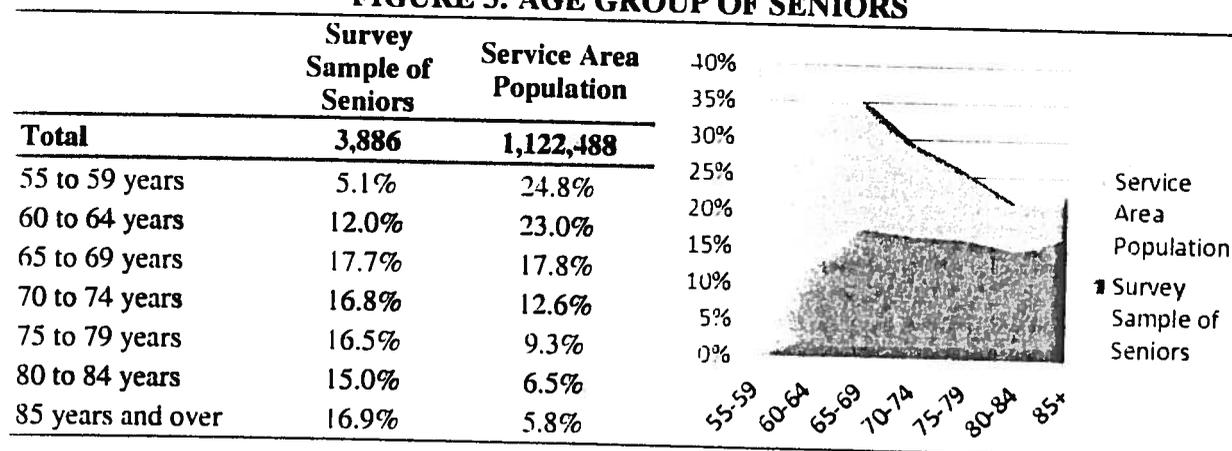
	Population Size	Sample Size	Representation
Seniors Receiving Services	64,642	3,401	1.64
Seniors Not Receiving Services	614,298	824	3.41
Caregivers	14,753	1,181	1.62
ADRC	31,349	2,940	2.80

Demographic Characteristics of Seniors

The confidence interval is based on the theory that the sample is demographically similar to the population. Demographics of individuals who reported that they were over 55 and the demographics reported by caregivers (caregivers were asked to report on the demographics of the individual for whom they were a caregiver) were compared to the demographics of individuals residing in the service areas. Service area population demographics were obtained from the 2010 Decennial Census and the 2010 American Community Survey. Information on these data sets can be found on the web at www.factfinder.census.gov.

Compared to the service area senior population, the survey respondents are older; however, the overall pattern of age distribution is very similar. A small percentage of survey respondents are 55 to 59 years old (n=197, 5.1%) or 60 to 64 years old (n=466 (12%), whereas 24.8% and 23% of the service area population is between these ages, respectively. However, for both the survey sample and the service area senior population, the percentage peaks at 65 to 69 years (n=688, 17.7% of the sample and 17.8% of the population), reaches a low point at 80 to 84 years (n=584, 15% of the sample and 6.5% of the population), then increases slightly at 85 years and over (n=656, 16.9% of the sample and 5.8% of the population). (See Figure 3.) Therefore, it can be assumed that the sample is fairly representative of individuals 65 years and older. For this reason, further comparisons are conducted using the population of seniors aged 65 and older.

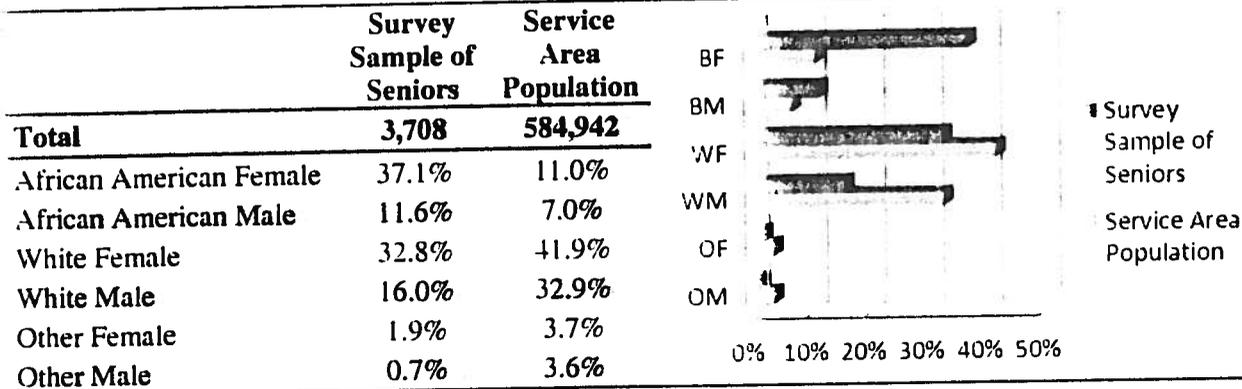
FIGURE 3: AGE GROUP OF SENIORS



A much larger percentage of the survey sample are African American female (n=1,375, 37.1%) or African American male (n=430, 11.6%) than the service area population (11% and 7%, respectively). Conversely, a smaller percentage of the survey sample are White/Caucasian female (n=1,215, 32.8%) or White/Caucasian male (n=593, 16%) compared to the service area population (41.9% and 32.9%, respectively). Very few respondents were of other races (Native American females: n=21, 0.6%; Hispanic females: n=16, 0.4%; Other females: n=21, 0.6%; females of more than one race: n=11, 0.3%; Native American males: n=10, 0.3%; Hispanic males: n=7, 0.2%; Other males: n=6, 0.2%; males of more than one race: n=3, 0.1%). These populations are also relatively small in the population (other females - including Hispanic,

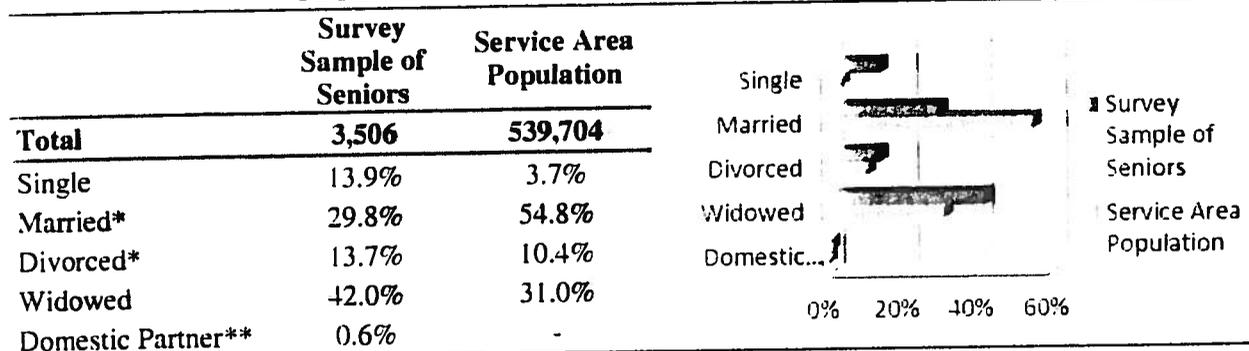
Native American, and those of two or more races: 3.7%; other males – including Hispanic, Native American, and those of two or more races: 3.6%). (See Figure 4.) Therefore, the sample is not representative by race and gender and the findings should be analyzed for differences among these demographic groups.

FIGURE 4: RACE AND GENDER OF SENIORS



The survey sample has a much larger percentage of individuals who are widowed (n=1,472, 42%) or single (n=487, 13.9%) than exist in the service area senior population (31% and 3.7%, respectively). Conversely, there is a much smaller percentage of individuals who are married (n=1,044, 29.8% of the sample compared to 54.8% of the population). A similar percentage of respondents are divorced (n=481, 13.7%) as are in the service area senior population (10.4%). (See Figure 5.) Therefore, the sample is not representative by marital status and the findings should be analyzed for differences among these demographic groups.

FIGURE 5: MARITAL STATUS OF SENIORS

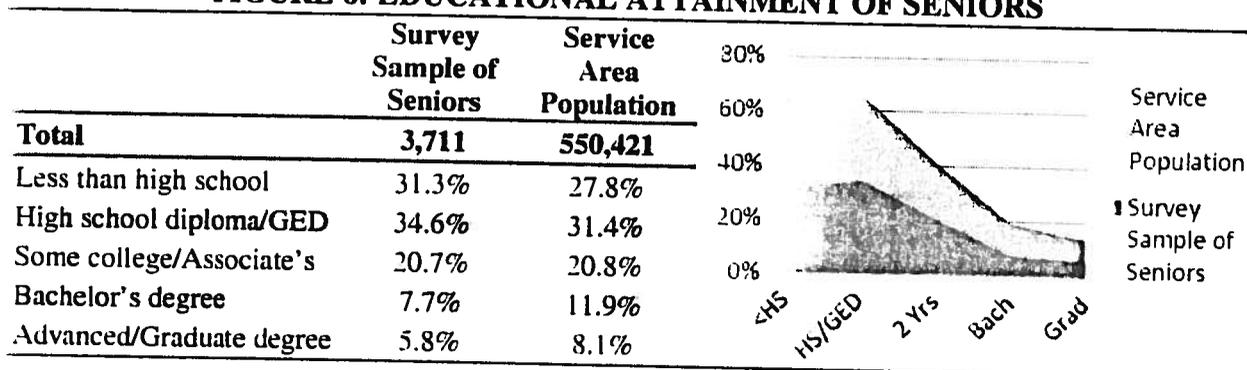


*Individuals in the service area population categorized as "Married, spouse absent, not separated" were excluded from the counts.
 **Individuals who are in a domestic partnership were not included in the population counts as the Census does not include this category in the marital status calculation. Inclusion of this category in the population counts could lead to a duplication of individuals currently classified as single ("never married").

The level of educational attainment of the survey sample is very similar to the educational attainment of the service area senior population. More than half of the respondents completed less than high school (n=1,160, 31.3%) or received a high school diploma or GED (n=1,285, 34.6%), compared to 27.8% and 31.4% of the service area population, respectively. Twenty

percent of the respondents (n=768) and the service area senior population attended some college or earned an Associate's degree. The percentage of respondents who earned a Bachelor's degree (n=284, 7.7%) or an Advanced/Graduate degree (n=214, 5.8%) are also similar to the percentage in the service area senior population (11.9% and 8.1%, respectively). (See Figure 6.) Therefore, the sample is representative by educational attainment.

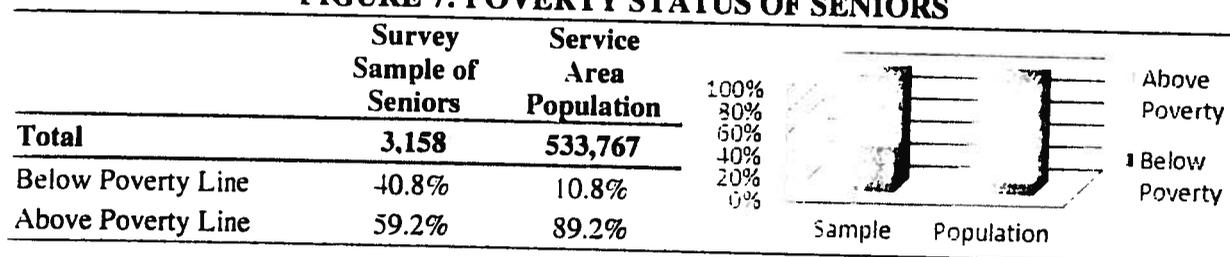
FIGURE 6: EDUCATIONAL ATTAINMENT OF SENIORS



Poverty status for the survey sample was determined by comparing the individuals' responses to questions regarding income and number of people supported by the income to the U.S. Census Bureau chart of Poverty Thresholds for 2010 by Size of Family and Number of Related Children Under 18 Years. Although the groupings used in the survey did not match exactly to the thresholds used by the Census, and the number of individuals supported by the respondent's income who are under 18 are unknown, utilization of the respondent's marital status helped to mitigate this factor. As such, these figures may only be utilized as estimates of the poverty status of the survey sample and not actual figures.

In comparison to the service area senior population, respondents to the survey are estimated to more likely be below the poverty line (n=1,289, 40.8% compared to 10.8% of the service area population). (See Figure 7.)

FIGURE 7: POVERTY STATUS OF SENIORS



Overall, the demographic characteristics of the survey sample are not representative of the general population of seniors residing in the areas served by the AAA's. Rather, the survey sample tends to be older, widowed, and below the poverty line, as well as are more likely to be African American and female.

Demographic Characteristics of Individuals Who Have a Disability

Of the 4,773 surveys completed, 521 (10.9%) reported that they were under 65 years of age and had a disability. Service area population demographics for individuals between 18-64 years of age were obtained from the 2010 American Community Survey. County specific data on persons with disabilities was available for only 34 of the 40 counties covered by this report. Those for which data was not available are Allendale, Bamberg, Calhoun, Lee, McCormick, and Saluda. Of the 2,546,767 individuals between the ages of 18 to 64 residing in these 34 counties, roughly 12% have a disability.

Similar to the senior sample, the sample of persons with disabilities differs from the population in gender (69.7% of the sample are female compared to 50.1% of the population) and race (52.6% of the sample are African American compared to 31% of the population). In addition, 262 respondents (53.1% of those who responded to the income questions) are considered to be below the poverty threshold compared to 27.4% of the population.

Reclassification into Mutually Exclusive Categories

For purposes of analysis, the respondents were re-classified into mutually exclusive categories of each type of targeted population in order to compare responses by targeted group. Seniors receiving services are now those who are over the age of 55, reported that they were receiving services, are not caring for another individual, and most often were answering the survey for themselves. This group comprises 57.3% (n=2,737) of the sample. Seniors not receiving services are those who are over the age of 55, did not report that they were receiving services, are not caring for another individual, and most often were answering the survey for themselves. This group comprises 12.7% (n=606) of the sample. Caregivers comprise 24.2% (n=1,156) of the sample, are caring for another individual (senior, person with disability, or child under 18), and may or may not be over the age of 55. Persons with disabilities are the smallest group (n=232, 4.9%) and represent those who have a disability, are between the ages of 18 and 64, and are not caring for another individual.

A TwoStep Cluster Analysis using Akaike information criterion (AIC) for model selection and log-likelihood distance measurement was conducted to group demographic variables into four clusters. The average silhouette, which is a measure of cohesion and separation within the clusters is 0.3 (Fair). The inputs into the analysis are: whether or not the individual is considered to be below the poverty line (Importance=1.0), gender (Importance=1.0), race (Importance=1.0), marital status (Importance=0.37), educational attainment (Importance=0.23), and age group (Importance=0.06). Several different models were tested and this was deemed to be the most comprehensive in terms of fitting the largest number of individuals and have the best quality.

The first cluster (Cluster 1) is comprised of 891 respondents (18.7% of the sample and 30% of those classified). Individuals in this cluster are above the poverty line (75.5%), male (94.7%), predominantly white (61.4%), mostly married (49%), with a high school diploma or GED (31.5%). The most common age group for this cluster is between 70 to 74 years old (15.4%).

Cluster 2 is comprised of 603 respondents (12.6% of the sample and 20.3% of those classified). Individuals in this cluster are above the poverty line (60.9%), female (100%), white (99.9%), mostly widowed (60.6%), with a high school diploma or GED (36.4%). The most common age group for this cluster is older than 85 years (21.7%).

Cluster 3 is comprised of 643 respondents (13.5% of the sample and 21.6% of those classified). Individuals in this cluster are below the poverty line (100%), female (96.9%), African American (99.2%), mostly widowed (51.5%), with less than a high school diploma (53.7%). The most common age group for this cluster is older than 85 years (21.8%).

Cluster 4 is comprised of 837 respondents (17.5% of the sample and 28.1% of those classified). Individuals in this cluster are above the poverty line (100%), female (100%), African American (100%), mostly married (43%), with a high school diploma or GED (42.3%). The most common age group for this cluster is between 70 to 74 years old (20.6%).

The remaining 1,799 (37.7%) of respondents did not report one or more demographic variables and could not be included in the cluster analysis. The majority of these respondents are female (valid percent = 74.9%), married (valid percent = 30.1%) or widowed (valid percent = 41.7%), with a high school diploma/GED (valid percent = 34.6%) or less (valid percent=29.8%). The most under-reported demographic were the items used to determine if the individual is below the poverty line (income and number supported by income) with 849 (47.2% of the 1,799) not reporting on either of these items.

Service Needs by Targeted Group

A principle components factor analysis was conducted to determine if respondents responded similarly to certain groups of items. The solution identified five components that explained most of the variance among the variables. The model was found to be statistically appropriate for the variables in the solution. This means that there is a high proportion of variance in the variables which is caused by common underlying factors (*KMO Measure of Sampling Adequacy* = 0.958) and that significant relationships exist among the variables (*Bartlett's Test of Sphericity* $X^2 = 69.298.2$, $df=465$, $p<0.001$). The five components are classified as: Personal and Home Care, Senior Center Activities, Maintaining Independence, Information Referral and Assistance, and Monetary Assistance.

Personal and Home Care

The Personal and Home Care component is comprised of the following nine items: transportation to the grocery store, doctor's office, pharmacy, or other errands; having someone bring a meal to me in my home every day; help keeping my home clean; help with repairs and maintenance of my home or yard; help with personal care or bathing; help with washing and drying my laundry; having someone help me with my prescription medicine; keeping warm or cool as the weather changes; and modifications to my home so that I can get around safely.

A reliability analysis determined that these nine items have good internal reliability, with a Cronbach alpha of 0.923, meaning that the scores for items are approximately 92% consistent among cases. Therefore, adding together the scores on these nine variables for each case creates a statistically reliable composite measure. For ease in interpretation, the composite was calculated by averaging each individual's responses to the nine items. Doing so also allows for an individual to have a composite score even if they did not respond to any one of the items.

Of the 4,773 respondents, 4,711 had valid scores for the composite. The average score for the Personal and Home Care Needs composite is 2.45 (SD=1.03) on a scale of 1 to 4, where a higher score represents a greater importance for helping the individual remain where they are now. The scores for the composite are slightly positively skewed (0.152), meaning that the frequency of scores is heavier at the bottom half of the scale. The Kurtosis measurement (-1.334) indicates that the distribution of scores is flat (does not peak in the middle) and a higher number of scores are in the tails than in the middle. This means that many respondents reported that personal and home care needs are either very important or not at all important, and very few reported quite a bit or a little importance.

On average, seniors receiving services view personal and home care needs to be more than a little important (*mean*=2.41, *median*=2.22, *n*=2,709, *sd*=1.05). The most important of these needs are transportation for errands (*mean*=2.66, *median*=3.0, *n*=2,596, *sd*=1.32), home repairs and maintenance (*mean*=2.62, *median*=3.0, *n*=2,600, *sd*=1.31), keeping warm or cool as the weather changes (*mean*=2.67, *median*=3.0, *n*=2,588, *sd*=1.32), and home modifications to improve safety (*mean*=2.57, *median*=3.0, *n*=2,588, *sd*=1.31). The least important services to seniors who are already receiving services are personal care (*mean*=2.0, *median*=1.0, *n*=2,589, *sd*=1.27) and housekeeping (specifically laundry) (*mean*=2.08, *median*=1.0, *n*=2,597, *sd*=1.29). (See Figure 8.)

Seniors who have not received services view personal and home care needs to be a little important (*mean*=2.07, *median*=1.78, *n*=591, *sd*=0.97). The only service deemed to be quite a bit important by most of the respondents is home repairs and maintenance (*mean*=2.48, *median*=3.0, *n*=561, *sd*=1.28). The least important services to seniors who are not already receiving services are personal care (*mean*=1.61, *median*=1.0, *n*=543, *sd*=1.04), housekeeping (specifically laundry) (*mean*=1.75, *median*=1.0, *n*=543, *sd*=1.1), and nursing care (specifically assistance with prescription medicine) (*mean*=1.74, *median*=1.0, *n*=542, *sd*=1.11). (See Figure 8.)

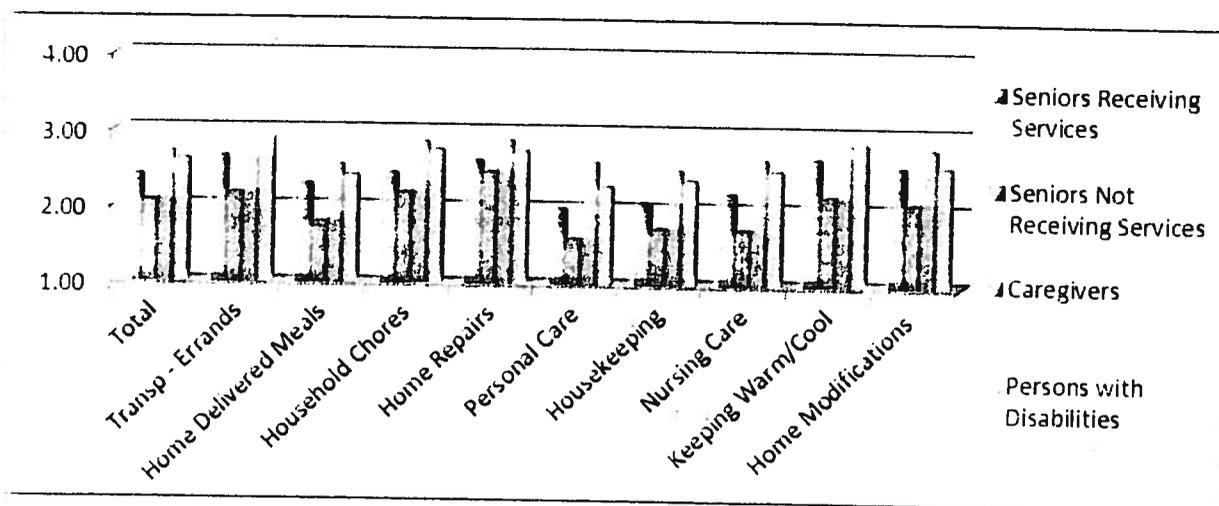
Caregivers view personal and home care needs to be quite a bit important (*mean*=2.72, *median*=2.78, *n*=1,142, *sd*=0.95). All but one of the services are deemed to be quite a bit important by most of the respondents (*median score* = 3.0, *sd*=1.2-1.3). The least important service to caregivers is housekeeping (specifically laundry) (*mean*=2.51, *median*=2.0, *n*=1,107, *sd*=1.29). (See Figure 8.)

Persons with disabilities view personal and home care needs to be slightly less than quite a bit important (*mean*=2.62, *median*=2.56, *n*=232, *sd*=0.92). The most important service to persons with disabilities is transportation for errands (*mean*=2.91, *median*=4.0, *n*=222, *sd*=1.27). Other

important services to persons with disabilities are household chores (specifically keeping home clean) (*mean*=2.76, *median*=3.0, *n*=221, *sd*=1.24), home repairs and maintenance (*mean*=2.75, *median*=3.0, *n*=222, *sd*=1.24), keeping warm or cool as the weather changes (*mean*=2.88, *median*=3.0, *n*=223, *sd*=1.22), and home modifications for safety (*mean*=2.58, *median*=3.0, *n*=220, *sd*=1.25). (See Figure 8.)

FIGURE 8: PERSONAL AND HOME CARE NEEDS BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Personal and Home Care Composite	2.41	2.07	2.72	2.62
Transportation for Errands	2.66	2.18	2.68	2.91
Home Delivered Meals	2.30	1.81	2.56	2.42
Household Chores	2.45	2.20	2.86	2.76
Home Repairs/Maintenance	2.62	2.48	2.89	2.75
Personal Care	2.00	1.61	2.61	2.29
In-Home Housekeeping	2.08	1.75	2.51	2.38
Nursing Care/Prescription Assistance	2.21	1.74	2.66	2.51
Keeping Warm/Cool	2.67	2.18	2.87	2.88
Home Modifications	2.57	2.10	2.81	2.58

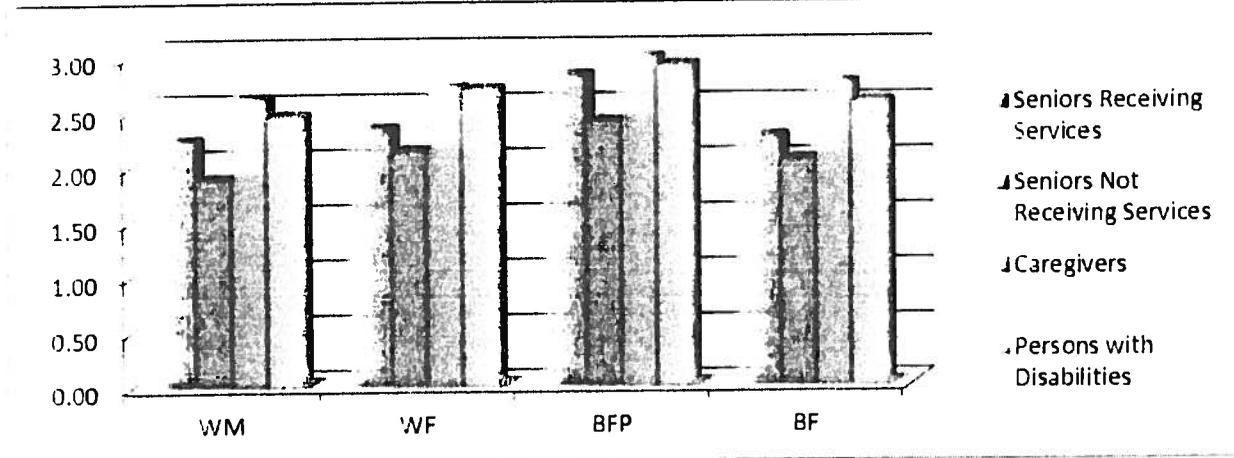


The difference in the personal and home care needs composite is significantly different between the targeted groups ($F=59.83$, $df=3$, $p<0.001$). Therefore, caregivers and persons with disabilities view personal and home care needs to be more important than do seniors receiving services and seniors who have not received services. However, the target group categorization only accounts for 3.7% of the variability in this composite ($r^2=0.037$).

The age of the respondent has a significant impact on their perceived need for personal and home care needs ($F=57.03, df=3, p<0.001$). This indicates that respondents who are in most need of these services are those who are greater than 85 years old and are receiving services as well as caregivers of those who are greater than 85 years old. African Americans, females, those with less than a high school education, and individuals below the poverty line also rated these services as being of greater importance to them ($F=64.48, df=3, p<0.001, F=56.64, df=3, p<0.001, F=62.63, df=3, p<0.001, and F=64.42, df=3, p<0.001, respectively$). Those who are single or widowed, particularly persons with disabilities who are single, rated these services as being of greater importance to them than individuals who are divorced or married ($F=57.61, df=3, p<0.001$).

Overall, the demographic cluster of respondents who reported that these services are of greatest importance to them is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line and most likely to be over the age of 85).

FIGURE 9: PERSONAL AND HOME CARE NEEDS BY CLUSTER



Senior Center Activities

The Senior Center Activities component is comprised of the following eight items: transportation to the senior center; group dining; recreation/social events; getting exercise; exercising with others; counseling (specifically having someone to talk to when feeling lonely); nutrition counseling; and having a senior center close to home.

A reliability analysis determined that these nine items have good internal reliability, with a Cronbach alpha of 0.900, meaning that the scores for items are approximately 90% consistent among cases. Therefore, adding together the scores on these eight variables for each case creates a statistically reliable composite measure. For ease in interpretation, the composite was calculated by averaging each individual's responses to the eight items. Doing so also allows for an individual to have a composite score even if they did not respond to any one of the items.

Of the 4,773 respondents, 4,651 had valid scores for the composite. The average score for the Senior Center Activities composite is 2.86 (SD=0.90) on a scale of 1 to 4, where a higher score represents a greater importance for helping the individual remain where they are now. The scores for the composite are negatively skewed (-0.380), meaning that the frequency of scores is heavier at the top of the scale. The Kurtosis measurement (-0.957) indicates that the distribution of scores is flat (does not peak in the middle) and a higher number of scores are in the tails than in the middle. This means that more respondents reported that senior center activities are very important than those that reported they are of quite a bit or a little importance.

On average, seniors receiving services view senior center activities to be quite a bit important (*mean=3.01, median=3.13, n=2,700, sd=0.88*). All of the items have a median value of either quite a bit or very important. The most important of these needs are recreation/social events (*mean=3.03, median=4.0, n=2,616, sd=1.14*), getting exercise (*mean=3.24, median=4.0, n=2,611, sd=1.02*), counseling (having someone to talk to) (*mean=3.11, median=4.0, n=2,618, sd=1.12*), and having a senior center close to home (*mean=3.12, median=4.0, n=2,601, sd=1.20*). The least, but still quite a bit, important service to seniors who are already receiving services is transportation to the senior center (*mean=2.53, median=3.0, n=2,581, sd=1.36*). (See Figure 10.)

Seniors who have not received services view senior center activities to be between a little important and quite a bit important (*mean=2.51, median=2.5, n=582, sd=0.89*). The most important of these needs are getting exercise (*mean=2.99, median=3.0, n=558, sd=1.09*), counseling (having someone to talk to) (*mean=2.64, median=3.0, n=556, sd=1.20*), and getting information on how to eat healthy (*mean=2.64, median=3.0, n=554, sd=1.17*). The least important service to seniors who are not already receiving services is transportation to the senior center (*mean=1.88, median=1.0, n=534, sd=1.17*). (See Figure 10.)

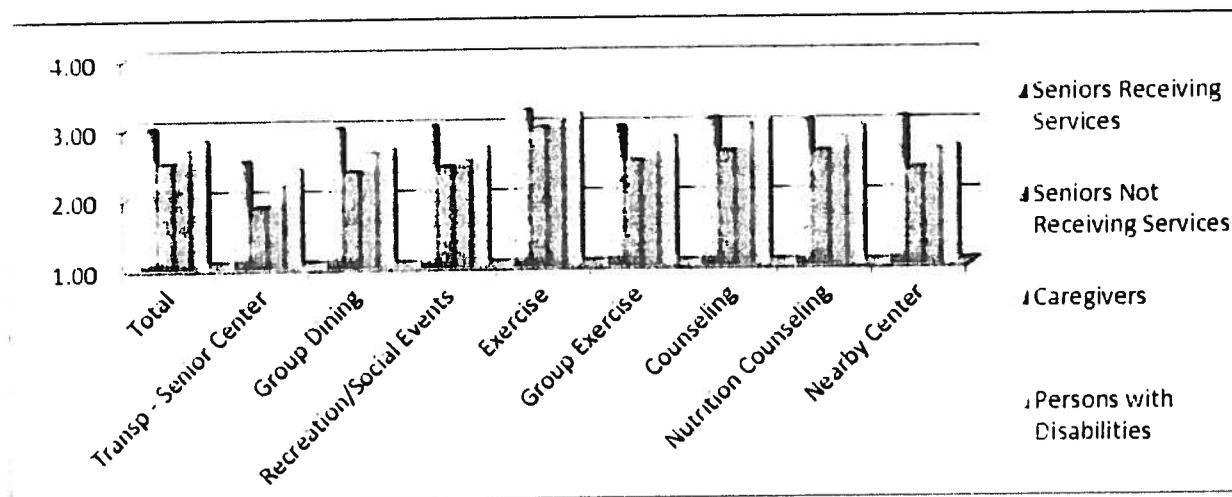
Caregivers view senior center activities to be slightly less than quite a bit important (*mean=2.70, median=2.71, n=1,139, sd=0.90*). All but two of the services are deemed to be quite a bit important by most of the respondents (*median score = 3.0, sd=1.1-1.3*). The least important services to caregivers are recreation/social events (*mean=2.52, median=2.0, n=1,106, sd=1.20*) and transportation to the senior center (*mean=2.17, median=2.0, n=1,089, sd=1.31*). (See Figure 10.)

Persons with disabilities view senior center activities to be slightly less than quite a bit important (*mean=2.84, median=2.88, n=230, sd=0.86*). The most important service to persons with disabilities is getting exercise (*mean=3.18, median=4.0, n=223, sd=0.98*). Other important services to persons with disabilities are counseling (having someone to talk to) (*mean=3.09, median=3.0, n=225, sd=1.03*), and nutrition counseling (*mean=2.99, median=3.0, n=219, sd=1.08*). The least important service to persons with disabilities is transportation to the senior center (*mean=2.42, median=2.0, n=219, sd=1.35*). (See Figure 10.)

Transportation to the senior center is the least important of all the senior center activities for each of the targeted groups. Of these groups, it is the most important to seniors receiving services and persons with disabilities.

FIGURE 10: SENIOR CENTER ACTIVITIES BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Senior Center Activities Composite	3.01	2.51	2.70	2.84
Transportation to the Senior Center	2.53	1.88	2.17	2.42
Group Dining	3.00	2.38	2.64	2.71
Recreation/Social Events	3.03	2.45	2.52	2.72
Exercise	3.24	2.99	3.05	3.18
Group Exercise	3.00	2.51	2.59	2.85
Counseling (someone to talk to)	3.11	2.64	3.02	3.09
Nutrition Counseling	3.06	2.64	2.82	2.99
Nearby Senior Center	3.12	2.39	2.65	2.70



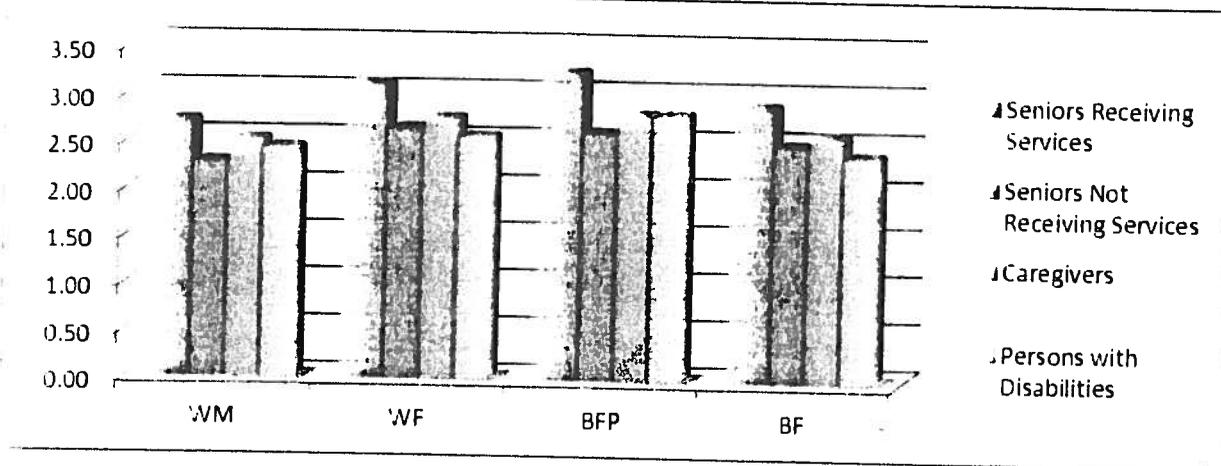
The difference in the senior center activities composite is significantly different between the targeted groups ($F=68.84$, $df=3$, $p<0.001$). Therefore, seniors receiving services and persons with disabilities view senior center activities to be more important than do seniors not receiving services and caregivers. However, the target group categorization only accounts for 4.3% of the variability in this composite ($r^2=0.043$).

The age of the respondent has a significant impact on their perceived need for senior center activities ($F=5.38$, $df=4$, $p<0.001$). This indicates that respondents who are in most need of these services are those who are between the ages of 65 and 84. African Americans, females, those with a high school diploma/GED or less, and individuals below the poverty line also rated these services as being of greater importance to them ($F=221.5$, $df=1$, $p<0.001$, $F=92.25$, $df=1$, $p<0.001$, $F=16.0$, $df=4$, $p<0.001$, and $F=72.94$, $df=1$, $p<0.001$, respectively). Those who are single or widowed, particularly seniors who are receiving services and persons with disabilities who are

widowed, rated these services as being of greater importance to them than individuals who are divorced or married ($F=60.86, df=3, p<0.001$).

Overall, the demographic cluster of respondents who reported that these services are of greatest importance to them is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line and most likely to be over the age of 85), the majority of whom are seniors receiving services. The second group to whom these services are important are individuals in Cluster 2 (White females, widowed, with a high school education, who are above the poverty line and most likely to be over the age of 85) who are receiving services. It must be noted that respondents between the ages of 65 and 74 had a higher average score on the composite than individuals over 85, the age group of respondents was of the least importance to the cluster prediction, and only approximately 20% of Clusters 2 and 3 are over the age of 85. Therefore, it is most likely that the senior center activities are most important to widowed females with a high school education or less who are between the ages of 65 and 74.

FIGURE 11: SENIOR CENTER ACTIVITIES BY CLUSTER



Maintaining Independence

The Maintaining Independence component is comprised of the following four items: preventing falls and other accidents; help making choices about future medical care and end of life decisions (Healthcare Directives); someone to protect my rights, safety, property or dignity (Ombudsman – Protection); and someone to call when I feel threatened or taken advantage of (Ombudsman – Complaint).

A reliability analysis determined that these four items have good internal reliability, with a Cronbach alpha of 0.88, meaning that the scores for items are approximately 88% consistent among cases. Therefore, adding together the scores on these four variables for each case creates a statistically reliable composite measure. For ease in interpretation, the composite was calculated by averaging each individual’s responses to the four items. Doing so also allows for an individual to have a composite score even if they did not respond to any one of the items.

Of the 4,773 respondents, 4,630 had valid scores for the composite. The average score for the Maintaining Independence composite is 2.79 (SD=1.08) on a scale of 1 to 4, where a higher score represents a greater importance for helping the individual remain where they are now. The scores for the composite are negatively skewed (-0.338), meaning that the frequency of scores is higher at the top of the scale. The Kurtosis measurement (-1.318) indicates that the distribution of scores is flat (does not peak in the middle) and a higher number of scores are in the tails than in the middle. This means that many respondents reported that services to help maintain independence are very important, and very few reported quite a bit or a little importance.

On average, seniors receiving services view services to help in maintaining independence to be quite a bit important (*mean*=2.80, *median*=3.0, *n*=2,671, *sd*=1.10). The most important of these needs is having someone to call if feeling threatened or taken advantage of (*mean*=2.92, *median*=4.0, *n*=2,599, *sd*=1.25). All three of the remaining services are considered to be quite a bit important (preventing falls: *mean*=2.76, *median*=3.0, *n*=2,571, *sd*=1.27; healthcare directives: *mean*=2.7, *median*=3.0, *n*=2,588, *sd*=1.27; and protection of rights: *mean*=2.85, *median*=3.0, *n*=2,576, *sd*=1.27). (See Figure 12.)

Seniors who have not received services view services to help in maintaining independence to be a little important (*mean*=2.4, *median*=2.25, *n*=569, *sd*=1.07). All of the services were deemed to be a little important (preventing falls: *mean*=2.38, *median*=2.0, *n*=553, *sd*=1.24; healthcare directives: *mean*=2.25, *median*=2.0, *n*=550, *sd*=1.21; and protection of rights: *mean*=2.41, *median*=2.0, *n*=550, *sd*=1.28), with the most important of these being someone to call if feeling threatened or taken advantage of (*mean*=2.47, *median*=2.0, *n*=550, *sd*=1.28). (See Figure 12.)

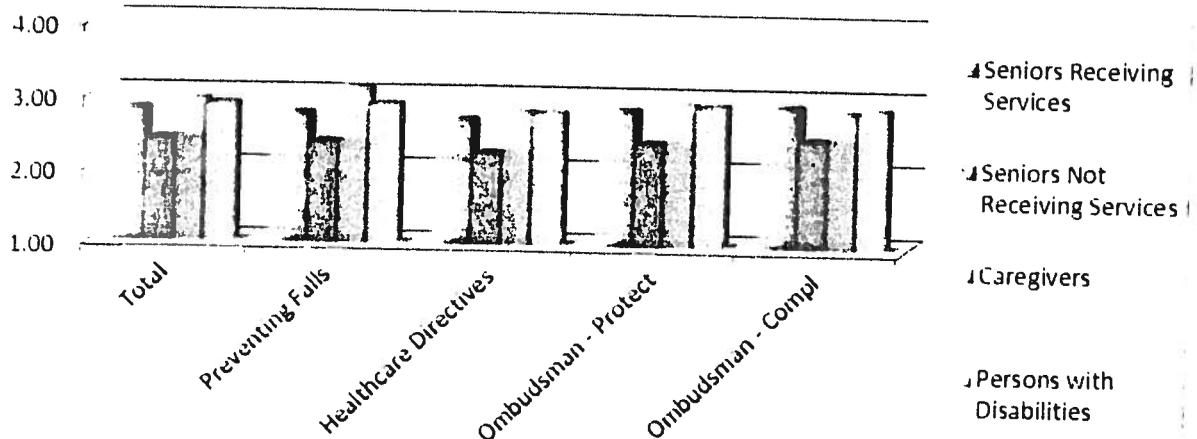
Caregivers view services to help in maintaining independence to be quite a bit important (*mean*=2.93, *median*=3.25, *n*=1,128, *sd*=1.01). The most important of these services is preventing falls (*mean*=3.1, *median*=4.0, *n*=1,106, *sd*=1.14). The remainder of the services were deemed to be quite a bit important (healthcare directives: *mean*=2.81, *median*=3.0, *n*=1,102, *sd*=1.21; protection of rights: *mean*=2.93, *median*=3.0, *n*=1,102, *sd*=1.22; and someone to call if feeling threatened or taken advantage of: *mean*=2.85, *median*=3.0, *n*=1,108, *sd*=1.24). (See Figure 12.)

Persons with disabilities view services to help in maintaining independence to be quite a bit important (*mean*=2.88, *median*=3.0, *n*=227, *sd*=1.04). All of the services were deemed to be quite a bit important (preventing falls: *mean*=2.9, *median*=3.0, *n*=221, *sd*=1.22; healthcare directives: *mean*=2.81, *median*=3.0, *n*=220, *sd*=1.21; protection of rights: *mean*=2.92, *median*=3.0, *n*=218, *sd*=1.22; and someone to call if feeling threatened or taken advantage of: *mean*=2.9, *median*=3.0, *n*=218, *sd*=1.2). (See Figure 12.)

Preventing falls is most important to caregivers; whereas having someone to call if feeling threatened or taken advantage of is most important to seniors (both those receiving services and those not receiving services). Persons with disabilities perceive all of these services to be equally important.

FIGURE 12: MAINTAINING INDEPENDENCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Maintaining Independence Composite	2.80	2.40	2.93	2.88
Preventing Falls	2.76	2.38	3.10	2.90
Healthcare Directives	2.70	2.25	2.81	2.81
Ombudsman - Protection	2.85	2.41	2.93	2.92
Ombudsman - Complaints	2.92	2.47	2.85	2.90

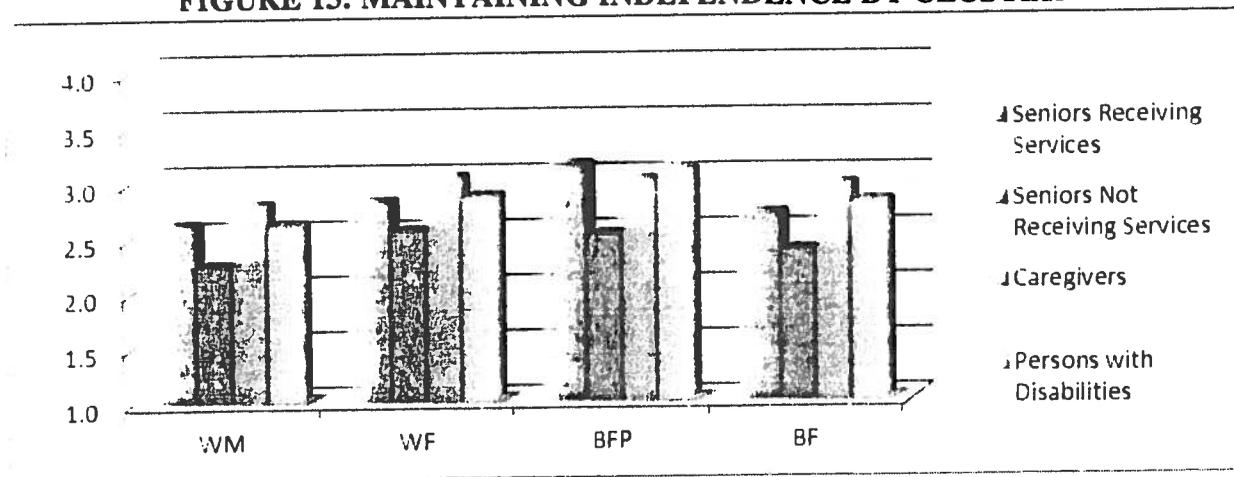


The difference in the maintaining independence composite is significantly different between the targeted groups ($F=33.08$, $df=3$, $p<0.001$). Therefore, caregivers and persons with disabilities view services to help maintaining independence to be more important than do seniors receiving services and seniors who have not received services. However, the target group categorization only accounts for 2.1% of the variability in this composite ($r^2=0.021$).

The age of the respondent has a significant impact on their perceived need for personal and home care needs ($F=33.98$, $df=3$, $p<0.001$). This indicates that respondents who are in most need of these services are those who are greater than 75 years old and are receiving services as well as caregivers of those who are greater than 70 years old. African Americans, females, those with a high school diploma/GED or less, and individuals below the poverty line also rated these services as being of greater importance to them ($F=31.99$, $df=3$, $p<0.001$, $F=36.33$, $df=3$, $p<0.001$, $F=24.49$, $df=4$, $p<0.001$, and $F=35.58$, $df=3$, $p<0.001$, respectively). Those who are single or widowed, particularly persons with disabilities who are single and caregivers of individuals who are widowed, rated these services as being of greater importance to them than individuals who are divorced or married ($F=31.46$, $df=3$, $p<0.001$).

Overall, the demographic cluster of respondents who reported that these services are of greatest importance to them is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line and most likely to be over the age of 85), the majority of whom are seniors receiving services, caregivers of these individuals, or persons with disabilities. The second group to whom these services are important are individuals in Cluster 2 (White females, widowed, with a high school education, who are above the poverty line and most likely to be over the age of 85) who are not receiving services or caregivers of these individuals. It must be noted that respondents who are older than 75 years had about the same average score on the composite as individuals over 85, the age group of respondents was of the least importance to the cluster prediction, and only approximately 20% of Clusters 2 and 3 are over the age of 85. Therefore, it is most likely that services to maintain independence are most important to widowed females with a high school education or less who are 75 years or older.

FIGURE 13: MAINTAINING INDEPENDENCE BY CLUSTER



Information, Referral & Assistance and I-CARE

This section is comprised of the following two items: Knowing what services are available and how to get them (IR&A); and Information or help applying for health insurance or prescription coverage (I-CARE). A reliability analysis determined that these two items have only fair internal reliability, with a Cronbach alpha of 0.572, meaning that the scores for items are approximately 57% consistent among cases. Adding together the scores on these two variables for each case does not create a statistically reliable composite measure. Furthermore, these two items are two completely separate services as defined by the AAA's. Therefore, a composite is not created and these two variables are considered separately.

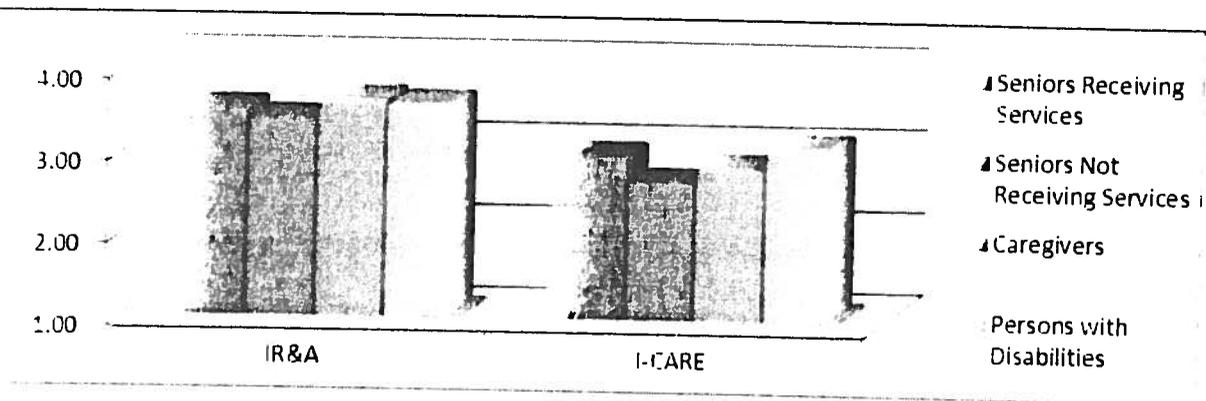
Of the 4,773 respondents, 4,526 reported on how important information, referral and assistance services are to keeping them where they are now. On average, all of the targeted groups view IR&A to be quite a bit to very important (*mean=3.39-3.63, median=4.0*). The results of the Kruskal Wallis test indicate that there was significant differences between the target groups (X^2_K).

$w=26.0, df=3, p<0.001$). In particular, caregivers view this service to be more important than do seniors receiving services ($t=-3.83, p=0.001$) and seniors not receiving services ($t=4.72, p<0.001$). (See Figure 14.)

Of the 4,773 respondents, 4,443 reported on how important information or help applying for health insurance or prescription coverage (I-CARE) is to keeping them where they are now. Seniors receiving services and persons with disabilities view IR&A to be quite a bit to very important ($mean=2.98, median=4.0, n=2,576, sd=1.21$ and $mean=3.11, median=4.0, n=222, sd=1.15, respectively$), whereas caregivers and seniors not receiving services view this service to be quite a bit important ($mean=2.85, median=3.0, n=1,096, sd=1.2$ and $mean=2.67, median=3.0, n=549, sd=1.27, respectively$). The results of the Kruskal Wallis test indicate that there was significant differences between the target groups ($X^2_{K-W}=40.15, df=3, p<0.001$). In particular, seniors receiving services and persons with disabilities view this service to be more important than do caregivers ($t=3.31, p=0.006$ and $t=-3.01, p=0.016, respectively$) and seniors not receiving services ($t=5.46, p<0.001$ and $t=-4.51, p<0.001, respectively$). (See Figure 14.)

FIGURE 14: IR&A AND I-CARE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Information, Referral & Assistance	3.50	3.39	3.63	3.58
Insurance Counseling (I-CARE)	2.98	2.67	2.85	3.11



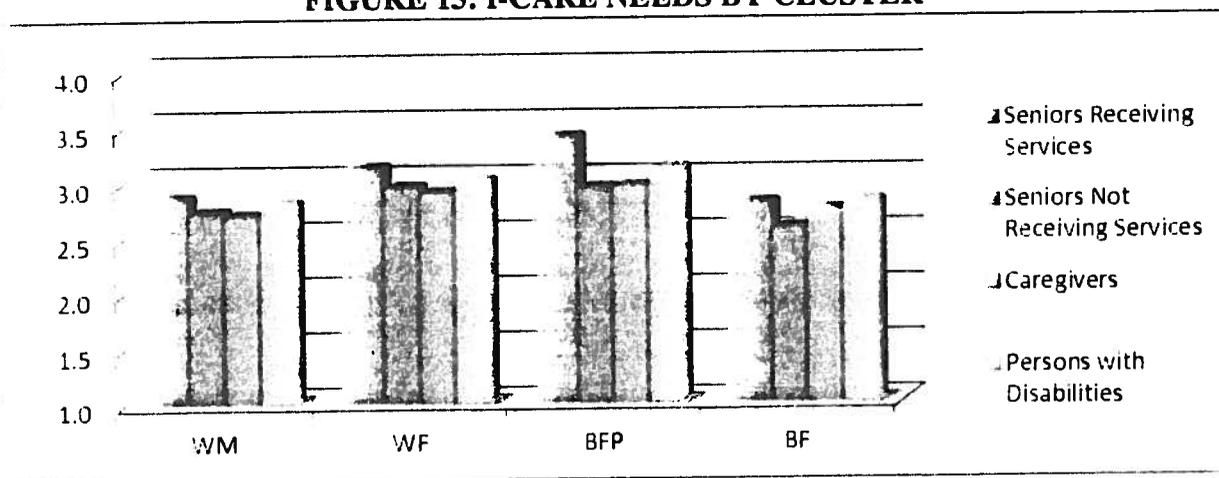
African Americans with an Associate's degree or less have a greater perceived need for IR&A ($t=6.35, df=1, p=0.012$ and $t=10.4, df=4, t=0.034, respectively$). Since most of the respondents viewed this service to be quite a bit to very important, there are no other significant differences by demographics.

The age of the respondent has a significant impact on their perceived need for I-CARE ($X^2_{K-W}=27.6, df=4, p<0.001$). This indicates that respondents who are in most need of these services

are those who are less than 64 years old. African Americans, females, those with a high school education or less, and individuals below the poverty line also rated these services as being of greater importance to them ($t=153.39$, $df=1$, $p<0.001$, $t=16.12$, $df=1$, $p<0.001$, $t=90.2$, $df=4$, $p<0.001$, and $t=78.64$, $df=1$, $p<0.001$, respectively). Those who are single or divorced, particularly rated these services as being of greater importance to them than individuals who are married or widowed ($t=18.48$, $df=3$, $p<0.001$).

Overall, the demographic cluster of respondents who reported that I-CARE services are of greatest importance to them is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line and most likely to be over the age of 85) ($t=80.78$, $df=3$, $p<0.001$). The second group to whom these services are important are individuals in Cluster 2 (White females, widowed, with a high school education, who are above the poverty line and most likely to be over the age of 85). It must be noted that respondents who are younger than 65 years had a higher average response to need for I-CARE services than individuals over 85, the age group of respondents was of the least importance to the cluster prediction, and only approximately 20% of Clusters 2 and 3 are over the age of 85. Therefore, it is most likely that I-CARE services are most important to widowed females with a high school education or less who are younger than 65 years and persons with disabilities.

FIGURE 15: I-CARE NEEDS BY CLUSTER



Monetary Assistance

The Monetary Assistance component is comprised of the following eight items: help paying for utilities or an unexpected bill; dental care and/or dentures; hearing exam and/or hearing aids; paying for an eye exam and/or eyeglasses; health insurance; help paying for healthy food; medical care; prescriptions or prescription drug coverage.

A reliability analysis determined that these nine items have good internal reliability, with a Cronbach alpha of 0.933, meaning that the scores for items are approximately 93% consistent

among cases. Therefore, adding together the scores on these eight variables for each case creates a statistically reliable composite measure. For ease in interpretation, the composite was calculated by averaging each individual's responses to the eight items. Doing so also allows for an individual to have a composite score even if they did not respond to any one of the items.

Of the 4,773 respondents, 4,584 had valid scores for the composite. The average score for the Monetary Assistance composite is 2.42 (SD=1.06) on a scale of 1 to 4, where a higher score represents a greater importance for helping the individual remain where they are now. The scores for the composite are slightly positively skewed (0.061), meaning that the frequency of scores are greater at the bottom of the scale. The Kurtosis measurement (-1.36) indicates that the distribution of scores is flat (does not peak in the middle) and a higher number of scores are in the tails than in the middle. This means that many respondents reported that personal and home care needs are either very important or not at all important, and very few reported quite a bit or a little importance.

On average, seniors receiving services view monetary assistance to be slightly more than a little important (*mean=2.42, median=2.38, n=2,628, sd=1.08*). The most important of these needs are for utilities or an unexpected bill (*mean=2.48, median=2.0, n=2,510, sd=1.28*) and dental care and/or dentures (*mean=2.48, median=2.0, n=2,513, sd=1.31*). The least important service to seniors who are already receiving services is hearing exams and/or hearing aids (*mean=2.1, median=1.0, n=2,458, sd=1.28*). (See Figure 16.)

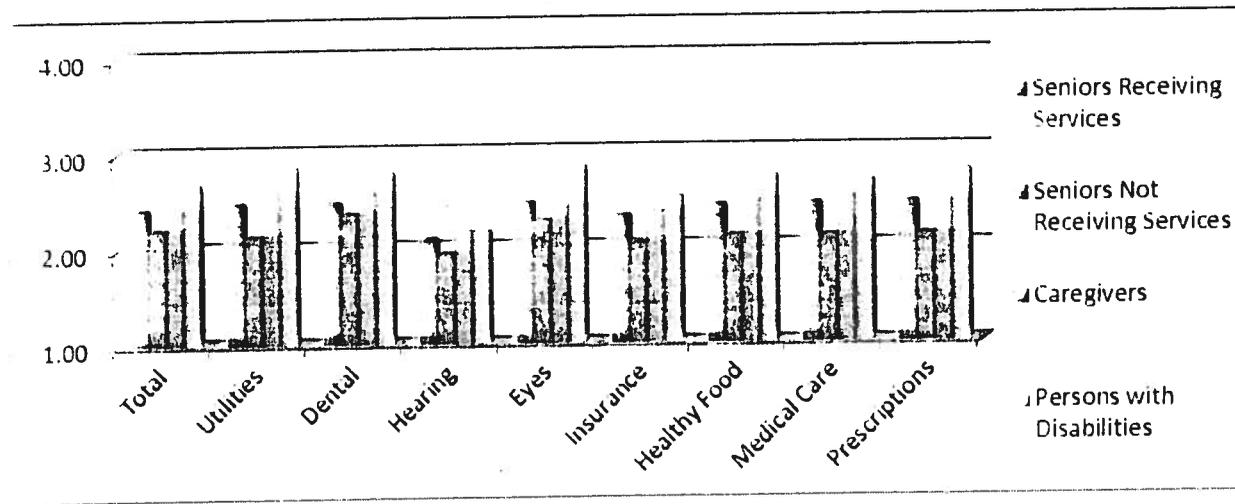
Seniors who have not received services view monetary assistance to be a little important (*mean=2.21, median=2.13, n=579, sd=1.07*). The most important of these needs are for dental care and/or dentures (*mean=2.37, median=2.0, n=553, sd=1.32*) and eye exam and/or eyeglasses (*mean=2.29, median=2.0, n=544, sd=1.3*). The least important services to seniors who are not receiving services are hearing exams and/or hearing aids (*mean=1.95, median=1.0, n=528, sd=1.21*) and health insurance (*mean=2.04, median=1.0, n=520, sd=1.3*). (See Figure 16.)

Caregivers view monetary assistance to be between a little and quite a bit important (*mean=2.5, median=2.5, n=1,130, sd=1.02*). The most important of these needs are for utilities or an unexpected bill (*mean=2.58, median=3.0, n=1,089, sd=1.2*), dental care and/or dentures (*mean=2.58, median=3.0, n=1,089, sd=1.27*), and eye exam and/or eyeglasses (*mean=2.57, median=3.0, n=1,076, sd=1.28*). The least important service for caregivers is paying for hearing exams and/or hearing aids (*mean=2.18, median=2.0, n=1,049, sd=1.27*). (See Figure 16.)

Persons with disabilities view monetary assistance to be slightly less than quite a bit important (*mean=2.68, median=2.88, n=210, sd=0.94*). The most important of these needs are for utilities or an unexpected bill (*mean=2.85, median=3.0, n=199, sd=1.1*) and eye exam and/or eyeglasses (*mean=2.85, median=3.0, n=199, sd=1.22*). The least important service to persons with disabilities is help paying for hearing exam and/or hearing aids (*mean=2.18, median=2.0, n=194, sd=1.27*). (See Figure 16.)

FIGURE 16: MONETARY ASSISTANCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Monetary Assistance Composite	2.42	2.21	2.50	2.68
Utilities or an unexpected bill	2.48	2.14	2.58	2.85
Dental Care and/or Dentures	2.48	2.37	2.58	2.79
Hearing Exam and/or Hearing Aids	2.10	1.95	2.18	2.18
Eye Exam and/or Eyeglasses	2.47	2.29	2.57	2.85
Health Insurance	2.33	2.04	2.36	2.53
Healthy Food	2.44	2.12	2.54	2.74
Medical Care	2.45	2.12	2.51	2.69
Prescriptions or Prescription Drug Coverage	2.46	2.13	2.51	2.79



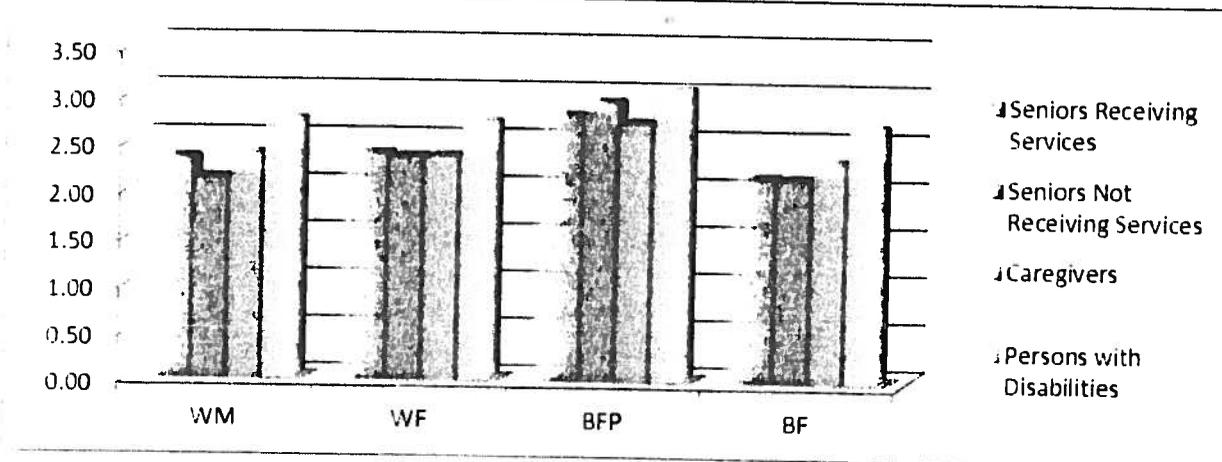
The difference in the monetary assistance composite is significantly different between the targeted groups ($F=14.03$, $df=3$, $p<0.001$). Therefore, caregivers and persons with disabilities view monetary assistance to be more important than do seniors receiving services and seniors who have not received services. However, the target group categorization only accounts for 0.9% of the variability in this composite ($r^2=0.009$).

The age of the respondent has a significant impact on their perceived need for monetary assistance ($F=8.15$, $df=4$, $p<0.001$). This indicates that respondents who are in most need of these services are those who are younger than 65 years old. African Americans, females, those who have received an Associate's degree or less, and individuals below the poverty line also rated these services as being of greater importance to them ($F=360.78$, $df=1$, $p<0.001$, $F=7.61$, $df=1$, $p=0.006$, $F=91.47$, $df=4$, $p<0.001$, and $F=314.13$, $df=1$, $p<0.001$, respectively). Caregivers, seniors who are receiving services, and seniors who are not receiving services who are single or divorced rated these services as being of greater importance to them than individuals who are

widowed or married ($F=12.34$, $df=3$, $p<0.001$). Persons with disabilities who are widowed reported that monetary assistance is less important than it is to single, married, and divorced persons with disabilities.

Overall, the demographic cluster of respondents who reported that these services are of greatest importance to them is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line). Persons with disabilities also reported monetary assistance to be quite a bit important.

FIGURE 17: MONETARY ASSISTANCE BY CLUSTER



Caregiver Needs

The Caregiver Needs component is comprised of the following five items: monetary assistance for services; information and referral; training on caring for someone at home; Adult Day Care; Respite.

A reliability analysis determined that these nine items have good internal reliability, with a Cronbach alpha of 0.835, meaning that the scores for items are approximately 84% consistent among cases. Therefore, adding together the scores on these five variables for each case creates a statistically reliable composite measure. For ease in interpretation, the composite was calculated by averaging each individual's responses to the eight items. Doing so also allows for an individual to have a composite score even if they did not respond to any one of the items.

Caregivers were asked to report the number of seniors, persons with disabilities, seniors with disabilities, and children for whom they care. These responses were used to categorize caregivers into four types: caregivers of seniors ($n=243$, 21.6%), caregivers of seniors with disabilities ($n=615$, 54.6%), caregivers of persons with disabilities ($n=168$, 14.9%), and caregivers of children ($n=100$, 8.9%). It must be noted that these items on the survey were not mutually exclusive, and as such, respondents may have selected more than one response for the same individual. Furthermore, approximately half of the caregivers of children are also the

caregiver for a senior or senior with a disability, and approximately half of the caregivers of persons with disabilities are also the caregiver for a senior or a senior with a disability.

Of the 1,156 caregiver respondents, 1,032 had valid scores for the composite. The average score for the caregiver needs composite is 2.82 (SD=0.87) on a scale of 1 to 4, where a higher score represents a greater agreement with the statement. The scores for the composite are negatively skewed (-0.396), meaning that the frequency of scores are greater at the top of the scale. The Kurtosis measurement (-0.725) indicates that the distribution of scores has only a slight peak in the middle and a higher number of scores in the tails. This means that many respondents reported that caregiver services are either very important or not at all important, and a few reported quite a bit or a little importance.

Caregivers of seniors (who do not have a disability) agree that caregiver services are necessary to help them care for the individual(s) (*mean*=2.7, *median*=2.8, *n*=209, *sd*=0.98). The most important of these needs are for monetary assistance in acquiring services (*mean*=2.82, *median*=3.0, *n*=197, *sd*=1.15), information and referral for services (*mean*=2.78, *median*=3.0, *n*=196, *sd*=1.12), and temporary relief from caregiver duties (respite) (*mean*=2.79, *median*=3.0, *n*=196, *sd*=1.18). (See Figure 18.)

Caregivers of seniors who do have a disability agree that caregiver services are necessary to help them care for the individual(s) (*mean*=2.88, *median*=3.0, *n*=585, *sd*=0.84). The most important of these needs is for temporary relief from caregiver duties (respite) (*mean*=3.22, *median*=4.0, *n*=547, *sd*=1.06), followed by monetary assistance for acquiring services (*mean*=3.11, *median*=3.0, *n*=551, *sd*=1.06) and information and referral for services (*mean*=3.03, *median*=3.0, *n*=542, *sd*=1.04). (See Figure 18.)

Caregivers of persons who have a disability (and are under 60 years of age) agree that caregiver services are necessary to help them care for the individual(s) (*mean*=2.73, *median*=2.8, *n*=146, *sd*=0.86). The most important of these needs are for monetary assistance in acquiring services (*mean*=3.06, *median*=3.0, *n*=132, *sd*=1.08), information and referral for services (*mean*=2.79, *median*=3.0, *n*=130, *sd*=1.13), and temporary relief from caregiver duties (respite) (*mean*=2.86, *median*=3.0, *n*=124, *sd*=1.19). (See Figure 18.)

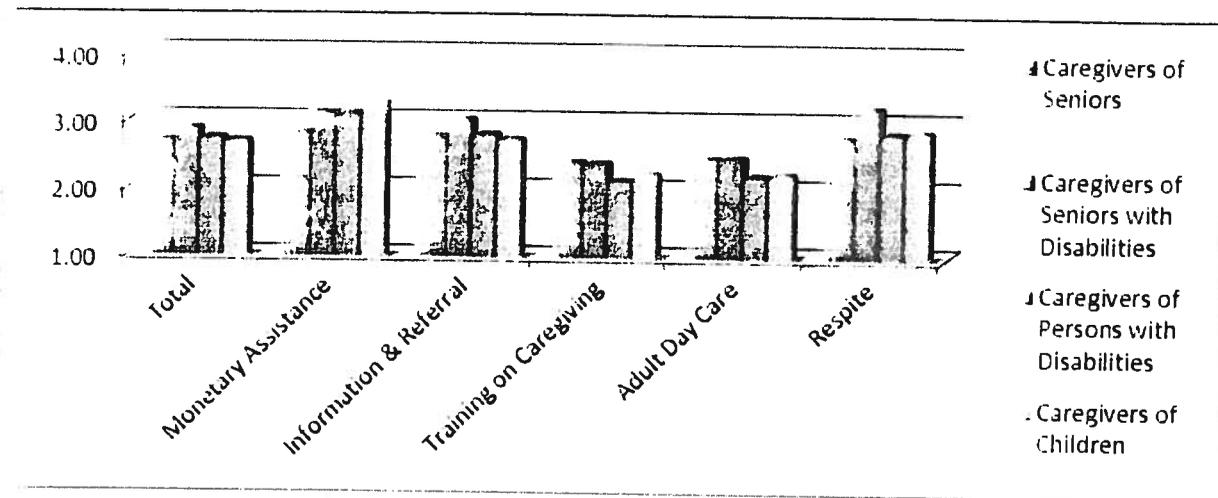
Seniors who are also caregivers of children agree that caregiver services are necessary to help them care for the individual(s) (*mean*=2.72, *median*=2.7, *n*=76, *sd*=0.81). The most important of these needs are for monetary assistance in acquiring services (*mean*=3.31, *median*=4.0, *n*=75, *sd*=1.15), followed by information and referral for services (*mean*=2.77, *median*=3.0, *n*=70, *sd*=1.22) and temporary relief from caregiver duties (respite) (*mean*=2.88, *median*=3.0, *n*=65, *sd*=1.21). Note that some of these senior caregivers of children also care for other seniors. (See Figure 18.)

The difference in the caregiver needs composite is significantly different between the type of person being cared for ($F=3.22$, $df=3$, $p=0.022$). Therefore, caregivers of seniors with disabilities have the greatest need for services than caregivers of seniors without disabilities, caregivers of persons with disabilities who are under 60, and caregivers of children. However, the target group

categorization only accounts for 0.9% of the variability in this composite ($r^2=0.009$). Monetary assistance and respite are the services most needed by all types of caregivers, followed by information and referral. There are no differences in the needs of caregivers based on demographics.

FIGURE 18: CAREGIVER NEEDS BY WHO CARE IS PROVIDED TO

	Caregivers of Seniors	Caregivers of Seniors with Disabilities	Caregivers of Persons with Disabilities	Caregivers of Children
Caregiver Needs Composite	2.70	2.88	2.74	2.70
Monetary Assistance	2.82	3.11	3.08	3.27
Information & Referral	2.78	3.03	2.81	2.74
Training on Caregiving	2.41	2.40	2.14	2.24
Adult Day Care	2.47	2.48	2.21	2.24
Respite	2.79	3.22	2.85	2.88



DISCUSSION

The representation of seniors receiving services, caregivers and persons with disabilities who have sought help through the ARDC's in the survey samples is quite good. This is somewhat less so for those seniors who have not received services. On the whole, the sample of both seniors and persons with disabilities is older, more likely to be below the poverty line, more likely to be female, more likely to be African American, and more likely to be without a spouse than the senior population as a whole. This is reflective of the population served by the AAA's/ADRC's.

The need for services is complex, dependent upon demographic factors, the targeted group, and the services available and offered. A single list of priorities that covers everyone can't, and shouldn't, be developed. The market for services is segmented and should be approached in that manner, as it is being approached by the aging network. Seniors receiving services, seniors not

receiving services, persons with disabilities and caregivers all prioritize the need for services differently. In addition, different demographic groups prioritize services differently.

In this report, SWS presents the needs as reported by the respondents by target group, demographic clusters, and the two combined. It has further divided the needs by the five service components and the service components by the services within those components. We have also provided an additional breakdown for caregivers. This information is presented in written and graphic form. This information can be utilized as a rich source for in-depth planning for services in the State of South Carolina.

STATEWIDE SERVICE PRIORITIES RECOMMENDED TO ADDRESS THE NEEDS IDENTIFIED AND A TIMELINE FOR IMPLEMENTATION

Using a principle components factor analysis, SWS identified five components that classify the service needs of the target groups it was asked to conduct a needs assessment with. What was found was that the priorities placed on service needs vary among the target groups served by the senior services/ARDC network. Furthermore, priorities vary from one region to another among these target groups and vary within the target groups in many instances depending upon demographic variables. Given this variation, statewide service priorities should be, in the opinion of SWS, broad, consisting of the five components that the analysis classifies services into according to the responses from the respondents to the needs assessment. These five components are: Personal and Home Care, Senior Center Activities, Maintaining Independence, Information Referral and Assistance, and Monetary Assistance. The services that fall under each of these are defined earlier in this report. More specific service priorities should be determined at the regional level, since the variation of need from region to region is so great.

Timelines for implementation are dependent upon the planning process, oversight of those conducting that process and availability of funds. It would be presumptuous of SWS to make recommendations in this area. SWS does propose the following timeline.

1. SWS prepare a 15-20 minute PowerPoint presentation of the findings of the state level needs assessment after completion of the report.
2. The regional directors notify SWS by October 26 if they would like to have a personal presentation or a Webinar presentation of the PowerPoint.
3. The presentation be made prior to Thanksgiving.

FINDINGS: REGION 1 – APPALACHIA

Representation of the Population

A total of 730 surveys were completed in Region 1. Respondents were asked a series of questions to determine if the respondent is a senior receiving services, a senior not receiving services, a caregiver, or an individual with a disability (the ARDC target population). These categories are not mutually exclusive and an individual could fall into more than one of these categories or none at all. Of the 730 surveys completed, 524 (71.8%) were categorized as a senior receiving services, 130 (17.8%) were categorized as a senior not receiving services, 133 (18.2%) were categorized as being a caregiver, and 376 (51.5%) were categorized as an individual with a disability.

For Region 1, the confidence interval for the sample of seniors receiving services is 4.21 points at a 95% confidence level assuming 50% agreement on the item in question. For items where there is greater agreement, the likelihood that the responses are representative of the population increases. Therefore, there is a relatively high probability that the findings represent the responses that can be expected from seniors receiving services (plus or minus 4.21 percentage points). The confidence interval for seniors not receiving services is higher (8.59 points at a 95% confidence level assuming 50% agreement), which indicates the sample of these seniors is less representative of the population of seniors not receiving services but is acceptable. The representation of caregivers is also acceptable (8.44 points at a 95% confidence level assuming 50% agreement), and the representation of individuals with a disability who have received services through the ADRC is relatively high (4.33 points at a 95% confidence level assuming 50% agreement). (See Table 1-1.)

TABLE 1-1: SAMPLE REPRESENTATION OF POPULATION

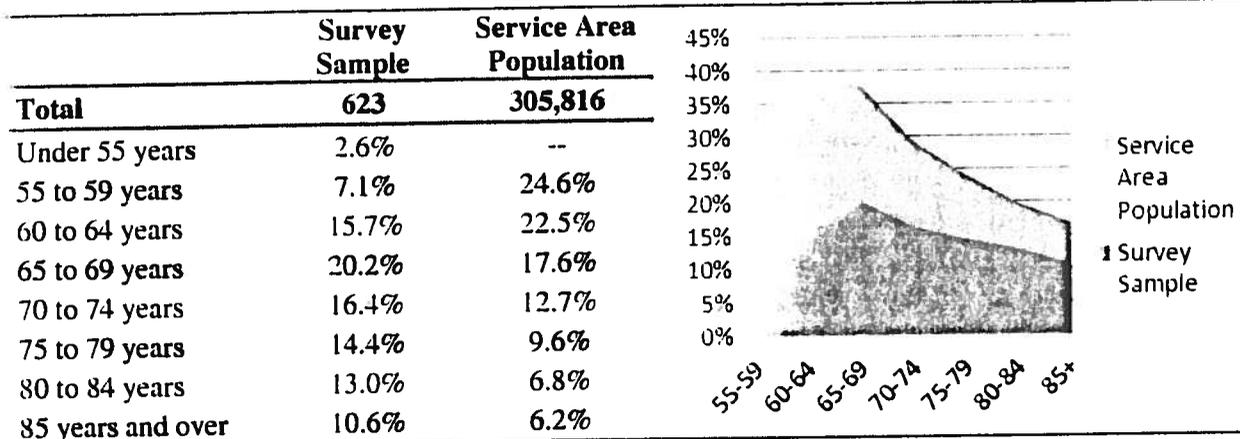
	Population Size	Sample Size	Representation
Seniors Receiving Services	15,892	524	4.21
Seniors Not Receiving Services	145,786	130	8.59
Caregivers	9,098	133	8.44
ADRC	1,403	376	4.33

Demographic Characteristics of Seniors

Compared to the service area senior population, the survey respondents are older; however, the overall pattern of age distribution is very similar. A small percentage of survey respondents are under 55 (n=16, 2.6%), 55 to 59 years old (n=44, 7.1%), or 60 to 64 years old (n=98, 15.7%), whereas 24.6% and 22.5% of the service area senior population is between these ages, respectively. However, for both the survey sample and the service area senior population, the percentage peaks at 65 to 69 years (n=126, 20.2% of the sample and 17.6% of the population) and slowly declines until it reaches 85 years and over (n=66, 10.6% of the sample and 6.2% of

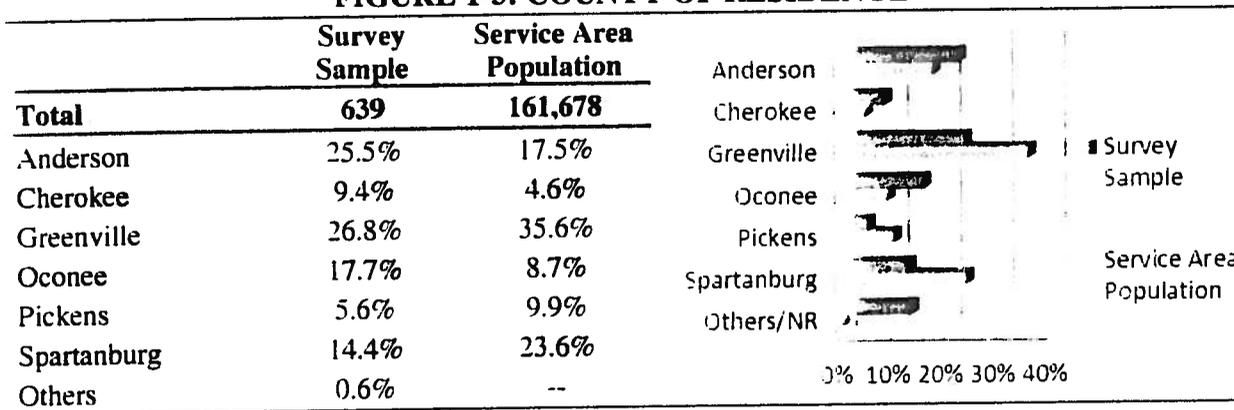
the population). (See Figure 1-2.) For this reason, further population figures only include seniors ages 65 and older.

FIGURE 1-2: AGE GROUP



Larger proportions of the survey sample reside in Anderson (n=163, 25.5%), Cherokee (n=60, 9.4%), and Oconee (n=113, 17.7%) counties than in the broader service area senior population (17.5%, 4.6%, and 8.7%, respectively). Smaller proportions of the survey sample reside in Greenville (n=171, 26.8%) and Spartanburg (n=92, 14.4%) than in the service area senior population (35.6% and 23.6%, respectively). This was done intentionally in order to ensure representation from the smaller counties and to increase the power of comparisons by county. The only county where over-representation of the smaller counties did not occur is in Pickens county, which represents only 5.6% (n=36) of the sample compared to 9.9% of the service area senior population. (See Figure 1-3.)

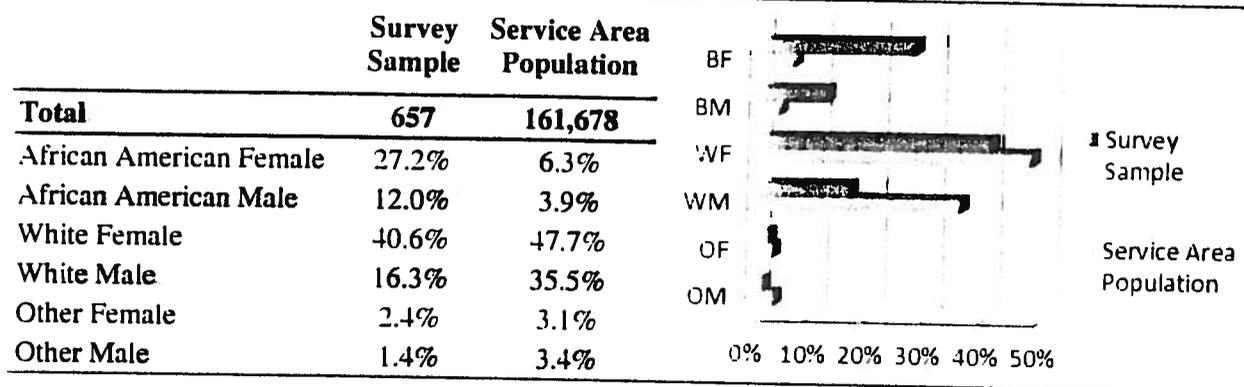
FIGURE 1-3: COUNTY OF RESIDENCE



A much larger percentage of the survey sample are African American/African American female (n=179, 27.2%) or African American male (n=79, 12%) than in the service area senior population (6.3% and 3.9%, respectively). Conversely, a smaller percentage of the survey sample are White/Caucasian female (n=267, 40.6%) or White/Caucasian male (n=107, 16.3%) compared to the service area senior population (47.7% and 35.5%, respectively). Very few respondents were of other races (females: n=16, 2.4%; males: n=9, 1.4%). These populations are

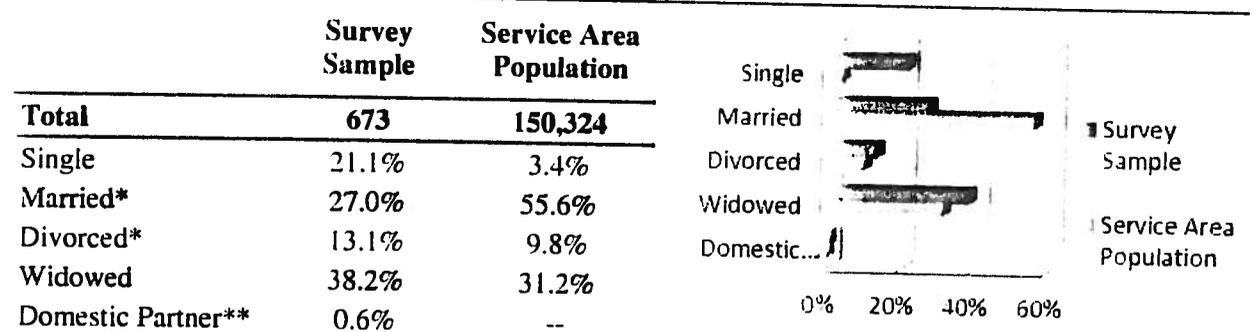
also relatively small in the service area senior population (other females: 3.1%; other males: 3.4%). (See Figure 1-4.)

FIGURE 1-4: RACE AND GENDER OF SENIORS



The survey sample has a much larger percentage of individuals who are single (n=142, 21.1%) or widowed (n=257, 38.2%) than exist in the service area senior population (3.4% and 31.2%, respectively). Conversely, there is a much smaller percentage of individuals who are married (n=182, 27% of the sample compared to 55.6% of the service area senior population). A similar percentage of respondents are divorced (n=88, 13.1%) as are in the service area senior population (9.8%). (See Figure 1-5.)

FIGURE 1-5: MARITAL STATUS OF SENIORS



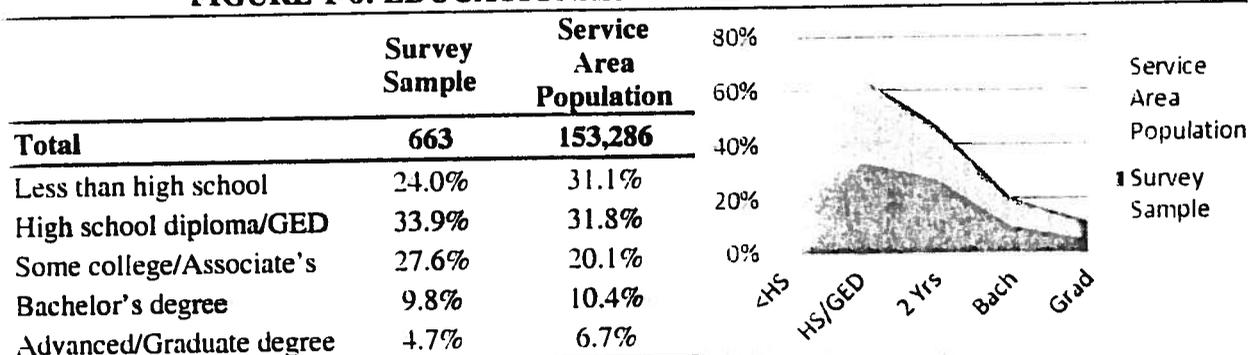
*Individuals in the service area population categorized as "Married, spouse absent, not separated" were excluded from the counts.

**Individuals who are in a domestic partnership were not included in the population counts as the Census does not include this category in the marital status calculation. Inclusion of this category in the population counts could lead to a duplication of individuals currently classified as single ("never married").

The level of educational attainment of the survey sample is very similar to the educational attainment of the service area senior population. More than half of the respondents completed less than high school (n=159, 24%) or received a high school diploma or GED (n=225, 33.9%), compared to 31.1% and 31.8% of the service area senior population, respectively. A slightly higher percentage of the respondents (n=183, 27.6%) attended some college or earned as Associate's degree than the service area senior population (20.1%). The percentage of respondents who earned a Bachelor's degree (n=65, 9.8%) or an Advanced/Graduate degree

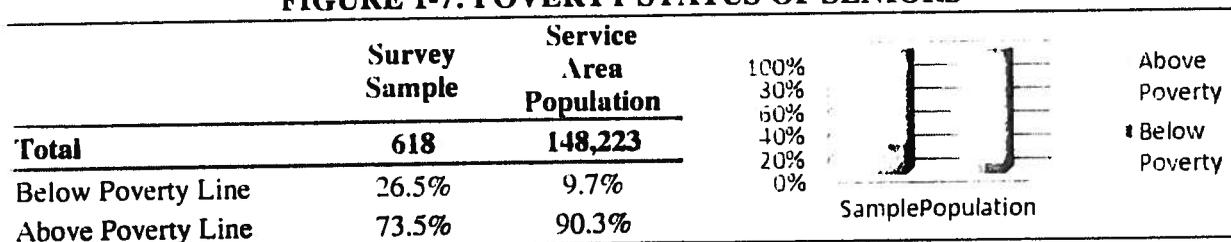
(n=31, 4.7%) are similar to the percentage in the service area senior population (10.4% and 6.7%, respectively). (See Figure 1-6.)

FIGURE 1-6: EDUCATIONAL ATTAINMENT OF SENIORS



In comparison to the service area senior population, respondents to the survey are estimated to more likely be below the poverty line (n=164, 26.5% compared to 9.7% of the service area senior population). (See Figure 1-7.)

FIGURE 1-7: POVERTY STATUS OF SENIORS



Overall, the demographic characteristics of the survey sample are not representative of the general population of seniors residing in the areas served by the AAA's. Rather, the survey sample tends to be older, single or widowed, and below the poverty line, as well as more likely to be African American and female.

Demographic Characteristics of Individuals Who Have a Disability

Only 20 survey respondents from this region are considered to have a disability and also be under the age of 65. Therefore, the characteristics of these individuals are not compared to the service area population.

Reclassification into Mutually Exclusive Categories

For purposes of analysis, the respondents were re-classified into mutually exclusive categories of each type of targeted population in order to compare responses by targeted group. Seniors receiving services are now those who are over the age of 55, reported that they were receiving services, are not caring for another individual, and most often were answering the survey for

themselves. This group comprises 65.6% (n=473) of the sample. Seniors not receiving services are those who are over the age of 55, did not report that they were receiving services, are not caring for another individual, and most often were answering the survey for themselves. This group comprises 14.1% (n=102) of the sample. Caregivers are caring for another individual (senior, person with disability, or child under 18), and may or may not be over the age of 55. This group comprises 17.5% (n=126) of the sample. Persons with disabilities are the smallest group (n=20, 2.8%) and represent those who have a disability, are between the ages of 18 and 64, and are not caring for another individual.

Four clusters of individuals were identified previously and are described under the statewide analysis. Cluster 1 is comprised of 171 respondents (23.4% of the sample and 32.6% of those classified). Cluster 2 is comprised of 118 respondents (16.2% of the sample and 22.5% of those classified). Cluster 3 is comprised of 58 respondents (7.9% of the sample and 11.1% of those classified). Cluster 4 is comprised of 177 respondents (24.2% of the sample and 33.8% of those classified). The remaining 206 (28.2%) of respondents did not report one or more demographic variables and could not be included in the cluster analysis.

Service Needs by Targeted Group

A principle components factor analysis was conducted previously to determine if respondents responded similarly to certain groups of items. The solution identified five components that explained most of the variance among the variables. The five components are classified as: Personal and Home Care, Senior Center Activities, Maintaining Independence, Information Referral and Assistance, and Monetary Assistance.

Personal and Home Care

The Personal and Home Care component is comprised of the following nine items: Transportation to the grocery store, doctor's office, pharmacy, or other errands; Having someone bring a meal to me in my home every day; Help keeping my home clean; Help with repairs and maintenance of my home or yard; Help with personal care or bathing; Help with washing and drying my laundry; Having someone help me with my prescription medicine; Keeping warm or cool as the weather changes; and Modifications to my home so that I can get around safely. Scores for items are approximately 92% consistent among cases. The composite was calculated by averaging each individual's responses to the nine items.

On average, seniors receiving services view personal and home care needs to be a little important (*mean*=2.08, *median*=2.0, *n*=472, *sd*=0.86). The most important of these needs are transportation for errands (*mean*=2.34, *median*=2.0, *n*=459, *sd*=1.22), household chores (*mean*=2.24, *median*=2.0, *n*=462, *sd*=1.22), keeping warm or cool as the weather changes (*mean*=2.23, *median*=2.0, *n*=459, *sd*=1.24), and home modifications to improve safety (*mean*=2.3, *median*=2.0, *n*=459, *sd*=1.23). The least important services to seniors who are already receiving services are personal care (*mean*=1.7, *median*=1.0, *n*=461, *sd*=1.05), housekeeping (specifically

laundry) (*mean=1.78, median=1.0, n=460, sd=1.08*), and nursing care/prescription assistance (*mean=1.83, median=1.0, n=457, sd=1.09*). (See Figure 1-8.)

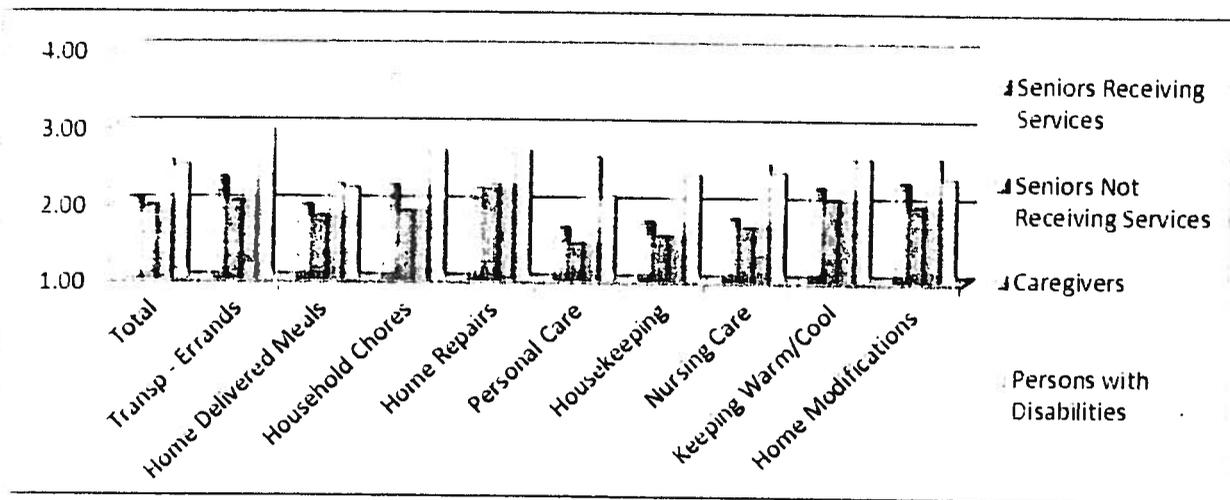
Seniors who have not received services view personal and home care needs to be a little important (*mean=1.97, median=1.67, n=101, sd=0.94*). The only service deemed to be a little important by most of the respondents is home repairs and maintenance (*mean=2.25, median=2.0, n=93, sd=1.22*). The least important services to seniors who are not already receiving services are personal care (*mean=1.49, median=1.0, n=91, sd=1.0*), housekeeping (specifically laundry) (*mean=1.6, median=1.0, n=88, sd=1.0*), and nursing care (specifically assistance with prescription medicine) (*mean=1.71, median=1.0, n=90, sd=1.1*). (See Figure 1-8.)

Caregivers view personal and home care needs to be between a little and quite a bit important (*mean=2.56, median=2.56, n=126, sd=0.93*). All but two of the services are deemed to be quite a bit important by most of the respondents (*median score = 3.0, sd=1.2-1.3*). The least important services to caregivers are home delivered meals (*mean=2.25, median=2.0, n=122, sd=1.26*) and housekeeping (specifically laundry) (*mean=2.39, median=2.0, n=122, sd=1.3*). (See Figure 1-8.)

Persons with disabilities view personal and home care needs to be between a little and quite a bit important (*mean=2.5, median=2.56, n=20, sd=0.76*). The most important service to persons with disabilities is transportation for errands (*mean=3.0, median=4.0, n=20, sd=1.26*). Other important services to persons with disabilities are home repairs and maintenance (*mean=2.7, median=2.5, n=20, sd=1.3*), keeping warm or cool as the weather changes (*mean=2.6, median=2.5, n=20, sd=1.23*), household chores (specifically keeping home clean) (*mean=2.7, median=3.0, n=20, sd=1.38*), and housekeeping (specifically laundry) (*mean=2.4, median=3.0, n=20, sd=1.19*). (See Figure 1-8.)

FIGURE 1-8: PERSONAL AND HOME CARE NEEDS BY TARGETED GROUP

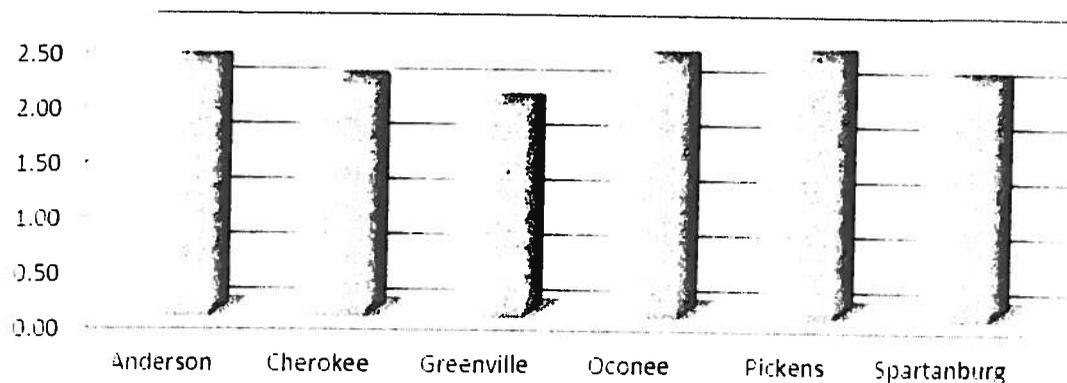
	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Personal and Home Care Composite	2.08	1.97	2.56	2.50
Transportation for Errands	2.34	2.03	2.59	3.00
Home Delivered Meals	1.98	1.84	2.25	2.20
Household Chores	2.24	1.91	2.67	2.70
Home Repairs/Maintenance	2.20	2.25	2.66	2.70
Personal Care	1.70	1.49	2.61	2.11
In-Home Housekeeping	1.78	1.60	2.39	2.40
Nursing Care/Prescription Assistance	1.83	1.71	2.54	2.42
Keeping Warm/Cool	2.23	2.07	2.60	2.60
Home Modifications	2.30	1.99	2.61	2.35



The difference in the personal and home care needs composite is significantly different between the targeted groups ($F=12.65$, $df=3$, $p<0.001$). Therefore, caregivers and persons with disabilities view personal and home care needs to be more important than do seniors receiving services and seniors who have not received services. However, the target group categorization only accounts for 5% of the variability in this composite ($r^2=0.050$).

The age of the respondent has a significant impact on their perceived need for personal and home care needs ($F=4.44$, $df=4$, $p=0.002$). This indicates that respondents who are in most need of these services are those who are greater than 85 years old and are receiving services as well as persons with disabilities who are under 55. African Americans, those with a high school diploma/GED or less, and individuals below the poverty line also rated these services as being of greater importance to them ($F=14.22$, $df=1$, $p<0.001$, $F=6.7$, $df=4$, $p<0.001$, and $F=9.74$, $df=1$, $p=0.002$, respectively). Those who are widowed rated these services as being of greater importance to them than individuals who are single, divorced or married ($F=4.34$, $df=3$, $p=0.005$). For seniors, those who have a disability have a significantly greater need for personal and home care services ($diff=0.42$, $t=5.97$, $df=571$, $p<0.001$). Individuals residing in Anderson, Oconee, and Pickens County had significantly greater need than individuals residing in Greenville or Spartanburg counties ($F=2.63$, $df=9$, $p=0.005$). There are no differences by demographic cluster.

FIGURE 1-9: PERSONAL AND HOME CARE NEEDS BY COUNTY



Senior Center Activities

The Senior Center Activities component is comprised of the following eight items: transportation to the senior center; group dining; recreation/social events; getting exercise; exercising with others; counseling (specifically having someone to talk to when feeling lonely); nutrition counseling; and having a senior center close to home. The scores for items are approximately 90% consistent among cases. The composite was calculated by averaging each individual's responses to the eight items.

On average, seniors receiving services view senior center activities to be quite a bit important (*mean*=2.8, *median*=2.8, *n*=471, *sd*=0.72). All but one of the items has a median value of either quite a bit or very important. The most important of these needs are having a senior center close to home (*mean*=2.98, *median*=4.0, *n*=562, *sd*=1.22), getting exercise (*mean*=3.02, *median*=3.0, *n*=462, *sd*=1.07), recreation/social events (*mean*=2.91, *median*=3.0, *n*=461, *sd*=1.1), and counseling (having someone to talk to) (*mean*=2.92, *median*=3.0, *n*=464, *sd*=1.1). The least important service to seniors who are already receiving services is transportation to the senior center (*mean*=2.18, *median*=2.0, *n*=461, *sd*=1.23). (See Figure 1-10.)

Seniors who have not received services view senior center activities to be slightly less than quite a bit important (*mean*=2.69, *median*=2.85, *n*=98, *sd*=0.85). The most important of these needs are getting exercise (*mean*=3.12, *median*=3.0, *n*=94, *sd*=1.01), counseling (having someone to talk to) (*mean*=2.76, *median*=3.0, *n*=90, *sd*=1.19), recreation/social events (*mean*=2.78, *median*=3.0, *n*=93, *sd*=1.17), and exercising with others (*mean*=2.83, *median*=3.0, *n*=90, *sd*=1.15). The least important service to seniors who are not already receiving services is transportation to the senior center (*mean*=1.99, *median*=1.0, *n*=89, *sd*=1.21). (See Figure 1-10.)

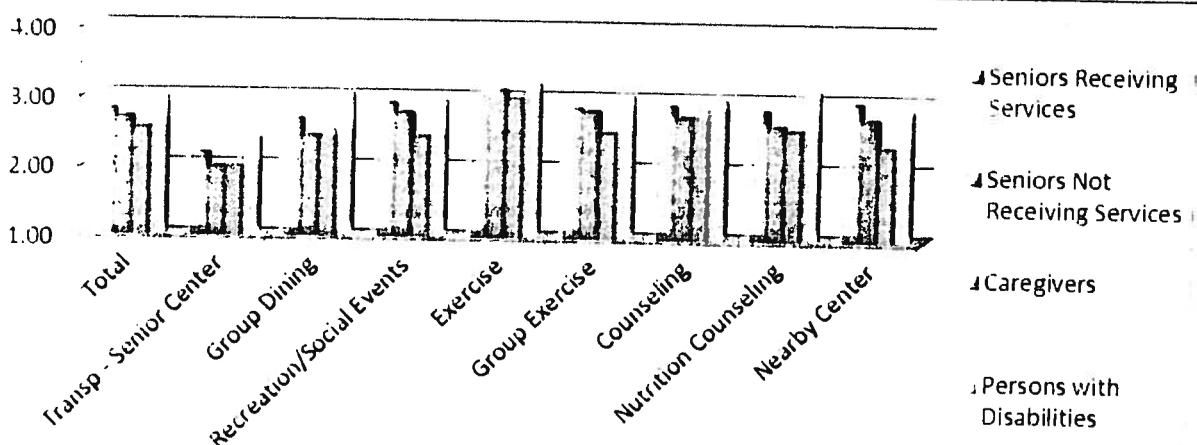
Caregivers view senior center activities to be between a little and quite a bit important (*mean*=2.55, *median*=2.5, *n*=125, *sd*=0.79). The most important of these needs are getting exercise (*mean*=3.0, *median*=3.0, *n*=122, *sd*=1.04), exercising with others (*mean*=2.52, *median*=3.0, *n*=115, *sd*=1.13), counseling (having someone to talk to) (*mean*=2.86, *median*=3.0, *n*=124, *sd*=1.11), and getting information on eating healthy (*mean*=2.58, *median*=3.0, *n*=123, *sd*=1.12). The least important service to caregivers is transportation to the senior center (*mean*=2.0, *median*=1.0, *n*=119, *sd*=1.25). (See Figure 1-10.)

Persons with disabilities view senior center activities to be quite a bit important (*mean*=2.84, *median*=2.98, *n*=20, *sd*=0.76). The most important services to persons with disabilities are getting exercise (*mean*=3.21, *median*=3.0, *n*=19, *sd*=0.79) and nutrition counseling (*mean*=3.17, *median*=3.5, *n*=18, *sd*=0.99). The least important service to persons with disabilities is transportation to the senior center (*mean*=2.4, *median*=2.0, *n*=20, *sd*=1.35). (See Figure 1-10.)

Transportation to the senior center is the least important of all the senior center activities for each of the targeted groups. Of these groups, it is the most important to seniors receiving services and persons with disabilities.

FIGURE 1-10: SENIOR CENTER ACTIVITIES BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Senior Center Activities Composite	2.80	2.69	2.54	2.98
Transportation to the Senior Center	2.18	1.99	2.00	2.40
Group Dining	2.68	2.44	2.52	3.05
Recreation/Social Events	2.91	2.78	2.44	2.95
Exercise	3.02	3.12	3.00	3.21
Group Exercise	2.86	2.83	2.52	3.05
Counseling (someone to talk to)	2.92	2.76	2.86	3.00
Nutrition Counseling	2.86	2.64	2.58	3.17
Nearby Senior Center	2.98	2.75	2.35	2.89

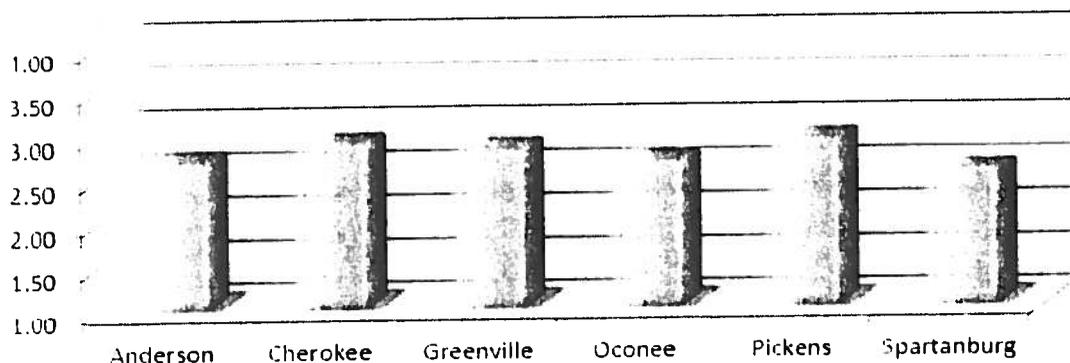


The difference in the senior center activities composite is significantly different between the targeted groups ($F=4.64$, $df=3$, $p=0.003$). Therefore, seniors receiving services and persons with disabilities view senior center activities to be more important than do seniors not receiving services and caregivers. However, the target group categorization only accounts for 1.9% of the variability in this composite ($r^2=0.019$).

African Americans and females rated these services as being of greater importance to them ($F=4.66$, $df=1$, $p=0.031$, $F=12.98$, $df=1$, $p<0.001$, respectively). Those who are single, widowed or divorced rated these services as being of greater importance to them than individuals who are married ($F=3.46$, $df=3$, $p=0.016$). Individuals who reside in Cherokee, Greenville, and Pickens County reported a greater need for senior center activities than did individuals residing in other counties ($F=3.17$, $df=9$, $p=0.001$). For seniors, those who have a disability have a significantly greater need for senior center activities ($diff=0.14$, $t=2.3$, $df=560.6$, $p=0.022$).

Overall, the demographic cluster of respondents who reported that these services are of greatest importance to them is Cluster 3 (Black females, widowed, with less than high school education, who are below the poverty line and most likely to be over the age of 85), the majority of whom are seniors receiving services. The second group to whom these services are important are individuals in Cluster 2 (White females, widowed, with a high school education, who are above the poverty line and most likely to be over the age of 85) who are receiving services.

FIGURE 1-11: SENIOR CENTER ACTIVITIES BY COUNTY



Maintaining Independence

The Maintaining Independence component is comprised of the following four items: preventing falls and other accidents; help making choices about future medical care and end of life decisions (Healthcare Directives); someone to protect my rights, safety, property or dignity (Ombudsman – Protection); and someone to call when I feel threatened or taken advantage of (Ombudsman – Complaint). The scores for items are approximately 88% consistent among cases. The composite was calculated by averaging each individual’s responses to the four items.

On average, seniors receiving services view services to help in maintaining independence to be between a little and quite a bit important (*mean=2.53, median=2.5, n=468, sd=1.0*). The most important of these needs is having someone to call if feeling threatened or taken advantage of (*mean=2.68, median=3.0, n=461, sd=1.2*). Preventing falls is the only one considered to be a little important (*mean=2.31, median=2.0, n=458, sd=1.21*). (See Figure 1-12.)

Seniors who have not received services view services to help in maintaining independence to be a little important (*mean=2.37, median=2.25, n=94, sd=1.03*). All of the services were deemed to be a little important (preventing falls: *mean=2.41, median=2.0, n=91, sd=1.19*; healthcare directives: *mean=2.22, median=2.0, n=89, sd=1.18*; protection of rights: *mean=2.4, median=2.0, n=88, sd=1.25*; having someone to call if feeling threatened or taken advantage of: *mean=2.36, median=2.0, n=85, sd=1.25*). (See Figure 1-12.)

Caregivers view services to help in maintaining independence to be quite a bit important (*mean=2.84, median=3.0, n=125, sd=1.0*). The most important of these services is preventing

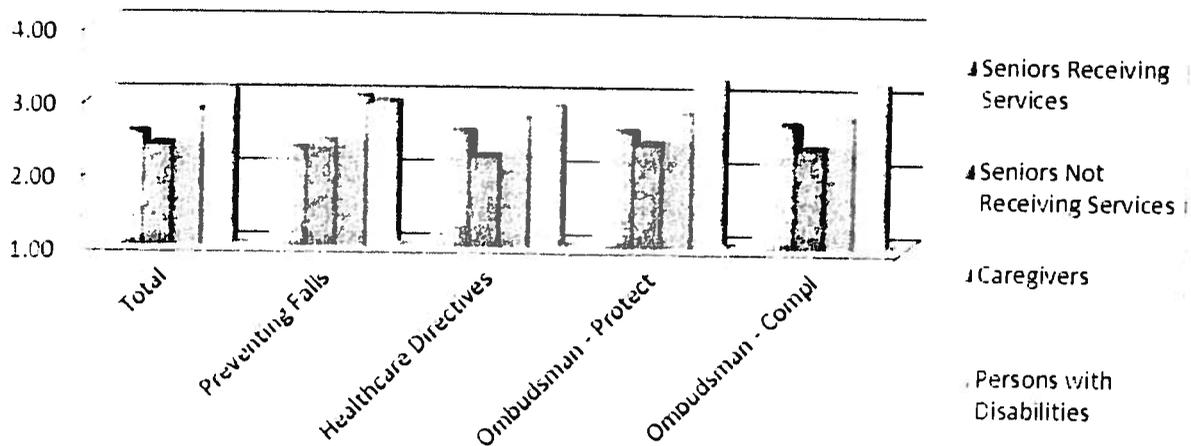
falls (*mean=3.02, median=4.0, n=124, sd=1.16*). The remainder of the services were deemed to be quite a bit important (healthcare directives: *mean=2.73, median=3.0, n=124, sd=1.17*; protection of rights: *mean=2.8, median=3.0, n=123, sd=1.23*; and someone to call if feeling threatened or taken advantage of: *mean=2.76, median=3.0, n=120, sd=1.28*). (See Figure 1-12.)

Persons with disabilities view services to help in maintaining independence to be quite a bit important (*mean=3.1, median=3.25, n=20, sd=0.91*). All of the services were deemed to be quite a bit or very important (preventing falls: *mean=2.95, median=3.0, n=19, sd=1.08*; healthcare directives: *mean=2.89, median=3.0, n=19, sd=1.05*; protection of rights: *mean=3.26, median=4.0, n=19, sd=0.99*; and someone to call if feeling threatened or taken advantage of: *mean=3.22, median=3.5, n=18, sd=0.94*). (See Figure 1-12.)

Preventing falls is most important to caregivers; whereas having someone to call if feeling threatened or taken advantage of is most important to seniors (both those receiving services and those not receiving services). Persons with disabilities perceive the services of the ombudsman to be the most important.

FIGURE 1-12: MAINTAINING INDEPENDENCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Maintaining Independence Composite	2.53	2.37	2.84	3.10
Preventing Falls	2.31	2.41	3.02	2.95
Healthcare Directives	2.55	2.22	2.73	2.89
Ombudsman - Protection	2.56	2.40	2.80	3.26
Ombudsman - Complaints	2.68	2.36	2.76	3.22



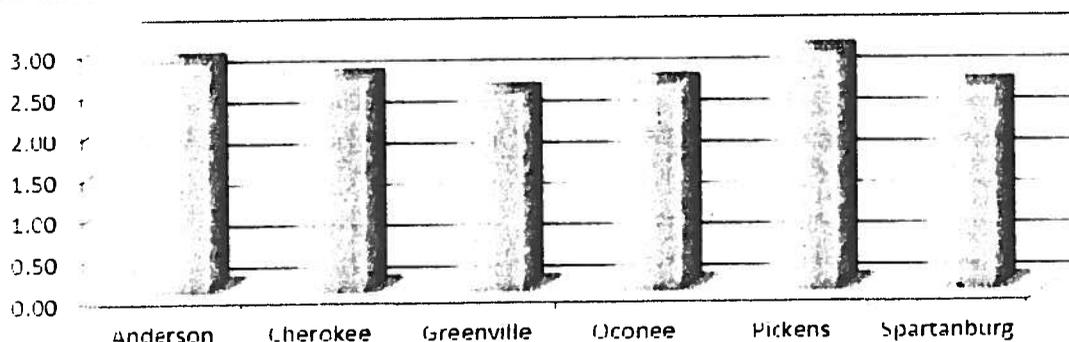
The difference in the maintaining independence composite is significantly different between the targeted groups ($F=6.55, df=3, p<0.001$). Therefore, caregivers and persons with disabilities view services to help maintaining independence to be more important than do seniors receiving services

and seniors who have not received services. However, the target group categorization only accounts for 2.7% of the variability in this composite ($r^2=0.027$).

The age of the respondent has a significant impact on their perceived need for personal and home care needs ($F=2.52$, $df=3$, $p=0.040$). This indicates that respondents who are in most need of these services are those who are greater than 75 years old and those who are disabled and under 55. African Americans, those with a high school diploma/GED or less, and individuals below the poverty line also rated these services as being of greater importance to them ($F=10.03$, $df=1$, $p=0.002$, $F=3.37$, $df=4$, $p=0.010$, and $F=9.16$, $df=1$, $p=0.003$, respectively). For seniors, those who have a disability have a significantly greater need for services to maintain independence ($diff=0.43$, $t=5.15$, $df=560$, $p<0.001$). Individuals who reside in Anderson and Pickens County expressed a greater need for these services than those residing in Greenville and Spartanburg County ($F=10.03$, $df=1$, $p=0.002$).

Overall, the demographic cluster of respondents who reported that these services are of greatest importance to them is Cluster 3 (Black females, widowed, with less than high school education, who are below the poverty line and most likely to be over the age of 85), the majority of whom are seniors receiving services, caregivers of these individuals, or persons with disabilities. It must be noted that respondents who are older than 75 years had about the same average score on the composite as individuals over 85, the age group of respondents was of the least importance to the cluster prediction, and only approximately 20% of Clusters 3 is over the age of 85. Therefore, it is most likely that services to maintain independence are most important to African Americans with a high school education or less who are 75 years or older.

FIGURE 1-13: MAINTAINING INDEPENDENCE BY COUNTY



Information, Referral & Assistance and I-CARE

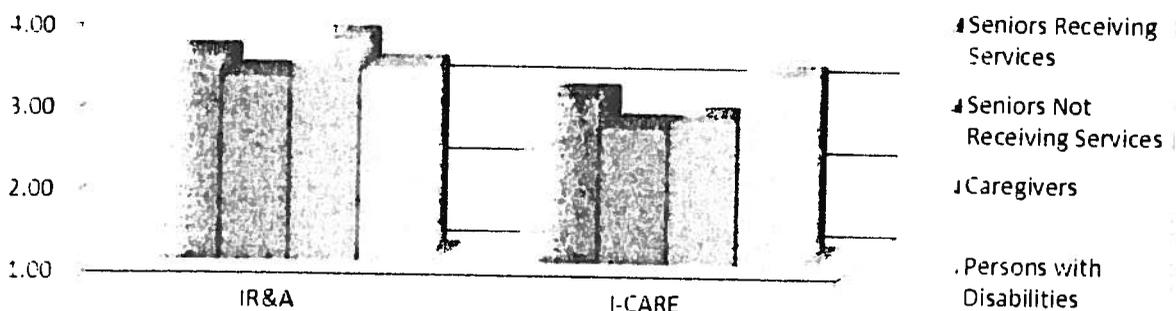
This section is comprised of the following two items: Knowing what services are available and how to get them (IR&A); and information or help applying for health insurance or prescription coverage (I-CARE). A reliability analysis determined that these two items have only fair internal reliability. Therefore, a composite is not created and these two variables are considered separately.

Of the 730 respondents, 704 reported on how important information, referral and assistance services are to keeping them where they are now. All of the targeted groups view IR&A to be very important (*mean=3.23-3.67, median=4.0*). The results of the Kruskal Wallis test indicate that there was significant differences between the target groups ($X^2_{K-W}=11.34, df=3, p=0.010$). In particular, caregivers view this service to be more important than do seniors not receiving services and persons with disabilities. (See Figure 1-14.)

Of the 730 respondents, 694 reported on how important information or help applying for health insurance or prescription coverage (I-CARE) is to keeping them where they are now. Persons with disabilities view IR&A to be quite a bit to very important (*mean=3.26, median=4.0, n=19, sd=1.1*). Seniors receiving services, caregivers, and seniors not receiving services view this service to be quite a bit important (*mean=3.0, median=3.0, n=462, sd=1.16; mean=2.74, median=3.0, n=121, sd=1.17; and mean=2.64, median=3.0, n=92, sd=1.3, respectively*). The results of the Kruskal Wallis test indicate that there was significant differences between the target groups ($X^2_{K-W}=10.83, df=3, p=0.013$). In particular, persons with disabilities view this service to be more important than do caregivers and seniors not receiving services. (See Figure 1-14.)

FIGURE 1-14: IR&A AND I-CARE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Information, Referral & Assistance	3.46	3.23	3.67	3.33
Insurance Counseling (I-CARE)	3.00	2.64	2.74	3.26



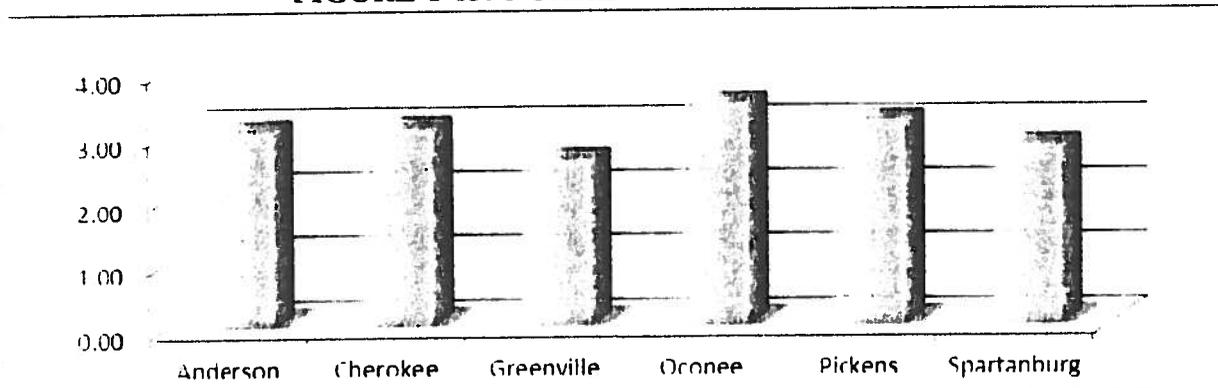
Individuals residing in Anderson, Oconee, and Pickens expressed the greatest need for this service ($X^2_{K-W}=20.93, df=8, p=0.007$). For seniors, those who have a disability have a significantly greater need for IR&A (*diff=0.16, t=1.96, df=552.6, p=0.050*). Since most of the respondents viewed this service to be quite a bit to very important, there are no other significant differences by demographics.

The age of the respondent has a significant impact on their perceived need for I-CARE ($X^2_{K-W}=27.8, df=4, p<0.001$). This indicates that respondents who are in most need of these services

are those who are less than 64 years old. African Americans, those with an Associate's degree or less, and individuals below the poverty line also rated these services as being of greater importance to them ($t=11.62$, $df=1$, $p=0.001$; $t=10.1$, $df=4$, $p=0.039$; and $t=4.63$, $df=1$, $p=0.032$, respectively). For seniors, those who have a disability have a significantly greater need for I-CARE ($diff=0.20$, $t=2.0$, $df=552$, $p=0.045$). Individuals residing in Anderson, Cherokee, Oconee, and Pickens expressed the greatest need for this service ($X^2_{k-w}=39.8$, $df=8$, $p<0.001$).

Overall, the demographic clusters of respondents who reported that I-CARE services are of greatest importance to them are Cluster 2 (White females, widowed, with a high school education, who are above the poverty line and most likely to be over the age of 85) and Cluster 3 (Black females, widowed, with less than high school education, who are below the poverty line and most likely to be over the age of 85) ($X^2_{k-w}=80.78$, $df=3$, $p<0.001$). It must be noted that respondents who are younger than 65 years had a higher average response to need for I-CARE services than individuals over 85, the age group of respondents was of the least importance to the cluster prediction, and only approximately 20% of Clusters 2 and 3 are over the age of 85. Therefore, it is most likely that I-CARE services are most important to females with a high school education or less who are younger than 65 years and persons with disabilities.

FIGURE 1-15: I-CARE NEEDS BY COUNTY



Monetary Assistance

The Monetary Assistance component is comprised of the following eight items: help paying for utilities or an unexpected bill; dental care and/or dentures; hearing exam and/or hearing aids; paying for an eye exam and/or eyeglasses; health insurance; help paying for healthy food; medical care; prescriptions or prescription drug coverage. The scores for items are approximately 93% consistent among cases. The composite was calculated by averaging each individual's responses to the eight items.

On average, seniors receiving services view monetary assistance to be slightly more than a little important ($mean=2.32$, $median=2.5$, $n=460$, $sd=0.91$). The most important of these needs are for utilities or an unexpected bill ($mean=2.52$, $median=3.0$, $n=447$, $sd=1.29$), medical care ($mean=2.59$, $median=3.0$, $n=441$, $sd=1.31$), and prescriptions or prescription drug coverage

(*mean=2.55, median=3.0, n=442, sd=1.29*). The least important services to seniors who are already receiving services are hearing exams and/or hearing aids (*mean=1.82, median=1.0, n=445, sd=1.15*) and paying for an eye exam and/or eyeglasses (*mean=2.06, median=1.0, n=445, sd=1.23*). (See Figure 1-16.)

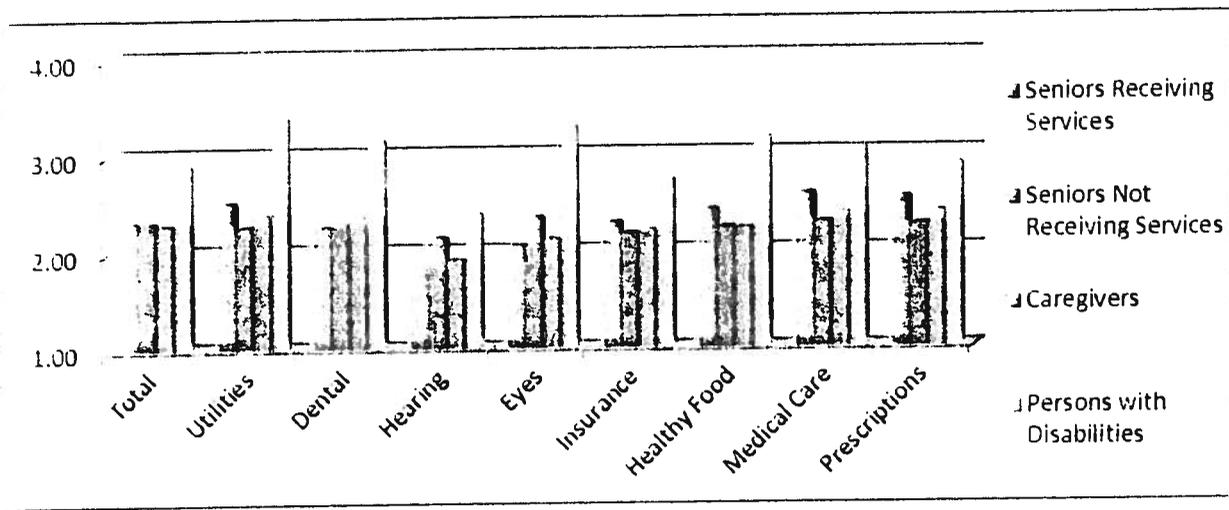
Seniors who have not received services view monetary assistance to be a little important (*mean=2.32, median=2.27, n=98, sd=1.07*). All but one of the services are considered to be a little important (*mean=2.19-2.36, median=2.0, sd=1.19-1.3*). The least important service to seniors who are already receiving services is hearing exams and/or hearing aids (*mean=2.15, median=1.0, n=89, sd=1.3*). (See Figure 1-16.)

Caregivers view monetary assistance to be a little important (*mean=2.29, median=2.29, n=123, sd=0.93*). All but one of the services are considered to be a little important (*mean=2.13-2.4, median=2.0, sd=1.18-1.26*). The least important service to caregivers is hearing exams and/or hearing aids (*mean=1.92, median=1.0, n=117, sd=1.18*). (See Figure 1-16.)

Persons with disabilities view monetary assistance to be quite a bit important (*mean=2.9, median=3.0, n=19, sd=0.88*). The most important of these needs are for utilities or an unexpected bill (*mean=3.39, median=4.0, n=18, sd=0.85*), dental care and/or dentures (*mean=3.17, median=4.0, n=18, sd=1.1*), eye exam and/or eyeglasses (*mean=3.28, median=4.0, n=18, sd=1.07*), and paying for healthy food (*mean=3.17, median=4.0, n=18, sd=1.15*). The least important service to persons with disabilities is help paying for hearing exam and/or hearing aids (*mean=2.39, median=2.0, n=18, sd=1.29*). (See Figure 1-16.)

FIGURE 1-16: MONETARY ASSISTANCE BY TARGETED GROUP

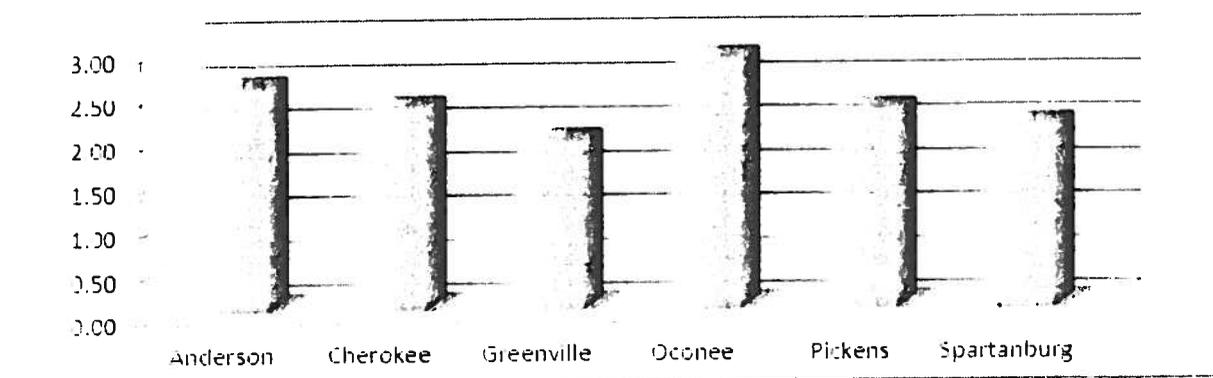
	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Monetary Assistance Composite	2.32	2.32	2.29	2.91
Utilities or an unexpected bill	2.52	2.27	2.39	3.39
Dental Care and/or Dentures	2.26	2.29	2.37	3.17
Hearing Exam and/or Hearing Aids	1.82	2.15	1.92	2.39
Eye Exam and/or Eyeglasses	2.06	2.36	2.13	3.28
Health Insurance	2.30	2.19	2.22	2.75
Healthy Food	2.43	2.25	2.24	3.17
Medical Care	2.59	2.30	2.39	3.06
Prescriptions or Prescription Drug Coverage	2.55	2.27	2.40	2.89



The difference in the monetary assistance composite is not significantly different between the targeted groups ($F=2.55, df=3, p=0.055, r^2=0.011$). The age of the respondent has a significant impact on their perceived need for monetary assistance ($F=9.23, df=4, p<0.001$). This indicates that respondents who are in most need of these services are those who are younger than 65 years old. African Americans, those who have received an Associate's degree or less, and individuals below the poverty line also rated these services as being of greater importance to them ($F=30.64, df=1, p<0.001$; $F=10.4, df=4, p<0.001$; and $F=11.29, df=1, p<0.001$, respectively). Individuals who are single or divorced rated these services as being of greater importance to them than individuals who are widowed or married ($F=6.94, df=3, p<0.001$). For seniors, those who have a disability have a significantly greater need for monetary assistance ($diff=0.37, t=4.76, df=556, p<0.001$). Individuals residing in Anderson and Oconee counties expressed the greatest need for monetary assistance ($F=10.67, df=9, p<0.001$).

Overall, the demographic clusters of respondents who reported that these services are of greatest importance to them are Cluster 2 (White females, widowed, with a high school education, who are above the poverty line and most likely to be over the age of 85) and Cluster 3 (Black females, widowed, with less than high school education, who are below the poverty line) ($F=5.66, df=3, p=0.001$).

FIGURE 1-17: MONETARY ASSISTANCE BY CLUSTER



Caregiver Needs

The Caregiver Needs component is comprised of the following five items: monetary assistance for services; information and referral; training on caring for someone at home; Adult Day Care; Respite. The scores for items are approximately 84% consistent among cases. The composite was calculated by averaging each individual's responses to the eight items. Doing so also allows for an individual to have a composite score even if they did not respond to any one of the items.

Caregivers were asked to report the number of seniors, persons with disabilities, seniors with disabilities, and children for whom they care. These responses were used to categorize caregivers into four types: caregivers of seniors ($n=15$, 13.3%), caregivers of seniors with disabilities ($n=74$, 65.5%), caregivers of persons with disabilities ($n=17$, 15%), and caregivers of children ($n=7$, 6.2%). It must be noted that these items on the survey were not mutually exclusive, and as such, respondents may have selected more than one response for the same individual. Furthermore, approximately half of the caregivers of children are also the caregiver for a senior or senior with a disability, and approximately half of the caregivers of persons with disabilities are also the caregiver for a senior or a senior with a disability.

Caregivers of seniors (who do not have a disability) disagree that caregiver services are necessary to help them care for the individual(s) ($mean=2.15$, $median=2.2$, $n=15$, $sd=1.05$). The most important need is for temporary relief from caregiver duties (respite) ($mean=2.54$, $median=3.0$, $n=13$, $sd=1.39$). (See Figure 1-18.)

Caregivers of seniors who do have a disability agree that caregiver services are necessary to help them care for the individual(s) ($mean=2.88$, $median=3.0$, $n=74$, $sd=0.69$). The most important of these needs is for temporary relief from caregiver duties (respite) ($mean=3.34$, $median=4.0$, $n=70$, $sd=0.92$), followed by monetary assistance for acquiring services ($mean=3.14$, $median=3.0$, $n=70$, $sd=0.89$) and information and referral for services ($mean=2.94$, $median=3.0$, $n=70$, $sd=0.95$). (See Figure 1-18.)

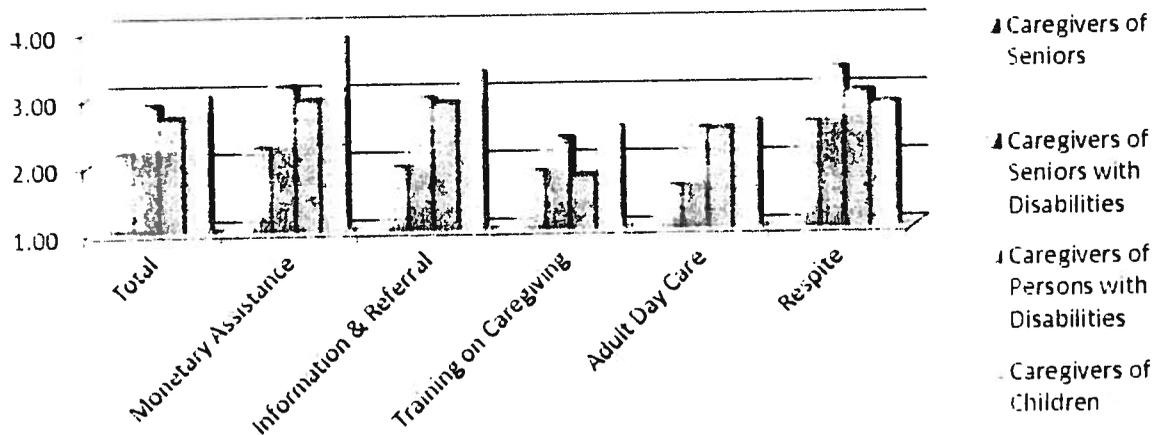
Caregivers of persons who have a disability (and are under 60 years of age) agree that caregiver services are necessary to help them care for the individual(s) ($mean=2.68$, $median=2.8$, $n=17$, $sd=0.87$). The most important of these needs are for monetary assistance in acquiring services ($mean=2.93$, $median=3.0$, $n=15$, $sd=1.1$), information and referral for services ($mean=2.88$, $median=3.0$, $n=17$, $sd=1.17$), and temporary relief from caregiver duties (respite) ($mean=3.0$, $median=3.0$, $n=15$, $sd=1.2$). (See Figure 1-18.)

Seniors who are also caregivers of children agree that caregiver services are necessary to help them care for the individual(s) ($mean=3.0$, $median=3.0$, $n=7$, $sd=0.59$). The most important need is for monetary assistance in acquiring services ($mean=3.86$, $median=4.0$, $n=7$, $sd=0.38$), followed by information and referral for services ($mean=3.33$, $median=3.5$, $n=6$, $sd=0.82$). Note that some of these senior caregivers of children also care for other seniors. (See Figure 1-18.)

The difference in the caregiver needs composite is significantly different between the type of person being cared for ($F=3.99$, $df=3$, $p=0.010$). Therefore, caregivers of seniors with disabilities and caregivers of children have greater need for services than caregivers of seniors without disabilities. However, the target group categorization only accounts for 9.9% of the variability in this composite ($r^2=0.099$). Monetary assistance and respite are the services most needed by all types of caregivers, followed by information and referral. There are no differences in the needs of caregivers based on demographics.

FIGURE 1-18: CAREGIVER NEEDS BY WHO CARE IS PROVIDED TO

	Caregivers of Seniors	Caregivers of Seniors with Disabilities	Caregivers of Persons with Disabilities	Caregivers of Children
Caregiver Needs Composite	2.15	2.87	2.68	3.00
Monetary Assistance	2.23	3.14	2.93	3.86
Information & Referral	1.93	2.94	2.88	3.33
Training on Caregiving	1.85	2.34	1.79	2.50
Adult Day Care	1.62	2.47	2.47	2.57
Respite	2.54	3.34	3.00	2.83



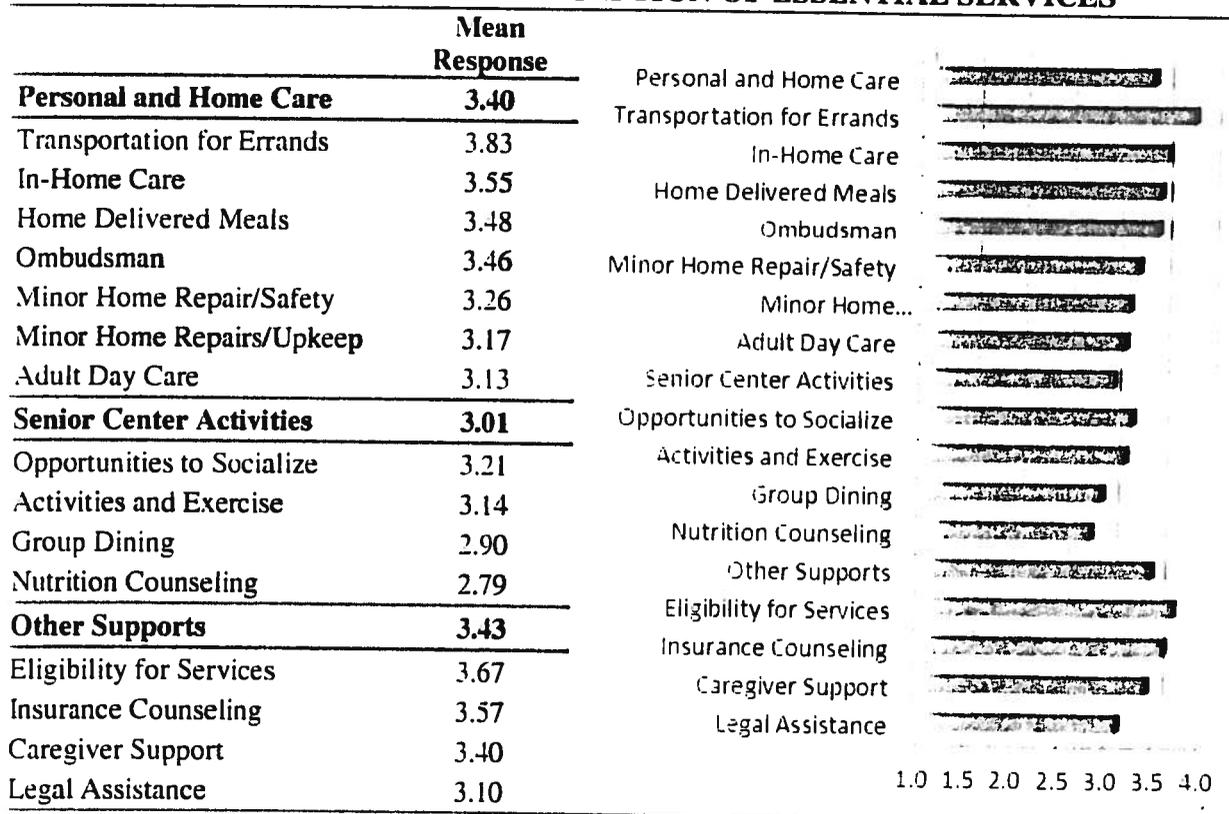
Partner/Professional Survey

Three composites were created from the questions on the partner survey related to preserving services. These three composites are: Personal and Home Care (which consists of items related to home delivered meals, in-home care, minor home repairs/property upkeep, transportation for errands, adult day care, ombudsman, and minor home repair/maintenance/home safety), Senior Center Activities (which consists of items related to group dining services, activities and exercise, nutrition counseling, and opportunities to socialize), and Other Supports (which consists of items related to insurance counseling, information on service eligibility, legal assistance, and caregiver supports).

Overall, Personal and Home Care services (*mean=3.4, median=3.43, n=31, sd=0.46*) and other supports (*mean=3.43, median=3.5, n=30, sd=0.44*) are viewed to be more essential services to helping seniors and those with disabilities in Region 1 to remain independent. The most essential services are transportation for errands (*mean=3.83, median=4.0, n=30, sd=0.38*), information on eligibility for community and other services (ADRC) (*mean=3.67, median=4.0, n=30, sd=0.55*), insurance counseling/Medicare counseling services (*mean=3.57, median=4.0, n=30, sd=0.57*), and in-home care (housekeeping, laundry, personal care) (*mean=3.55, median=4.0, n=29, sd=0.69*). (See Figure 1-19.)

Partners and professionals who reported that their primary line of business is in providing personal and/or home care (such as nutrition/meals, adult day services or in-home, or transportation) reported that personal and home care services (*mean=3.43, n=7, sd=0.53*) and other supports (*mean=3.5, n=7, sd=0.25*) were more essential than senior center activities (*mean=2.86, n=7, sd=0.66*). Partners and professionals who reported that their primary line of business is in community or senior centers reported that personal and home care services (*mean=3.03, n=4, sd=0.47*) and other supports (*mean=3.0, n=4, sd=0.20*) were not as essential as senior center activities (*mean=3.38, n=4, sd=0.95*). Partners and professionals who reported that their primary line of business is in healthcare or wellness (such as skilled nursing, healthcare, health and wellness, mental health or behavioral health) reported that personal and home care services (*mean=3.4, n=13, sd=0.43*) and other supports (*mean=3.46, n=13, sd=0.49*) were more essential than senior center activities (*mean=2.87, n=13, sd=0.54*).

FIGURE 1-19: PARTNER PERCEPTION OF ESSENTIAL SERVICES



Overall, partners' perceptions of how their organization interacts with the AAA are positive. The majority are knowledgeable of the services offered (n=19, 73.3%), know who is eligible to receive services (n=19, 65.5%), believe that the AAA is a critical partner for their organization (n=25, 83.3%), refer clients to the AAA/ADRC (n=22, 71%), and disagree that there are unmet needs for caregivers (n=17, 77.3%), seniors (n=18, 82.6%), and persons with disabilities (n=19, 82.6%).

Of concern is that 65.5% of partners (n=19) stated that they are not aware of the AAA's strategic plan, only 37% (n=10) understand how the AAA/ADRC sets priorities for which clients receive services, and 45.2% (n=14) stated that the services offered by the AAA/ADRC are easily accessible. Only 36% of partners (n=9) stated that the clients are able to pay part of the cost of their services, and 90.9% (n=20) agreed that the AAA/ADRC should offer providers the opportunity to contract for fixed reimbursement rates. (See Figure 1-20.)

FIGURE 1-20: PARTNER PERCEPTIONS OF INTERACTIONS WITH AAA

	Agree	Disagree	Total Responses
Knowledgeable of Services	73.3%	26.7%	30
Aware of Strategic Plan	34.5%	65.5%	29
Know who is Eligible	65.5%	34.5%	29
Understand Priorities for Services	37.0%	63.0%	27
Critical Partner	83.3%	16.7%	30
Refer to AAA	71.0%	29.0%	31
Services Easily Accessible	54.8%	45.2%	31
Clients able to Pay	36.0%	64.0%	25
Unmet Needs for Caregivers	22.7%	77.3%	22
Unmet Needs for Seniors	28.0%	72.0%	25
Unmet Needs for PWD	17.4%	82.6%	23
Fixed Reimbursement	90.9%	9.1%	22

For seniors, the geographic areas that are most underserved are, in order of prominence:

- Rural areas in all counties
- Greenville County as a whole, plus Upper and Lower Greenville County
- Oconee County
- Specific communities:
 - Belton
 - Anderson
 - Honea Path
 - Pelzer
 - the Golden Strip area

The services most needed by seniors on the underserved areas are, in order of prominence:

- Transportation
- In-home care
- Home delivered meals
- Home modifications, upkeep and repair
- Also mentioned as needs were Information and Referral, MH/addiction, socialization, and adult day care

The services most needed by person with disabilities in the underserved areas are, in order of prominence:

- Transportation
- In-home care
- Home repair/modification
- LTC placement
- Also mentioned as needed were cost-share, meals, adult day care, caregiver support

Quotes

Assistance with long term placement. I am unaware of any agency that provides "placement services" for individuals or families.

I Would love to have a resource or contact person for placement issues. I work with adult protective services and we do not offer placement only. 2. One agency to investigate abuse, neglect and exploitation in both the community and facilities

I think the services you provide are definitely a needed service. You have helped quite a number of my clients in so many areas. God Bless you and the ones that work this program.

Many [persons with disabilities] will need on going assistance due to low income and inability to provide for basic needs

Is there a possibility of having an online application for seniors to apply for assistance? Currently, it takes forever to get a phone call returned.

Oconee County and Pickens County greatly need additional services for seniors and persons with disabilities. Both counties senior programs are nonexistent. Transportation and Home Care services are very difficult to obtain. There is only one senior center in Oconee County which is not accessible for all seniors in the county.

The most needed services are for those that fall in the "middle", make too much income for Medicaid/State supported services, but do not make enough to pay privately for services long term, assisted living or skilled nursing.

Service Priorities Recommended To Address the Needs Identified and a Timeline for Implementation

Using a principle components factor analysis, SWS identified five components that classify the service needs of the target groups it was asked to conduct a needs assessment with. What was found was that the priorities placed on service needs vary among the target groups served by Region 1. Furthermore, priorities vary within the target groups in many instances depending upon demographic variables. Given this variation, service priorities need to follow priorities established by the staff and board of Region 1 following the needs identified as most important within each of the five components. This, in part will depend on where the planners wish to place their emphasis. The needs assessment for the Region provides a great deal of evidence of what is important to each target group and to the demographic groups presently being served. It would be presumptuous of SWS to make recommendations to those responsible for the planning in the Region of which services and target populations should be emphasized. However, what the target groups believe is important is presented in the report.

Timelines for implementation are dependent upon the planning process, oversight of those conducting that process and availability of funds. SWS proposes the following timeline.

1. SWS prepare a 15-20 minute PowerPoint presentation of the findings for the Region's needs assessment after completion of the report.
2. The regional director notify SWS by October 26 if the Region would like to have a Webinar presentation of the PowerPoint.
3. The presentation be scheduled.

Discussion and Summary

As might be expected, the population in need is more poor, more African-American, more female, less likely to have a spouse, older and with fewer social supports than the general senior population in the region. These demographic characteristics are often connected.

Overall, respondents viewed Information, Referral, and Assistance to be the service most important to helping them stay where they are, followed by I-CARE (Insurance Counseling), caregiver services, senior center activities, services to help them maintain independence, and personal and home care. The most important service to caregivers is respite care, followed by monetary assistance in obtaining services. Within senior center activities, respondents viewed exercise and counseling (having someone to talk to) to be the most valuable. Services to help in maintaining independence came in fifth, with the most important services being those of the Ombudsman. Monetary assistance is only slightly more than a little important, with the most important being help with payments for medical care and prescriptions or prescription drug coverage. Personal and home care is viewed to be the least important, with the most important

of these being transportation for errands and home repairs and modifications (for both upkeep and for safety).

However, these are generalizations. There is a great deal of variation within categories. For example, service needs of caregivers vary depending upon whom they are caring for and what the age of the person(s) they are caring for is. Personal and home care, which is viewed as the least important to seniors who are already receiving services, is viewed as very important to caregivers and persons with disabilities. Needs within categories vary according to age, race and gender. Mean scores, therefore, for the sample as a whole, are not necessarily a good guide for planning. Rather, the needs perceived by each group should be examined separately and in detail. This is a segmented market and should be approached as one, as Region 1 is doing. It is strongly recommended that the Service Needs by Targeted Group sections of this report be carefully reviewed by the staff and policy makers of Region 1 rather than an attempt be made to produce a single list of needs in order of priority.

In this report, SWS presents the needs as reported by the respondents to the needs assessment survey by target group, demographic clusters and the two combined. It has further divided the needs by the types of services provided and has provided an additional breakdown for caregivers. This information is provided in written and in graphic form. This information can be utilized as a rich source for in-depth planning for services in the Region.

While partners believe they have a good relationship with the AAA, they believe they have little interaction with the AAA on the planning process, have little knowledge of the plan, do not understand how priorities are set for which clients receive services and have very little knowledge of the strategic plan or the planning process. In short, the partners feel that they are a strong part of service provision and a small part of planning and prioritizing. This may or may not be an important issue, but should be explored.

**Area Plan Update for the Appalachian Council of Governments
Long Term Care Ombudsman Program
2014 – 2017**

The Regional Ombudsman (Nancy Hawkins) is supervisor of both the Ombudsman Program and the Friendly Visitor Program. Three Ombudsman staff members (Jamie Guay, Sandy Dunagan & Tiwanda Simpkins) devote 100% of their work hours to their assigned Ombudsman job responsibilities. The Volunteer Coordinator's (Ericca Livingston) time is divided between assigned Ombudsman responsibilities and her work as the Volunteer Coordinator. The Intake Coordinator (Jessica Winters) is responsible for receiving intakes and entering data into the Ombud system. She is also responsible for completing required reports.

There is anticipated turnover in the Ombudsman program with the upcoming retirement of the Regional Ombudsman and the hiring of a replacement. Also Ms. Jamie Guay resigned as of May 31, 2013 and her position will also have to be filled.

The Long Term Care Ombudsmen investigate complaints made by or on behalf of residents living in nursing homes, residential care/assisted living facilities, special needs and disabilities facilities, sub-acute units in hospitals, psychiatric hospitals, clients of mental health centers and hospice homes.

For the year 2010 - 2011 this program opened **1,058** Cases and closed **1, 071** Cases. For the year 2011 – 2012 this program opened **1,077** Cases and closed **1,071** Cases. The number of cases is expected to increase each year.

Continuous efforts are made to ensure timely and responsive access to the services of the Long Term Care Ombudsman Program.

The Ombudsman staff work with various agencies in an effort to advocate for residents, i.e Local Law Enforcement, Office of the Attorney General, DHEC, Division of Health Licensing and DHEC, Division of Certification. We also work with the South Carolina Legal Services and Adult Protective Services as needed. By working with these various agencies many cases have been successfully resolved and/or perpetrators being prosecuted.

Ombudsman staff members are also responsible for advocating for residents through mediations, consultations and education. Community Presentations and Facility Staff In-Services are provided upon request. Due to the large volume of cases received in this region, the community presentations and facility in-services have to be limited each month. Topics for these include: The Laws regarding Abuse, Neglect and Exploitation, Residents Rights, Dealing with Difficult Behaviors and Dementia Dialogues.

For the Year of 2010 – 2011 a total of **727** Consultations were completed, **29** Facility Staff In-Services and Community Presentations were provided and **6** Resident/Family Council Meetings were attended. **68** Friendly Visits were made by Ombudsman Staff and **83** Friendly Visits were made by Volunteers. For the program year for 2011 - 2012, this program completed **833** Consultations and **30** Facility Staff In-Services and Community Presentations and **6** Resident/Family Council Meetings were attended. **137** Friendly Visits were made by Ombudsman Staff and **92** Friendly Visits were made by Volunteers.

The Ombudsman Program continues to work with local Law Enforcement agencies in an effort to educate them on the laws concerning vulnerable adults and the Ombudsman Program. A goal is set to work with at least one law enforcement agency in each county, to set up and provide training for law enforcement personnel.

Recruitment efforts are on-going via newspaper ads, area newsletters and community presentations.

During on-site visits to the facilities Ombudsman staff members will continue to check on each facility's Emergency Preparedness plan and will keep a current record of relocation plans.

The Ombudsman Program continues to provide and promote the Friendly Visitor Program in which volunteers are trained and make on-site visits to facilities who have signed up to participate in the Friendly Visitor Program. There are currently **13** volunteers in the Friendly Visitor Program and **20** facilities who have signed up to participate in the program.

The long range goals of this program are to provide all of the above services in a timely manner and in an efficient manner that is most beneficial to the residents living in the facilities.

Major strengths of the Ombudsman Program include:

- Continued improvement in the working relationship with facilities. Each of the Ombudsman staff members do strive to work with facility staff in promoting open communication and encouraging efforts to be made that will be most beneficial for the resident. In recent years the program has seen an increase in the number of the consultations requested by facility staff.
- The number of mediations continues to be increasing. Ombudsman staff members have been able to have both the facility staff and the family members to sit down and work together toward finding ways to resolve issues of concern.
- The Ombudsman program continues to work with the Greenville County Probate Court in implementation of a monitoring program. Ombudsman staff provide Friendly visits to facilities in which monitoring can be done of those residents who have a Guardian and/or Conservator assigned by the court. A report is then sent in to the Probate Court identifying any problems and/or concerns that need to be addressed by the Probate Court.
- The Ombudsman program has a Friendly Visitor Program in which volunteers are assigned to a facility that they visit weekly. During the volunteers weekly visits they strive to build a relationship with the residents. The volunteer also works closely with staff members, offering encouragement and support for their efforts. While visiting, the volunteer is able to monitor the residents care and activities. If there are issues of concern they are able to advocate on the residents behalf and work with staff members to resolve the issues. This program has been very successful in that those facilities who are currently participating have shown a decrease in the number of complaints reported to the Ombudsman program. The Friendly Visitor Program will continue to grow, so that new volunteers are always entering the program as experienced volunteers retire for service. This will prevent service gaps in the participating facilities.

Major Weaknesses of the Ombudsman Program include:

- There has been an increase in the number of reports filed by facilities which has made an increase to the number of cases that each of the Ombudsman staff have at any given time. On average each Ombudsman staff member has 40–50 open cases that they have been assigned. With the added responsibilities of community and facility trainings, friendly visits and other job responsibilities, it is very difficult to get the cases completed in a timely manner.

- The Ombudsman Program currently has insufficient staffing. The Regional Ombudsman's position is currently being filled part time by Nancy Hawkins. Efforts need to be made to replace this position with a full time staff member. Also Jamie Guay, Long Term Care Ombudsman, resigned as of May 31, 2013. Efforts will be made to replace this position in the immediate future also.
- Because of the number of cases received, the cases are given priority as to action taken, i.e. the most serious cases of Abuse and Neglect being given top priority. All other activities are completed as time allows, i.e. community education, facility trainings and friendly visits. (Public awareness of factors related to Abuse, Neglect and Exploitation will result in increased reporting.)
- Due to the large case load of each Ombudsman, they still are unable to complete quarterly visits to every facility in the region. The number of visits has increased but needs improvement.
- The Ombudsman Program does not have the opportunity to attend Resident Council meetings very often due to the fact that we must be invited in order to attend. In the past two years the Ombudsman staff have attended 12 Council meetings (6 in 2010–2011 and 6 in 2011-2012). Efforts to become more involved in these meetings will continue by the Ombudsman staff meeting with the Resident Council President during on-site visits to facilities and offering to provide a presentation concerning advocacy for residents or request to have permission to attend one of their meetings.
- The Ombudsman Program cannot provide Facility staff In-Services unless the facility is willing to allow it. Efforts are made during any/all on-site visits to educate facility staff of the Ombudsman Staff's willingness to provide those trainings. Also contacts are made to community groups in an effort to request time to provide presentations. However many times these offers are not accepted.
- The Friendly Visitor Program has an on-going fluctuation in the number of volunteers participating. Many times there are health issues or just the fact that after beginning the program the volunteer may decide that this is not what they want to participate in. Currently facilities have to volunteer to participate in the program and it is difficult to match up volunteers with a facility when the volunteer wants to remain in their community and not drive out of their area. This causes a delay in getting a volunteer assigned to some facilities.

- This program is also looking at the possibility of additional cuts in the State Budget in the upcoming year. Because of cuts to this program, efforts are going to have to be made to increase the number of volunteers working with the program.

Final South Carolina ADRC October 2012 - March 2013

Appalachia Aging and Disability Resource Center (Appalachia AAA/Council of Governments)

ADRC Local/Program-Level Section

Grantee and Report Preparer (Program Site) -- Appalachia Aging and
Disability Resource Center (Appalachia AAA/Council of Governments)

State:	SC
Grantee Organization (Name of Lead State Agency):	Lt. Governor's Office on Aging
ADRC Name (to the public):	Appalachian Aging and Disability Resource Center
Report Preparer Contact	Tim
First Name:	
Last Name:	Womack
Telephone Number:	8642429733
E-mail Address:	twomack@scacog.org
Notes	

Staffing -- Appalachia Aging and Disability Resource Center
(Appalachia AAA/Council of Governments)

There is no information supplied for this section

ADRC Service Area and Model -- Appalachia Aging and Disability Resource Center (Appalachia AAA/Council of Governments)

<p>Program Site Model and Operating Organizations: --> What functions and services do each of your operating organizations offer? Please check all the boxes that apply::</p>	<p>Outreach and Marketing, Information and Referral/Assistance, Benefits Counseling, Options Counseling, SHIP Counseling, Advocacy, Assisting with Medical or Pharmaceutical Assistance, Caregiver Support Services (such as grandchildren helping grandparents), Prevention, Health Promotion, or Risk Reduction Programs, Transportation Services or Service Coordination, Older Americans Act Services not otherwise listed (e.g. Meals on Wheels), Screening/Intake or Medicaid or Other Public LTC Programs, Assisting to Complete and/or Submit Financial Eligibility Applications, Local Contact Agency (for MDS 3.0 Section Q)</p>
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ADRC Contacts -- Appalachia Aging and Disability Resource Center (Appalachia AAA/Council of Governments)

Total Contacts to the ADRC During Reporting Period	Oct 1, 2012
Enter the dates between which these data were collected: Start date::	
Enter the dates between which these data were collected: End date:: Mar 31, 2013	
Total Contacts made to ADRC during this period (calls or walk-ins)	4327
Contacts by Type	3851
Contacts by Consumers:	
Contacts by Caregivers :	12
Contacts by Professionals:	8
Contacts by Others (not consumers, caregivers, or professionals):	297
Unknown Contacts:	159

Person-Centered Transition Support: Care Transitions from Hospital to Home -- Appalachia Aging and Disability Resource Center (Appalachia AAA/Council of Governments)

Hospitals you are planning to partner with to offer care transitions programs

Partnership -- Appalachia Aging and Disability Resource Center (Appalachia AAA/Council of Governments)

Total Number of Formal Partnerships 11

Additional Files and Information

Materials Uploaded:

Current Files:

FY 2012 SHIP Year End Progress Report

Appalachian AHH
Region

The purpose of this report is for sub-grantees to indicate SHIP activities performed during **September 1, 2012 through December 31, 2012** and state proposed activities for 2013.

- I. *What actions did your region take in FY 2012 to expand your outreach and counseling efforts?*

Our current staffing includes a benefit counselor who is responsible for Outreach. We performed more outreach events which were coordinated with health care agencies, senior centers, and the senior population. We also participated in senior expos, many agency fairs and provided consumer education session throughout the region during this time period.

During winter, 2000 Medicare calendars (with local contact info) were distributed.

 - A. *What changes will your region make in 2013 to enhance these efforts?*

Having a person “focused” on outreach, it becomes a part of our monthly schedule.
- II. *What actions did your region take to reach more consumers through presentations and health fairs?*

We performed more outreach events which were coordinated with health care agencies, senior centers, and the senior population. We also participated in senior expos, many agency fairs and provided consumer education session throughout the region during the year.

 - A. *What changes will your region make in 2013?*

Will continue the same strategy.
- III. *What actions did you reach take to increase the number of consumers reaching your office through direct contact such as in-person, telephone calls and home visits?*

Home visits are performed for clients when the client has limited access to a local resource. The biggest increases were in telephone contacts with clients regarding “complex” problems.

Our agency will use a team-based approach with different employees in the aging department to ensure phone calls and consumer contact is initiated within a timely period and we complete a through intake on each caller.

 - A. *What changes will your region make to increase direct contacts in 2013?*

Continue offering on-site enrollment events in each county during Open Enrollment. Have goal of establishing a year round site in Spartanburg staffed by volunteers.
- IV. *What actions did you region take to reach more beneficiaries under age 65?*

FY 2012 SHIP Year End Progress Report

Region

We conducted New to Medicare Training Sessions, outreach events in cooperation with Senior Centers, hospitals, and home health centers. We attend interagency meetings with other local organizations to help spread information to their clients regarding Medicare services to seniors, Medicare beneficiaries and disabled individuals. Many of our outreach events involved housing complexes that serve older adults and disabled individuals.

- A. *What are your 2013 strategies to reach more consumers under age 65?*
Scheduling New to Medicare sessions for the year to refer callers to sessions.

- V. *What was your region's strategy for reaching LIS eligibles?*

- A. *What are your strategies for 2013?*
We will continue to distribute materials regarding LIS subsidy help, and Medicare and Part D Drug Assistance in all outreach materials. We will work more closely with local Medicaid offices, home health agencies, and local Social Security offices for referrals. Again our providing option counseling with FCP clients is helping to identify additional individuals eligible for benefits. We will continue to include benefits check up as part of outreach events at housing complexes.

- VI. *What was your strategy or process for enrolling consumers into Part D plans?*
Our agency made sure Medicare Beneficiaries were aware of the new Part D annual Enrollment Period. Our agency provided numerous benefit check-up workshops and outreach events to make sure Medicare Beneficiaries were aware of their medical coverage and their options for help with prescriptions, medical and health coverage. Our agency helped to enroll and disenroll numerous Medicare Beneficiaries into more cost-effective Medical and Part D Plans.

Enrollment events were scheduled in each county during annual enrollment period. A schedule is attached. The sites in Cherokee, Oconee and Greenville were staffed by volunteers. Greenville County included 1 new site, The Cascades and enrollment assistance continued at Covenant UMC and Senior Action.

- A. *What is your strategy for increasing Part D enrollment in 2013?*
More pre-Open enrollment efforts. A staffing vacancy curtailed some of the efforts in 2012. Also hope that funding will allow having a temporary person in office during open enrollment. This staffing also helps with additional outreach efforts during this period.



SMP Progress Report Guidelines

for

7/1/2012 thru 12/31/2012

Region Appalachian

The SMP Grant is to support regions in achieving the following AOA outcomes. Please list your goals and describe activities to implement key requirements of the program.

- 1. What did you do to promote the National and Regional SMP Program?** We continually arrange outreach events, have a quarterly newsletter which entails the SMP Program, Schedule and attend senior health fairs, medical health fairs, and communicate with senior housing complexes.

What were your regional marketing activities? To have monthly outreach events to seniors, Medicare beneficiaries, and senior housing complexes. To distribute quarterly newsletter to our partner agencies and the aging community, SMP brochures which entail the SMP Program, SMP Bag distribution at all outreach, senior fairs, health fairs attended. Meet and Greet Community Partners about the SMP Program to their clients on a Quarterly Basis.

Describe all efforts with the National SMP program such as webinars, ordering materials, etc. Webinars to Staff and Volunteers, Quarterly Volunteer Meetings, SMP Brochures, SMP Bag Distribution, Quarterly Newsletters, Outreach Events, Health Fairs, Senior Health Fairs, Ordering of SMP Material for all outreach activities, Word of mouth.

- 2. What did you do to improve beneficiary education and Inquiry resolution?**

Education: Outreach Events, One-on One meetings with Volunteers and Medicare Beneficiaries, brochures explaining what the SMP Program entails, explanation by phone,

Simple Inquiries: Resolve issues over the phone; through one-on-one meetings and consultations

Complex Inquiries: Directed to Crystal Strong at the State Office Level

Include numbers served through Simple, Complex, Media and Group Education. List follow-ups, resolution process and intake process. We have conducted Media Airings (Marques Wideman on TV News several times), more controlled outreach events with SMP as the main focus, we are also follow-up with the SC Dept of Insurance, Medicare, and the State Level as well.

Are inquiries entered into SMART-Facts bi-weekly ___No___? If not, why? There were 2 Major staff changes in the aging department, new measures have been enacted to put information into SMART-Facts now on a bi-weekly basis.

3. How did you foster the National SMP Program Visibility?

Do you have a link to the national SMP? Yes

How do you market the national SMP (newspaper, promotional items, etc)? Newsletter, Newspaper, Word of Mouth, at every outreach activity.

Number of group presentations conducted: 25 for this time period.

What were your outreach goals? The outreach goals are to inform clients about the SMP Program in all 6 counties by conducting at least 2 SMP Outreach events a month. **Did you meet or exceed your goals?** We did exceed our goals of SMP Outreach goals.

What is your improvement plans? Improvement Plans consist of educating every Aging Employee of the SMP Program and to promote the SMP Program on every outreach activity by the Aging Employees. We will also make our volunteers aware of any changes in the SMP Program; provide each volunteer with the quarterly newsletter to distribute to clients in each county, work with our community partners on a quarterly basis to help promote the SMP Program. Continue to have Media airings to let the public know of the Aging Community and the SMP Program.

4. How did you improve efficiency?

How many SMP volunteers do you have? ___13___

Did contacts or inquiries increased or decreased? Contacts and inquiries have increased **WHY?** Due to our volunteers, more education of the SMP Program to employees, and more distribution of the SMP Program through outreach activities.

What are your strategies to improve contacts for the next report period? Improved Education and Meeting with our Volunteers, Improved Education with Aging Employees, New Quarterly Newsletter to Community Agencies and Partner Agencies, Outreach Activity Events, Word of Mouth, One-on-one meeting with clients and Medicare beneficiaries.

What were the prevalent fraud trends in your area and what did you do to inform or help consumers? Medicare Fraud, billing issues by doctors and hospital, errors in payment information sent to Medicare.

5. In addition to reaching all populations, how did you target underserved populations? Partnership with local Medicaid Offices, Social Security Office, COAs, Hospitals, community partners, community agencies to help get the education and awareness of the SMP Program to clients, outreach events, word of mouth.

6. ***Who were your targeted underserved populations?*** Seniors, Medicare Beneficiaries, Low-Income Individuals, Disabled Individuals
7. ***Who are your new partners since last report period?*** Pickens County Medicaid
 Oconee County Medicaid
 Pickens County Medicaid
 Regenes HealthCare-Cherokee County
 Regenes HealthCare-Spartanburg County
 Greenville County Medicaid
 Spartanburg County Medicaid
 Cherokee County Medicaid
 Anderson County Medicaid
 Social Security Administration-Greenville County
 Christopher Lynn Estates-Cherokee County
 Bethlehem Center-Spartanburg County
 AARP Volunteer Program-Nancy Eaker Spartanburg County
 Sterling Community Center-Greenville County
8. ***What new approaches did you implement since last report period and what will you do different for the current period? What are you goals for the upcoming period?*** To reach a wider audience of Medicare Beneficiaries and Disabled Individuals, to achieve more volunteers for the SMP program, to focus on more client resolution of SMP issues, to communicate on a monthly basis with the State Office on changes in the SMP Program, to increase over SMARTFACTS numbers for the upcoming period.
9. ***Please list all events and trainings for the upcoming period.***
- Pickens County Medicaid Office
 Monday, January 14 9:30 am – 10:30 am
 Oconee County Medicaid Office
 Monday, January 14 12:00am – 12:00 pm
 Spartanburg Medicaid Office
 Tuesday, January 15 1:00pm – 1:45pm
 Spartanburg Mental Health
 Tuesday, January 15 12:20pm – 12:50pm
 Archibald Rutledge – Senior Centers of Spartanburg County
 Tuesday, January 15 11:40am – 12:10 pm
 Regenes Healthcare- Gaffney, SC
 Tuesday, January 15 10:30am-11:00am
 Cherokee County Medicaid Office
 Tuesday, January 15 9:00am – 10:00am
 Sterling Center
 Thursday, January 17 12:30pm – 1:30 pm
 Greenville County Medicaid Office
 Thursday, January 17 11:00am – 12:00pm
 Sterling Community Center Greenville, SC

Monday, February 11 10:30am – 11:30am
Social Security Administration – Greenville, SC
Thursday, February 14 12:30pm – 1:30pm
Seniors Take Charge-Spartanburg County Library
Thursday, February 21 2:00pm-3:30pm
Bethlehem Center-Spartanburg County
Tuesday, February 26 10:30am – 11:30 am
Landwood Ridge Senior Housing- Greenville SC
Wednesday, March 13
Jay's Place Easley, SC
Tuesday, March 19
Christopher Lynn Estates Gaffney, SC
April 23, 2013
CC Woodson Recreation Center Spartanburg, SC
Wednesday, May 29 10:00am – 1:00pm
Morningside Assisted Living Anderson, SC
Thursday, April 11
Senior Living Expo Seneca, SC
Thursday, May 23
Foothills Family Resource Center – Slater, SC
Monday, June 3 10:00am – 12:00pm
Middle Tyger Community Center Lyman, SC
Tuesday, June 10
Greenville County Health Dept Greenville, SC
Wednesday, June 12 9:00am-1:00pm
Greer Library – Jean M. Smith Branch Greer, SC
Thursday, June 13 9:00am-11:00am

I-CARE/SHIP Training –Appalachian Council of Govts
Tuesday, May 21, 2013
Tuesday, May 28, 2013
Tuesday, June 4
Tuesday, June 11
Tuesday, June 18
Tuesday, June 25

Outreach Events are added to the calendar as far in advance as possible. These are the firm calendar dates through June 25. Other events will be added as needed via community requests. Dates for Open Enrollment have not yet been determined but will be added as needed and as soon as possible. Most Outreach Events are conducted by the Outreach Coordinator on a Monthly Basis with an emphasis on the SMP Program and Medicare Fraud during Medicare Presentations, Meet and Greet with Community Partners, and Senior Health Fair Events, Health Fair/Wellness Events.

- 10. Please list your process for maintaining the confidentiality of client's records and SMP information.**
Client information is maintained in files by the Benefits Counselor, I-Care Coordinator, and the Aging Director, all confidential information including SMP data is processed into the Smart Facts System

within a timely period. No other individuals have access to this information at any time besides the Executive Director upon his request.

Program Area: Family Caregiver Support and Seniors Raising Children Programs

Purpose

The Family Caregiver Support Program is designed to reduce the stress often experienced by caregivers as they struggle to balance their personal lives with the various needs of the care receiver. The FCSP assists those who are providing care to a person(s) 60 years or older who is unable to perform at least two (2) activities of daily living without significant assistance or has a diagnosis of Alzheimer's or one of its related diseases. This eligibility must be confirmed by a health care professional. Caregivers are offered support following: a review of their and the care receiver's benefits and an assessment of their both their needs. Support may come in the form of appropriate referrals to other agencies, financial assistance within program guidelines and validation of their emotional state during the process.

Seniors Raising Children addresses the needs of those grandparents age 55 years and older raising grandchildren ages 0-18 years who reside with them full time. This program also allows support for those persons raising an adult child with disabilities who is related by blood or marriage. Like the FCSP, there is an assessment and discussion of the needs identified and how best to obtain them. Referrals may be made and financial assistance may be available within program guidelines.

Activities

Family Caregiver Advocate provides the following to Caregivers:

- Performs an assessment to assist in determining needs
- Benefits counseling to identify possible discretionary funds that may bring additional financial support to the family/caregiver
- Refers to agencies and programs felt to be appropriate based on previous assessment
- Encourages the development of support groups within the region for both FCS and SRC programs
- Provides limited short-term financial assistance for eligible consumers by funding:
 - Respite care
 - Supplemental supplies such as safety equipment and hardware, incontinent items, nutritional supplements (Boost, Ensure, Glucerna)
 - School supplies, clothing, fees for related school activities, summer camps/activities.

Outcomes/Results

- Caregivers and the care recipients are provided with current resources available to them based on the assessment process which include:
 - Applications for services from other community based resources
 - Program descriptions and brochures

- Resources guides (All About Seniors and National Caregiver Foundation)
- Advanced directives
- Other most requested documents of Durable Powers of Attorney and Wills
- Location of Support groups available
- Caregivers and the care recipients are empowered to advocate for their needs identified during the assessment process offering them more consumer choice.

Changes from Last Year

- The FCSP developed a new internal procedure that would expedite the intake process and ensure that every referral had a personal contact with an Advocate.
- Those eligible and deemed priority caregivers were served in real time and there was no waiting for financial assistance from the program.
- Over 60% of the caregivers served are new to the program.
- All of the funds were committed and spent with the Respite and Supplemental Services programs through FCSP.

VERIFICATION OF INTENT

The Area Plan submitted for the Appalachian Region for the period July 1, 2009, through June 30, 2013, includes all activities and services to be provided by the Appalachian Area Agency on Aging. The Area Agency on Aging shall comply with applicable provisions of the Older Americans Act, as amended and other legislation that may be passed during the period identified. The Area Agency on Aging will assume full authority to develop and administer this Area Plan in accordance with all requirements of the Act and related State policy. In accepting this authority, the Area Agency on Aging assumes responsibility to develop and administer this Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older people in the planning and service area.

This Area Plan was developed in accordance with all rules and regulations specified under the Older Americans Act and the Lieutenant Governor's Office on Aging. The Area Agency on Aging agrees to comply with all standard assurances and general conditions submitted in the Area Plan throughout the four year period covered by the plan. This Area Plan is hereby submitted to the South Carolina Lieutenant Governor's Office on Aging for approval.

The Appalachian Area Agency on Aging certifies that it is responsible for the oversight of the provision of Aging Services throughout the Appalachia Region. This responsibility includes, but is not limited to, the following functions:

1. Contract management
2. Programmatic and fiscal reporting activities
3. Oversight of contracted service delivery
4. Coordination of services and planning with the state office, service contractors, and other entities involved in serving and planning for the older population in the PSA
5. Provision of technical assistance and training to contractors and other interested parties
6. Provision of public information and advocacy related to Aging Program activities and issues

(Date)	Signature (Executive Director of Area Agency on Aging)
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(Date)	Signature (Aging Unit Director)
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The Area Agency Advisory Council has reviewed and approved this Area Plan Update.

(Date)	Signature (Chairperson, Area Agency Advisory Council)
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The Governing Body of the Area Agency on Aging has received and approved this Area Plan Update.

(Date)	Signature (Chairperson, Governing Board)
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BYLAWS
Appalachian Council of Governments
Regional Aging Advisory Committee
Area Agency on Aging

PREAMBLE

The Advisory Committee for Aging Program Planning of the South Carolina Appalachian Council of Governments (SCACOG) does hereby set forth the following Bylaws to govern its operation.

The term "Council" is used to designate the Appalachian Council of Governments. The term "Committee" is used to designate the Regional Aging Advisory Committee. The Committee shall function in an advisory capacity and not in a policy-making capacity.

PURPOSE AND RESPONSIBILITIES

The duties of the Committee are to:

1. Advise the SCACOG Area Agency on Aging on matters relating to the development of the regional area plan.
2. Promote and encourage local communities to recognize the needs and promote the establishment of programs for older adults or person with disabilities.
3. Support and advocate on behalf of programs and services for older adults and persons with disabilities.
4. Establish service and program priorities based upon the needs of the local communities and the region.
5. Provide assistance in conducting public hearings to solicit local community input regarding the needs of older persons and persons with disabilities.

MEMBERSHIP

The Committee will be composed of at least the following:

1. Three individuals from each county with a population of 100,000 or more.
2. Two individuals from each county with a population of less than 100,000.
3. The overall size of the Committee shall be limited to sixteen (16) unless designated otherwise by the Council. Council Board members choosing to serve on the Committee will not affect the composition/representation on the Advisory Committee.
4. More than 50% older persons.
5. Representatives who fall into at least one or more of the following categories: minority, caregiver, representative of the business community, representative of older persons, health care provider, program consumer, or a member of the general public with a demonstrated interest in the well-being of seniors, persons with disabilities and/or community transportation needs. Citizen members shall be defined as individuals who are not employed by an agency and/or an organization which either receives funds prioritized by the Council or which works closely with the Council.

6. Recommendations to add or fill Committee vacancies shall come from current membership, ensuring each county is represented. When a vacancy occurs on the Committee, the Chairperson shall notify the COG Board delegation of the county with the vacancy.

MEETINGS

1. The committee shall meet at least six times annually or at such other time and date as called by the Chairman.
2. The majority of the members of the Committee shall constitute a quorum for the purpose of conducting business.
3. Only members of the Advisory Committee may vote on any matter before the Committee. Members must abstain from voting on issues that present a conflict of interest.
4. In the event of the absence of the Chairman and Vice-Chairman at a meeting of the Committee, the Advisory Committee members may select a temporary Chairman for that particular meeting and proceed as scheduled.

OFFICERS AND THEIR DUTIES

1. The officers of the Committee shall consist of a Chairman and a Vice-Chairman. The Chairman shall be a Council member appointed by the Council chairman in March, with the concurrence of the full Council. The vice-chairman shall be chosen from and by the members of the committee.
2. The Chairman shall preside at all meetings of the Committee. The Chairman shall be responsible for attending the meetings of the Council and presenting the recommendations of the committee to the Council, as needed.
3. The Vice-Chairman shall assume the duties of the chairman in the absence of the Chairman.

MEETING ATTENDANCE

If a member is absent for three (3) consecutive meetings without contacting SCACOG staff prior to the meeting, the Chairman shall notify such member in writing of his absence, and if the member fails to attend the next regular meeting, the individual shall be notified that he has been removed from the Committee.

COMMITTEES

Ad Hoc Sub-committees and/or Project Groups shall be established as needed by the Committee. The Chairman shall appoint members of these Sub-Committees/Groups. Person from outside the committee may be added to provide the required technical expertise required for the area under review.

RECORDS

SCACOG staff will make and keep a record of all Committee meetings. Records shall be maintained within the SCACOG.

10/02/09

S.C. Appalachian COG - AAA/ADRC Reports Review & Reimbursement Procedures

In an attempt to assure that Lt. Governor's Office directives concerning the review of client data on a monthly basis is being carried out, the S.C. Appalachian Council of Governments has adopted the following procedures for reviewing client data prior to compiling and submitting the monthly request for funds to the LGOA and prior to reimbursing its vendors:

Client Programmatic Data Review:

- Run the HHS25a

An HHS25a for each agency is run from the beginning of the fiscal year through the date that the report is actually run. This gives the most recent data in the system relative to a particular client. This report is reviewed to determine if clients are missing entire assessment information. If so, then their units are deducted from the current month's MUSR request for funds.

- Run LG97c

An LG97c is run for each agency for each service that they provide. This report is run for July 1 through the last day of the current month's request for funds. This report is reviewed to determine clients who have not been re-assessed, to note clients who are under-age, to view risk scores and to determine if new assessment forms are being utilized. If any of this information can not support a client as eligible, then units are deducted. Client data is also reviewed to determine if any clients are staff members or to determine if they are otherwise ineligible for a particular service based upon the criteria established by the State.

- Client Assessment Screens

Actual client data is pulled up from the AIM assessment report screens to review client data entered when client eligibility is in question particularly concerning special eligibility situations.

Once the HHS25a , LG97c and client assessment screens have been run or reviewed and notations made of any client data that is in question, then the LG93 is run to determine how many units to disallow based upon the period of time affected by the above findings.

- Run LG93

Based upon the period of time involved, the number of disqualified units reflected on the MUSR will be deducted from the request each month based upon the units reported on the LG93. Units are deducted from the major project carried out by an entity. As data is properly updated, units may be added back as these reports are run on a year-to-date basis each month.

MUSR Fiscal Review

- SCACOG has always reimbursed its vendors using the MUSR since it was developed as the reimbursement tool and will continue this practice as part of the implementation of the Area Plan for our Aging program.

Each vendor who contracts with the S.C. Appalachian COG to provide Aging services within the Appalachian region is required to collect, compile and to enter data onto AIM.

- Vendor award documents provide data concerning the unit rates to be reimbursed for each service, total units contracted, and number of reimbursable units by the funding sources under which we contract through the State. Although vendors do not have to track their funds by funding sources, per se, SCACOG has to track this information for reporting purposes.

Each month, vendors are required to run and to review the same reports above as does the AAA/ADRC. Vendor review and management of their client data greatly reduces the number of units that may have to be deducted from the reimbursement requested.

- Vendors submit to the COG a copy of their MUSR report each month to assure that they have reviewed the report as well. The MUSR budget data is compared and/or updated based upon the latest Budget Award. Units deducted based upon the review of client programmatic data are noted on the applicable MUSR pages and revised dollars earned are pencilled in.

Vendors also submit a composite Reimbursement Request form called the Report of Documentation of Expenditures. The Report of Documentation of Expenditures (RODOE), is a Y-T-D request form compiled by project. It also includes budget data and percentage calculations that allow this monthly report to serve as a monitoring tool. The RODOE is a compilation of the calculated dollars earned from the MUSR report and serves as the signed request form from each vendor. The form captures dollars budgeted, actual dollars earned, dollars allowed and calculation of funds to be remitted by service category by project for the month.

Follow Up Documentation Report

Copies of any changes to the above forms are sent back to each vendor after processing for their review. They are asked to sign and return to the AAA/ADRC the Follow Up Documentation Report verifying that they have reviewed any revisions made to their reports/request and that they agree or disagree and/or have made the needed changes to their files.

Reimbursement

The AAA/ADRC reimburses each vendor by check and attaches a remittance detail that reflects dollars paid by service category by project to accommodate posting to the vendor's records. Vendors do not have to track remittances sent to them by any federal or state designation.



2014 – 2017 VERIFICATION OF INTENT

The Area Plan submitted for the Appalachian Region for the period of July 1, 2013 through June 30, 2017, includes all activities and services provided by the Sc. Appalachian Council of Governments Planning Service Area (PSA) and Area Agency on Aging (AAA)/Aging and Disability Resource Center (ADRC). The PSA and AAA/ADRC shall comply with applicable provisions of the Older Americans Act (OAA), as amended and other legislation that may be passed during this period identified. The PSA and AAA/ADRC will assume full authority to develop and administer this Area Plan in accordance with the Act and related State policy. In accepting this authority, the PSA and AAA/ADRC assumes responsibility to develop and administer this Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older persons in the planning and service area.

This Area Plan was developed in accordance with all rules, regulations, and requirements specified under the OAA and the Lieutenant Governor's Office on Aging (LGOA), including the South Carolina Aging Network's Policies and Procedures Manual and the LGOA Multigrant Notice of Grant Award's (NGA's) Terms and Conditions. The PSA and AAA/ADRC agrees to comply with all standard assurances and general conditions submitted in the Area Plan throughout the four (4) year period covered by the plan. This Area Plan is hereby submitted to the South Carolina Lieutenant Governor's Office on Aging for approval.

The Appalachian Council of Governments PSA and AAA/ADRC certifies that it is responsible for overseeing the provision of Aging Services throughout the Appalachian region. This responsibility includes, but is not limited to, the following functions:

1. Contract management
2. Programmatic and fiscal reporting activities
3. Oversight of contracted service delivery
4. Coordination of services and planning with the LGOA, service contractors, and other entities involved in serving and planning for the older population in the planning and service area
5. Provision of technical assistance and training to providers/contractors and other interested parties
6. Provision of public information and advocacy related to aging program activities and issues

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7. Provision of all activities, programs, and services contained within the South Carolina Aging Network's Policies and Procedures Manual, and compliant with all Notice of Grant Award's (NGA's) Terms and Conditions, and assurances from the Administration on Aging (AoA) and Lieutenant Governor's Office on Aging (LGOA).

6-26-2013
Date

John G. Hill
Signature of Executive Director
Planning Service Area (PSA)

6-26-2013
Date

Karen B. Carter
Signature of Aging Unit Director

The Area Agency Advisory Council has reviewed and approved this Area Plan.

6-26-2013
Date

Joseph B. Dill
Signature of Chair, Area Agency
Advisory Council

The Governing Board of Planning Service Area (PSA) has received and approved this Area Plan.

Date

Signature of Governing Board Chair



**2014 – 2017 AREA PLAN
VERIFICATION OF ADMINISTRATION ON AGING'S (AoA'S) AND LIEUTENANT
GOVERNOR'S OFFICE ON AGING'S (LGOA'S) STANDARD ASSURANCES AND
GENERAL CONDITIONS**

ASSURANCE CATEGORIES

- A. PLANNING AND SERVICE AREA (PSA) AND AREA AGENCY ON AGING (AAA)/AGING AND DISABILITY RESOURCE CENTER (ADRC) GENERAL AND ADMINISTRATIVE ASSURANCES
- B. AAA/ADRC TRAINING RESOURCES ASSURANCES
- C. CLIENT DATA COLLECTION ASSURANCES
- D. FISCAL ASSURANCES
- E. MONITORING AND COMPLIANCE ASSURANCES
- F. PROCUREMENT AND CONTRACTUAL ASSURANCES
- G. COORDINATION, OUTREACH, AND INFORMATION AND REFERRAL ASSURANCES
- H. STATE PLAN ASSURANCES FROM THE ADMINISTRATION ON AGING (AoA)

2014 – 2017 AREA PLAN ASSURANCES

- A. PLANNING AND SERVICE AREA (PSA) AND AREA AGENCY ON AGING (AAA)/AGING AND DISABILITY RESOURCE CENTER (ADRC) GENERAL AND ADMINISTRATIVE ASSURANCES
 - 1. The Planning Service Area (PSA), Area Agency on Aging (AAA)/Aging and Disability Resource Center (ADRC), and the AAAs'/ADRCs' providers/contractors must comply with the policies and procedures set by the Older Americans Act (OAA), the current South Carolina Aging Network's Policies and Procedures Manual, current Notices of Grant Award (NGA) Terms and Conditions, and any Program Instructions (PI) issued by the Lieutenant Governor's Office on Aging (LGOA) and the Administration on Aging (AoA) during the Area Plan period.
 - 2. The AAA/ADRC shall ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, shall include a focus on the needs of low income minority older individuals and older individuals residing in rural areas. (OAA 306(a)(4)(C))
 - 3. The PSA, AAA/ADRC, and the AAAs'/ADRCs' providers/contractors shall comply with all applicable Federal and State laws, regulations, and guidelines.

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4. The PSA and AAA/ADRC shall have a comprehensive, written policies and procedures manual for complying with all of its functions as prescribed by the OAA, the LGOA, and the South Carolina Aging Network's Policies and Procedures Manual. These written policies and procedures shall be available for inspection upon request and are subject to the South Carolina Freedom of Information Act (FOIA) requirements. The AAA/ADRC may not adopt the South Carolina Aging Network's Policies and Procedures Manual as a substitute for developing a regional manual, but may use it as a guide for what should be included in the regional manual. A summary of the written policies and procedures should be noted in the Area Plan.
5. The AAA/ADRC accepts the standards and programmatic requirements issued for all services authorized by the Lieutenant Governor's Office on Aging. All providers/contractors and/or vendors of services shall be monitored for compliance with such standards and carry out the standards and requirements in the delivery of each service to be reimbursed with funds awarded under this plan.
6. The PSA and AAA/ADRC shall maintain professional office policies and procedures which reflect effective (best) business practices in order to ensure the quality delivery of programs and services to South Carolina's aging population and adults with disabilities.
7. The AAA/ADRC shall provide a qualified full-time director of the aging unit and an adequate number of qualified staff to carry out the functions required under the Area Plan. (CFR 1321.55(b))
8. The AAA/ADRC shall maintain a Regional Aging Advisory Council (RAAC) whose purpose is:
 - a. to advise the AAA/ADRC on all matters related to the development of the Area Plan;
 - b. to advise on the administration of the plan; and
 - c. to advise on operations conducted under the plan.The RAAC shall have no decision-making authority that is binding on the AAA/ADRC staff or on the AAA/ADRC Executive Board. (OAA 306(a)(6)(D))
9. Through its Area Plan, the AAA/ADRC shall provide the LGOA information on how board members are selected, appointed, or elected; the established terms of office; and RAAC by-laws.
10. The PSA and AAA/ADRC directors shall be expected to be engaged and informed aging advocates who work to promote senior matters and educate the community on issues facing the aging network and their respective regional AAA/ADRC.
11. Each PSA are encouraged to have at least one (1) board meeting annually that is dedicated to aging issues and shall invite the LGOA Director and senior staff to attend.
12. All Planning Service Area (PSA) Directors are required to attend quarterly and scheduled PSA Directors' meetings at the LGOA, or to send an appropriate representative, approved by the LGOA Director.
13. All AAA/ADRC Directors are required to attend monthly and scheduled ADRC meetings or to send an appropriate representative, approved by the LGOA Director.

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14. PSA Directors and their governing board members shall be encouraged to provide a minimum of six (6) hours of community service annually in their region. Options for community service may be conducted through, but not limited to, working at a group meal site; delivering home-delivered meals; or volunteering in an adult day care, assisted living facility, or a multipurpose senior center. The desired goal of this community service is for the PSA leaders to see firsthand the many challenges and obstacles facing older persons, persons with disabilities, and their families and caregivers and to seek solutions in order to improve the aging network in their regions.
15. The PSA director shall ensure that all contact information for all respective PSA board members provided to the LGOA is accurate and up-to-date and comply with the South Carolina Freedom of Information Act (FOIA).
16. The AAA/ADRC shall use grants made under the Older Americans Act (OAA) to pay part of the cost of the administration of the Area Plan, including preparation of plans, evaluation of activities carried out under such plans, development of a comprehensive and coordinated system for delivery of services to older adults and caregivers, development and operation of multipurpose senior centers, and the delivery of legal assistance as required under the OAA of 1965, as amended in 2006, and in accordance with the regulations, policies, and procedures established by the LGOA, the Assistant Secretary of the AoA, the Secretary of the U.S. Department of Health and Human Services and State legislation. (OAA 303 (c) (1) and (2) and CFR 1321.11)
17. The AAA/ADRC shall assure through the Area Plan that it has protocols in place to provide technical and programmatic assistance and training opportunities for AAA/ADRC staff and providers/contractors as required by the South Carolina Aging Network's Policies and Procedures Manual.
18. The AAA/ADRC is responsible for designing and implementing a regional training and education plan. This plan should be comprehensive in nature and reflect the training requirements identified by the AAA/ADRC, address the service priorities in the Area Plan, and complement State efforts. The training should address geographical characteristics, demographics, infrastructure, GIS Mapping, and local and community partnering resources. The annual needs assessment is the blueprint necessary to identify the types of trainings necessary in the region. Regional training shall also address all required LGOA client data tracking systems, as well as any other fiscal or programmatic requirements of the LGOA.
19. The AAA/ADRC and providers/contractors shall not means test for any service under Title III. When contributions are accepted, or cost sharing implemented, providers/contractors shall not deny services to any individual who does not contribute to the cost of the service. (OAA 315(b)(3) and CFR 1321.61(e))
20. The AAA/ADRC shall comply with Title VI of the Civil Rights Act of 1964 and shall require such compliance from all providers/contractors under the Area Plan. (CFR 1321.5(c))

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21. The AAA/ADRC shall comply with all the appropriate Titles of the Americans with Disabilities Act of 1990, require such compliance from all contractors under the Area Plan, and assure that otherwise eligible older individuals shall not be subjected to discrimination under any program or activity under the Area Plan. (CFR 1327.5 and 1321.5 (c))
22. The AAA/ADRC shall assure that residency or citizenship shall not be imposed as a condition for the provision of services to otherwise qualified older individuals.
23. The AAA/ADRC shall assess the level of need for supportive services including legal assistance, transportation, nutrition services, and multipurpose senior centers within the planning and service area. (OAA 306(a)(1))
24. The AAA/ADRC shall assure that the special needs of older individuals residing in rural areas are taken into consideration and shall describe in the Area Plan how those needs have been met and how funds have been allocated to services to meet those needs. (OAA 307(a)(10))
25. The AAA/ADRC shall utilize Geographic Information System (GIS) mapping in order to determine if Older Americans Act (OAA) targeted client populations are being served in its planning and service areas.
26. The AAA/ADRC shall establish effective and efficient procedures for coordination of entities conducting programs under the OAA and entities conducting other Federal programs for older individuals at the local level. (OAA 306(a)(12))
27. Where there are an identifiable number of older individuals in the PSA who are Native Americans, the AAA/ADRC shall require outreach activities to such individuals and encourage such individuals to access the assistance available under the OAA. (OAA 306(a)(6)(G))
28. The AAA/ADRC shall assure the coordination of planning, identification and assessment of needs, and provision of services for older individuals with disabilities, (with particular attention to those with severe disabilities) with agencies that develop or provide services for individuals with disabilities. (OAA 306(a)(5))
29. The AAA/ADRC, in carrying out the State Long Term Care Ombudsman program, shall expend not less than the total amount of funds appropriated and expended by the agency in fiscal year 2000 in carrying out such a program under the OAA. (OAA 306(a)(9))
30. The AAA/ADRC, when seeking a waiver from compliance with any of the minimum expenditures for priority services, shall demonstrate to the LGOA that services furnished for such category within the PSA are sufficient to meet the need for those services and shall conduct a timely public hearing upon request. (OAA 306(b))
31. The AAA/ADRC shall, to the maximum extent practicable, coordinate services under the Area Plan with services that may be provided under Title VI in the planning and service area. (OAA 306(a)(11)(B) and (C))

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32. The AAA/ADRC shall ensure that clients receive an initial assessment and then reassess service recipients no less than annually, with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, older individuals residing in rural areas, and eligible individuals, as defined in the Older Americans Act of 1965 (OAA) §518, 42 U.S.C. §3056p, as amended in 2006. Assessments must be recorded on the LGOA Assessment Form. No reimbursements will be made without proper and current assessments.
33. Based on that assessment, the AAA/ADRC shall assure that services delivered with resources under the Area Plan are provided to individuals with the highest priority scores.
34. Assessed individuals who must be terminated because of low priority scores shall be provided an opportunity to continue to receive services as a private pay recipient or as a partial-pay recipient subsidized through local resources, if available.
35. The LGOA requires that the AAA/ADRC directly provide ombudsman, information and assistance, insurance counseling, and family caregiver services. (OAA 307(a)(8)(A)and(C))
36. The AAA/ADRC shall provide other direct services, only with a waiver approved by the State agency, and only when such direct provision is necessary to assure an adequate supply of such services, or where such services are directly related to the AAA's/ADRC's administrative functions, or where such services of comparable quality can be provided more economically by the AAA/ADRC. (OAA 307(a)(8)(A)and(C))
37. The AAA/ADRC shall administer the nutrition programs with the advice of a dietitian (or an individual with comparable expertise). Whenever the AAA/ADRC allows providers/contractors to purchase catered meals directly, or has providers/contractors who prepare meals on site, the AAA/ADRC shall assure that such providers/contractors have agreements with a registered dietitian who provides such advice. (OAA 339(G))
38. The AAA/ADRC shall 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. (OAA 307(a)(18))
39. The AAAs/ADRCs are responsible for developing emergency/disaster preparedness and response plans for their planning and service area regions that are updated and reviewed annually. These plans should incorporate all requirements of the South Carolina Aging Network's Policies and Procedures Manual regarding Emergency Management and Disaster Preparedness.
40. In addition, the AAA/ADRC shall ensure that each of its providers/contractors has a disaster preparedness plan that is reviewed and updated annually.
41. AAAs/ADRCs shall meet with county emergency management directors in their regions to ensure that there is a working relationship between the counties and the

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AAAs/ADRCs. AAAs/ADRCs are expected to maintain current and up-to-date emergency contact information for AAA/ADRC staff, directors of providers/contractors, and county emergency management officials in the event of a disaster or emergency, and submit this information with their Area Plans. The AAA/ADRC will designate staff to be on call throughout the duration of the declared disaster and this staff shall maintain communications with the LGOA Emergency Preparedness Coordinator.

- 42. The AAA/ADRC must ensure that lists of clients compiled under any programs or services are used solely for the purpose of providing or evaluating services. AAAs/ADRCs shall obtain written assurance from providers/contractors stating that they will comply with all LGOA confidentiality requirements, as well as any and all applicable Federal and State privacy and confidentiality laws, regulations, and policies. The AAA/ADRC shall provide the LGOA with confidentiality assurances through its Area Plan, annual Area Plan updates, or as changes are made.
- 43. The AAA/ADRC and its providers/contractors under the grant must have written procedures for protecting the identifying client information against unlawful distribution through any means, physical or electronic. All identifying client data must be protected through limited access to electronic records. Each employee with access to identifying client information must sign a notice prepared by the grantee specifying the requirement to maintain confidentiality and the penalty for failure to comply.
- 44. Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936.
- 45. Each AAA/ADRC shall meet with its provider(s)/contractor(s) to discuss questions, concerns, obstacles, and/or technical assistance required to be successful, either in group or one-on-one sessions. A summary of these meetings shall be maintained on file. Issues raised, and any resolutions achieved, in these meetings shall be addressed in the quarterly AAA/ADRC and providers/contractors meetings.
- 46. Each AAA/ADRC shall host a quarterly regional meeting with its providers/contractors. At a minimum, each quarterly meeting shall address the following topics:

Quarter One:	Quarter Two:
<ul style="list-style-type: none"> • AAA/ADRC Area Plan; • Needs assessment; • Comparison of service delivery to GIS mapping to ensure that all clients with the greatest needs within the entire county are being served; • Challenges in business operations (what is working and what isn't working); • Training requests and topics for providers/contractors; 	<ul style="list-style-type: none"> • Career development; • Continuing education training or Continuing Education Units (CEU); • Educational workshops; and • Other issues and concerns.

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<ul style="list-style-type: none"> • Best practices; • AAA/ADRC goals and mission for the year; and • Other issues and concerns. 	
<p>Quarter Three:</p> <ul style="list-style-type: none"> • Modernizing operations; • Community resources and new partnerships; • Aging focus; • Business development; and • Other issues and concerns. 	<p>Quarter Four:</p> <ul style="list-style-type: none"> • End of year Area Plan review; • Strategic planning and forecasting session for specific regional needs and concerns; • Analyzing end of the year data (comparing data to the GIS mapping that the AAAs/ADRCs are required to provide to the LGOA); and • Other issues and concerns.

47. The following constitutes a substantial change in the approved Area Plan and requires an amendment to the Area Plan:
- a. change or termination of a service contractor;
 - b. reduction in the funding for priority services procured; and/or
 - c. loss or change in the services available in any county in the region.

B. AAA/ADRC TRAINING RESOURCES ASSURANCES

1. The AAA/ADRC shall appoint an AAA/ADRC Training Liaison for its planning and service area region. This liaison shall serve as the LGOA point of contact for AIM operations in its region. The liaison shall provide program overview information for AAA/ADRC providers/contractors for general aging network structure and operations. In addition, his/her primary role shall be to assure earned service units and client data are being captured, tracked, and reconciled in the AIM system for reimbursement.
2. The AAA/ADRC Training Liaison shall have a firm understanding of programmatic operations and overall knowledge of finance and accounting operations for the aging network. The AAA/ADRC shall appoint the person within the AAA/ADRC who provides quality assurance and reconciliation of the provider/contractor invoices for OAA services in the AAA/ADRC region. (Note: The best candidate may be the financial manager and/or accounting reimbursement officer/manager. This person should have a strong working relationship with the person authorized to approve payment of funds to the provider/contractor for service units earned.) The liaison shall be responsible for assuring that the AAA's/ADRC's providers/contractors are appropriately tracking service units earned in the AIM system for all OAA funds.
3. The AAA/ADRC Training Liaison shall train new providers/contractors, field questions in the region, and provide assistance with challenges of the AIM tracking system. The

liaison shall be the only person authorized to make contact with the LGOA AIM Coordinator. On the rare occasion that the liaison cannot assist the provider/contractor, he/she may contact the LGOA AIM Coordinator for assistance. The liaison shall be responsible for forwarding the information received from the AIM Coordinator to the providers/contractors. The liaison shall be the point of contact for providers/contractors needs and shall ensure accurate, quality tracking, and monitoring for reimbursement of OAA services, prior to billing the LGOA.

4. The AAA/ADRC shall assure on-going training within its region of operation for its providers/contractors. At a minimum, the AAA/ADRC shall do the following:
 - assure that a minimum one monthly e-mail is disseminated to their providers/contractors regarding a variety of aging issues, including but not limited to outreach opportunities, outreach events, national initiatives, activity development, resources, etc.
 - host an aging orientation meeting within the first thirty (30) days of a new contract agreement for all new providers/contractors in their region. Materials provided in the orientation shall include, but are not limited to, the following:
 - a general overview of the LGOA and ADRC network operations and roles;
 - a LGOA two-sided flyer;
 - a LGOA benefits guide;
 - a SC Access flyer;
 - a copy of the AAA/ADRC Area Plan;
 - a copy of the SC Aging Network's Policies and Procedures Manual;
 - a summary of structure of the aging network in South Carolina;
 - a copy of general AAA/ADRC goals for that operating year;
 - an AAA/ADRC staffing contact sheet; and
 - a copy of the AAA/ADRC Strategic Plan.
5. The AAAs/ADRCs shall assure that an Advanced Information Manager (AIM) training session is provided by the AAA/ADRC Training Liaison and an operation manual shall be given to the new provider/contractor within the first thirty (30) days of a new contract agreement.

C. CLIENT DATA COLLECTION ASSURANCES

1. The AAA/ADRC and its providers/contractors will utilize the Advanced Information Management (AIM) system to document and track units of services delivered. Reimbursements for service funds will be supported by client data correctly entered into AIM. The AAA/ADRC will assure that service providers/contractors are trained properly and monitored accordingly, and that AIM data is inputted monthly by the tenth (10th).
2. The AAA/ADRC shall ensure that each group dining site uses the LGOA approved LG-94 sign-in sheet and that each client sign his/her name or make a mark on the sign-in sheet daily. In addition, home-delivered meal drivers must sign and date a document daily listing their clients and certifying that the meals were delivered. The provider/contractor dining manager will sign and date that document after the driver has returned to the operational site.

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3. The AAA/ADRC shall utilize On-line Support Assistant (OLSA) to record contacts. The AAA/ADRC shall accurately input and monitor data, and provide training for appropriate AAA/ADRC staff and providers/contractors. All client contact data will be captured and immediately keyed into OLSA (preferably by an AIRS Certified Specialist) after a contact is made with a client, successfully ensuring accuracy and timeliness.
4. The AAA/ADRC shall utilize the State Health Insurance Program (SHIP) Talk system to input insurance-related data after a contact is made with a client, successfully ensuring accuracy and timeliness.

D. FISCAL ASSURANCES

1. The PSAs and AAAs/ADRCs shall be good stewards of OAA and LGOA funding and be accountable for programmatic budgeting, monitoring, and operation. The AAA/ADRC shall assure in writing, through its Area Plan, that I&R/A funding is not being used to fund other programs outside of the I&R/A program area. Should the LGOA determine the AAA/ADRC is in violation of using I&R/A funds for other activities, then funding for I&R/A services may be withheld in the future.
2. The PSA and AAA/ADRC shall provide satisfactory assurance that such fiscal control and accounting procedures shall be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal and State funds paid under the Area Plan to the AAA/ADRC, including funds paid to the recipients of grants or contracts. (OAA 307(a)(7)(A))
3. The AAA/ADRC shall assure that funds received under the OAA shall supplement and not supplant any Federal, State, or local funds expended to provide services allowable under Title III. (OAA 321(d))
4. Each funding source shall have a distinct client population for the duration of the contract period or until the client's service is terminated. A new client, who is in need of the service and meets the eligibility criteria of that funding source, will be added when such vacancies occur.
5. The PSAs and AAAs/ADRCs shall include as part of their Area Plans, a breakdown of the components of the unit cost for each different unit of service and the methodology showing how the unit cost is determined. The cost justification shall include the assessment costs, activities costs, product costs, administrative costs, and any other relevant variable that contributes to the overall rate.
6. The AAA/ADRC shall ensure that it has a process in place to verify how the provider's/contractor's unit costs are determined and that the units are being earned.
7. All invoices and financial and program reports must be submitted in the format provided by the LGOA and on the schedule(s) set by the LGOA. Invoices and financial reports shall be submitted to the Accounting and Finance Division, while program reports will be submitted to the appropriate program manager as stipulated by the LGOA.
8. The AAA/ADRC shall submit a total aging budget, disclose all sources and expenditures of funds that the AAA/ADRC receives or expends to provide services to older

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- individuals, and the cost allocation plan, or approval of the indirect cost rate from the funding agency, used to prepare such budget. (OAA 306(a)(13)(E))
9. The AAA/ADRC shall expend all prior year's funds first, before expending any new funds.
 10. Planning and Administration funds for Titles III-B, III-C, III-C-2, and III-E must be expended before any program development of III-E service funds are expended for subgrantee staff activities or internal operations.
 11. The AAA/ADRC shall assure that any funds received under the Area Plan, or funds contributed toward the non-Federal share, shall be used only for activities and services to benefit older individuals and others specifically provided for in Title III of the OAA or in State legislation. This shall not be construed as prohibiting the AAA/ADRC from providing services by using funds from other sources. (OAA 301 (d))
 12. The LGOA requires that AAAs/ADRCs shall maintain proper records with all necessary supporting documents. Such records must be in a form, approved by the LGOA, which provides an accurate and expeditious determination of the status of all Federal and non-Federal funds at any time; including the disposition of funds received and the nature and amount of all expenditures and obligations claimed against OAA and State allotments. The AAA/ADRC shall enter the liability for the local matching funds in the appropriate accounts when payment is requested from the LGOA. The AAAs/ADRCs shall assure the LGOA that all funds requested for payment shall be for service units and services actually provided and earned by the providers/contractors. The AAAs/ADRCs shall provide and maintain written assurances through their Area Plans and annual updates to monitor and audit the payment requests for accuracy and integrity purposes.
 13. Any AAA/ADRC that expends a total of \$500,000 or more in Federal awards must monitor delivery and have an audit that complies with OMB Circular A-133. The audit shall be submitted to the LGOA within nine (9) months after the close of the organization's fiscal year.
 14. The AAA/ADRC shall consult with relevant service providers/contractors and older individuals to determine the best method for accepting voluntary contributions that comply with the Cost Sharing policies of the LGOA and the OAA, as amended in 2006. (OAA 315(b)(2))
 15. The AAA/ADRC shall assure that any revenue generated from voluntary contributions or cost sharing shall be used to expand the services for which such contributions or co-pays were given. (OAA 315(a)and(b))
 16. The voluntary contributions system adopted shall be clearly explained to individuals who use the agency's services. The explanation shall be made both verbally and in writing at the time service delivery is arranged; and shall be posted in a conspicuous location accessible to clients within the site. The explanation shall include the voluntary nature of the contribution, confidentiality policies, and how contributions are collected and used. The AAA/ADRC shall ensure that this is included in procurement contracts and each provider's/contractor's policy shall be included in the AAA's/ADRC's Area Plan annual

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update.

17. The AAA/ADRC shall assure that amounts expended for services to older individuals residing in rural areas shall not be less than the amounts expended for such services in fiscal year 2000. (OAA 307(a)(3)(B))
18. The AAA/ADRC shall assure that the AAA/ADRC and all its providers/contractors meet all matching requirements for funds awarded under the Area Plan.
19. The AAA/ADRC shall assure that any funds received from the State for Cost of Living Adjustment shall be used for personnel costs only.
20. The AAA/ADRC shall submit an independent audit to the Lieutenant Governor's Office on Aging (LGOA), Division of Finance and Accounting, within 180 days after the close of the project year.
21. A final financial report for the grant period shall be submitted to the LGOA, within forty-five (45) days of the close of each State fiscal year in the grant period (August 14) or within forty-five (45) days of the last payment made, whichever occurs first.
22. The AAA/ADRC shall assure that funds received for Nutrition Services Incentive Program (NSIP) shall be used only for the purchase of United States agricultural commodities or commercially prepared meals served in the Title III-C services and that NSIP funds shall be distributed throughout the region based on the percentage of eligible meals served by each provider/contractor. (OAA 311(d)(2))
23. The AAA/ADRC shall not use funds received under the OAA to pay any part of a cost, including an administrative cost, incurred to carry out a contract or commercial relationship that is not carried out to implement the OAA. (OAA 306(a)(14))

E. MONITORING AND COMPLIANCE ASSURANCES

1. The PSA Director and AAA/ADRC Director shall ensure that providers/contractors are earning their units in accordance with the OAA and LGOA policies.
2. The AAA/ADRC shall ensure that anyone compensated by an AAA/ADRC or provider/contractor cannot be counted as a service unit earned. When monitoring aging services, the AAA/ADRC must match service clients with a list of AAA/ADRC and provider/contractor employees to ensure funding and programmatic integrity.
3. The AAA/ADRC shall assure that no group dining facility shall be funded unless an average of twenty-five (25) eligible participants attends daily. All group dining sites must serve at least twenty-five (25) clients per day or request a LGOA Group Dining Waiver.
4. The AAA/ADRC shall assure that an OAA III C-2 home delivered meal shall be delivered to a participant for no less than five days a week unless it is documented that the participant is receiving meal(s) from another source. Further, in addition to federal eligibility requirements, special consideration shall be given to those eligible clients living alone, those in isolated rural areas, and those seventy-five (75) years of age or

older. (OAA 336)

5. Each AAA/ADRC shall be provided copies of the group dining site activity calendars from the group dining providers/contractors monthly for approval. The AAAs/ADRCs shall scan and forward by email copies of approved monthly site activity calendars to the LGOA Policy and Planning Manager by the close of business on the last business day of the month.
6. As a means of monitoring for quality assurance, the AAA/ADRC Director, or designated appointee, shall personally deliver a minimum of three (3) home-delivered meals from three (3) different home-delivered meal routes monthly. Any issues that arise from these monitoring visits shall be corrected within three (3) business days. A monthly report of these home visits, including the name of the staff member making the visit, shall be provided in writing to the LGOA during the monthly AAA/ADRC Directors' meeting. In the report, the AAA/ADRC Director shall guarantee that all services contracted with the provider/contractor, which are to be reimbursed by the LGOA, are in fact being provided according to OAA and LGOA standards. The AAA/ADRC shall use the Monthly Home-Delivered Meal Monitoring Form provided by the LGOA to report the home monitoring visits.
7. The AAA/ADRC Director, or their designee, shall visit at least three (3) group dining sites monthly and provide the LGOA with a written report summarizing each visit. In the summary, the AAA/ADRC Director shall assure that all services contracted by the provider/contractor, and being reimbursed by the LGOA, are being provided.

F. PROCUREMENT AND CONTRACTUAL ASSURANCES

1. Service procurement contracts must incorporate all components of the South Carolina Aging Network's Policies and Procedures Manual. Through the direction of the South Carolina Aging Network's Policies and Procedures Manual, each of the PSA's procurement contracts for aging services shall be based on meeting the unique regional needs of each planning and service area.
2. The PSA and AAA/ADRC shall require all programs funded under the Area Plan to be operated fully in conformance with the LGOA and all applicable Federal, State and local fire, safety, health and sanitation standards or licensing prescribed by law or regulation. (CFR1321.75(a))
3. The PSA and AAA/ADRC shall contract only with service delivery agencies that shall provide to the AAA/ADRC all program information and reports required by the Lieutenant Governor's Office on Aging. Provision of timely and correct data shall be in a format and contain such information as the LGOA may require the AAA/ADRC to submit. (OAA 307(a)(6))
4. All PSA and AAA/ADRC Requests for Proposal (RFP) shall provide direction, coordination, and planning in the fulfillment of contractual agreements with providers/contractors.

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5. All contractual agreements must include a procedure for the resolution of grievances or concerns between the Planning Service Area (PSA), AAA/ADRC, and provider/contractor.
6. When there is grievance between the AAA/ADRC and a provider/contractor, all efforts shall be made by the AAA/ADRC to resolve the issue. Minimal contact should be made at the State level and only after all attempts have failed to resolve the issues locally. The Lieutenant Governor's Office on Aging (LGOA) shall serve only as a source of information to the AAA/ADRC regarding the resolution process. All grievances shall be handled by the AAA/ADRC and provider/contractor unless the grievance includes illegal, immoral, and/or unethical behavior, at which time the LGOA and proper authorities shall be notified. If the AAA/ADRC wants to include the LGOA, or cannot work out the issue, then the LGOA may be contacted to assist with the resolution process through guidance only.
7. The PSA and AAA/ADRC must advertise the Request for Proposal (RFP) in legal ads in newspapers throughout the region and post information in a prominent spot on its website at least thirty (30) days before the release of the RFP. The AAA/ADRC shall notify the LGOA Policy Manager so that the RFP can be posted on the LGOA web site.
8. The PSA and AAA/ADRC shall include in each solicitation for providers/contractors of any service under the OAA, a requirement that the applicant will:
 - a. Specify how the organization intends to satisfy the service needs of low income minority individuals and older individuals residing in rural areas;
 - b. Provide services to low income minority individuals in accordance with their need for such services;
 - c. Meet specific objectives set by the AAA/ADRC, for providing services to low income minority individuals; (OAA 306(a)(4)(A))
 - d. Make a good faith effort to obtain a client consent form from all service recipients to allow their information to be included in AIM for research and advocacy purposes.
9. All contracts for the procurement of services or goods which are supported with financial assistance through the LGOA, must adhere to applicable Federal and State procurement codes (COG: OMB Circulars A102 and A-87) (PN-P: OMB Circulars A110 and A-122).
10. The AAA/ADRC and providers/contractors shall have the Knowledge, Skills and Abilities (KSA) to use professional practices of performing, reporting, tracking, and administering their Older American Act (OAA) and State funding, and this should be reflected in all procurement contracts and RFPs.
11. The PSA and AAA/ADRC shall have legal representation on their RFP (Request for Proposal) Board.
12. The PSA and AAA/ADRC shall host a pre-RFP application informational meeting for potential providers/contractors three weeks following the public release of the RFP to explain the RFP process and aging network policies/procedures and to answer

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- questions about the RFP. The date, time, and location of the meeting shall be included in the RFP packet. This shall assure fairness in the bid process. Opportunities for submitting written questions shall be provided by the AAA/ADRC before the pre-application meeting.
13. Prior to engaging in a contract, the PSA and AAA/ADRC shall assure through the RFP bid and contract that the provider/contractor has the necessary equipment, technology, software, and trained staff to operate in a professional manner and to execute or administer the duties.
 14. An AIM Operational Manual shall be provided at the start of the bid process so that providers/contractors know what is expected in advance if the provider/contractor gets the contract.
 15. The PSA and AAA/ADRC shall provide all potential providers/contractors with an overview of the LGOA organization and procurement process before submitting a bid for contract in order that they understand the proper procedures and policies.
 16. The AAA/ADRC shall encourage each group dining provider to be a member of the National Council on Aging (NCOA) / National Institute of Senior Centers (NISC) or to operate according to NISC's national standards for senior centers and group dining sites.
 17. The AAA/ADRC shall require, through the procurement contract, that the provider's/contractor's representative attend quarterly regional meetings. This representative shall be required to take the information provided and disseminate it appropriately and incorporate it into his/her organization immediately.
 18. If the AAA/ADRC finds that a provider/contractor under the Area Plan has failed to comply with the terms of the contract or with Federal or State laws, regulations and policies, the AAA/ADRC may withhold that portion of the reimbursement related to that failure to comply. The Regional Aging Advisory Council (RAAC) shall recommend appropriate procedures for consideration by the Governing Board of the AAA/ADRC. (OAA 306(e)(1))
 19. In the event that the PSA and AAA/ADRC finds that a provider/contractor has failed to comply with the terms of the contract or is unable to deliver services as contracted, the AAA/ADRC should initiate a thirty (30) day Corrective Action Plan (CAP) to resolve the issue. If the issue cannot be resolved the AAA/ADRC may determine the provider/contractor high-risk, in accordance with the South Carolina Aging Network's Policies and Procedures Manual.
 20. The AAA/ADRC shall afford providers/contractors due process, such as that described for AAAs/ADRCs in OAA Section 306(f)(2)(B) before making a final determination regarding withholding providers'/contractors' reimbursements.
 21. Electronic copies of procurement contracts and all amendments thereto, shall be provided to the LGOA's Policy and Planning Manager within thirty (30) days of execution or as amended.

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22. The AAA/ADRC agrees to comply with the “Debarment and Suspension” terms and conditions of 45 C.F.R. § 92.35 or 45 C.F.R. § 74.13 as applicable to the AAA/ADRC and/or provider/contractor.
23. The AAA/ADRC shall only purchase services from providers/contractors that will provide the LGOA with all requested data in the format necessary to document the outcome of services purchased.
24. The AAA/ADRC shall assure that any facility authorized for use in programs operated under the Area Plan shall have annual certification that the facility complies with the appropriate fire, safety and sanitation codes. (CFR 1321.17(4))
25. The AAA/ADRC shall assure that a facility purchased for use as a multi-purpose senior center with OAA or State Permanent Improvement funds, shall continue to be used for the same purpose for not less than ten (10) years after acquisition, or twenty (20) years after construction.
26. Prior to authorizing use of OAA or State Permanent Improvement funds for renovation, purchase or construction, the AAA/ADRC shall require assurance from the grantee that funding is, and shall continue to be, made available for the continued operations of these senior centers. (OAA 312)
27. The AAA/ADRC shall assure that group dining service facilities are located in as close proximity to the majority of eligible individuals' residences as feasible. Particular attention shall be given to the use of multipurpose senior centers, churches, or other appropriate community facilities for such group dining service. (OAA 339(E))
28. When possible, the AAA/ADRC shall enter into arrangements and coordinate services with organizations that are Community Action programs and meet the requirements under section 675(c)(3) of the Community Services Block Grant Act. (42 U.S.C.9904(c)(3)) and (OAA 306(a)(6)(C))
29. The AAA/ADRC shall take into account, in connection with matters of general policy arising in the development and administration of the Area Plan, the views of recipients of services under the Area Plan. (OAA 306(a)(6)(A))
30. Where possible, the AAA/ADRC shall enter into arrangements with organizations providing day care services for children or adults, and respite for families, to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families. (OAA 306(a)(6)(C))
31. The AAA/ADRC shall assure that demonstrable efforts shall be made to coordinate services provided under the OAA with other State services that benefit older individuals and to provide multi-generational activities involving older individuals as mentors to youth and support to families. (OAA 306(a)(23))
32. The AAA/ADRC shall coordinate any mental health services provided with III B funds with the mental health services provided by community health centers and by other public agencies and nonprofit private organizations. (OAA 306(a)(6)(F))

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33. The AAA/ADRC shall maintain the integrity and public purpose of services provided, and service contractors, under the OAA, in all contractual and commercial relationships. (OAA306(a)(13)(A))
34. The AAA/ADRC shall demonstrate that a loss or diminution in the quality or quantity of the services provided under the Area Plan has not resulted and shall not result from such contracts or commercial relationships, but rather, shall be enhanced. (OAA 306(a)(13)(C) and (D))
35. The AAA/ADRC shall not give preference in receiving services under the OAA to particular older individuals as a result of a contract or commercial relationship. (OAA 306(a)(15))
36. The AAA/ADRC shall require nutrition service providers/contractors to reasonably accommodate the particular dietary needs arising from health requirements, religious requirements, or ethnic backgrounds of eligible individuals and require caterers to provide flexibility in designing meals that are appealing to older individuals participating in the program. (OAA 339 (A) and (B))
37. The AAA/ADRC shall enter into contract only with providers/contractors of legal assistance who can:
 - a. demonstrate the experience or capacity to deliver legal assistance;
 - b. assure that any recipient of funding for legal assistance shall be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act;
 - c. require providers/contractors of legal assistance to give priority to cases related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect and age discrimination; and
 - d. attempt to involve the private bar in legal assistance activities. (OAA 307(a)(11)(A) through (E))
38. The AAA/ADRC shall make special efforts to provide technical assistance to minority providers/contractors of services whether or not they are providers/contractors of the AAA/ADRC. (OAA 307(a)(32))
39. The AAA/ADRC is responsible for on-going contract management; establishing procedures for contract cost containment; reviewing and approving contracts; setting criteria for contract amendments; reviewing and analyzing provider/contractor fiscal and program reports; conducting quality assurance reviews; and reviewing meal vendor performance.
40. The AAA/ADRC shall collaborate with providers/contractors to develop an emergency service delivery plan for group dining and home-delivered meals, transportation, and home care. This emergency service delivery plan must be included in the Area Plan submitted to the LGOA by the AAA/ADRC, as well as included in each contract signed between the AAA/ADRC and an aging service provider/contractor. The emergency plan shall also cover general agency operations

during periods of crisis, hazardous weather, emergencies, and unscheduled closings.

41. Providers/Contractors shall submit holiday schedules to their AAA/ADRC for approval and the providers/contractors shall adhere to their approved holiday schedule. The AAAs/ADRCs shall include their providers'/contractors' holiday schedules in their Area Plan. These scheduled closings shall be part of the contract established between the AAA/ADRC and providers/contractors. Any changes to the scheduled holiday closings must be noted in the Area Plan update.
42. The AAA/ADRC shall afford an opportunity for a public hearing upon request, in accordance with published procedures, to any agency submitting a plan to provide services; issue guidelines applicable to grievance procedures for older individuals who are dissatisfied with or denied services funded under the Area Plan; and afford an opportunity for a public hearing, upon request, by a provider/contractor of (or applicant to provide) services, or by any recipient of services regarding any waiver requested. (OAA 307(a)(5) (A) through (C))

G. COORDINATION, OUTREACH, AND INFORMATION AND REFERRAL ASSURANCES

1. Coordination and outreach efforts should be detailed in the Area Plan, with particular emphasis on coordination with entities conducting Federal programs as outlined in Section 403 B-10 of the South Carolina Aging Network's Policies and Procedures Manual.
2. The AAA/ADRC shall have a visible focal point of contact where anyone can visit or call for assistance, information, or referrals on any aging and/or adults with disability issue.
3. The AAA/ADRC shall require providers/contractors to use outreach efforts that shall identify individuals eligible for assistance under the OAA, with special emphasis on
 - a. Older individuals residing in rural areas
 - b. Older individuals with greatest economic need
 - c. Older individuals with greatest social need
 - d. Older individuals with severe disabilities
 - e. Older individuals with limited English speaking ability
 - f. Older individuals with Alzheimer's disease or related disorders and caregivers
 - g. Low income minority individuals in each of the above populations. (OAA 306(a)(4)(B))
4. The AAA/ADRC and those with whom they contract must take adequate steps to ensure that persons with limited English language skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this grant award.
5. The AAA/ADRC shall provide for the identification of public and private resources in or serving persons in, the planning and service area as part of their overall outreach and coordination efforts. Local aging partners should be brought into the AAA's/ADRC's planning process in order to better serve the region's older population. The

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AAA/ADRC shall work to coordinate the programs funded under the Area Plan with such resources to increase older persons' access to quality services. Coordination and outreach efforts should be detailed in the Area Plan, with particular emphasis on coordination with entities conducting Federal programs as outlined in Section 403 B-10 of the South Carolina Aging Network's Policies and Procedures Manual. Where appropriate, the AAA/ADRC shall consider joint funding and programming to better serve older persons.

6. The AAA/ADRC shall employ a fulltime (or fulltime equivalent) Information and Referral/Assistance (I&R/A) Specialist as a requirement of receiving Title III-B and Title III-E funding.

H. **ASSURANCES REQUIRED BY THE ADMINISTRATION ON AGING (AoA)** (Taken directly from the Program Instructions for the 2013 State Plan)

These assurances are required by the Administration on Aging (AoA) and the Lieutenant Governor's Office on Aging (LGOA) for the Planning Service Area (PSA) and AAA/ADRC (AAA)/Aging and Disability Resource Center (ADRC) as part of the 2013 State Plan submission. (The assurances below are from the 2013 State Plan Instructions provided by the AoA.) By signing this document, the PSA and AAA/ADRC have assured they shall adhere to these Older Americans Act requirements.

Section 306(a) of the Older Americans Act (OAA), AREA PLANS

(2) Each AAA/ADRC 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 shall 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 AAA/ADRC shall 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 AAA/ADRC shall—

(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 sub clause (I);

(ii) provide assurances that the AAA/ADRC shall include in each agreement made with a provider/contractor of any service under this title, a requirement that such provider/contractor shall—

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(I) specify how the provider/contractor 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/contractor;

(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 AAA/ADRC, 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 AAA/ADRC 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 AAA/ADRC met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall use outreach efforts that shall 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 AAA/ADRC shall provide assurance that the AAA/ADRC shall ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, shall include a focus on the needs of low income minority older individuals and older individuals residing in rural areas.

(5) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall 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 AAA/ADRC shall:

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 AAA/ADRC with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each AAA/ADRC shall provide assurances that the AAA/ADRC, in carrying out the State Long Term Care Ombudsman program under section 307(a)(9), shall expend not less than the

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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 AAA/ADRC 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 AAA/ADRC shall 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 AAA/ADRC shall, 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 AAA/ADRC shall 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 AAA/ADRC shall provide assurances that the AAA/ADRC shall maintain the integrity and public purpose of services provided, and service providers/contractors, under this title in all contractual and commercial relationships.

(13)(B) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall 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 AAA/ADRC shall provide assurances that the AAA/ADRC shall 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 shall not result from such non-governmental contracts or such commercial relationships.

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

(13)(E) Each AAA/ADRC shall provide assurances that the AAA/ADRC 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 AAA/ADRC shall provide assurances that funds received under this title shall not be used to pay any part of a cost (including an administrative cost) incurred by the AAA/ADRC 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 shall 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.

The AAA/ADRC certifies compliance with all of these assurances and requirements of the OAA, as amended, the Federal regulations pertaining to such Act, and the policies of the LGOA

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throughout the effective period of this Area Plan. Should any barriers to compliance exist, the AAA/ADRC shall develop procedures to remove such barriers. Some assurances may be modified by Federal regulations issued or the OAA reauthorization during the plan period. In such event, a revised list of assurances shall be issued.

By signing this Assurances document, the Planning and Service Area (PSA) and Area Agency on Aging (AAA) and Aging and Disability Resource Center (ADRC) accept the assurances mandated by the Older Americans Act (OAA), Administration on Aging (AoA) and Lieutenant Governor's Office on Aging (LGOA), and will ensure that components of these assurances are included in the 2014 – 2017 Area Plan.

6-26-13
Date

Steven R. Pelino
Signature of Executive Director
Planning Service Area (PSA)

6-26-13
Date

Karen B. Carter
Signature of Aging Unit Director

The Area Agency Advisory Council has reviewed and approved these Assurances.

6-26-13
Date

Joseph B. Dill
Signature of Chair, Area Agency
Advisory Council

The Governing Board of Planning Service Area (PSA) has received and approved these Assurances.

Date

Signature of Chair, PSA Governing Board