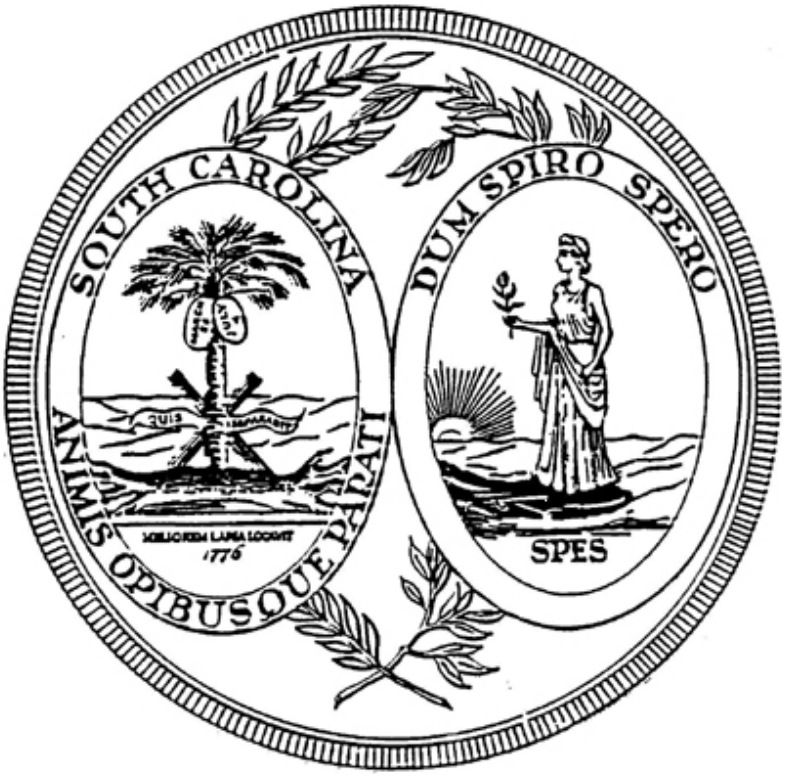
State Plan on Aging
2009 - 2012



STATE OF SOUTH CAROLINA

OFFICE OF THE LIEUTENANT GOVERNOR

Office on Aging

SOUTH CAROLINA
STATE PLAN ON AGING

2009 – 2012

The Honorable Andre Bauer

Lieutenant Governor

State Constitutional Officer responsible for the

State Office on Aging

Mr. Tony Kester

Interim Director, State Unit on Aging

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CHAPTER 1: INTRODUCTION

A. Purpose

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

This Plan provides a blueprint for how the SUA will manage OAA programs, services, and other activities from October 1, 2008 through September 30, 2012. It provides guidance on how the SUA will carry out its mission of enhancing the quality of life of all older citizens, regardless of whether they participate in OAA programs. This four-year Plan incorporates major goals and objectives developed by the Lieutenant Governor's Office on Aging through the submission of the FY 2006-2008 Area Plans, as well as input from various needs assessments carried out throughout the state and from the State AARP, the Silver-Haired Legislature, the SC White House Conference on Aging, the US White House Conference on Aging, the SC Joint Legislative Committee on Aging, waiting lists and numerous surveys conducted by the Lieutenant Governor's Office on Aging.

The Plan impacts the many partners and allies who work to improve the lives of older citizens. Success would not be possible without the Area Agencies on Aging (AAAs) and local contractors and sub-grantees. Without cooperation, coordination and collaboration by many state agencies and private sector organizations, effectiveness would be greatly limited. Finally and most importantly, the SUA could not succeed without the efforts of the many older citizens who volunteer their time to help others, participate in advocacy organizations and provide input and guidance to the SUA.

South Carolina's aging programs have undergone significant change since the submission of the 2005-2008 State Plan. The Older Americans Act was amended in 2006; the Deficit Reduction Act and the Medicare Modernization Act have been enacted. South Carolina and the nation have recognized that with growth of the baby boomer population, we will have to change the way we provide services to our seniors if we are to manage the dramatic growth in long term care costs that the state and the nation faces. Today's seniors want choice and we, as good stewards of our state's and nation's resources, must modernize our service delivery system to incorporate our citizens' needs in a cost effective manner. This State Plan on Aging will describe how the State of South Carolina will implement Choices for Independence over the next four years, as well as lay out a long term strategic plan that will attempt to address how our state will modernize its service delivery system in the future.

B. Verification of Intent

The Plan is hereby submitted for the State of South Carolina for the period October 1, 2008 through September 30, 2012. It includes all assurances and activities to be conducted under provisions of the Act (as amended) during the period identified. The SUA has been given the authority to develop and administer the Plan in accordance with all requirements of the Act, and is primarily responsible for the coordination of all State activities related to the purposes of the OAA, i.e., development of comprehensive and coordinated systems for the delivery of supportive services, including multipurpose

senior centers and nutrition services, and to serve as the effective and visible advocate for the elderly in South Carolina.

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

7-10-08
Date

Interim Director, Office on Aging

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

7/10/08
Date

Andre Bauer, **Lieutenant Governor**
State of South Carolina

* Please see statement from Governor Mark Sandford's office on last page (page 232) of the State Plan.

CHAPTER 2: EXECUTIVE SUMMARY

As South Carolina faces the challenges of the 21st century, it is critical to establish priorities to ensure a comprehensive and coordinated plan that addresses the graying of the state. Like the nation, South Carolina is undergoing significant changes in many areas. While we no longer face the threat of a cold war, we face the threat of on-going terrorism and the consequences of a global economy, global competition, de-regulation, corporate downsizing and the associated implications. Many in our population face considerable change as they approach retirement age.

As we adjust to the impact of the baby boomer generation, we must face the problems of how we will pay for Social Security, Medicare, state, and local programs when adequate funding is questionable. Corporations are reducing or eliminating health insurance plans for retirees. Our growing senior population is living longer, government is downsizing or slowing its rate of growth, the role of government is under question, the population wants reduced taxes and government, and personal responsibility is being redefined.

South Carolina faces the growth of in-migrating seniors who wish to enjoy the climate, lower cost of living and various cultural and natural resources. The successful incorporation of these newcomers into our communities will have an important impact on them and the demand for resources as they age. South Carolina also has many less fortunate seniors who have not shared in the wealth of a growing economy and may face difficult years as they age. "The mixing of those with different backgrounds and perspectives can benefit us, as long as we work toward a common goal of bettering all age groups throughout South Carolina's communities. The way communities, churches, governments and private interests rise to meet the challenges of this population will determine the quality of life as we face the next millennium" ("Opportunities, Challenges, Choices", Mature Adults Count: A Profile of South Carolina's Older Population 2006, SC Lieutenant Governor's Office on Aging).

South Carolina's aging programs have undergone significant change since the submission of its 2005-2008 State Plan. The State Unit on Aging has been transferred to the Lieutenant Governor’s Office and is now a fully functioning entity within the Lieutenant Governor’s Office. The Family Caregiver Support Program has been implemented and is growing and changing. The Medicare Modernization Act has been implemented and thousands of South Carolina’s seniors have been helped over the last two years in receiving guidance for Medicare Part D and helping them to decide which plan is best for them. We have also implemented a Rental Assistance Program for low income seniors with a partnership with the SC State Housing Finance and Development Authority. Many other key initiatives have involved evidence-based research and evidence-based wellness and prevention programs. The State Unit on Aging (SUA) is also in the midst of transitioning our state’s service delivery system to a fully competitive procurement process at the AAA level.

Programs and services designed to meet the needs of this population must continue to evolve within ever-changing political and economic environments. South Carolina's approach to preparing for the aging of its population is focused on helping its senior citizens maintain their independence and allowing choice in the services they receive. South Carolina has recognized that with the significant growth in its senior population,

there will not be adequate public resources to pay for significantly increased levels of long-term care.

Seniors wish to remain independent and in their homes. South Carolina has sought to build public/private initiatives that help all of our seniors, while still meeting the needs of the frailest and economically needy. It is clear that public policy on aging issues must emphasize personal and family responsibility. Furthermore, public policy must promote those behaviors and attitudes that prevent many of the negative outcomes often associated with the aging process. This plan focuses on services provided with public funding but also addresses strategies to involve the private sector and the faith-based community in expanding the options available for older South Carolinians and their families. It builds on the US Administration on Aging's Strategic Action Plan for FY 2007-2012 and addresses how South Carolina as a state will meet the five key goals of this plan:

- Goal 1: Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access existing health and long term care options
- Goal 2: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers
- Goal 3: Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare
- Goal 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation
- Goal 5: Maintain effective and responsive management

In summary, South Carolina's Lieutenant Governor's Office on Aging has embarked on a long term effort, as has the rest of the nation, to modernize its service delivery system to meet the needs and desires of its changing senior population. The FY 2009-2012 State Plan on Aging recognizes that we must change and implement many or all of the initiatives that address the issues facing our state's seniors and the nation if we are to be able to meet the challenges of the 21st Century.

CHAPTER 3: OVERVIEW OF THE 2009 – 2012 STATE PLAN: IMPLEMENTATION OF CHOICES FOR INDEPENDENCE AND MODERNIZATION OF AGING SERVICES IN SOUTH CAROLINA

This Chapter presents issues to be addressed through the Plan for the period October 1, 2008 through September 30, 2012 and beyond. These issues were identified through the submission of the FY 2006-2008 Area Plans, as well as input from various needs assessments carried out throughout the state and from the State AARP, the Silver-Haired Legislature, the SC White House Conference on Aging, the US White House Conference on Aging, the SC Joint Legislative Committee on Aging, waiting lists and numerous surveys conducted by the Lieutenant Governor's Office on Aging. The Lieutenant Governor's Office on Aging used data gathered from a variety of other sources, including the 2000 Census and The American Community Survey, and *Mature Adults Count* reports.

The Plan discusses the graying of South Carolina, providing an overview of the diversity of its older adult population. Basic socio-economic, health, and functional status profiles are given. Census data show that the over 60 population is disproportionately poor, with low formal education attainment. The divergence between native older South Carolinians and older in-migrants that are generally higher income and better educated poses interesting opportunities and challenges for the future.

The health and functional status of persons 60+ is of special interest because of the implications for public policy and health care/long term care costs. With increases of frail, 85+ elderly, there will be increased need for acute care and long term care, both institutional and community-based. The numbers of persons suffering from dementia and Alzheimer's disease will grow dramatically over the next twenty five years, with the cost of care increasing anywhere from four to seven times current costs. The demands on informal caregivers such as family and friends will increase.

The Plan outlines the major challenges that face us individually and collectively as an aging society. Implementation of the strategies will require partnerships among all state agencies and between public and private sectors. Individuals and families face the need to take on greater personal responsibility and accountability for their lives and life decisions to ensure that their later years are productive and healthy. Many seniors face the prospect of being caught between caring for their children and parents. Individuals and families must take greater responsibility for planning their financial future and take preventive steps to enhance their personal health in preparation for their later years. Government must carefully use its scarce resources together with all available resources to empower, enable and assist our seniors and their families to meet the opportunities, challenges and choices that the dramatic aging of our society will present. The quality and vision of our public policy will have a significant impact on the changes caused by the aging of our population. It is for this purpose that the State Unit on Aging offers this plan. With the implementation of Choices for Independence and related legislation, and the need to modernize how we do business in serving our state's seniors, this plan lays out key issues, goals, outcomes and strategies for the next four years and beyond on how we propose and plan to accomplish our mandates from both the state and federal governments.

Key Outcomes and Strategies

A. Implementation of Choices for Independence

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

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

Each of these issue/initiative areas focus on enhancing personal choice and enhancing our older South Carolinians' and their caregivers' ability to remain healthy and independent as long as possible. Increased funds on the state and federal level for home and community-based services help seniors remain independent and delay costly institutionalization which saps the resources of the individual and his or her family or results in public funding for these services. Implementation of Aging and Disability Resource Centers and focusing on building a case management system together with information and services for family caregivers and seniors also enhance independence and choice. The Medicare Modernization Act and Evidence-Based prevention and wellness programs assist through providing affordable prescription drugs and providing training in programs to prevent injuries and falls. Long term care training helps to provide our state's citizens comprehensive training and information to help them decide whether or not to purchase long term care insurance, which type to purchase and also how to make smart decisions for the many choices that a senior and his/her family will face as they begin to need long term care.

B. Modernization of Aging Services in South Carolina

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

1. Collaboration with other state health and human services agencies to coordinate and maximize services to seniors
2. Meaningful Senior Centers: Senior Centers as the Town Square
3. Increased Competition/Cost control/Accountability
4. Information Technology
5. Expand and modernize nutrition services
6. Energizing the Alzheimer's Resource Coordination Center
7. Building partnerships with the faith-based network to provide services to seniors

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

South Carolina implemented a competitive procurement process during the last four years under its FY 2005-2008 State Plan on Aging. The SUA is continuing to work toward providing greater competition, further outreach to underserved areas of the state, and controlling costs and providing greater accountability for the limited resources that it has. The Lieutenant Governor's Office on Aging is working to modernize its senior centers to make them the “Town Square” so that they provide an entire range of activities and services to seniors. We are in the process of expanding and modernizing our nutrition services through providing vouchers, frozen and shelf stable meals, and using providers that have normally not participated in the aging service system. The Alzheimer’s Resource Coordination Center is in the process of bringing in new advisory board members and developing an Alzheimer’s State Plan. This effort will bring in new partners to leverage the current system’s resources and utilize other sources of funding. Finally, we plan on building a viable and growing partnership with the state’s faith-based network of churches through the major denominations to partner with their programs and educate them and their members about the many services and information available as a means to help our state’s seniors and citizens make educated decisions for the future.

C. Long Term Care Reform and Community Living Incentives

The SUA has organized its issues and efforts into six basic areas for Long Term Care Reform and Community Living Incentives in South Carolina. Many of these are in response to requirements of the Administration on Aging. Others are in response to the needs of South Carolina’s seniors and their caregivers. They are as follows:

1. Reform Medicaid/Medicare and provide choice and personal incentives
2. Implement the Long Term Care Partnership
3. Systems Transformation Grant
4. Tax Incentives
5. Payments for Caregivers
6. Reverse Mortgages

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

Services and the Administration on Aging for policies and initiatives that will work in South Carolina and benefit South Carolina's seniors and caregivers.

The Lieutenant Governor's Office on Aging will continue to work with the SC Department of Health and Human Services to implement the Long Term Care Partnership, and it will work to expand the programs and initiatives in the Systems Transformation grant. South Carolina will explore and advocate for tax incentives for the purchase of long term care insurance and for caregivers, either through tax credits or deductions. The Lieutenant Governor's Office on Aging will also work with the SC Department of Health and Human Services to provide payments to caregivers through their programs. Finally, the Lieutenant Governor's Office on Aging will advocate for the effective laws and regulations concerning reverse mortgages so that seniors are not taken advantage of and be able to benefit from them. All of these initiatives will be focused on providing incentives for remaining in the community and reforming the Medicaid and Medicare programs to provide the greatest array of options possible for our seniors and their caregivers.

D. Senior Transportation

Transportation is critical for seniors and persons with disabilities, as well as low to moderate income members of South Carolina's population, to maintain their independence and remain at home. South Carolina like many other states lacks a coordinated and affordable transportation system that currently meets the needs of its population. This system will be significantly lacking in the future as South Carolina ages. In order to address the many problems concerning transportation services in South Carolina, the Lieutenant Governor's Office on Aging has established the following goals:

- Develop a coordinated statewide transportation plan to build an affordable statewide system of public transportation to meet the needs of South Carolina's citizens.
- Provide adequate funding mechanisms to accomplish the Department of Transportation's statewide plan in the future.
- Provide a coordinated public transportation system to meet the needs of South Carolina's citizens.
- Expand the Lower Savannah pilot mobility transportation system statewide.

E. Geriatric Trained Professional Workforce

South Carolina is the first state in the nation to implement a geriatric physician loan program. This is the first step in a process to build incentives for building an adequate trained geriatric workforce of professionals in the state. The Lieutenant Governor's Office on Aging's goal is to ensure an adequate supply of trained geriatricians and other health professionals trained in geriatrics or gerontology in order to better serve the health care needs of older adults in South Carolina. This state plan will address how we plan to solve this growing shortage as our senior population grows.

F. Evidence-Based Research

The SUA has organized its issues and initializes into four basic areas for Evidence – Based Research in South Carolina. They are as follows:

1. South Carolina Seniors' Cube
2. Advanced POMP/Medicare Grant
3. Prevention and Wellness Evidence-Based Research
4. ADDGS Grant – (Alzheimer's)

South Carolina has been a national leader in the use of evidence-based research to improve its services and as a means to advocate for resources for the state's seniors. The Lieutenant Governor's Office on Aging, with the support of the Duke Endowment, in partnership with the USC Arnold School of Public Health and the Office of Research and Statistics, created the South Carolina Seniors' Cube – an award winning effort to conduct research and policy analysis. Additionally, findings from research from the Advanced Performance Outcomes Measurement Project have established the existence of a threshold effect for nutrition services for reducing hospital utilization by seniors. Further work is being conducted using Medicare data which may result in potentially significant savings for the Medicaid and Medicare programs in the future.

The Lieutenant Governor's Office on Aging also is administering health promotion/disease prevention evidence-based programs and collecting and analyzing data to determine to what degree the programs are working in community-based settings. Those programs to be analyzed include the Chronic Disease Self Management Program (*Living Well* in SC), A Matter of Balance, a fall prevention program, and the Arthritis Foundation Exercise Program administered by the health department. Data from these programs will be entered in to the unique Senior Cube that is part of the Office of Research and Statistics to research the impact of the programs on hospitalizations and health care utilization. Additionally, the Lieutenant Governor's Office on Aging is administering an Alzheimer's Disease Demonstration Grant to States project (ADDGS). The ADDGS grant outlines two goals for the project:

1. Improve access to home and community-based services for individuals with Alzheimer's disease and related disorders (ADRD) by targeting underserved minority and rural populations in the three-county area of Charleston, Berkeley, and Dorchester.
2. Expand consumer choice and consumer-directed long term care support for caregivers through the Aging and Disability Resource Center (ADRC), the Family Caregiver Support Program (FCSP), and the SC Alzheimer's Association (SCAA) to effect systems change.

G. Emergency Preparedness

The Lieutenant Governor's Office on Aging has two major areas of concern with emergency preparedness:

1. State Disaster Plan
2. State Pandemic Flu Plan

South Carolina is currently revising and updating its state disaster plan to properly align itself with state disaster procedures. This will update and make procedures for assisting

seniors in alignment with other units of state and local government in South Carolina. The Lieutenant Governor's Office on Aging also is working with the SC Department of Health and Environmental Control to follow the guidelines and requirements of the State Pandemic Flu Plan.

H. Elder Rights

The Lieutenant Governor's Office on Aging has addressed a number of issues concerning elder rights in the FY 2009-2012 State Plan on aging:

1. Prevention of Abuse, Neglect and Exploitation
2. Improvement of Quality of Care for Residents of Long Term Care Facilities
3. Decisions Regarding Health Care and End-of-Life
4. Legal Services
5. Volunteer Program and Mental Health

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

- To reduce the prevalence of elder abuse, neglect and exploitation in home and institutional settings
- To improve the quality of care in facilities through increased participation in the Advancing Excellence and Culture Change programs
- To empower residents to know and exercise their rights, voice their concerns and, to the extent possible, act on their own behalf or to seek outside assistance
- To identify and resolve resident problems relating to poor facility practices
- To identify and represent the interests of residents and seek appropriate remedies
- To improve access to legal assistance services for older adults who have no other legal resources
- To increase awareness and promote the use of advance directives for health care planning in the community and long term care facilities through training and education
- To increase partnering and collaborative opportunities to increase knowledge of advance directives for health care providers
- To increase the awareness of the occurrence of mental illness and substance abuse in the older adult population
- Create process maps of Adult Protective Services Providers' services for vulnerable adults to include legal services information
- Develop a gap analysis of services including legal support available for and needed by vulnerable adults
- Compile statistical information that documents and supports the need for the development of legal services or legislative initiatives to fill existing gaps

- Develop partnerships with organizations such as the Junior League to create programs for vulnerable adults who lack capacity
- Develop partnerships with organizations such as AARP to recruit volunteers (Friendly Visitors) on an ongoing basis and utilize these partnerships to create a dynamic base of volunteers to provide an ongoing pool of visitors for residents of long term care facilities
- Develop a complete system of centralized secure files and records to maintain comprehensive information on volunteers statewide
- Input information and compile statistical information that documents the visits made by Friendly Visitors
- Solicit facilities to participate in the program with a goal of 60% participation within three years

I. Volunteer and Employment Opportunities

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

The trend toward earlier and longer retirement creates some new challenges for South Carolina's seniors. While the majority of senior "transplants" tend to be of middle income or above, many of South Carolina's lifelong residents have lived in rural communities with below-the-national-average income levels. Many native South Carolina seniors are ineligible for federal financial assistance, and with skyrocketing health care costs, must continue to work in order to afford the basics.

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

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

Programs currently utilizing a sizeable number of volunteers are the home delivered meals program, State Health Insurance Program (SHIP), Advance Directives, Five Wishes and the Friendly Visitor Program. The Lieutenant Governor's Office on Aging continues to build partnerships with community organizations and other parts of state government in order to increase volunteer efforts. With the implementation of the Living Well and Alzheimer's Disease Demonstration Grant to States project, the SUA

continues to explore ways to utilize volunteers for expanding the outreach of its programs.

J. Education and Training

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

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

K. Resource Allocation:

The methods used by the SUA to allocate funds to the area agencies are described in Chapter 8. OAA funds and most state funds, except when otherwise directed by law are allocated based on a multi-factored formula. The factors include an equal base, percent of population 60+ below poverty, percent of minority population 60+, percent of population who are moderately or severely impaired, and the percent of state rural population. An examination of the recipients of services through the Aging Network shows that those populations in greatest economic and social need and minorities are served in numbers greater than their general representation in the population. No further targeting measures are indicated at this time.

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

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

CHAPTER 4: OVERVIEW OF THE STATE UNIT ON AGING

A. State Unit on Aging

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

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

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

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

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

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

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

B. Lieutenant Governor

The Lieutenant Governor of the State of South Carolina is the chief administrative officer of the SUA, and provides overall leadership for agency staff. This includes responsibilities for interpreting state and federal policies and ensuring the implementation of such policies and related procedures statewide.

C. Director

The Director of the SUA is responsible for the overall administration of SUA policies, coordination and review of legislation, both federal and state, broad advocacy activities, liaison with public and private agencies and organizations, and representing the interests of the SUA to executive management.

D. The State Unit on Aging

This Lieutenant Governor's Office on Aging has developed a plan which will allow the alignment of the organizational structure to focus the agency, its employees and its resources towards the consumer.

This process involved a review of the mission, vision and values of the organization; development of a workforce plan, including knowledge transfer from staff nearing retirement and a staff succession plan. These efforts involve: identification of career paths; identification of competencies required for the various career paths; assessment of current employees; determination whether or not there exist within the organization an adequate number of employees with the competencies required for succession purposes and identification of developmental opportunities for employees to strengthen required competencies.

A streamlined organizational structure will provide an additional focus on the customer, the processes, the strategy and the staff. The goal is for everyone to be headed in the same direction with a shared purpose. This process, which began in October of 2007, with implementation in the Spring of 2008, will be substantially complete in the Summer of 2008.

Other Activities

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

E. Designation of Planning and Service Areas (PSAs)

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

Service providers receive federal and state funding through performance-based contracts, i.e., the provider agrees to provide a specified amount of a specific service at an agreed-upon unit rate. To earn funds, service must be provided. In addition to services provided through state and federal funds (many of which require local matching funds), most providers also receive funding through a variety of local sources; some of

these include United Way contributions, church and civic donations, private donations, fees for non-federal programs, and funds generated through fund-raising activities.

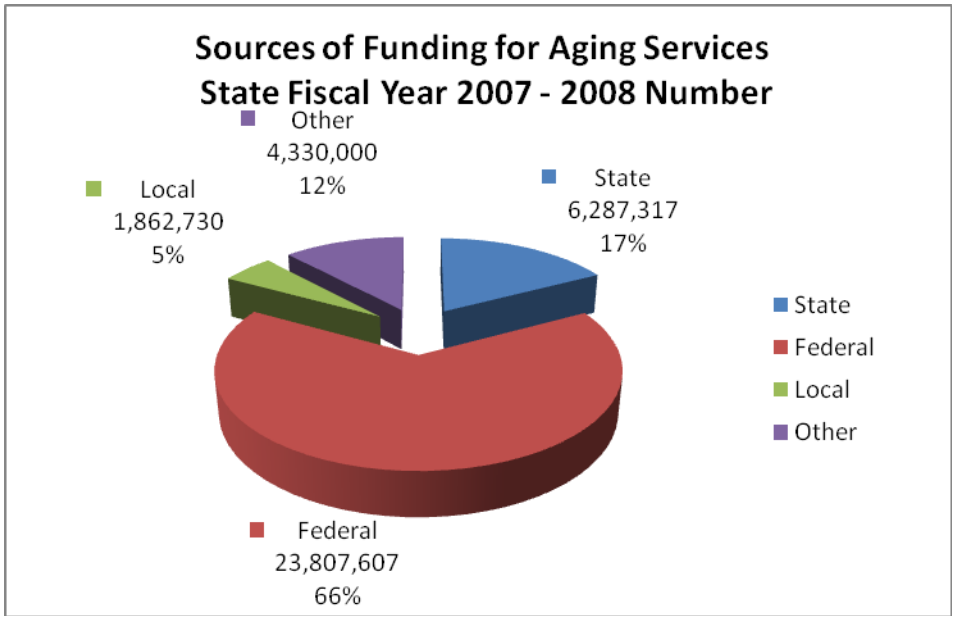
F. Funding Sources

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

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

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

The chart below shows funding amounts in place for the State Fiscal Year 2007 – 2008.



Federal Programs:

Older Americans Act - Title III: funds services such as home care, transportation, health promotion and wellness programs, group dining, home delivered meals, nutrition education, information, referral and assistance, family caregiver support and outreach, elder abuse prevention activities, and the long term care ombudsman program.

Older Americans Act - Title V (Senior Community Service Employment Program) funds employment and training services to people age 55 and older who meet income guidelines. Title V is administered by the SUA and one national contractor: Experience Works, Inc. In addition to receiving training and employment experience, Title V workers also supplement the work force for Aging Network providers and many other non-profit organizations.

Older Americans Act -Title VII: comprised of three advocacy programs: the Long Term Care Ombudsman Program (LTCOP); Prevention of Elder Abuse and Exploitation; and Legal Assistance Development programs. These programs exist to inform seniors, protect and enhance the rights and benefits of older adults and help them to make end-of-life decisions.

Health Insurance Counseling Program - (I-CARE): Beneficiaries face a myriad of choices and rules when choosing supplemental health insurance and understanding the Medicare program. For these reasons, the Omnibus Budget Reconciliation Act of 1990 established federally funded, state-managed, Insurance Counseling and Assistance programs for Medicare beneficiaries. In 1992, HCFA (now CMS) awarded the first grants for this program. The Medicare Modernization Act of 2003 added additional responsibilities to the program when beneficiaries were required to purchase prescription drug coverage through Medicare.

The I-CARE/State Health Insurance Program is a complex program that provides counseling through trained I-CARE personnel at the state and regional levels. It is also volunteer-based and designed to provide Medicare information and assistance to beneficiaries and caregivers, using a peer approach that involves recruiting and training Medicare beneficiaries and retired seniors to provide the counseling. To avoid any potential conflict of interest, the grant prohibits insurance and medical sales agents from being volunteer counselors.

The SUA allocates a portion of the grant funds received to AAAs using the OAA intrastate allocation formula. No match is required for I-CARE funds. The AAA may use the funding to augment I-CARE coordinator salary, to support volunteer meals, travel, training and recognition. Remaining funds support program administration and training costs associated with initial and upgrade training for volunteers. Supplemental funding is also distributed to the AAAs when awarded by CMS.

Senior Medicare Patrol - In 1997, the Administration established demonstration projects that utilize the skills and expertise of retired professionals to identify and report error, fraud, and abuse in the Medicare program. This program operates in tandem with the I-CARE program. The SUA allocates the AoA grants in the same way it allocates I-CARE funds to the AAAs. Senior Medicare Patrol funds require a twenty-five percent (25%) match. These funds may be used for the same allowable costs as I-CARE funding.

Senior Medicare Patrol coordinators and volunteers raise awareness of misuse of the Medicare program and work with experts in the community to teach older individuals, families and caregivers how to take an active role in protecting Medicare coverage and reporting fraudulent practices.

Social Services Block Grant (SSBG) - The SUA administers SSBG funds designated to serve meals to homebound persons who meet income requirements. Such persons may be under the age of 60 but must be most in need of services as determined by assessment. This program is operated in conjunction with the Title III home-delivered meals program. SSBG also funds services provided by Aging Network provider agencies, but not administered by the SUA.

Nutrition Services Incentive Program administered through the US Department of Agriculture – As amended by the *Older Americans Act (OAA) of 2000*, the NSIP is the new name for the USDA's cash or commodity program, formerly known as the Nutrition Program for the Elderly (NPE). The commodity program for NSIP is funded through an appropriation to USDA and administered by the Food and Nutrition Service's (FNS) Food Distribution Division.

The purpose of NSIP is to reward effective performance by States and Tribal organizations in the efficient delivery of nutritious meals to older individuals through the use of cash or commodities. This financial support, either as cash or commodities, is to support programs funded, in whole or in part, under Titles III and VI of the OAA.

Meals meeting certain requirements and served to specified persons are eligible for partial reimbursement through the AoA. This includes meals served under Title III of the OAA, the Social Services Block Grant, and state-funded nutrition services.

State Sources:

Match for Federal Programs - The OAA requires that states meet a 5% matching requirement to receive the federal funds.

State Grant - After meeting the 5% match requirement and the Alternate Care for the Elderly (ACE) allocation, the balance of general revenue funds is divided equally among the designated PSAs. It is intended that these funds be used to match federal resources other than OAA funds, and shall not be used to supplant regional resources. When there is an across the board budget cut, this portion of pass-through funding is reduced.

Alternative Care for the Elderly - These funds are used to provide services for functionally impaired older persons, and are distributed according to the same intra-state formula used for the OAA.

Home and Community-Based Services - These funds are appropriated as Supplemental State Funds by the SC Legislature for a wide array of home and community-based services such as home delivered meals, group dining, transportation, home care, home modifications, bags of groceries, etc. All of these programs are designed to help seniors remain at home. The program allows considerable flexibility for the Area Agencies on Aging and local service contractors to meet local service needs.

Senior Citizens Center Permanent Improvement Fund - This program, funded by earmarked taxes and licensing fees from bingo games, provides capital improvement funds for the construction and renovation of multi-purpose senior centers throughout the

state. Projects are subject to all state regulations for capital improvement projects. Enabling legislation established the fund for $948,000 annually.

Cost of Living Supplement - The General Assembly enacted permanent legislation effective July 1, 1990 that made AAAs and local service providers eligible for state base and performance pay increases in an amount commensurate with the portion of state funds used for payroll. Funds in this line item are designated for continuing the previously awarded cost of living increases in salaries paid to aging network employees with state revenue. Whenever the General Assembly authorizes cost of living or performance pay increases for state employees, that proportional increase is added to the maintenance of effort amount in this line item. Local service providers stopped receiving cost of living supplements when the SUA moved to competitive procurement in FY 2005-2006.

Geriatric Loan Forgiveness Program – This state program provides up to $35,000 in funds to assist physicians in repaying student loans. In return, they agree to remain in South Carolina for five years and care for the state's ever increasing senior population. The SC Legislature enacted this program in FY 2005-2006 under Chapter 21, Title 43 of the 1976 Code Section 43-21-200 with an annual State appropriation of $140,000. This is the first such act in the United States.

Other Sources:

ElderCare Trust Fund - Section 43-21-160 of the Code of Laws of South Carolina, 1976, as amended requires that all monies received from voluntary contributions must be used to award grants to public and private non-profit agencies and organizations to establish and administer innovative programs and services that assist older persons to remain in their homes and communities with maximum independence and dignity. The ElderCare Trust Fund shall supplement and augment programs and services provided by or through state agencies but may not take the place of these programs and services.

Alzheimer's Resource Coordination Center - The ARCC, located within the SUA, was established by state legislation (Title 44 Chapter 36) in 1994. The center's goal is to serve as a statewide focal point for coordination, service system development, information, referral, caregiver support, and education to assist persons with Alzheimer's disease and related disorders (ADRD) and their families and caregivers. The Governor appoints the ARCC Advisory Council whose members represent state agencies and organizations identified in the statute. The Advisory Council also includes persons who have an interest in Alzheimer's disease. The Center receives an annual appropriation from the state of $150,000 to be used to fund seed grants for respite and education programs.

Emergency Rental Assistance Program – This program assists seniors, who are renting and experience an emergency situation, to remain in their home by providing emergency rent funds. This program is made available through a grant from the SC State Housing Finance and Development Authority.

G. Programs and Services

For the FY 2009 - 2012 Plan period, the SUA supports through federal and state funds the following services. The SUA may identify other sources of funds to support services where state and federal funds are not available.

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

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

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

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

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

The ***A Matter of Balance*** program has also been proven to reduce the fear of falling in older adults. This fall prevention class is held twice a week for four weeks. Class locations can be found on the Lt. Governor's Office on Aging website. Both of these programs are partially funded through the Administration on Aging.

Additionally, routine health screenings, nutritional assessment, counseling and follow-up are provided.

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

Eforms are available online at www.scaccesshelp.org for **Medicaid Long Term Care** (Medicaid-eligible individuals interested in receiving services in their homes or those

needing nursing home placement) and **GAPS** (the state-sponsored prescription coverage for seniors that helps "fill the gap" with their Medicare Part D drug coverage.)

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

Employment Services - Title V of the OAA funds the Senior Community Service Employment Program. This program provides training to persons 55 and over who are low-income to assist them in entering the job market or transitioning to other types of employment. Enrollees receive training and experience by working for non-profit organizations.

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

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

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

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

Legal Services Development - These services identify and provide services that will provide support to the older adult, including information on legal services and referral to appropriate agencies to deal with specific situations, information on and initiatives to address frauds and scams, advocacy, and interaction with other agencies to obtain services, thereby protecting the older person's dignity, rights, autonomy and financial security.

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

Mature Adults Count is a 10-year series of electronic publications that has recorded and tracked statistics about South Carolinians aged 50 and above. The latest report published in 2006, ***Mature Adults Count: Opportunities, Challenges and Choices,*** describes how our older population is in the process of doubling in size, and how decision-makers and policymakers may find both opportunities and challenges as they make choices about how our state will react to the tremendous demographic changes that are occurring in South Carolina. Both state level data and county level data are available at http://www.scmatureadults.org/.

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

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

South Carolina Seniors' Cube Is a nationally unique comprehensive statewide electronic database of the senior population's health care statistics and services, which integrates information from multiple data systems. Its quick query data analysis tool shows multiple relationship factors so researchers can examine cost-effective strategies for maintaining the health and well-being of the senior population to allow seniors to remain independent longer. Funding has been provided through the Duke Endowment and has resulted in a partnership with the USC Arnold School of Public Health and the South Carolina State Budget and Control Board, Office of Research and Statistics.

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

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

Additional Related Activities:

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

Alzheimer's Resource Coordination Center - Act 195 of 1993 directed the Joint Legislative Committee on Aging to form a Blue Ribbon Task Force to study the planning, coordination and delivery of services for individuals with Alzheimer's disease and related disorders, their families and caregivers. Following a recommendation of this Task Force and subsequent legislation, a statewide Alzheimer's Resource Coordination Center (ARCC) was established in the SUA under the direction of an Advisory Committee appointed by the Governor. The mission of the ARCC is to improve the quality of life for

persons with Alzheimer's disease and related dementias through planning, education, coordination, advocacy, service system development and communication. Competitive grants are awarded annually to promote the delivery of services.

Summer School of Gerontology - 2008 marks the 32nd year of this annual event. A broad array of classes is offered each year to persons working in programs and services for older adults. The Summer School is held at appropriate locations throughout South Carolina annually. Classes are offered on a continuing education credit basis.

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

The most recent report is for the period October 1, 2006 through September 30, 2007. The following tables show data from the NAPIS report for Fiscal Year 2006 – 2007.

SOUTH CAROLINA NAPIS FY 2006-2007					
	TOTAL CLIENTS	TOTAL UNITS	TITLE III DOLLARS	TOTAL EXPENDITURE	% TITLE III DOLLARS
Cluster 1 Services					
PERSONAL CARE	464	42,044	$153,990	$666,478	23.11%
HOMEMAKER	2,845	160,519	$954,912	$2,098,368	45.51%
CHORE					
HOME DEL MEALS	13,300	1,972,979	$2,363,693	$10,594,641	22.31%
ADULT DAY CARE	76	40,694	$42,632	$360,813	11.82%
Cluster 2 Services					
CONGREGATE MEALS	11,467	1,013,331	$3,424,688	$6,284,103	54.50%
NUTRITION COUNSELING	256	1,317	$3,738	$8,701	42.96%
ASSISTED TRANSP					
Cluster 3 Services					
TRANSPORTATION	4,812	1,800,858	$2,467,418	$6,881,960	35.85%
LEGAL ASSISTANCE	821	2,410	$77,169	$146,466	52.69%
NUTRI ED (Health Prom)	1,144	33,924	$59,317	$96,792	61.28%
INFO & ASST.	8,388	13,672	$492,608	$492,608	100.00%
OUTREACH	750	1,731	$0	$21,031	0.00%
PHYSICAL FITNESS	3,394	161,161	$223,248	428939	52.05%
OTHER			$37,687	$369,990	10.19%
TOTALS			$10,301,100	$28,450,890	36.21%

UNDUPLICATED COUNT BY CHARACTERISTICS OF CLIENTS SERVED	
Clients by Minority Status:	
African-American	14543
Hispanic	50
American Indian/Native Alaskan	49
Asian American/Pacific Islander	25
Non-Minority/Other	15006
TOTAL	**29673**
Rural Clients	16775
Clients in Poverty	17283
Clients in Poverty/Minority	8419
New Clients Served	11807
17,283 (58.24%) of all clients are below poverty level. 56.5% live in rural areas.	

SOURCE: NAPIS 2007

The SUA annually provides the number of individuals awaiting receipt of services.

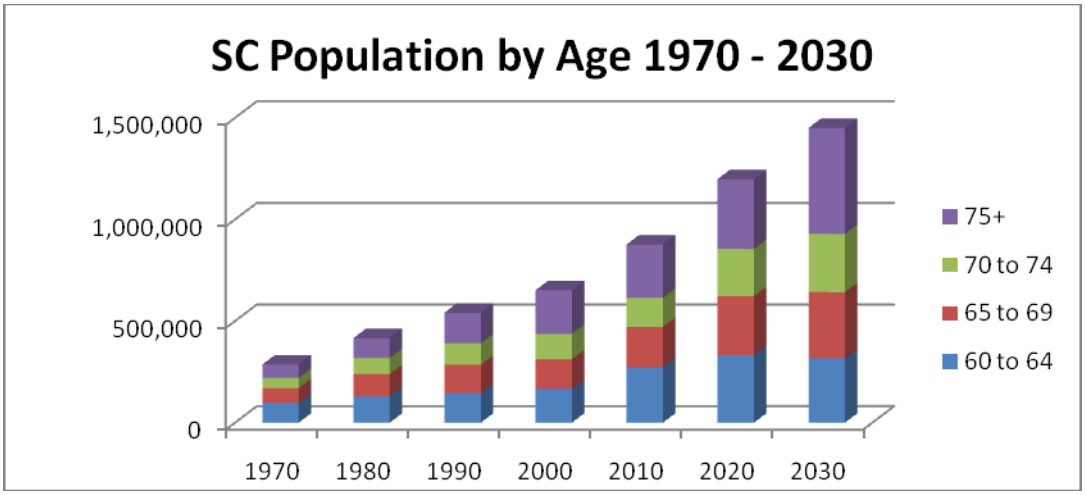
NUMBER OF PERSONS WAITING FOR SERVICES AT THE END OF 2007	
Home-Delivered Meals	2,531
Congregate Meals	535
Home Care (Levels 1, 2, and 3)	1237
Transportation	194
Escorted Transportation	36
Adult Day Care	23
Alzheimer's Respite	10
Health Promotion	34
Care Management	15

SOURCE: NAPIS 2007

CHAPTER 5: CHARACTERISTICS OF THE OLDER POPULATION

A. Introduction

South Carolina has experienced a significant growth of seniors or mature adults over the last few decades. The baby boom has begun to have a dramatic impact and will continue to affect the nation and South Carolina's communities and institutions over the next twenty years. The state's population has grown from 286,272 persons aged 60 and over since 1970 to 651,482 in the year 2,000, a 128% increase in thirty years.



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

South Carolina Population by Age 1970-2030							
	1970	**1980**	**1990**	**2000**	**2010**	**2020**	**2030**
50 to 54	131,916	149,126	159,507	262,543	326,406	309,755	302,530
55 to 59	115,021	149,937	148,762	206,762	302,301	339,621	305,344
60 to 64	95,312	128,816	144,020	166,149	270,852	332,083	316,028
65 to 69	74,257	110,235	140,455	145,599	200,488	289,980	325,913
70 to 74	50,967	79,292	105,850	124,449	142,661	232,716	286,921
75 to 84	53,117	77,797	119,881	165,016	184,258	244,666	380,339
Total 60+	286,272	416,144	540,955	651,482	876,512	1,198,333	1,450,487
Total 65+	190,171	287,328	396,935	485,333	605,660	866,250	1,134,459
Total 75+	65,736	97,801	150,630	215,285	262,511	343,554	521,625
Total 85+	11,830	20,004	30,749	50,269	78,253	98,888	141,286

Source: 1970-2000 Projections: US Census Bureau Decennial Census 1970, 1980, 1990, and 2000. 2010-2025 Projections: US Census Bureau, Population Division, Interim State Population Projections, 2005.

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

Nationally, South Carolina ranks 29th with 12.60% of its population 65 and over. This population has increased from 40,000 (3% of the population) in 1900, to 485,333 in 2000

(12.25% of the total population) and is projected to reach 1,134,459 (22% of the population) in 2030."

Resident Population 65 Years and Over - July 2005					
State	**Percent**	**Rank**	**State**	**Percent**	**Rank**
United States	12.4	(X)	Arizona	12.8	26
Florida	16.8	1	Kentucky	12.6	27
West Virginia	15.3	2	Tennessee	12.6	28
Pennsylvania	15.2	3	South Carolina	12.6	29
North Dakota	14.7	4	New Hampshire	12.5	30
Iowa	14.7	5	Michigan	12.4	31
Maine	14.6	6	Indiana	12.4	32
South Dakota	14.2	7	Mississippi	12.3	33
Rhode Island	13.9	8	New Mexico	12.2	34
Arkansas	13.8	9	Wyoming	12.2	34
Montana	13.8	10	Minnesota	12.1	36
Hawaii	13.7	11	North Carolina	12.1	36
Connecticut	13.5	12	Illinois	12.0	38
Ohio	13.3	13	Louisiana	11.8	39
Massachusetts	13.3	14	Maryland	11.5	40
Missouri	13.3	14	Idaho	11.5	41
Delaware	13.3	16	Washington	11.5	42
Nebraska	13.3	17	Virginia	11.4	43
Alabama	13.3	18	Nevada	11.3	44
Oklahoma	13.2	19	California	10.7	45
Vermont	13.2	20	Colorado	10.0	46
New York	13.1	21	Texas	9.9	47
Wisconsin	13.0	22	Georgia	9.6	48
Kansas	13.0	23	Utah	8.8	49
New Jersey	13.0	24	Alaska	6.6	50
Oregon	12.9	25	District of Columbia	12.2	(X)
Symbol					
X Not applicable.					

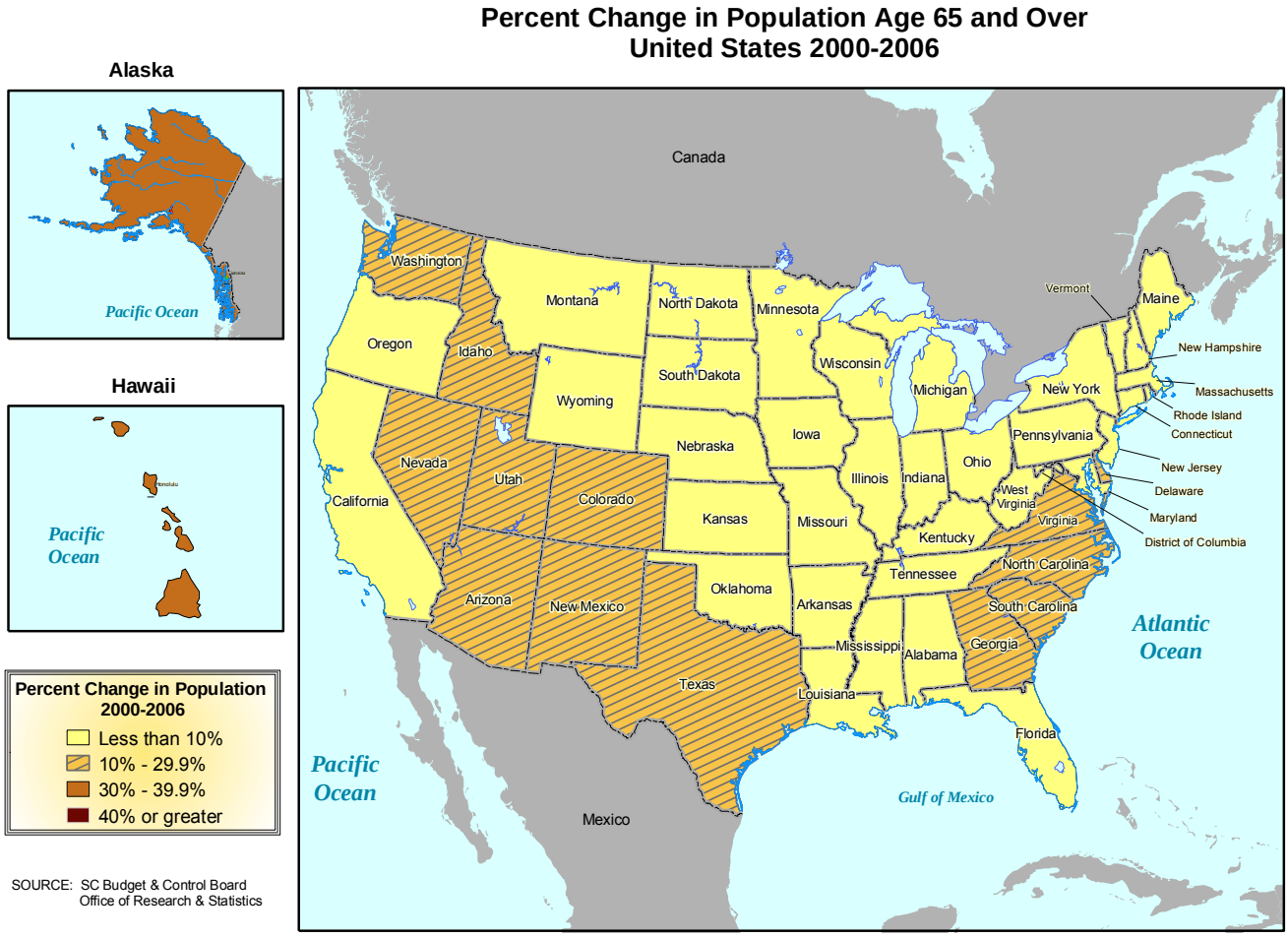
See Table 21, Statistical Abstract of the United States, 2007.

Cautionary note about rankings:

The ranks in some tables are based on estimates derived from a sample(s). Because of sampling and nonsampling errors associated with the estimates, the ranking of the estimates does not necessarily reflect the correct ranking of the unknown true values. Thus, caution should be used when making inferences or statements about the states' true values based on a ranking of the estimates. As an example, the estimated total (average, percent, ratio, etc.) for State A may be larger than the estimates for all other states. This does not necessarily mean that the true total (average, percent, ratio, etc.) for State A is larger than those for all other states. Such an inference typically depends on --among other factors-- the size of the difference(s) between the estimates in question, and the size of their associated standard errors.

The map and table below show that from 2000 to 2006, South Carolina's growth rate ranked ninth in the nation with a 13.52% rate of growth of its 65+ population. Clearly, South Carolina has seen a significant growth in its senior population.

UNITED STATES PERCENT POPULATION CHANGE: AGE 65+



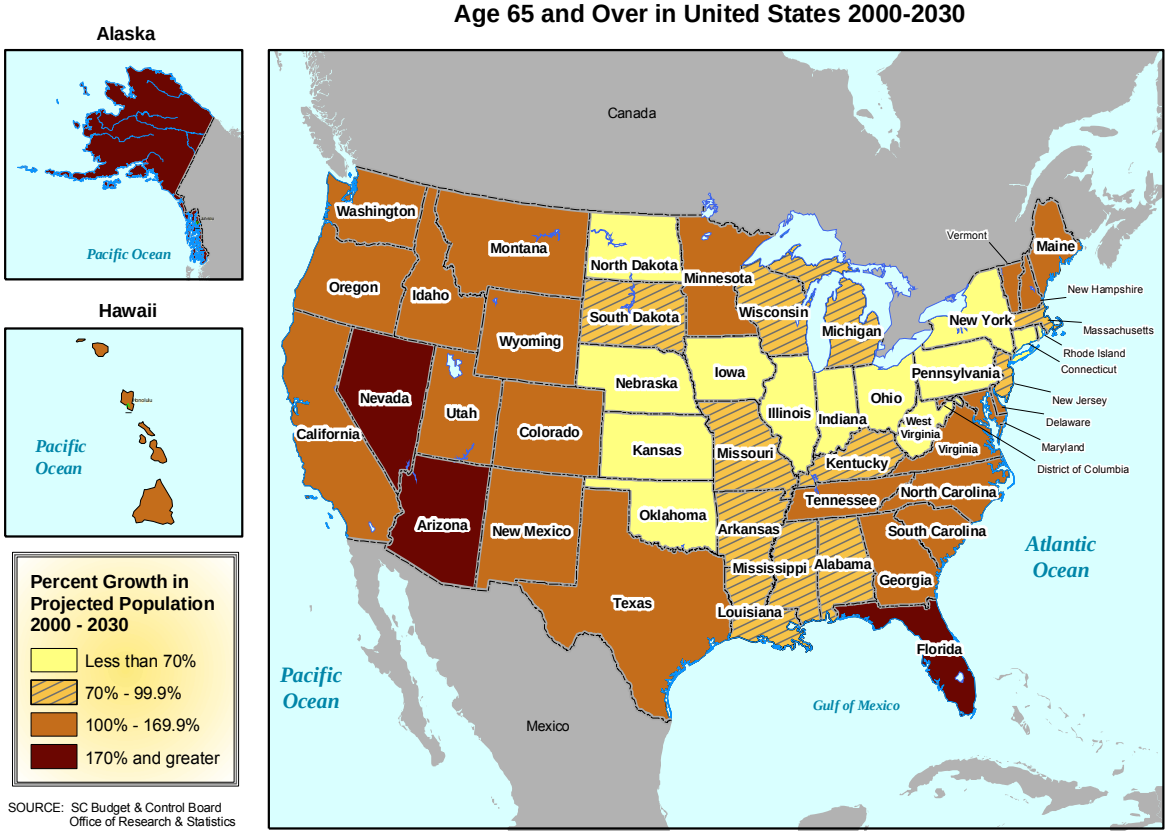
PERCENT PROJECTED GROWTH UNITED STATES: AGE 65+

Percent Change - US Population 2000 – 2006						
Rank	**State**	**Population Estimate 2000**	**Population Estimate 2002**	**Population Estimate 2005**	**Population Estimate 2006**	**% Growth**
1	Alaska	36,101	38,929	43,885	45,630	26.40
2	Nevada	221,473	240,723	269,119	276,943	25.05
3	Utah	191,342	199,424	218,411	225,539	17.87
4	Arizona	671,924	699,171	762,957	790,286	17.62
5	Georgia	788,814	819,660	884,787	912,874	15.73
6	Idaho	146,529	152,207	164,206	169,173	15.45
7	Colorado	418,373	433,111	464,600	477,186	14.06
8	New Mexico	213,336	220,594	235,884	242,600	13.72
9	**South Carolina**	**487,491**	**502,461**	**537,319**	**553,396**	**13.52**
10	Delaware	102,195	104,965	111,900	114,574	12.11
11	Texas	2,082,401	2,144,686	2,278,572	2,334,459	12.10
12	Virginia	795,618	820,328	867,975	887,768	11.58
13	Washington	664,217	680,320	721,369	738,369	11.16
14	Hawaii	161,362	166,459	175,384	179,370	11.16
15	North Carolina	972,589	1,000,350	1,054,835	1,076,951	10.73
16	New Hampshire	148,564	152,170	160,407	162,629	9.47
17	Tennessee	705,465	718,617	752,736	769,222	9.04
18	Oregon	439,010	447,362	469,223	478,180	8.92
19	California	3,611,095	3,707,923	3,868,404	3,931,514	8.87
20	Wyoming	57,865	59,137	61,813	62,750	8.44
21	Maryland	601,594	616,575	642,248	650,568	8.14
22	Florida	2,813,589	2,863,025	2,986,142	3,037,704	7.97
23	Montana	121,185	123,587	128,581	130,592	7.76
24	Vermont	77,746	79,087	81,827	82,966	6.71
25	Kentucky	505,561	509,021	527,884	537,294	6.28
26	Alabama	581,059	587,567	605,683	615,597	5.94
27	Minnesota	595,366	603,572	620,860	627,394	5.38
28	Mississippi	344,034	346,783	358,437	362,172	5.27
29	Maine	183,809	186,658	190,870	192,639	4.80
30	Arkansas	374,449	375,582	385,178	390,421	4.27
31	Indiana	753,739	758,364	776,655	784,219	4.04
32	Oklahoma	456,629	458,745	468,886	473,545	3.70
33	Michigan	1,221,300	1,229,344	1,252,607	1,260,864	3.24
34	Missouri	755,838	759,213	772,963	778,891	3.05
35	Wisconsin	703,422	706,672	718,550	724,034	2.93
36	New York	2,452,885	2,475,659	2,515,050	2,522,686	2.85
37	South Dakota	108,169	108,536	110,275	111,183	2.79
38	District of Columbia	69,769	70,073	71,251	71,331	2.24
39	Illinois	1,501,077	1,503,909	1,526,488	1,534,476	2.23
40	Ohio	1,509,329	1,513,134	1,527,542	1,531,994	1.50
41	New Jersey	1,114,747	1,118,524	1,125,164	1,127,742	1.17
42	Louisiana	517,561	520,440	531,659	523,346	1.12
43	Nebraska	232,298	232,046	233,398	234,655	1.01
44	West Virginia	276,978	276,242	277,800	278,692	0.62
45	Kansas	356,274	354,118	356,425	357,709	0.40
46	Connecticut	470,747	469,014	470,147	470,443	-0.06
47	Iowa	436,081	433,479	434,524	435,657	-0.10
48	Massachusetts	861,196	858,698	856,298	855,962	-0.61
49	North Dakota	94,464	93,819	93,071	92,874	-1.68
50	Pennsylvania	1,919,076	1,903,168	1,887,801	1,885,323	-1.76
51	Rhode Island	152,489	150,996	148,957	147,966	-2.97

Source: US Census Bureau, 2006 Population Estimates

The map and table below show the projected growth of the 65+ population nationally. South Carolina is projected to rank 14th by 2030 based on the 2000 census. South Carolina is projected to have an increase of 133.7% growth in the 65+ population by 2030.

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



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

Source: US Census Bureau, Population Division, Interim State Population Projections, 2005

B. Population Trends

The growth of South Carolina's 60 and over population will continue to increase significantly over the next twenty-five years. Overall, persons 60 and above are anticipated to increase from 651,482 in 2000 to 1,450,487 in 2030 for a 123% increase. The fastest growing segments of our senior population will be in the 75+ and 85+ age categories.

For the population over 60, the fastest growing counties between 1990 and 2000 were Beaufort (71.1%), Horry (54.8%), Berkeley (48.3%), McCormick (46.0%), and Lexington (43.5%).

The counties with the largest percentage concentration of persons 60+ were McCormick (23.0%), Oconee (21.3%), Orangeburg (21.3%), Beaufort (20.7%), Georgetown (20.5%), and Union (20.5%).

Tables in Appendix E show the projected growth by county of the 60 plus, 75 plus, and 85 plus populations in South Carolina by region from 2000 to 2025.

C. Growth of 85+ Population

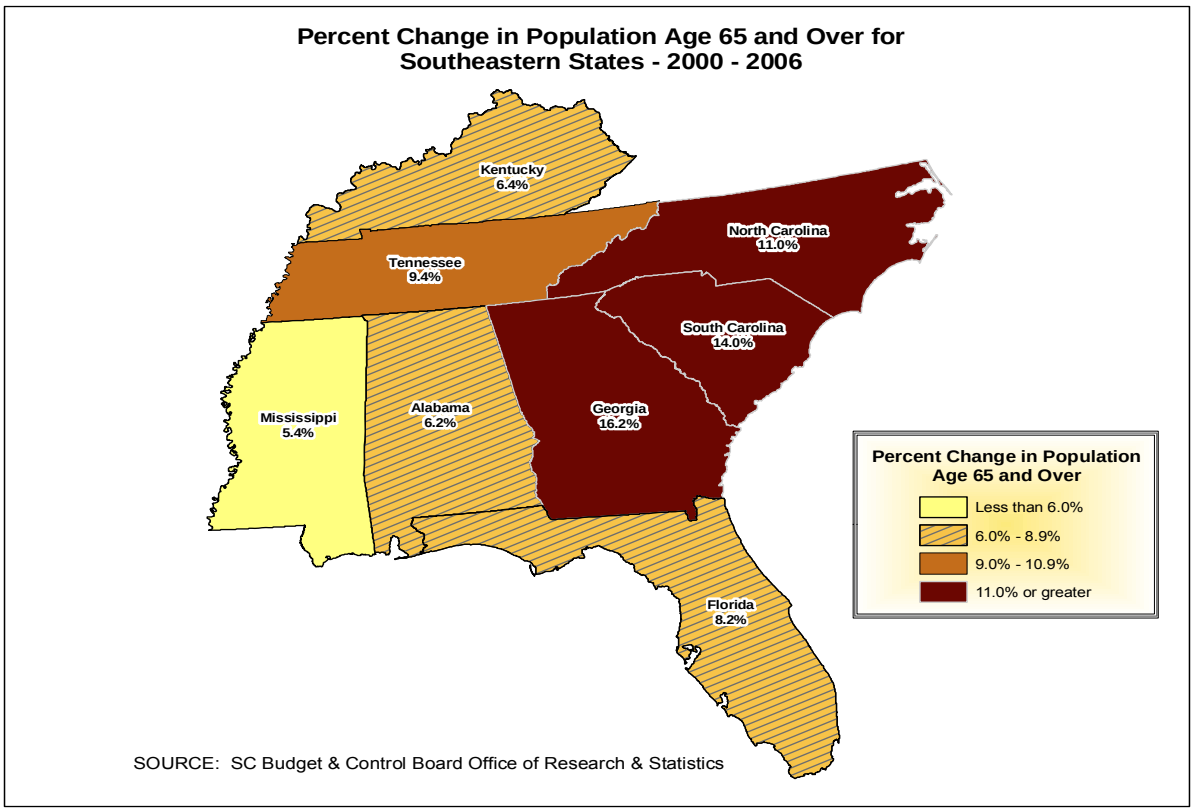
When looking at the 85 and over population from 1980 to 2000, we can see the significant rate of growth in this sector. All ages have increased by 28.6 percent. However, South Carolinians aged 75 to 84 have increased by 112.1 percent, and those 85 and over have

increased by 151.3 percent. When looking at growth from 2000 to 2006, we see the impact of the Baby Boomers on the state's population in the chart below:

SC Population Growth by Age Group				
	1970 - 1980	1990 - 2000	1980 - 2000	2000 - 2006
All ages	11.7%	15.1%	28.6%	7.4%
50 to 54 years	7.0%	64.6%	76.1%	12.9%
55 to 59 years	-0.8%	39.0%	37.9%	36.8%
60 to 64 years	11.8%	15.4%	29.0%	31.1%
65 to 69 years	27.4%	3.7%	32.1%	13.6%
70 to 74 years	33.5%	17.6%	57.0%	7.2%
75 to 84 years	54.1%	37.6%	112.1%	11.6%
85 years and over	53.7%	63.5%	151.3%	35.0%

Source: US Census Bureau - 1980, 1990, 2000 Decennial Census and 2006 Population Estimates

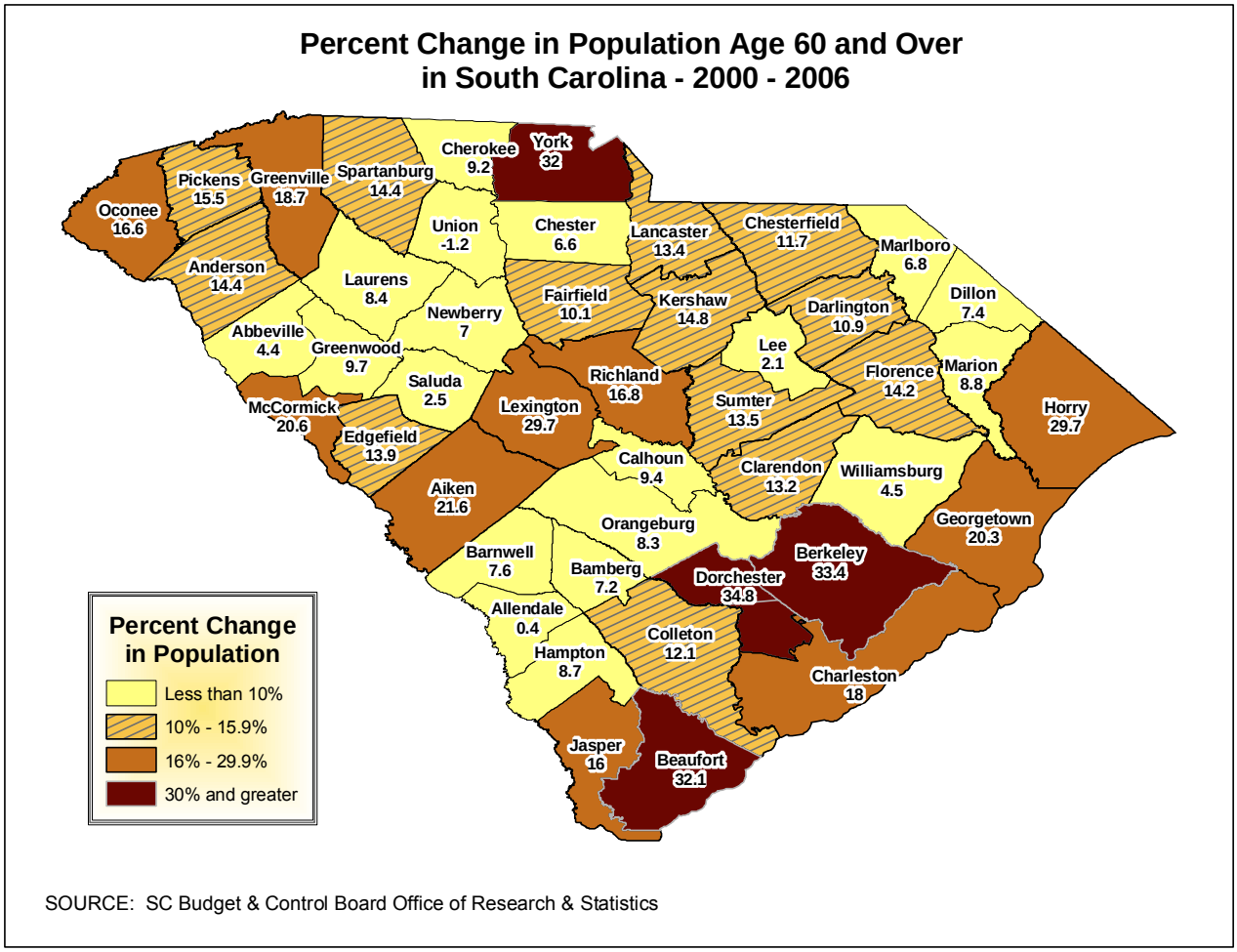
SOUTHEASTERN STATES PERCENT POPULATION CHANGE: AGE 65+



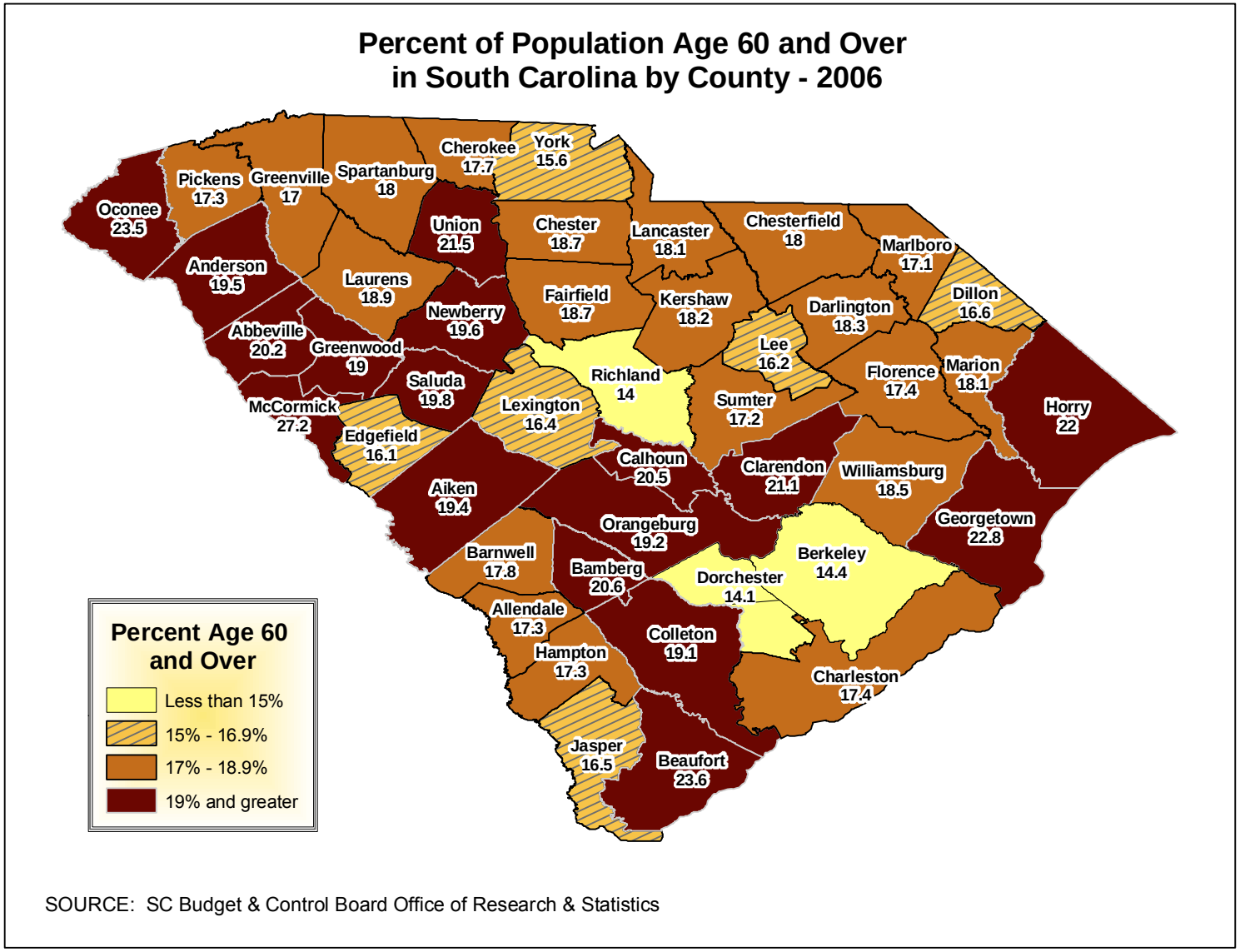
Southeastern States Percent Population Changes for Age 65+							
State	1990 Population 65+	2000 Population 65+	# Change 1990-2000	% Change 1990-2000	2006 Population Estimate 65+	# Change 2000-2006	% Change 2000-2006
Alabama	522,989	579,798	56,809	10.9%	615,597	35,799	6.2%
Florida	2,369,431	2,807,597	438,166	18.5%	3,037,704	230,107	8.2%
Georgia	654,270	785,275	131,005	20.0%	912,874	127,599	16.2%
Kentucky	466,845	504,793	37,948	8.1%	537,294	32,501	6.4%
Mississippi	321,284	343,523	22,239	6.9%	362,172	18,649	5.4%
North Carolina	804,341	969,048	164,707	20.5%	1,076,951	107,903	11.1%
South Carolina	396,935	485,333	88,398	22.3%	553,396	68,063	14.0%
Tennessee	618,818	703,311	84,493	13.7%	769,222	65,911	9.4%

Source: US Census Bureau, Population Estimates Division

PERCENT CHANGE FOR SC COUNTIES IN 60+ POPULATION 1990 – 2000



South Carolina Percent Change in Population 60 Plus by County and PSA: 2000-2006													
County	**2000**	2006	# Change	% Change	County	2000	2006	# Change	% Change	County	2000	2006	# Change	% Change
Appalachia					Upper Savannah					Catawba				
Anderson	30,374	34,755	4,381	14.4%	Abbeville	5,013	5,233	220	4.4%	Chester	5,765	6,146	381	6.6%
Cherokee	8,710	9,511	801	9.2%	Edgefield	3,569	4,065	496	13.9%	Lancaster	10,140	11,503	1,363	13.4%
Greenville	59,857	71,038	11,181	18.7%	Greenwood	11,817	12,966	1,149	9.7%	Union	6,162	6,086	-76	-1.2%
Oconee	14,206	16,558	2,352	16.6%	Laurens	12,246	13,277	1,031	8.4%	York	23,572	31,117	7,545	32.0%
Pickens	17,135	19,789	2,654	15.5%	McCormick	2,306	2,780	474	20.6%	Regional Total	45,639	54,852	9,213	20.2%
Spartanburg	42,556	48,687	6,131	14.4%	Saluda	3,675	3,767	92	2.5%	Santee-Lynches				
Regional Total	**172,838**	200,338	27,500	15.9%	Regional Total	38,626	42,088	3,462	9.0%	Clarendon	6,222	7,044	822	13.2%
Central Midlands					Lower Savannah					Kershaw	9,136	10,488	1,352	14.8%
Fairfield	4,050	4,459	409	10.1%	Aiken	24,217	29,445	5,228	21.6%	Lee	3,260	3,328	68	2.1%
Lexington	30,447	39,479	9,032	29.7%	Allendale	1,850	1,858	8	0.4%	Sumter	15,878	18,014	2,136	13.5%
Newberry	6,910	7,397	487	7.0%	Bamberg	3,013	3,231	218	7.2%	Regional Total	34,496	38,874	4,378	12.7%
Richland	41,725	48,739	7,014	16.8%	Barnwell	3,854	4,148	294	7.6%	Trident				
Regional Total	**83,132**	100,074	16,942	20.4%	Calhoun	2,812	3,075	263	9.4%	Berkeley	16,460	21,958	5,498	33.4%
Pee Dee					Orangeburg	16,067	17,401	1,334	8.3%	Charleston	48,842	57,653	8,811	18.0%
Chesterfield	6,949	7,759	810	11.7%	Regional Total	51,813	59,158	7,345	14.2%	Dorchester	12,423	16,748	4,325	34.8%
Darlington	11,129	12,340	1,211	10.9%	Waccamaw					Regional Total	77,725	96,359	18,634	24.0%
Dillon	4,780	5,132	352	7.4%	Georgetown	11,544	13,887	2,343	20.3%	Low Country				
Florence	20,031	22,876	2,845	14.2%	Horry	40,423	52,437	12,014	29.7%	Beaufort	25,351	33,487	8,136	32.1%
Marion	5,752	6,261	509	8.8%	Williamsburg	6,404	6,692	288	4.5%	Colleton	6,729	7,545	816	12.1%
Marlboro	4,671	4,990	319	6.8%	Regional Total	58,371	73,016	14,645	25.1%	Hampton	3,390	3,685	295	8.7%
Regional Total	**53,312**	59,358	6,046	11.3%						Jasper	3,101	3,597	496	16.0%
										Regional Total	38,571	48,314	9,743	25.3%
	2000	2006	# Change	% Change										
South Carolina	**654,523**	772,431	117,908	18.0%	*Source: US Census Bureau, 2006 Population Estimates*									



SOURCE: SC Budget & Control Board Office of Research & Statistics

South Carolina Percent of Population 60 Plus by County and PSA											
County	**Total Population**	**Population 60+**	**% of Total**	**County**	**Total Population**	**Population 60+**	**% of Total**	**County**	**Total Population**	**Population 60+**	**% of Total**
Appalachia				**Upper Savannah**				**Catawba**			
Anderson	177,963	34,755	19.5%	Abbeville	25,935	5,233	20.2%	Chester	32,875	6,146	18.7%
Cherokee	53,886	9,511	17.7%	Edgefield	25,261	4,065	16.1%	Lancaster	63,628	11,503	18.1%
Greenville	417,166	71,038	17.0%	Greenwood	68,213	12,966	19.0%	Union	28,306	6,086	21.5%
Oconee	70,567	16,558	23.5%	Laurens	70,374	13,277	18.9%	York	199,035	31,117	15.6%
Pickens	114,446	19,789	17.3%	McCormick	10,226	2,780	27.2%	**Regional Total**	**323,844**	**54,852**	**16.9%**
Spartanburg	271,087	48,687	18.0%	Saluda	19,059	3,767	19.8%	**Santee-Lynches**			
Regional Total	**1,105,115**	**200,338**	**18.1%**	**Regional Total**	**219,068**	**42,088**	**19.2%**	Clarendon	33,339	7,044	21.1%
Central Midlands				**Lower Savannah**				Kershaw	57,490	10,488	18.2%
Fairfield	23,810	4,459	18.7%	Aiken	151,800	29,445	19.4%	Lee	20,559	3,328	16.2%
Lexington	240,160	39,479	16.4%	Allendale	10,748	1,858	17.3%	Sumter	104,430	18,014	17.2%
Newberry	37,762	7,397	19.6%	Bamberg	15,678	3,231	20.6%	**Regional Total**	**215,818**	**38,874**	**18.0%**
Richland	348,226	48,739	14.0%	Barnwell	23,265	4,148	17.8%	**Trident**			
Regional Total	**649,958**	**100,074**	**15.4%**	Calhoun	15,026	3,075	20.5%	Berkeley	152,282	21,958	14.4%
Pee Dee				Orangeburg	90,845	17,401	19.2%	Charleston	331,917	57,653	17.4%
Chesterfield	43,191	7,759	18.0%	**Regional Total**	**307,362**	**59,158**	**19.2%**	Dorchester	118,979	16,748	14.1%
Darlington	67,551	12,340	18.3%	**Waccamaw**				**Regional Total**	**603,178**	**96,359**	**16.0%**
Dillon	30,984	5,132	16.6%	Georgetown	60,860	13,887	22.8%	**Low Country**			
Florence	131,297	22,876	17.4%	Horry	238,493	52,437	22.0%	Beaufort	142,045	33,487	23.6%
Marion	34,684	6,261	18.1%	Williamsburg	36,105	6,692	18.5%	Colleton	39,467	7,545	19.1%
Marlboro	29,152	4,990	17.1%	**Regional Total**	**335,458**	**73,016**	**21.8%**	Hampton	21,268	3,685	17.3%
Regional Total	**336,859**	**59,358**	**17.6%**					Jasper	21,809	3,597	16.5%
								Regional Total	**224,589**	**48,314**	**21.5%**

	Total Population	**Population 60+**	**% of Total**
South Carolina	**4,321,249**	**772,431**	**17.9%**

Source: US Census Bureau, 2006 Population Estimates

D. In-migration

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

From 2000-2005 115,084 persons migrated to South Carolina. Of those individuals, 18,111 are aged 65 and above accounting for 15.7% of the total in-migration for the state for that period.

The increase in population 65 years and over is from the aging of the population and from in-migration. Counties that have out-migration of their youth tend to have a high percent of persons 65 years and over from aging in place. Counties with high out-migration are Abbeville, Chester, Laurens, Pickens, Saluda and Williamsburg. Counties that have in-migration of the older population have a higher percent of persons 65 and over from retirees (examples: Aiken, Beaufort, Charleston, Georgetown, Greenville, Horry, Lexington, McCormick and York). When retirees lose a spouse or their health or mobility (generally when they reach their upper seventies), they usually return to the state they migrated from for care from relatives. (Source: *South Carolina Data Center Newsletter*, December 2003)

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

Components of Population Change for Persons 65 Years and Older: 2000 - 2005

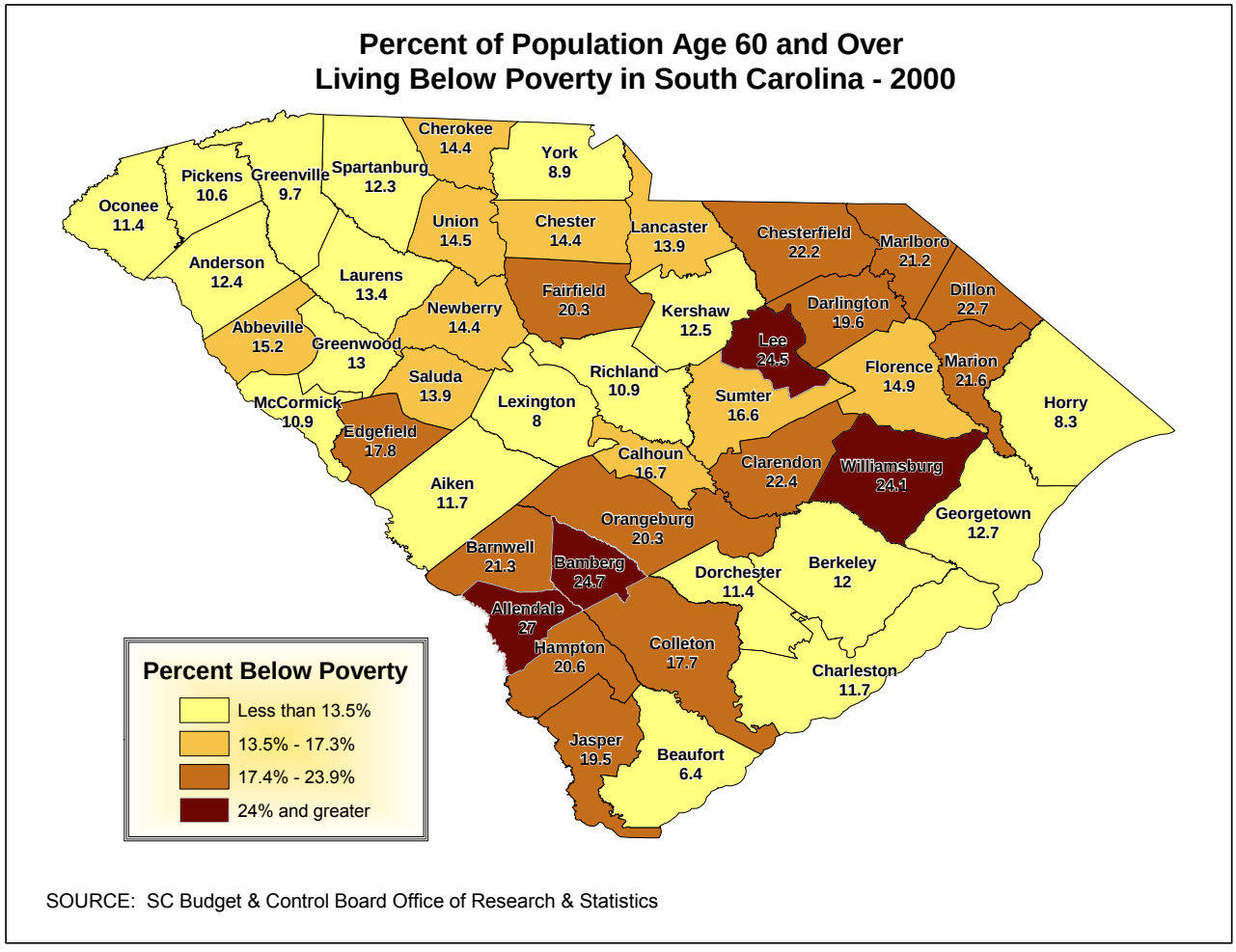
Geographic Area	Census 2000 Population	2005 Population Estimates	Total Population Change 2000-2005*	Deaths	Natural Increase	Net Migration
South Carolina	**485,333**	**534,980**	**49,647**	**134,613**	**166,149**	**18,111**
Abbeville	3,842	3,818	-24	953	1,163	-234
Aiken	18,287	20,583	2,296	5,202	5,825	1,673
Allendale	1,421	1,383	-38	381	423	-80
Anderson	22,627	24,361	1,734	6,658	7,613	779
Bamberg	2,314	2,310	-4	613	700	-91
Barnwell	2,962	2,986	24	859	878	5
Beaufort	18,754	24,010	5,256	3,882	6,286	2,852
Berkeley	11,261	14,165	2,904	3,124	5,019	1,009
Calhoun	2,102	2,025	-77	598	702	-181
Charleston	36,858	39,605	2,747	10,108	11,876	979
Cherokee	6,517	6,668	151	2,039	2,155	35
Chester	4,317	4,383	66	1,159	1,434	-209
Chesterfield	5,120	5,448	328	1,450	1,813	-35
Clarendon	4,538	5,018	480	1,186	1,659	7
Colleton	4,928	5,221	293	1,364	1,783	-126
Darlington	8,158	8,484	326	2,532	2,943	-85
Dillon	3,545	3,557	12	1,147	1,228	-69
Dorchester	8,791	10,765	1,974	2,565	3,562	977
Edgefield	2,669	2,717	48	728	899	-123
Fairfield	3,094	3,239	145	1,044	953	236
Florence	14,837	16,165	1,328	4,655	5,149	834
Georgetown	8,354	10,610	2,256	2,045	3,080	1,221
Greenville	44,573	48,796	4,223	12,329	14,990	1,562
Greenwood	9,075	9,457	382	2,567	2,706	243
Hampton	2,595	2,660	65	756	797	24
Horry	29,470	35,988	6,518	6,978	10,634	2,862
Jasper	2,269	2,374	105	560	815	-150
Kershaw	6,796	7,336	540	1,888	2,299	129
Lancaster	7,413	7,941	528	2,084	2,694	-82
Laurens	9,168	9,214	46	2,649	3,054	-359
Lee	2,504	2,488	-16	716	740	-40
Lexington	21,989	26,050	4,061	6,395	8,226	2,230
McCormick	1,645	2,034	389	435	641	183
Marion	4,298	4,438	140	1,286	1,455	-29
Marlboro	3,550	3,489	-61	1,117	1,106	-50
Newberry	5,323	5,378	55	1,520	1,569	6
Oconee	10,311	11,715	1,404	2,452	3,805	51
Orangeburg	12,091	12,506	415	3,297	3,974	-262
Pickens	12,616	14,111	1,495	3,396	4,418	473
Richland	31,475	33,025	1,550	8,941	10,132	359
Saluda	2,778	2,688	-90	775	893	-208
Spartanburg	31,740	33,733	1,993	9,398	10,668	723
Sumter	11,760	12,824	1,064	3,285	4,049	300
Union	4,670	4,605	-65	1,343	1,469	-191
Williamsburg	4,856	4,713	-143	1,321	1,549	-371
York	17,072	19,896	2,824	4,833	6,323	1,334

Source: U.S.Bureau of the Census, Department of Health and Environmental Control, and Office of Research & Statistics.

E. Socio-Economic Profile

As people grow older, they leave the workforce, and in many cases, their incomes decline. When reviewing South Carolina's senior population (those 60 +) for 2000, poverty or low income becomes a serious concern.

The following map and table show the number of persons over 60 in poverty for each planning and service area.



SOURCE: SC Budget & Control Board Office of Research & Statistics

PSA	POP	# POV	%	PSA	POP	# POV	%	PSA	POP	# POV	%
APPALACHIA				**UPPER SAVANNAAH**				**CATAWBA**			
Anderson	30,240	3,747	12.4	Abbeville	5,005	762	15.2	Chester	5,751	827	14.3
Cherokee	8,672	1,251	14.4	Edgefield	3,568	635	17.8	Lancaster	10,107	1,400	13.9
Greenville	59,563	5,791	9.7	Greenwood	11,781	1,529	12.9	Union	6,139	893	14.5
Oconee	14,116	1,603	11.4	Laurens	12,222	1,635	13.4	York	23,395	2,075	8.9
Pickens	17,034	1,812	10.6	McCormick	2,286	249	10.9	**SANTEE-LYNCHES**			
Spartanburg	42,408	5,230	12.3	Saluda	3,671	512	13.9	Clarendon	6,197	1,388	22.4
CENTRAL MIDLANDS				**LOWER SAVANNAH**				Kershaw	9,095	1,135	12.5
Fairfield	4,047	822	20.3	Aiken	24,112	2,828	11.7	Lee	3,244	796	24.5
Lexington	30,215	2,432	19.6	Allendale	1,844	498	27.0	Sumter	15,809	2,619	16.6
Newberry	6,892	9994	22.7	Bamberg	3,014	744	24.7	**TRIDENT**			
Richland	41,607	4,535	14.9	Barnwell	3,840	820	21.3	Berkeley	16,280	1,947	12.0
PEE DEE				Calhoun	2,804	469	16.7	Charleston	48,734	5,693	11.7
Chesterfield	6,933	1,537	20.3	Orangeburg	16,065	3,263	20.3	Dorchester	12,353	1,408	11.4
Darlington	11,101	2,173	19.6	**WACCAMAW**				**LOWCOUNTRY**			
Dillon	4,773	1,084	22.7	Georgetown	11,434	1,453	12.7	Beaufort	25,040	1,590	6.3
Florence	19,986	2,981	14.9	Horry	40,104	3,335	8.3	Colleton	6,711	1,188	17.7
Marion	5,753	1,241	21.6	Williamsburg	6,405	1,544	24.1	Hampton	3,392	698	20.6
Marlboro	4,656	985	21.2					Jasper	3,084	602	19.5

SC Totals: Total Over 60 Population = 651,482; Total Poverty over 60 =82,759; Percent of Over 60 in Poverty = 13.5 (3 year av.)
Source: Office of Research and Statistics based on Census 2000 data.

Income. The percent below poverty varies from 6.3% in Beaufort County to 27% in Allendale County. Poverty is especially high among older women and blacks. Single women over age 60, most of whom are widowed, divorced, or separated, are the largest group of older persons. Most have never been employed, or worked in jobs where pensions were not provided. They live mainly on their husband's pension or Social Security "survivor's" benefits. Most older blacks live on Social Security only, due to the reduced employment opportunities available to them during their working years. (Census 2000 data)

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

Based upon the American Community Survey, 2006, we see that these trends continue for the twenty most populous counties. Beaufort county has the lowest percentage of poverty for persons 65 and older.

Sources of Income. When looking at sources of income for persons 65 and older, US census data shows that for 2006 37% of income comes from Social Security, 15% comes from asset income, 18% comes from pensions, 28% from earnings and 3% from other. Based upon data from 1962 to 2000, Social Security remains a stable source, and earnings have risen from the 1980's and 1990's.

Poverty Status for the Population Age 65 Plus for the Top Twenty Most Populous SC Counties - 2006								
County	Population For Whom Poverty Status Is Determined		Under 100% poverty level		Under 150% poverty level		Under 200% poverty level	
	All Ages	65+	Number of 65+	% of 65+ for whom poverty status was determined	Number of 65+	% of 65+ for whom poverty status was determined	Number of 65+	% of 65+ for whom poverty status was determined
Aiken	149,229	20,671	2,793	13.5%	3,073	14.9%	2,347	11.4%
Anderson	175,494	24,096	2,750	11.4%	3,405	14.1%	4,032	16.7%
Beaufort	136,225	25,112	1,417	5.6%	1,211	4.8%	2,016	8.0%
Berkeley	149,693	14,049	1,941	13.8%	1,414	10.1%	2,016	14.3%
Charleston	320,416	38,758	4,197	10.8%	3,743	9.7%	3,686	9.5%
Darlington	66,611	8,553	689	8.1%	1,236	14.5%	1,268	14.8%
Dorchester	116,691	10,830	813	7.5%	919	8.5%	1,495	13.8%
Florence	128,221	14,783	2,519	17.0%	1,919	13.0%	1,884	12.7%
Greenville	405,431	48,314	5,079	10.5%	6,133	12.7%	5,345	11.1%
Greenwood	66,628	8,751	1,252	14.3%	983	11.2%	1,156	13.2%
Horry	234,856	38,233	3,645	9.5%	4,009	10.5%	3,063	8.0%
Laurens	68,786	9,757	1,714	17.6%	1,695	17.4%	911	9.3%
Lexington	238,689	26,375	2,490	9.4%	3,342	12.7%	2,504	9.5%
Oconee	70,567	12,546	1,379	11.0%	2,161	17.2%	1,227	9.8%
Orangeburg	86,016	11,841	2,362	19.9%	1,395	11.8%	1,788	15.1%
Pickens	104,611	13,888	1,153	8.3%	2,192	15.8%	1,693	12.2%
Richland	317,901	31,807	3,642	11.5%	3,619	11.4%	3,431	10.8%
Spartanburg	263,927	33,898	3,471	10.2%	6,141	18.1%	6,357	18.8%
Sumter	102,355	12,711	1,520	12.0%	2,057	16.2%	1,965	15.5%
York	195,070	21,161	1,891	8.9%	2,990	14.1%	1,731	8.2%

Source: U.S. Census Bureau, 2006 American Community Survey Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.
Note: An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution

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

2006 Poverty Status for Person Over 65 Years			
	Estimated Number of Persons Age 65+	Margin of Error	Percent of Persons Age 65+
Number 65 years and over for whom poverty level was determined :	532,736	+/-1,881	100.0%
Less than 50% of poverty	14,939	+/-2,159	2.8%
50% to 99% of poverty	49,032	+/-3,705	9.2%
100% to 124% of poverty	36,363	+/-2,988	6.8%
100% to 199% of poverty	102,101	+/-4,920	19.2%
200% of poverty or higher	330,301	***	62.0%

Source: US Census Bureau, 2006 American Community Survey

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

Based upon 2006 Census statistics, 12 percent of all South Carolinians 65 and older live below the poverty level (currently $10,210 for one person and $13,690 for a two person household). This income equates to $850.83 per month for one person and $1,140.83 per month for two persons. Approximately 38 percent of all persons 65 and older earn less than 200 percent of poverty (currently $20,420 for one person and $27,380 for two persons). This equates to $1,701.67 per month for one person and $2,281.67 per month for two persons.

2007 Health and Human Services Poverty Guidelines				
	Annual Income for One-Person Household	Monthly Income for One-Person Household	Annual Income for Two-Person Household	Monthly Income for Two-Person Household
Number 65 years and over for whom poverty level was determined :				
Living at 50% poverty	$5,105	$425.42	$6,845	$570
Living at 75% poverty	$7,658	$638.13	$10,268	$856
Living at 100% poverty	$10,210	$850.83	$13,690	$1,140.83
Living at 125% poverty	$12,763	$1,063.54	$17,113	$1,426.04
Living at 150% poverty	$15,315	$1,276.25	$20,535	$1,711.25
Living at 175% poverty	$17,868	$1,488.96	$23,958	$1,996.46
Living at 200% poverty	$20,420	$1,701.67	$27,380	$2,281.67

Source: US Department of Health and Human Services - 2007 Federal Poverty Guidelines

A significant factor especially for persons 65 and older who do not have adequate health insurance is that they may have to choose between purchasing expensive prescription medicines and food or housing.

Race. Minorities make up approximately 21.9% of the 60 and older population statewide, ranging from only 5.6% in Oconee County to 55.1% in Williamsburg County. The disparity in life expectancy between whites and blacks has remained at over 5 years, reflecting differences resulting from low income and inadequate health and preventive care. As the

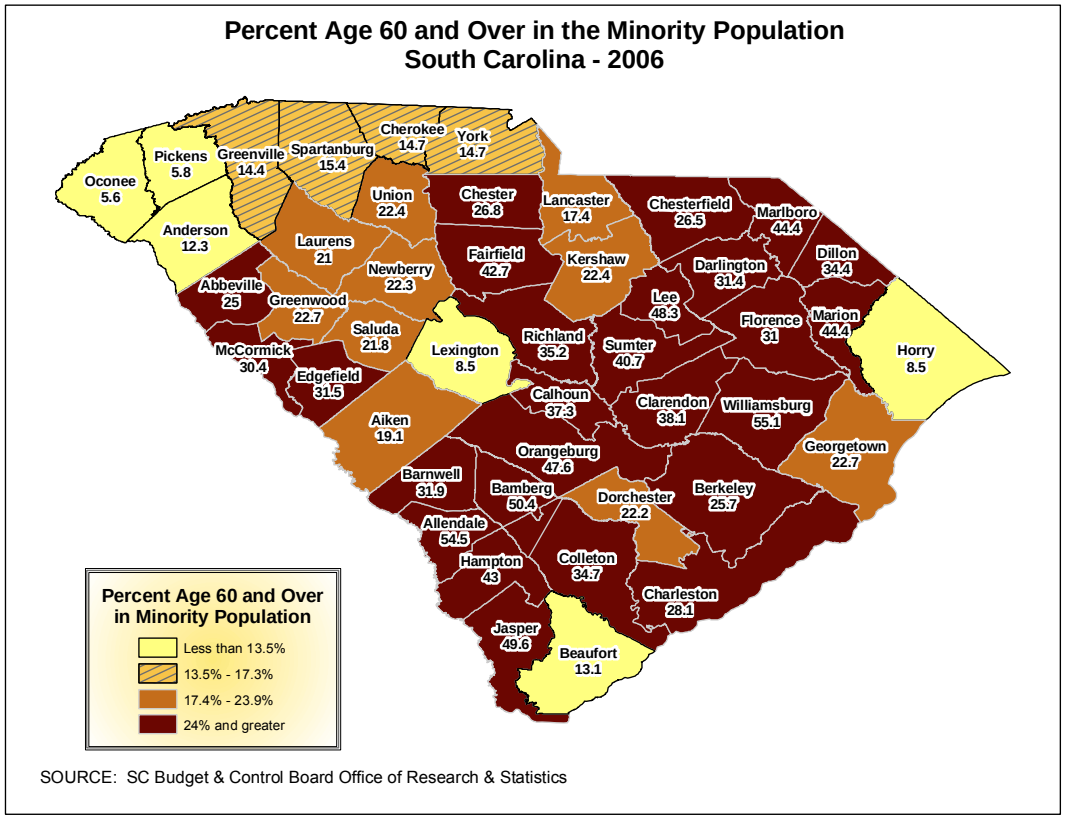
total population becomes more heterogeneous, the composition of the older population will likewise begin to reflect this diversity. As with gender, racial and minority status continues to pose additional vulnerability beyond that of old age.

The following table shows various groups by age, race and sex for South Carolina based upon 2006 Census statistics. The disparity in life expectancy between males and females, and whites and minorities is evident as they age.

SC Population by Age Group, Race and Sex 2006					
Age	**Age 50+**	**50-64**	**65-74**	**75-84**	**85+**
All races					
Male	613,080	383,122	135,627	73,490	20,841
Female	743,960	420,522	163,632	111,946	47,860
White					
Male	472,030	286,952	108,294	60,270	16,514
Female	551,768	302,105	124,981	87,814	36,868
Nonwhite					
Male	141,050	96,170	27,333	13,220	4,327
Female	192,192	118,417	38,651	24,132	10,992

Source: US Census Bureau, 2006 Population Estimates

The following map and table give the number and percentage of minority populations by planning and service areas in South Carolina.



South Carolina Counties - 2006 - Population Estimates for Age 60 and Over by PSA											
County	**Total 60+**	**Minority 60+**	**Percent**	**County**	**Total 60+**	**Minority 60+**	**Percent**	**County**	**Total 60+**	**Minority 60+**	**Percent**
Appalachia				**Upper Savannah**				**Catawba**			
Anderson	34,755	4,277	12.3%	Abbeville	5,233	1,306	25.0%	Chester	6,146	1,648	26.8%
Cherokee	9,511	1,399	14.7%	Edgefield	4,065	1,282	31.5%	Lancaster	11,503	2,007	17.4%
Greenville	71,038	10,217	14.4%	Greenwood	12,966	2,939	22.7%	Union	6,086	1,364	22.4%
Oconee	16,558	924	5.6%	Laurens	13,277	2,791	21.0%	York	31,117	4,577	14.7%
Pickens	19,789	1,150	5.8%	McCormick	2,780	844	30.4%	**Regional Total**	**54,852**	**9,596**	**17.5%**
Spartanburg	48,687	7,507	15.4%	Saluda	3,767	823	21.8%				**Santee-Lynches**
Regional Total	**200,338**	**25,474**	**12.7%**	**Regional Total**	**42,088**	**9,985**	**23.7%**	Clarendon	7,044	2,681	38.1%
Central Midlands				**Lower Savannah**				Kershaw	10,488	2,348	22.4%
Fairfield	4,459	1,906	42.7%	Aiken	29,445	5,612	19.1%	Lee	3,328	1,606	48.3%
Lexington	39,479	3,359	8.5%	Allendale	1,858	1,012	54.5%	Sumter	18,014	7,328	40.7%
Newberry	7,397	1,649	22.3%	Bamberg	3,231	1,627	50.4%	**Regional Total**	**38,874**	**13,963**	**35.9%**
Richland	48,739	17,175	35.2%	Barnwell	4,148	1,323	31.9%				**Trident**
Regional Total	**100,074**	**24,089**	**24.1%**	Calhoun	3,075	1,148	37.3%	Berkeley	21,958	5,640	25.7%
Pee Dee				Orangeburg	17,401	8,284	47.6%	Charleston	57,653	16,213	28.1%
Chesterfield	7,759	2,057	26.5%	**Regional Total**	**59,158**	**19,006**	**32.1%**	Dorchester	16,748	3,719	22.2%
Darlington	12,340	3,876	31.4%	**Waccamaw**				**Regional Total**	**96,359**	**25,572**	**26.5%**
Dillon	5,132	1,763	34.4%	Georgetown	13,887	3,152	22.7%				**Low Country**
Florence	22,876	7,091	31.0%	Horry	52,437	4,472	8.5%	Beaufort	33,487	4,378	13.1%
Marion	6,261	2,783	44.4%	Williamsburg	6,692	3,690	55.1%	Colleton	7,545	2,615	34.7%
Marlboro	4,990	2,215	44.4%	**Regional Total**	**73,016**	**11,314**	**15.5%**	Hampton	3,685	1,583	43.0%
Regional Total	**59,358**	**19,785**	**33.3%**					Jasper	3,597	1,783	49.6%
								Regional Total	**48,314**	**10,359**	**21.4%**

	Total 60+	**Minority 60+**	**Percent**
South Carolina Total	**772,431**	**169,143**	**21.9%**

Note: Minority population for 60+ = Total Population 60+ minus White Population 60+

Source: US Census Bureau, 2006 Population Estimates

Education. Educational attainment varies greatly among older South Carolinians. As shown below, 33.2 percent of our 65 and older population have less than a high school education compared to 16.3% of our 45 to 64 year olds. The table below indicates that future generations of older adults are more likely to have at least a high school education or higher. Education is a powerful predictor of health status and income. Educational attainment offers the hope of improved health status and quality of life.

2006 Estimated Educational Attainment by Age Group

	South Carolina	
Total:	#	%
25 to 44 years:	1,172,979	100.0%
Less than High School Diploma	166,862	14.2%
High School Diploma or higher	1,006,117	85.8%
Bachelor's or higher	276,216	23.5%
Graduate or professional degree	79,652	6.8%
45 to 64 years:	1,118,910	100.0%
Less than High School Diploma	182,048	16.3%
High School Diploma or higher	936,862	83.7%
Bachelor's or higher	270,770	24.2%
Graduate or professional degree	103,601	9.3%
65 years and over:	553,855	100.0%
Less than High School Diploma	183,995	33.2%
High School Diploma or higher	369,860	66.8%
Bachelor's or higher	100,151	18.1%
Graduate or professional degree	40,437	7.3%

Source: US Census Bureau - 2006 American Community Survey

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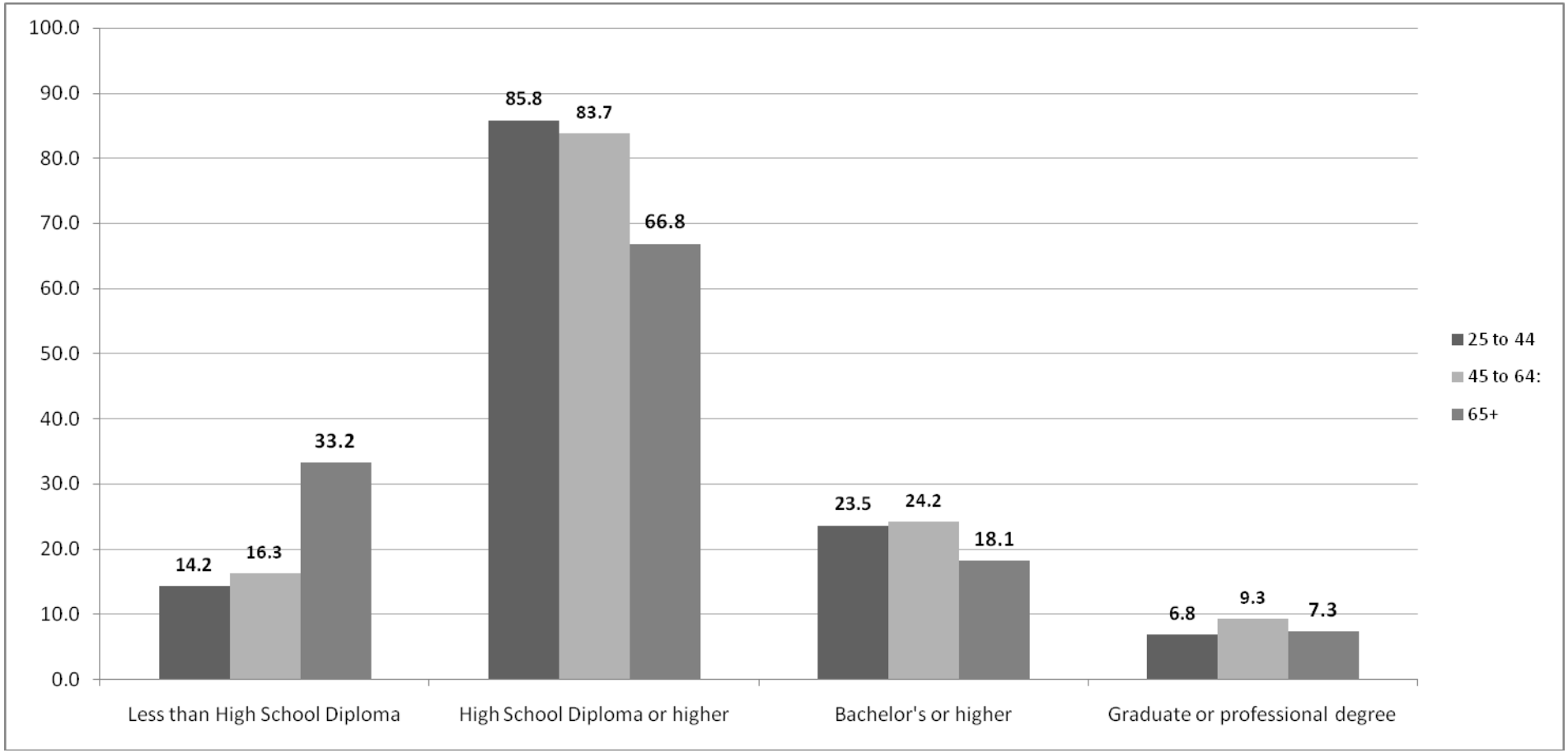
Educational Attainment in South Carolina by Age Group



Source: US Census Bureau - 2006 American Community Survey

DISTRIBUTION OF SOURCES OF INCOME FOR MARRIED COUPLES ANDNONMARRIED PEOPLE WHO ARE AGE 65 AND OVER, SELECTED YEARS 1962-2006

Year	Total %	Social Security %	Asset Income %	Pensions %	Earnings %	Other %
1962	100	31	16	9	28	16
1967	100	34	15	12	29	10
1976	100	39	18	16	23	4
1978	100	38	19	16	23	4
1980	100	39	22	16	19	4
1982	100	39	25	15	18	3
1984	100	38	28	15	16	3
1986	100	38	26	16	17	3
1988	100	38	25	17	17	3
1990	100	36	24	18	18	4
1992	100	40	21	20	17	2
1994	100	42	18	19	18	3
1996	100	40	18	19	20	3
1998	100	38	20	19	21	2
1999	100	38	19	19	21	3
2000	100	38	18	18	23	3
2001	100	39	16	18	24	3
2002	100	39	14	19	25	3
2003	100	39	14	19	25	2
2004	100	39	13	20	26	2
2005	100	37	13	19	28	3
2006	100	37	15	18	28	3

Note: A married couple is age 65 and over if the husband is age 65 and over or the husband is younger than age 55 and the wife is age 65 and over.

Reference population: These data refer to the civilian noninstitutionalized population.

***Source: Social Security Administration, 1963 Survey of the Aged, and 1968 Survey of Demographic and Economic Characteristics of the Aged; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 1977-2007*.**

Employment. Employment continues to be an important, although not primary, source of income for older adults. National data for 2001 indicate that Social Security was a major source of income for 37% of older couples and individuals, followed by asset income (15%), public and private pensions (18%), earnings (28%) and all other sources (3%).

Employment Status by Age Group								
	Total for age group:	**In labor force:**	**Total employed***	**Percent of age group employed**	**Percent of labor force employed**	**Total unemployed**	**Percent of labor force unemployed**	**Total not in labor force**
45 to 54 years:	618,659	485,140	462,372	74.7%	95.3%	22,768	4.7%	133,519
55 to 59 years:	275,411	184,269	176,248	64.0%	95.6%	8,021	4.4%	91,142
60 to 64 years:	224,840	104,695	100,333	44.6%	95.8%	4,362	4.2%	120,145
65 to 69 years:	168,659	43,995	41,921	24.9%	95.3%	2,074	4.7%	124,664
70 to 74 years:	132,839	21,064	20,231	15.2%	96.0%	833	4.0%	111,775
25+	2,845,744	1,807,540	1,710,630	60.1%	94.6%	96,910	5.4%	1,038,204
55+	1,054,106	367,387	351,804	33.4%	95.8%	15,583	4.2%	686,719
65+	553,855	78,423	75,223	13.6%	95.9%	3,200	4.1%	475,432
75+:	252,357	13,364	13,071	5.2%	97.8%	293	2.2%	238,993

**** Includes Civilian and Military***

Source: US Census Bureau, 2006 American Community Survey

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Employment and unemployment estimates may vary from the official labor force data released by the Bureau of Labor Statistics because of differences in survey design and data collection. For guidance on differences in employment and unemployment estimates from different sources go to Labor Force Guidance.

While the 2006 American Community Survey (ACS) data generally reflect the December 2005 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas, in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.

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

Insurance. Health insurance is a very important component of economic security. As the population ages, it is especially important for security as acute, chronic and disabling conditions become more prevalent. Most older Americans and South Carolinians are covered by health insurance, primarily by Medicare. Based on the 2007 Annual Social and Economic Supplement from the U.S. Census Bureau's Current Population Survey, 99.8% of all older South Carolinians are covered by government or private health insurance. Of all persons 65 and older, 97.2% have Medicare, 55.3% have private insurance, 13.7% are covered by military health care, and 10.9% have Medicaid coverage; .2% have no insurance. Most elderly, however, lack insurance coverage for long term care, leaving them especially vulnerable to the high cost of nursing home care.

Living Arrangements. As persons grow older or have chronic illnesses or conditions, the level of need for assistance raises the issue of living arrangement. Social and family supports are an important determinant of the well being and continued independence of older adults. Furthermore, approximately 66% of South Carolinians 65+ lived with at least one other related family member in a family household.

As people age, they are increasingly likely to live alone: 27% of 65+ year olds live alone. We may expect that the numbers of older adults living alone may increase as the baby boomers age; this cohort has been more likely to remain single and childless. The following table shows the numbers and percents of those 65+ living alone by county.

Population 65+ Living Alone in South Carolina and in the Top Twenty Most Populous Counties - 2006

	Total Age 65+		Male Living Alone			Female Living Alone			Total Living Alone	
	Estimate	Margin of Error	Estimate	Margin of Error	Percent Living Alone	Estimate	Margin of Error	Percent Living Alone	Estimate	Percent Living Alone
South Carolina	553,855	+/-1,881	38,896	+/-2,758	7.0%	110,449	+/-3,872	19.9%	149,345	27.0%
Aiken	21,537	+/-340	1,184	+/-441	5.5%	3,889	+/-724	18.1%	5,073	23.6%
Anderson	25,408	+/-319	1,958	+/-518	7.7%	4,407	+/-763	17.3%	6,365	25.1%
Beaufort	25,501	+/-608	1,611	+/-473	6.3%	4,199	+/-811	16.5%	5,810	22.8%
Berkeley	14,577	+/-256	960	+/-462	6.6%	2,277	+/-554	15.6%	3,237	22.2%
Charleston	40,380	+/-285	2,854	+/-816	7.1%	7,962	+/-925	19.7%	10,816	26.8%
Darlington	8,792	+/-3	646	+/-354	7.3%	1,457	+/-608	16.6%	2,103	23.9%
Dorchester	10,830	+/-447	359	+/-235	3.3%	1,675	+/-415	15.5%	2,034	18.8%
Florence	16,276	+/-107	1,089	+/-499	6.7%	3,221	+/-554	19.8%	4,310	26.5%
Greenville	49,909	+/-484	3,905	+/-828	7.8%	9,482	+/-1,046	19.0%	13,387	26.8%
Greenwood	9,271	+/-244	824	+/-435	8.9%	1,936	+/-607	20.9%	2,760	29.8%
Horry	38,716	+/-521	2,043	+/-690	5.3%	7,527	+/-1,115	19.4%	9,570	24.7%
Laurens	9,757	+/-466	982	+/-467	10.1%	1,868	+/-508	19.1%	2,850	29.2%
Lexington	26,934	+/-77	2,078	+/-594	7.7%	5,771	+/-781	21.4%	7,849	29.1%
Oconee	-	-	-	-	-	-	-	-	-	-
Orangeburg	12,743	+/-191	933	+/-447	7.3%	1,842	+/-522	14.5%	2,775	21.8%
Pickens	14,676	+/-428	1,120	+/-596	7.6%	3,205	+/-626	21.8%	4,325	29.5%
Richland	33,374	+/-319	2,118	+/-528	6.3%	7,023	+/-965	21.0%	9,141	27.4%
Spartanburg	34,819	+/-275	2,480	+/-776	7.1%	9,109	+/-1,205	26.2%	11,589	33.3%
Sumter	13,177	+/-2	756	+/-404	5.7%	2,748	+/-593	20.9%	3,504	26.6%
York	21,655	+/-443	1,491	+/-401	6.9%	3,934	+/-696	18.2%	5,425	25.1%

Source: US Census Bureau, 2006 American Community Survey

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An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.

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

Household Type for Population 65+ in South Carolina		
	2006 Estimate	**Margin of Error**
Total Population	**553,855**	+/-1,881
In family households	**364,810**	+/-5,668
In Non-family households:	**163,310**	+/-5,260
Male; Living alone	38,896	+/-2,758
Male; Not living alone	3,905	+/-801
Female; Living alone	110,449	+/-3,872
Female; Not living alone	3,680	+/-914
Nonrelatives	6,380	+/-1,255
In group quarters	**25,735**	+/-804

Source: US Census Bureau, 2006 American Community Survey

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2002 Elderly Households by Type and Income				
	Renters		**Owners**	
	#	**%**	**#**	**%**
Total Elderly Households	63,552	100.0	266,655	100.0
Very Low Income (0 to 50% of Median Family Income)	43,712	68.8	101,500	38.1
Other Low Income (51 to 80% of Median Family Income)	8,853	13.9	50,089	18.8
Moderate Income (81 to 95% of Median Family Income)	2,704	4.3	18,742	7.0

Note: Elderly Households refers to households having 1 or 2 persons with either person 62 years or over.

Source: Dept. of Housing and Urban Development, CHAS Table 1C, 2002 Estimates.

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

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

In South Carolina there are currently 194 nursing homes with 18,748 beds providing 24-hour skilled or intermediate nursing care and related services for persons with a wide range of physical and mental disabilities. Persons over 65 comprise 92.4% of the nursing home population. The percent of older adults residing in nursing homes in South Carolina

is 3 percent. The risk of persons age 65+ spending more than one year in a nursing facility is 22%.

South Carolina Nursing Home Joint Annual Report 2006	
Number of Nursing Homes (reporting)	194
Number of Beds Setup And Staffed	18,748
Admissions:	
Under age 65	2,280
65+	27,566
Total Admissions	29,846
Total Patient Days (P.D. = sum (Fac. P. D.))	6,370,675
Average Daily Census (ADC= sum(Fac. P.D. / Fac. Operating Days))	17,907
Total Facility days (=sum(Fac. Operating days))	69,828
ADC to Beds Differential	841
Percent Occupancy (=ADC/Beds)	96%
Percent of Nursing home Admissions Over Age 65	92.4%

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

There were 14,221 persons in the Medicaid Community Choices waiver program during 2007. These persons are at a nursing home level of care, but are able to remain at home. (Source: SC Department of Health and Human Services and Mature Adults Count)

F. Health and Functional Status Profile

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

For persons 65-74, some significant differences between whites and minorities are apparent. Minorities have a 7.3 percent mortality rate for cerebrovascular disease compared to 4.9 percent for whites. Whites are more likely to die from chronic lower respiratory disease than minorities (9.5 percent for whites compared to 2.8 percent for minorities). 6.6 percent of minorities die from diabetes mellitus as compared to 3.0 percent for whites. 3.7 percent of minorities die from nephritis, nephritic syndrome and nephrosis compared to 2.0 percent for whites.

When comparing whites and minorities aged 75 and over, the differences become less striking. Whites suffer a 7.0% mortality rate for Alzheimer's disease as compared to 4.5% for minorities. 6.3% of whites die from chronic lower respiratory disease as compared to 2.8% for minorities.

South Carolina Mortality for Six Leading Causes of Death - 2005						
	65 - 74					
	Total		White		Minority	
Cause of Death	Number	Percent	Number	Percent	Number	Percent
Cancer (Malignant neoplasms)	2,250	32.2%	1,703	33.8%	547	28.2%
Diseases of heart	1,690	24.2%	1,187	23.6%	503	25.9%
Chronic lower respiratory disease	535	7.7%	480	9.5%	55	2.8%
Cerebrovascular disease	389	5.6%	248	4.9%	141	7.3%
Diabetes mellitus	280	4.0%	152	3.0%	128	6.6%
Nephritis, nephrotic syndrome and nephrosis	147	2.1%	103	2.0%	71	3.7%
All other diseases	1,688	24.2%	1,167	23.2%	494	25.5%
All Causes	6,979	100.0%	5,040	100.0%	1,939	100.0%

	75 plus					
	Total		White		Minority	
Cause of Death	Number	Percent	Number	Percent	Number	Percent
Diseases of heart	5,205	27.1%	4,056	27.0%	1,149	27.4%
Cancer (Malignant neoplasms)	3,419	17.8%	2,643	17.6%	776	18.5%
Cerebrovascular disease	1634	8.5%	1262	8.4%	372	8.9%
Alzheimer's disease	1240	6.5%	1051	7.0%	189	4.5%
Chronic lower respiratory disease	1061	5.5%	942	6.3%	119	2.8%
Influenza and pneumonia	533	2.8%	430	2.9%	103	2.5%
All other diseases	6,126	31.9%	4,642	30.9%	1,484	35.4%
All Causes	19,218	100.0%	15,026	100.0%	4,192	100.0%

Source: SC Department of Health & Enviromental Control, 2005 Vital and Morbidity Statistics

The leading cause of hospitalization for older South Carolinians varies by age groups. Chest pain is the leading cause for hospitalization for the 45-64 age group. For individuals 65-74 major joint replacement or reattachment of the lower extremity is the leading cause of hospitalization, and, heart failure and shock are the leading causes of hospitalization for 75 and above.

South Carolina - 2006: Leading Causes of Hospitalization by Age Group						
Ages 45-64: Causes	**Total**		**White**		**Minority**	
	#	%	#	%	#	%
Total	117,242	100.00%	76,213	100.00%	38,681	100.00%
Chest pain	3,872	3.30%	2,402	3.15%	1,351	3.49%
Heart failure & shock	3,443	2.94%	1,369	1.80%	2,032	5.25%

South Carolina - 2006: Leading Causes of Hospitalization by Age Group						
Ages 65-74: Causes	**Total**		**White**		**Minority**	
	#	%	#	%	#	%
Total	70,302	100.00%	52,073	100.00%	17,001	100.00%
Major joint replacement or reattachment of lower extremity	3,232	4.60%	2,723	5.23%	466	2.74%
Heart failure & shock	3,118	4.44%	1,896	3.64%	1,167	6.86%
Chronic obstructive pulmonary disease	2,544	3.62%	2,092	4.02%	412	2.42%
Simple pneumonia & pleurisy age >17 w cc	2,408	3.43%	1,871	3.59%	494	2.91%
Percutaneous cardiovascular proc w drug-eluting stent w/o maj cv dx	1,764	2.51%	1,496	2.87%	232	1.36%
Esophagitis, gastroent & misc digest disorders age >17 w cc	1,641	2.33%	1,216	2.34%	399	2.35%
Percutaneous cardiovascular proc w drug-eluting stent w/o maj cv dx	2,850	2.43%	2,358	3.09%	436	1.13%
Esophagitis, gastroent & misc digest disorders age >17 w cc	2,851	2.43%	1,870	2.45%	922	2.38%
Chronic obstructive pulmonary disease	3,199	2.73%	2,336	3.07%	805	2.08%
Major joint replacement or reattachment of lower extremity	3,397	2.90%	2,620	3.44%	725	1.87%

South Carolina - 2006: Leading Causes of Hospitalization by Age Group						
Ages 75+: Causes	**Total**		**White**		**Minority**	
	#	%	#	%	#	%
Total	80,999	100.00%	62,124	100.00%	17,699	100.00%
Heart failure & shock	5,453	6.73%	3,991	6.42%	1,384	7.82%
Simple pneumonia & pleurisy age >17 w cc	3,977	4.91%	3,246	5.23%	662	3.74%
Septicemia age >17	2,695	3.33%	1,866	3.00%	788	4.45%
Major joint replacement or reattachment of lower extremity	2,544	3.14%	2,216	3.57%	302	1.71%
Intracranial hemorrhage or cerebral infarction	2,462	3.04%	1,775	2.86%	645	3.64%
Kidney & urinary tract infections age >17 w cc	2,378	2.94%	1,742	2.80%	602	3.40%

Source: SC Budget & Control Board, Office of Research & Statistics - Inpatient Hospital Reports

Note: The six leading causes for each age group were established using the total number of persons

Differences in hospitalizations between whites and minorities vary also. Whites are hospitalized more for joint replacement or reattachment of the lower extremity and minorities are hospitalized at a greater percentage for heart failure and shock.

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

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

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

PERSONS ASSESSED WITH AT LEAST ONE ACTIVITY OF DAILY LIVING OR INSTRUMENTAL ACTIVITY OF DAILY LIVING DIFFICULTY BY SELECTED CHARACTERISTICS BETWEEN 7/1/2006 AND 6/30/2007		
CHARACTERISTICS	NUMBER OF PERSONS SERVED	% ASSESSED WITH AT LEAST ONE DIFFICULTY
AGE (14,328 Assessed)		
55 – 64	1,888	8%
65 – 74	4,244	20%
75 – 84	5,938	33%
85 and Older	4,327	24%
HOUSEHOLD INCOME (13,945 Assessed)		
Poverty	9,597	51%
101 – 200% of Poverty	4,911	31%
201 – 300% of Poverty	580	3%
301+% of Poverty	176	1%
RACE (14,328 Assessed)		
White	8,370	43%
Non-White	8,837	45%
GENDER (14,328 Assessed)		
Male	4,897	24%
Female	12,279	64%
EDUCATIONAL LEVEL (11,952 Assessed)		
Less Than Third Grade	714	6%
3rd through 8th Grade	3,706	30%
Some High School	3,559	27%
High School Graduate	2,538	19%
Some College	1,023	8%
College Graduate	715	5%
LIVING ARRANGEMENT (13,506 Assessed)		
Live Alone	7,437	50%
Live with Others	6,136	41%
All Clients	17,207	88%
Source: AIM data Cluster 1of NAPIS: Services: Personal Care, Homemaker, Home-Delivered Meals, Adult Day Care, and Care Management.		

The difficulty of performing ADL and IADL increases with age. ADL/IADL impairment is also inversely related to low income and education: the lower the income and educational level, the greater the likelihood of impairment. This inverse relationship can be explained due to the better preventive care and health care received by higher income/educational groups as well as better ongoing management of chronic disease.

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

PERSONS 60+ WITH ACTIVITIES OF DAILY LIVING (ADL)		
PROBLEM	**% WITH PROBLEM**	**NUMBER OF PERSONS**
Feeding	3%	487
Dressing	15%	2,530
Bathing	21%	3,496
Toileting	7%	1,197
Bladder/Bowel	8%	1,361
I/O of Bed	14%	2,384
Unduplicated Count with at least one ADL		7,101
Persons Indicating 3 or More ADL		2,281
Source: AIM data Cluster 1of NAPIS Services (Above)		

PERSONS WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING (ADL) AGE 60 AND OVER		
PROBLEM	**% WITH PROBLEM**	**NUMBER OF PERSONS**
Normal Housework	61%	10,240
Cooking	60%	9,964
Checkbook	39%	6,450
Heavy Cleaning	75%	12,447
Shopping	63%	10,523
Medication	35%	5,883
Phone	14%	2,360
Unduplicated Count of Persons with at least one IADL		12,650
Persons Indicating 3 or More Problems		10,676
Source: Source: AIM data Cluster 1of NAPIS Services (Above)		

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

- In a national study, over 40% of caregivers have been providing assistance for five or more years and nearly one-fifth had been doing so for ten or more years.
- 5.8 – 7 million people (family, friends and neighbors) provide care to persons 65+ who need assistance with everyday activities.
- 52 million informal and family caregivers in the U.S. provide care to someone who is ill or disabled.
- 29.2 million family caregivers provide personal assistance to adults (18+) with a disability or chronic illness

According to the Lewin Group

- The aging of the baby boomers will more than double the number of older adults age 65+ with disabilities. The number of persons 65 + with a disability will increase from approximately 6 million in 1996-2000 to more than 14 million in 2045-2049 (with one or more ADLs or IADLs).
- As the baby boomer age the percent of persons with disabilities will increase from a low of 16.9% in 2025 to 18.9% in 2045.
- Based upon 2004-2005 data, 8.9% of persons 65-74 and 21.9% of persons 75-85 and 49.7% of persons 85+ have IADLs or ADLs.

CHAPTER 6: IDENTIFICATION OF ISSUES AND NEEDS

The SUA used a variety of mechanisms and resources to identify the needs of senior citizens of South Carolina for the FY 2009-2012 State Plan on Aging. Information gathered will aid state, regional and local agencies to plan for services to meet the needs of seniors. Additionally, the SUA took under serious consideration the Older Americans Act, as amended in 2006, and the key initiatives under Choices for Independence, the Deficit Reduction Act and the New Freedom Initiative. Both the federal initiatives and state efforts recognize that seniors want choice and information and assistance to help them and their loved ones remain independent and have the tools to make wise decisions and know where to go to get necessary services and information. They also recognize that resources will not be available in the future to address the needs of the baby boomer generation and the aging population of the state and the nation. Our efforts to determine the issues and needs of South Carolina's seniors reflect the needs and issues seen nationally.

Process for Developing Comparison of Major Issues and Needs – South Carolina used a number of approaches to determine what the major needs and issues are for the state's seniors. The SC Lieutenant Governor's Office on Aging used ten different sources to develop its matrix of comparison of needs for the FY 2009-2012 State Plan on Aging. The matrix shows eight major issues or needs where current and future initiatives need to be on-going if the state is not going to be overwhelmed with the growth in the senior population. These will need to be continued or implemented over the next four years, but also continued far past this on out to 2030. The eight areas shown were consolidated from many different specific issues and needs and thus categorized into broad areas that could be addressed. In general we looked at the top five issues/needs to include in the matrix. The information shown will aid state, regional and local agencies planning for services to meet the needs of seniors and caregivers.

A. South Carolina AARP

Each year, AARP South Carolina selects legislative priorities that are consistent with the policies adopted by AARP's Board of Directors. These priorities are based upon the needs of the state's residents and developed from feedback from member surveys, general member communications and AARP-sponsored hearings and events. Throughout the year, AARP South Carolina may work on other legislative and regulatory proposals as they arise. The 2008 South Carolina State Legislative Priorities are as follows:

1. **LONG-TERM CARE:** Provide additional funding for key long term care programs, especially those providing services that help seniors stay in their homes and communities.
2. **ID THEFT:** Pass legislation to give citizens the ability to lock access to personal credit information. Known as a security freeze, this tool allows citizens to combat identity thieves and prevent new account fraud.

3. **HEALTH CARE REFORM:** Support efforts to decrease the number of uninsured as well as efforts to improve health care quality.
4. **AFFORDABLE PRESCRIPTION DRUGS:** Promote options for South Carolina's older persons with lower incomes to save money on their prescription drug purchases.
5. **PAY DAY LENDING:** Pass legislation to rein in the predatory business practices of pay day lenders in South Carolina.

B. Silver Haired Legislature

The following resolutions were submitted to the 2008 Session of the General Assembly of South Carolina:

First Priority: Criminal Background Checks For In-Home Care Providers

That the General Assembly enact and the Governor sign legislation to require criminal background checks of all paid in-home care providers and their employees.

Second Priority: Increased Funding For Abused Elderly

That the General Assembly enact and the Governor sign legislation to provide increased statewide funding for necessary life-sustaining shelter, rent, and services needed to care for the increasing number of elderly abused victims who must be removed from their residences.

Third Priority: High Interest Loans

That the General Assembly enact and the Governor sign legislation to place reasonable caps on the interest rates offered by these lending organizations and to limit the number of individual loans at any given time.

Fourth Priority: Debt Forgiveness For Nurse Practitioners Specializing In Geriatric Care

That the General Assembly enact and the Governor sign legislation to establish debt forgiveness of educational expenses up to $20,000 per year, for a maximum of five years, for nurses who obtain certification in South Carolina and who practice in South Carolina as geriatric nurse practitioners.

Fifth Priority: Senior Transportation For An Affordable Fee

That the General Assembly enact and the Governor sign legislation to fund a program that offers affordable transportation for the seniors of South Carolina.

Other Resolutions:

The Silver-Haired Legislature also included a number of resolutions that should be noted:

- Increased Funding For In-Home And Community-Based Services
- Adult Daycare And Facility Funding For Those With Dementia
- Tax Credits For Taxpayers Who Help Delay Or Prevent The Institutionalization Of Those Certified By A Physician
- Volunteer Driver Liability Relief

- Unpaid Caregiver Training Program
- Statewide In-Home Respite Program

C. Lieutenant Governor's Office on Aging Waiting List

The Lieutenant Governor's Office on Aging annually reviews its waiting list for services needed by seniors in the state. This year's waiting list was developed from the waiting list created for seniors where funding was not adequate for either Older Americans Act services or from the state home and community-based services.

First Priority: Home And Community-Based Services (This Includes Home Delivered Meals, Group Dining, Home Care, Residential Maintenance And Adult Day Care

Second Priority: Transportation

D. Lieutenant Governor's Office on Aging Survey of Supplemental State Funds Initiative

The Lieutenant Governor's Office on Aging received $2.9 million in supplemental state funding for home and community-based services for FY 2006-2007. Due to the funding being one time funds, they were not available for use until January 2007. The LGOA implemented the program statewide in January and it is still operating in FY 2007-2008. The Lieutenant Governor's Office on Aging has surveyed all seniors to determine how the program has assisted them and whether they had additional needs. Based upon the survey the top needs are as follows:

First Priority: Increased funding for home and community-based services

Second Priority: Increased and expanded senior transportation

Third Priority: Expand and modify Nutrition Services (examples are multiple meals and availability seven days per week)

Fourth Priority: Expand and modernize Senior Centers to provide a full range of services

E. Lieutenant Governor's Office on Aging Survey of Area Agencies on Aging and Local Service Providers

The Lieutenant Governor's Office on Aging conducted an additional survey of all Area Agencies on Aging and local service providers during FY 2007-2008. The following areas were identified as the most common and important issues/needs where initiatives are necessary in the future in South Carolina:

1. Senior Transportation - a diverse array of transportation services are needed to help seniors remain independent and in their communities.
2. Increased funding for home and community-based services-the waiting list and other surveys have shown that considerable needs exists in the state to help low income seniors remain independent.
3. Strengthen the Family Caregiver Support Program through additional funds, services and tax benefits for caregivers.
4. Expand and Modify Nutrition Services, and provide multiple meals and meals up to seven days per week.

5. Expand and modernize Senior Centers for the coming Baby Boomer Age Wave.

F. Review of FY 2006-2008 Area Plans

The Lieutenant Governor's Office on Aging requests that the Area Agencies on Aging prepare a two year Area plan and then an update the following year. Data from the FY 2006-2008 Area Plans have been reviewed for existing and needed services. The results are shown as follows:

1. Senior Transportation - a diverse array of transportation services are needed to help seniors remain independent and in their community.
2. Increased funding for home and community-based services-the waiting list and other surveys have shown that considerable needs exists in the state to help low income seniors remain independent.
3. Strengthen the Family Caregiver Support Program through additional funds, services and tax benefits for caregivers.
4. Implement ADRC's statewide with a focus on building a Case Management System for South Carolina.
5. Expand and Modify Nutrition Services, and provide multiple meals and meals up to seven days per week.
6. Expand and modernize Senior Centers for the coming Baby Boomer Age Wave.

G. Recommendations of SC White House Conference on aging

First Priority: Health Care "There is a need to improve education on wellness, prevention and chronic disease management."

Second Priority: Need to Develop Senior Friendly Communities "Seniors have the need and the right to affordable and reliable, accessible transportation."

Third Priority: **Long Term Care and Continuum of Care** "Restructure Medicaid/Medicare and develop private and personal funding incentives for financing and providing additional flexible options for the long term care continuum."

Fourth Priority: Caregiving "The National Family Caregiver Program does not adequately address the needs of the two target populations: the caregivers taking care of seniors 60 and older, and seniors 60 and older caring for dependent children age 18 and younger."

Fifth Priority: Planning for the Future "There is a need for a quality comprehensive, coordinated information system that links agencies, organizations, and individuals to resources to support seniors and a plan to communicate those services to improve seniors' quality of life."

Sixth Priority: Housing There is a lack of proper and sufficient funding for adequate, affordable and accessible housing and supportive services for seniors."

Seventh Priority: Impact of Alzheimer's Disease on Families/Businesses/Government "The impact of Alzheimer's disease and related dementias in the United States is costing families, businesses and government billions of dollars. The number of people who will be affected by these diseases will reach epidemic proportions within the next decade."

Eighth Priority: Research "Establish a patient centered model of collaboration among health care and human service providers, researchers, insurance companies, and drug companies to provide lifestyle changes and preventive care."

Ninth Priority: Workforce Issues "We are not adequately preparing for an aging workforce or providing options to enhance & encourage continued employment."

Tenth Priority: In-Migration "Federal allocations of resources to address the Medicaid eligible population and other services for the older population need to more aggressively take into account the rapid in-migration of the retiring population among the states, rather than basing allocations only on census data."

H. US White House Conference on Aging

The White House Conference on Aging met in December, 2005 to determine the top issues and needs of seniors as prescribed by law. The conference reviewed numerous recommendations and arrived at the top ten resolutions which were published on December 14, 2005 as follows:

Resolution 1 "Reauthorize the Older Americans Act Within the First Six Months Following the 2005 White House Conference on Aging"

Resolution 2 "Develop a coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workforce"

Resolution 3 "Ensure that Older Americans have Transportation Options to Retain their Mobility and Independence"

Resolution 4 "Strengthen and Improve the Medicaid Program for Seniors"

Resolution 5 "Strengthen and Improve the Medicare Program

Resolution 6 " Support Geriatric Education and Training for all Healthcare Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers"

Resolution 7 "Promote Innovative Models of Non-Institutional Long-Term Care"

Resolution 8 "Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans"

Resolution 9 "Attain Adequate Numbers of Healthcare Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized in Geriatrics"

Resolution 10 "Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors"

I. SC Joint Legislative Committee on Aging

The Joint Legislative Committee on Aging met on February 7, 2008 for its annual public hearing to receive input from the Lieutenant Governor's Office on Aging and other interested organizations and individuals concerned about aging issues and the needs of seniors in South Carolina. The following major issues/needs were reported as the top areas of concern:

First Priority: Permanent Funding for Home and Community-Based Services -SC General Assembly needs to appropriate $2.9 million in recurring funds for home and community-based services.

Second Priority: Implement ADRC's throughout South Carolina – South Carolina needs one-stop locations to provide information and services to Seniors. Mobile units should be utilized in this effort for outreach to seniors in hard to reach and rural areas.

Third Priority: Long Term Care Insurance – The Lieutenant Governor's Office on Aging should work with the financial industry to educate seniors and adults on the need for long term care insurance and provide tips on purchasing it for the future.

Fourth Priority: Long Term Care Partnership- The Lieutenant Governor's Office on Aging should work with the Department of Health and Human Services to change the State Medicaid Plan to allow South Carolina to join the Long Term Care Partnership which will encourage individuals to purchase long term care insurance and shelter assets in partnership with the Medicaid program.

Fifth Priority: Need to Reform the Long Term Care Model – The Lieutenant Governor's Office on Aging should work to encourage choice and provide the means for seniors to remain at home, and work to reform the long term care continuum with special emphasis on modernizing the state's service delivery system.

J. SC Access and I, R & A Requests

The Lieutenant Governor's Office on Aging provides considerable information, referral and assistance to individuals and families through the SC Access system and through ten regional Area Agencies on Aging. Staff conducted a review of its information systems to determine the key issues/needs of seniors and caregivers in South Carolina. The following indicates those issues/needs most important as well as other areas that were noted in the research:

1. Senior Transportation - a diverse array of transportation services are needed to help seniors remain independent and in their communities.
2. Strengthen the Family Caregiver Support Program through additional funds, services and tax benefits for caregivers.
3. Other needs/issues: in view of SC Access and Information, Referral and Assistance being involved, there were many information and assistance requests for the following:
    - Basic Needs Assistance
    - Insurance Counseling
    - Benefits Counseling
    - Advocacy
    - Employment and Vocational issues

K. Comparison of Major Needs

When comparing the highest priority needs of the input from all sources considered, common themes were developed. The following table compares the top eight needs identified in this process:

Comparison of Major Issues/Needs FY 2009-2012 State Plan on Aging

Issues/Needs	AARP	Silver Haired Legislature	LGOA Waiting List	LGOA $2.9m Survey	LGOA Survey of AAA's & Providers	Area Plans	SC White House Conf. on Aging	White House Conf. on Aging - US	Jt. Legis. Comm. On Aging Hearing	SC ACCESS I& R Requests	Total
Senior Transportation		X	X	X	X	X	X	X		x	8
Increased Funds for Home & Comm. Based Care				X		X	X	X	X	X	6
Strengthen Family Caregiver Support Program					X	X	X			X	4
Long Term Care Reform Restructure Medicaid/Medicare& Provide Choice with Personal Incentives							X	X	X		3
Implement ADRC's Statewide with Focus on Building a Case Mgt. System						X		X	X		3
Expand and Modify Nutrition Services Multiple Meals 7 days per week				X	X	X					3
Support Geriatric Education to provide adequately trained professionals		X						X	X		3
Expand and Modernize Senior Centers for the coming Boomer Age Wave				X	X	X					3

Notes: The SC Lieutenant Governor's Office on Aging developed a number of surveys and reviewed other organizations' issues and needs to develop its overall comparison of major needs. The Office looked at essentially the five top priority needs of the various organizations and ranked them according to the number of times that they appeared as a top priority. There were many areas where issues/needs were slightly different and the LGOA took the liberty to consolidate the issues/needs into broader and more workable categories. It should be noted that there were many other issues and needs identified. The LGOA recognizes their importance, but this chart reflects those issues/needs that were identified most often as important issues/needs.

CHAPTER 7: ISSUES, OUTCOMES, AND STRATEGIES

As we review the key issues that face South Carolina over the next four years, it is apparent that state policy makers, providers of service and the public must carefully consider the trends facing the nation and the state of South Carolina as the population ages. The growth of the number of seniors needing long term care and related services, as well as the cost of providing such care will have a major impact on the nation and the state economy, local communities and families. South Carolina and the nation face the following challenges over the next twenty to thirty years:

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

Over the past twenty years, we have seen a shift from the provision of institution-based long-term care services to a continuum of care with the provision of residential care or assisted living to home and community-based models of service. With the increasing need for support for seniors and caregivers, we are moving toward the development of a seamless long-term support services system that is flexible and meets the needs of consumers. With the reauthorization of the Older Americans Act, As Amended in 2006, the passage of the Deficit Reduction Act and the passage of the Medicare Modernization Act the United States government has recognized that the nation and the various states must implement Choices for Independence. Governmental resources will not be available at either the federal or state level to provide for the future long term care and health care needs of our aging population without a change in the way we do business.

Prior to discussing various initiatives and programs that South Carolina will utilize to address these problems/issues over the next four years, we will elaborate on some of the key factors that move us toward a long-term support system.

Growth of the Senior Population

South Carolina has experienced a significant growth of seniors or mature adults over the last few decades. The Baby Boom has begun to have a dramatic impact and will continue to affect the nation and South Carolina's communities and institutions over the next twenty years. The state's population has grown from 286,272 persons aged 60 and over since 1970 to 651,482 in the year 2,000, a 128% increase in thirty years. The growth of South Carolinians 60+ will continue to increase significantly over the next twenty years. Overall, persons 60 and above

are anticipated to increase from 651,482 in 2000 to 1.450,487 in 2030 for a 123% increase. The fastest growing segments of our senior population will be in the 85+ age categories. South Carolina's 85+ population is expected to grow from 50,269 in 2000 to 141,286 or 181% in 2030.

The 75-84 and 85+ age groups are particularly important because of their higher incidence of Alzheimer's disease. In the 2000 census, there were an estimated 4 million people age 85+ in the United States. Nationally, this figure is expected to increase to 18 million in the next 50 years. Because of the nature of Alzheimer's disease and related dementias the growth of our really old population will have a significant impact on the need for health care and long term care.

Long Term Care and an Aging Society

Long term care services are those physical or mental health and social services designed to serve individuals who are unable to function well in performing activities of daily living (ADL) and instrumental activities of daily living (IADL). Examples of losses in the area of activities of daily living are bathing, dressing, eating, etc. Losses in the area of instrumental activities of daily living include shopping, money management, cleaning, cooking, etc. The person's functional losses may be minimal or they may be extensive enough that the person would meet nursing facility level of care criteria.

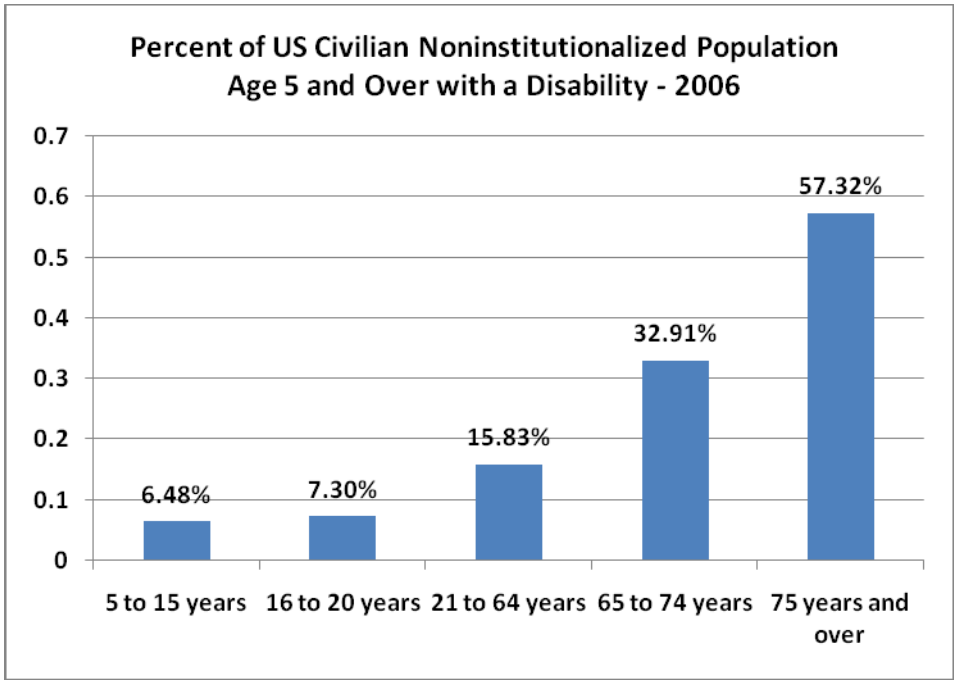
Such services may also be provided to individuals who require skilled care. They may be provided in the home and community, or in institutions. Generally, the need for such services is identified after there is a functional deterioration not related to having received acute care services. In most cases, persons discontinue receiving long term care services when they are again able to perform their ADL and IADL.

Growth in the Demand for Long Term Care Services

Most, but not all persons in need of long-term care are elderly. Of the older population with long term care needs that live in the community, about 30% (1.5 million persons) have substantial needs. Approximately 53% are aged 65 and older. Of these, about 25% are 85 and older. As South Carolina and the nation ages, we can expect significant increases in the demand for long term care services

Growth in the Number of Persons with Disabilities

According to the US Census, as people age a higher percentage of individuals experience moderate to severe disabilities. In 2006, 32.9% of persons 65 to 74, and 57.3 % persons over the age of 75 experienced some disability.



Source: US Census Bureau, 2006 American Community Survey

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

South Carolina is also experiencing an increase in the number of persons with disabilities as they age. Growth in the numbers of persons with disabilities will impact the need for long term care or home and community-based services.

The chart below indicates the number of South Carolinians with any disability.

Age Group	Total Population	Any disability		One Disability		Two or more disabilities	
		#	%	#	%	#	%
5 to 15	627,264	40,619	6.5%	33,264	5.3%	7,355	1.2%
16 to 64	2,780,504	413,503	14.9%	160,520	5.8%	252,983	9.1%
65+	532,736	232,540	43.7%	98,654	18.5%	133,886	25.1%

Source: US Census Bureau, 2006 American Community Survey

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

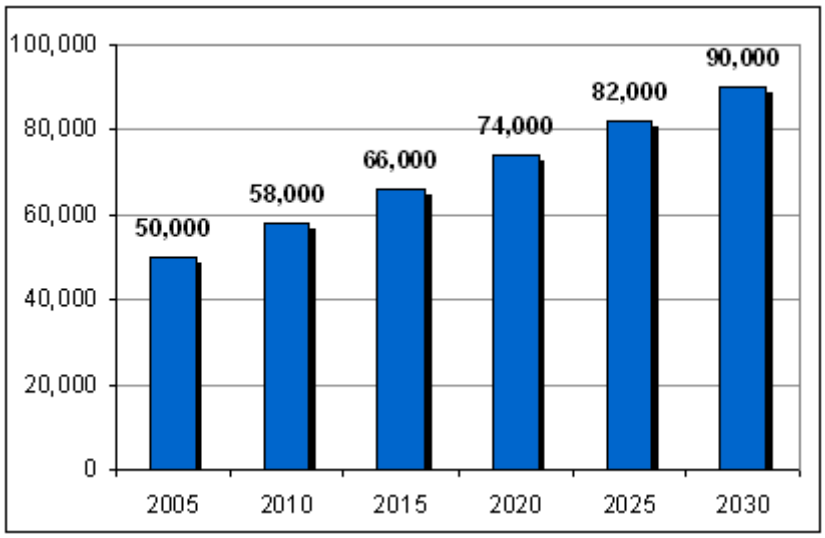
Based upon the 2006 American Community Survey, 25.1% of South Carolinians aged 65 and older have two or more disabilities. This is particularly significant when

considering that three or more disabilities makes a person eligible for long term care services.

Growth in the number of Persons with Alzheimer's Disease and Dementia

An estimated 4.5 million Americans have Alzheimer's disease, based on the number of cases detected in an ethnically diverse population sample and the 2000 census. This number is expected to continue to grow to 11.3 million to 16 million by the year 2050. South Carolina is also facing the same trends. The chart below shows the projected growth in the number of Alzheimer's cases in South Carolina. This growth will have a dramatic impact upon South Carolina's governmental programs, families, caregivers and businesses as society addresses how to handle the many problems and costs associated with this disease.

Projections of Alzheimer's Disease in South Carolina: 2005 – 2030



Source: http://www.scmatureadults.org/report06/alz06.asp

As of 2005, 56,754 persons in South Carolina have Alzheimer's disease and related dementias, based upon the Alzheimer's Disease Registry. By 2030, 90,000 South Carolinians will have Alzheimer's disease and related dementias. The average lifetime cost of an Alzheimer's patient is $174,000. The cost to individuals, families, Medicare, Medicaid, insurance companies and businesses would be $15.7 billion. With a 3% inflation factor, the cost would double to $31.4 billion.

Medicaid pays $40,400 per person for a full year of nursing home care based upon 2006 data. Currently 38% of an estimated 90,000 persons will be in a nursing home; 71.5% of persons in nursing homes are paid for by Medicaid; therefore, 24,453 of the 90,000 estimated persons with Alzheimer's disease and related disorders would be in a Medicaid nursing home bed in 2030. The cost would be $74,000 per person, or $1.8 billion and $543 million in state funds, assuming a 3% annual inflation rate. (Source: 2006 SC Mature Adults Count, and FY 2007 State Accountability Report)

The following chart shows the current prevalence of Alzheimer's disease in South Carolina by age, race and sex.

Registry Cases by ADRD Type, Gender and Age Group South Carolina Alzheimer's Disease Registry, 2005*										
	AD		Vascular		Mixed		Other		Total	
MEN										
	N	%	N	%	N	%	N	%	N	%
Under 65	1,015	10	491	20	65	9	1,372	31	2,943	16
65 – 74	2,374	23	645	26	172	25	1,092	27	4,383	24
75 – 84	4,160	39	888	36	298	43	1,196	27	6,542	36
85 +	2,993	28	477	19	166	24	673	15	4,309	24
WOMEN										
Under 65	1,232	5	399	10	63	4	835	15	2,529	7
65 – 74	3,674	14	706	17	234	16	961	18	5,577	15
75 – 84	9,421	38	1,428	35	601	41	1,920	35	13,609	37
85 +	10,953	43	1,534	38	577	39	1,746	32	14,810	41

Records for 2,057 individuals have missing values for gender or age.

AD=Alzheimer's disease or senile dementia: Vascular=Vascular dementia; Mixed=Both Alzheimer's disease and Vascular dementia in other medical conditions.

Rising Cost of Health Care and Long Term Care

National health care expenditures have risen dramatically between 1975 to 2005. Based upon the National Health Care Expenditures, total health care spending rose from $133.1 billion in 1975 to $1.99 trillion in 2005. This will continue to grow dramatically to $4.1 trillion in 2016. Approximately $2.1 trillion will be accounted for by hospitalizations, home health care, prescription drugs and nursing home care. Hospital care will increase from $51.8 billion in 1975 to $1.3 trillion in 2016, and home health care will increase from $623 million in 1975 to $111 billion in 2016. Prescription drugs will increase from $8 billion in 1975 to $498 billion in 2016. Nursing home expenditures will increase from $8.5 billion in 1975 to $210.9 billion in 2016. The chart following shows the dramatic growth of health care spending nationally and who pays. A large portion of these expenditures will be due to the growth of the senior population.

National Health Care Expenditures (in $millions

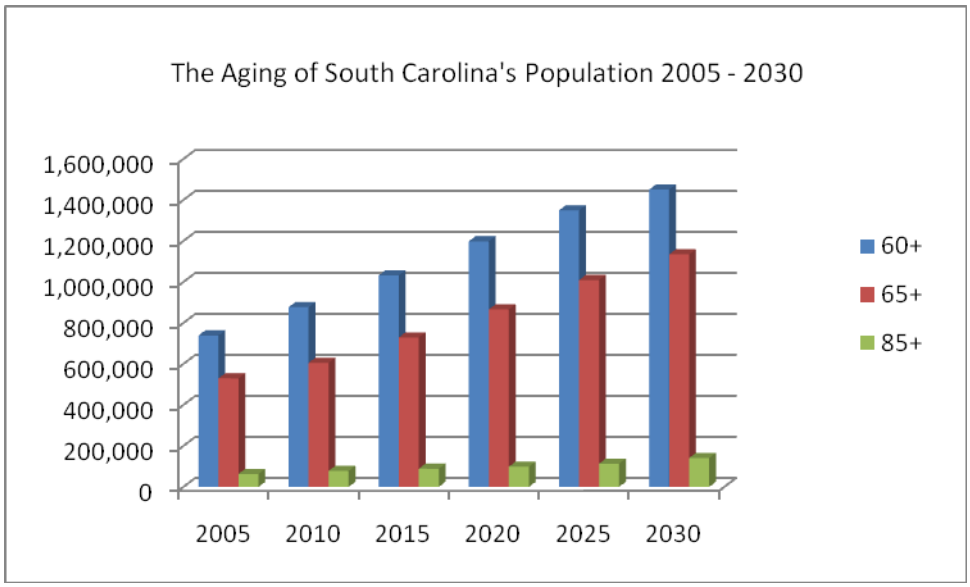
	National Health Expenditures	Medicare	Medicaid	State & Local			Hospital Care	Home Health Care	Prescription Drugs	Nursing Home Care
				Total S&L	Medicaid					
1975	133,126	16,336	7,409	19,549	6,037	**1975**	51,811	623	8,052	8,493
1976	152,475	19,694	9,153	20,405	6,036	**1976**	59,955	896	8,723	9,805
1977	172,821	22,891	9,896	23,310	7,568	**1977**	67,358	1,147	9,196	11,545
1978	194,598	26,668	10,919	26,269	8,547	**1978**	75,995	1,556	9,891	14,162
1979	220,444	30,922	12,705	30,337	9,627	**1979**	86,588	1,899	10,744	16,247
1980	253,916	37,180	14,484	34,789	11,548	**1980**	101,008	2,377	12,049	19,023
1981	294,182	44,544	17,061	39,503	13,247	**1981**	118,035	2,937	13,398	21,336
1982	330,736	52,082	17,533	43,606	14,478	**1982**	134,255	3,481	15,029	23,223
1983	365,333	59,261	19,159	47,100	16,106	**1983**	145,413	4,236	17,323	26,467
1984	402,282	65,857	20,664	49,823	17,569	**1984**	155,066	5,127	19,618	28,785
1985	439,876	71,444	22,651	54,306	18,286	**1985**	165,382	5,647	21,795	31,603
1986	471,784	76,395	25,402	61,145	19,981	**1986**	176,546	6,388	24,290	34,457
1987	512,950	82,610	27,788	68,418	22,551	**1987**	190,461	6,660	26,889	36,329
1988	573,990	88,486	31,010	74,740	24,070	**1988**	207,417	8,426	30,646	40,461
1989	638,708	100,637	35,241	82,270	26,712	**1989**	227,002	10,238	34,758	45,526
1990	714,019	109,504	42,546	92,849	31,115	**1990**	251,551	12,567	40,291	52,623
1991	781,611	120,624	56,679	102,143	36,532	**1991**	277,077	14,879	44,381	58,028
1992	849,049	135,996	67,957	110,672	40,230	**1992**	299,845	18,170	47,573	61,998
1993	912,557	149,964	76,770	120,853	45,604	**1993**	317,162	21,879	50,991	65,445
1994	962,196	167,669	81,294	131,661	53,120	**1994**	329,797	26,066	54,302	67,922
1995	1,016,503	184,393	86,144	137,535	58,718	**1995**	340,743	30,529	60,876	74,082
1996	1,068,899	198,748	92,054	140,321	60,116	**1996**	352,240	33,602	68,536	79,587
1997	1,125,381	210,375	95,155	146,292	63,323	**1997**	364,781	34,544	77,666	84,485
1998	1,190,890	209,212	99,533	156,123	69,461	**1998**	376,317	33,221	88,595	89,545
1999	1,265,270	212,813	108,334	165,217	75,853	**1999**	394,988	31,520	104,684	90,512
2000	1,353,256	224,301	118,032	178,632	83,563	**2000**	417,049	30,514	120,803	95,262
2001	1,469,605	247,662	132,617	196,864	92,691	**2001**	451,440	32,179	138,559	101,515
2002	1,602,832	265,722	147,345	212,728	101,673	**2002**	488,604	34,213	157,941	105,715
2003	1,733,436	283,524	161,316	224,587	110,317	**2003**	525,400	38,025	174,639	110,463
2004	1,858,888	312,803	172,157	237,381	119,884	**2004**	566,886	42,710	189,651	115,015
2005	1,987,689	342,047	178,796	258,997	134,314	**2005**	611,566	47,451	200,716	121,862
2006	2,122,488	417,645	178,070	267,555	135,438	**2006**	651,761	53,376	213,714	126,063
2007	2,262,335	444,689	190,544	285,364	145,969	**2007**	697,475	57,941	229,547	132,096
2008	2,420,021	478,603	204,886	304,346	157,129	**2008**	747,198	62,696	247,612	138,817
2009	2,596,015	515,758	220,724	325,496	169,485	**2009**	802,695	67,659	268,331	146,053
2010	2,776,434	553,576	238,033	348,235	183,006	**2010**	860,890	72,716	291,492	153,367
2011	2,966,422	594,272	257,183	372,928	197,980	**2011**	922,318	78,068	317,470	161,162
2012	3,173,431	641,182	278,098	399,604	214,315	**2012**	988,206	83,749	346,496	169,556
2013	3,395,773	690,340	300,902	428,279	232,137	**2013**	1,057,972	89,826	378,629	178,697
2014	3,628,576	742,104	325,622	458,901	251,470	**2014**	1,130,160	96,289	414,162	188,508
2015	3,874,559	799,219	352,601	491,832	272,582	**2015**	1,206,732	103,321	453,602	199,240
2016	4,136,856	862,661	381,703	527,122	295,327	**2016**	1,287,783	111,070	497,526	210,900

National Health Expenditure (NHE) Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965-2016 in PROJECTIONS format
The health spending projections were based on the 2005 version of the NHE released in January 2007.
NOTES: Federal and State and Local Medicaid expenditures include Medicaid SCHIP Expansion. Federal and State and Local "Other" funds include SCHIP.

South Carolina's Continuum of Care

The trends that we see nationally will also dramatically impact South Carolina's families and its state government. The following graph and tables show the tremendous growth in the senior population from 2005 through 2030.

The Aging of South Carolina's Population 2005-2030



The Aging of South Carolina's Population 2005-2030						
	2005	**2010**	**2015**	**2020**	**2025**	**2030**
60+	738,659	876,512	1,032,093	1,198,333	1,349,390	1,450,487
65+	529,410	605,660	729,179	866,250	1,009,242	1,134,459
85+	63,215	78,253	88,541	98,888	113,147	141,286

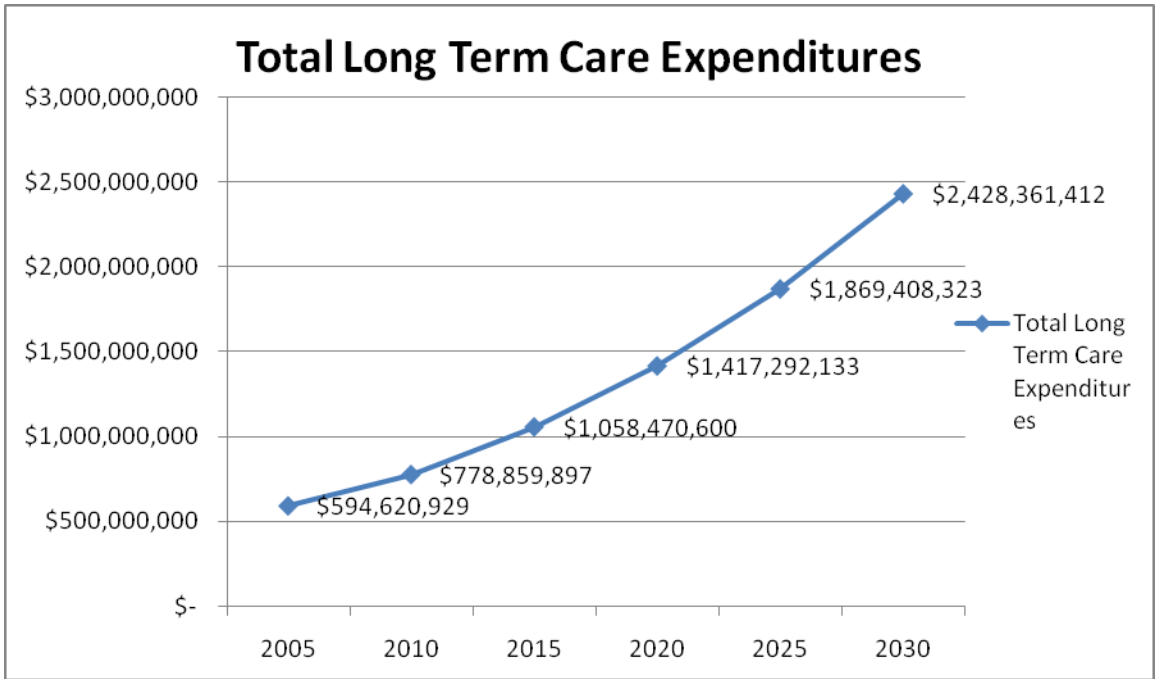
Source: 2005-2030 Projections: US Census Bureau, Population Division, Interim State Population Projections, 2005.

This population growth from 2005 through 2030 will dramatically impact South Carolina's continuum of care through the following programs:

- Medicaid nursing homes
- Community Long Term Care program (Medicaid waiver program for seniors and adults with disabilities)
- Palmetto Senior Care
- Residential Care Facilities
- Older Americans Act programs (home and community-based services)

When considering the growth of the population and using a conservative 3% annual cost increase factor for providing the above continuum of care, we can develop an

estimate for South Carolina of what maintaining the same level of care would be in 2030. The following chart will show the cost of providing the current service mix in 2030:



The above costs reflect total costs (federal and state funds). Assuming an approximately 30% state fund rate, South Carolina would have to increase state spending from $178 million in 2005 to $729 million in 2030. This represents almost quadrupling of the state's expenditures in the next twenty five years. Based upon this analysis, South Carolina must partner with the federal government to implement Choices for Independence during the next four to ten years if it is to avoid significant problems caused by the aging of the population.

Services provided through funding from the Older Americans Act will assist the State of South Carolina in providing cost/effective services which will work in conjunction with Medicaid, Medicare, private insurance and families to provide a continuum of care as well as helping to develop a long term support system through the SUA and the state's ten Area Agencies on Aging working with local service providers to meet the needs of our consumers. The following parts of this chapter will address those initiatives and program services that will be major areas of emphasis over the next four to ten years.

Implementation of Choices for Independence

1. Issue: Increased Funds for Home and Community-Based Services- During FY 2006-2007 the Lieutenant Governor's Office on Aging was appropriated $2.9 million in supplemental state funds for home and community-based services. This is a wide array of home and community-based services such as home delivered meals, group dining, transportation, home care, home modifications, bags of groceries, etc. All of these programs are designed to help seniors remain at home. The program allows considerable flexibility for the Area Agencies on Aging and local service

contractors to meet local service needs. During the first full year of service approximately 5,476 seniors received a variety of services. As of April, 2008 there are 4,391 seniors on waiting lists needing services. During the FY 2008-2009 state appropriation process the Lieutenant Governor's Office on Aging is hoping that the $2.9 million will be made recurring rather than supplemental. This will guarantee continuity of service for our state's seniors in the future. However, additional state funds are necessary if we are to serve all those on our waiting list. Based upon the above waiting list for congregate meals, home delivered meals and home care and average costs for each service, the Lieutenant Governor's Office on Aging would need an additional $5,988,210 in state funds to provide services to the waiting list population. This is based upon the following data:

- **Congregate Meals** – 516 seniors with 250 meals per year at $5.25 per meal equals $741,750
- **Home Delivered Meals** – 2,616 seniors with 250 meals per year at $5.75 per meal equals $3,433,500
- **Home Care** – 1,259 seniors with 90 units per year at $16 per visit equals $1,812,960

Goals:

- Obtain additional appropriated state funds on a recurring basis for the $2.9 million and the additional $5,988,210 million necessary to serve the persons on the current waiting list.
- Obtain additional state funds in the future to serve seniors in a cost effective manner to maintain choice and independence.
- Obtain a cost of living factor to be added to maintain current services in the future.

Outcomes:

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

Strategies:

- Continue to collect research and outcome data to support recurring funding for home and community-based services.
- Build and maintain partnerships with agencies and organizations concerned with seniors and their caregivers to support senior friendly policies and services.

- Advocate with state policy makers in the future for resources for services that promote choice and independence and a balanced long term care system for South Carolina.
- Provide cost effective services through competitive local service providers so that the maximum number of seniors are served with limited federal and state resources.

2. Issue: Statewide ADRC Implementation with Case Management

In 2003, the Administration on Aging and the Centers for Medicare and Medicaid Services, both part of the US Department of Health and Human Services, launched the Aging and Disability Resource Center (ADRC) grant initiative to promote the integration of long-term care information and referral services, benefits and options counseling services, and access to publicly and privately financed services and benefits for those in need of long-term supports and their families. ADRC grants were awarded to 10 states, of which South Carolina was one. Since 2003, South Carolina has opened 5 ADRCs, covering 25 of 46 counties that serve older adults and adults with disabilities.

The vision of the Administration on Aging is for all Area Agencies on Aging to become Aging and Disability Resource Centers so that in every community there is a highly visible and trusted place where people can turn for information on the full range of long term support options. Case Management will be an integral part of the ADRCs. In order to make the transition from AAA to ADRC, it is estimated that each AAA will need approximately $102,000.

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

Goals:

To have Aging and Disability Resource Centers in all ten aging regions of the state serving as highly visible and trusted places where people of all incomes and ages can turn for information on the full range of long-term support options and a single point of entry for access to public long-term support programs and benefits.

- assist consumers with **completing financial applications** for Medicaid
- have **functional** eligibility assessors within the ADRC
- have **financial** eligibility assessors within the ADRC
- ability to **track** the **eligibility status** of applicants as they move through the system
- provide **Case Management** services to those who need it most

Outcomes:

- Consumers of LTC would have one single entry point into the system
- Enable seniors and caregivers to have choice and remain independent at home whenever possible

- Those needing case management services could obtain them from the ADRC
- Document the need for and justify having ADRCs.

Strategies:

- **Build on the strong existing networks** for Aging Network (specifically I&R and Family Caregiver), I-CARE Programs and Independent Living Centers
- Develop partnerships with local community and state service providers
- Request adequate financial resources to open 5 additional ADRCs
- Establish or identify financial resources to sustain all 10 ADRCs
- Maintain and expand the statewide resource directory – SC Access
- Market use of eforms and expand number of eforms; get other agencies involved in using eform technology to drive costs down
- Complete "Bridges" project so consumers only have to tell their story once
- Have ADRC staff complete assessments and screenings (AIM, CLTC, etc.)
- Continue to collaborate with CLTC staff (using electronic referrals) to make the application process as seamless as possible for the consumer.
- **Overcome the stigma associated with Medicaid by serving all income groups and across disabilities;** ADRCs and can assist a wide range of individuals, including family caregivers, in obtaining long term supports and services in the most desirable and appropriate setting.
- Have ADRCs intervene in **critical pathways** to long term services and supports, such as hospital discharge planners, physicians or other health professionals, or long term supports providers, through options counseling; ADRCs convey the range of alternative services and settings available, as well as methods to pay so individuals can both plan ahead and make informed decisions about current needs.
- Pilot a case management system in Santee Lynches (Clarendon county)
- **Divert individuals from nursing facilities** by conducting **pre-admission screening through the ADRC**
- Play a role **in nursing facility transitions** under the Money Follows the Person Demonstration program (MFP)
- Develop and pass **legislation** to enhance and expand ADRCs.

3. Issue: Information, Referral And Assistance, SC Access

The mission of SC *Access* is to help older adults, adults with disabilities, and those who care for them access useful information about long term support and needed services. Through the use of a comprehensive web-based service directory, regional Information, Referral and Assistance Specialists (IR&A Specialists) and

staff at five regional Aging and Disability Resource Centers (ADRCs), individuals will be able to find options for care throughout South Carolina.

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

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

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

Goals:

- Ensure information in *SC Access* remains current through annual review
- Add information in a timely fashion to keep up with the evolving issues facing seniors, adults with disabilities, caregivers, aging professionals, and service providers
- Add service providers to include services and groups not currently well represented such as: prevention programs, health and wellness, recreational therapy, services for adults with disabilities, mobility issues
- Enhance the information on the Community Calendar
- Establish an ongoing marketing campaign that reaches professionals, civic organizations, the faith based community, and the consumer
- Recreate the OLSA Client Intake Screen to better capture data

- Conduct training that will build the skills of the IR&A Specialists
- Develop the capacity for information sharing between the aging network and 211 regarding information and referral
- Develop partnerships between the aging network and other community partners statewide to build a strong communication network
- Add state specific information to the "Learn About" for seniors and adults with disabilities

Outcomes:

- Consistent, accurate, up to date information will be available in all areas of *SC Access*
- Additional resources and service providers are added to the *SC Access* database
- South Carolinians will have access to information related to events in their local area related to aging or disabilities
- South Carolinians will know how to find information and resources in *SC Access*
- Data entered in OLSA will be more consistent and accurate, thereby making reporting more reliable
- IR&A Specialists will have the knowledge, skills, and ability needed to effectively and efficiently assist clients who contact them
- IR&A Specialists and 211 Counselors will have open communication to share information and suggestions on providing the best information and referral possible to the citizens of South Carolina
- The aging network and its community partners will have open, effective communication that will identify resources, find solutions to problem areas, and improve overall services to older adults, adults with disabilities and their caregivers
- Information on long term care in South Carolina will be available in "Learn About"

Strategies:

- Constant development and implementation of policies and procedures that allow *SC Access* staff to effectively maintain accurate, consistent, and current information in the database
- Develop working partnerships with individuals, groups, and organizations that can assist in identifying resources for inclusion as well as provide outlets for marketing efforts
- Creative marketing that uses traditional venues and media, word of mouth, and any new way to get the information to the public that may present itself

- Develop training materials to be used for internal staff and the staff of our partners to ensure that more professionals who have an opportunity to assist an individual will know how to use *SC Access*
- Use new technology (Forms Builder) from VisionLink to upgrade OLSA
- More local South Carolina events will be posted to the Community Calendar
- Develop IR&A steering committee to identify topics for monthly trainings to build IR&A knowledge, skills, and ability and to review and modify the information and referral standards
- Add new long term care planning information in "Learn About" based on questions and feedback received during presentations and long term care trainings
- Develop a partnership between the aging network and 211 to review training standards and identify opportunities for improvement in information and referral
- Use technology such as forums available through the Lieutenant Governor's Office on Aging Web 2.0 program to facilitate easy open communication and discussion between the aging network and our community partners

4. Issue: Family Caregiver Support Program

80% of all long term care services are provided in the home by unpaid family members. It is often this support that enables the older person to remain at home despite illness and disability, thus delaying or avoiding much more expensive care in an institution.

Today 560,000 family caregivers in SC provide 610 million hours of 'free' services to their chronically ill, disabled or aged loved ones. If their services had to be replaced by even low-paid health care workers, the cost would be more than $5.5 billion each year.

Families provide care willingly but at great personal cost to the caregiver's health, financial stability and their longevity.

The average caregiver foregoes $659,139 in salary and retirement benefits over the course of a lifetime, which impacts the caregiver's ability to support one's own care needs in the future.

The caregiver's own physical health is an influential factor in the decision to place an impaired relative in a long term care facility.

Caregiver support services have been shown to mitigate costs.

Respite decreases the risk to caregivers, reduces the risk of acute hospital admissions, and helps prevent or delay costly placements in assisted living or nursing homes.

Caregiver counseling and support improves health outcomes and extends caregiving.

National Family Caregiver Support Program – SC's Model is Consumer-Directed. Administered locally by the 10 Area Agencies on Aging (AAA), each AAA has a full-time Family Caregiver Advocate who works directly with family caregivers to help them work through the challenges of their own specific caregiver situation. Eligible caregivers may also obtain a mini-grant or budget to purchase services from the provider of their choice. Caregivers purchase the agreed upon services and are reimbursed later or they may access services through vouchers.

In fiscal year 2007, the SC Family Caregiver Support Program, using federal, state and local funds, provided the following support services to family caregivers across the state:

- Family Caregiver Advocates had 16,779 conversations with 7,974 family caregivers providing information and helping caregivers access existing community services.
- 2,409 family caregivers participated in 4,259 support, counseling or training sessions.
- 1,677 family caregivers received mini-grants that allowed them to purchase 144,605 hours of respite from the formal or informal provider of their own choice.
- 1,136 family caregivers received mini-grants that allowed them to purchase caregiver supplies or other needed caregiver services.

Goals:

Family caregivers in all counties will be recognized and supported for their valuable role in the long term care system; have access to high quality information, referral, and assistance; be able to choose from a full array of service options; and have access to respite care and other supportive services in their communities throughout the caregiving experience.

Outcomes:

- Improve the quality and availability of information to families and caregivers, including those caring for persons with Alzheimer's disease and related dementias.
- Obtain adequate funding to provide the ever increasing number of family caregivers in the state with consumer-directed, flexible caregiver support services.
- Increase availability of support groups, caregiver training, respite, and peer support options.
- Increase consumer choice.

Strategies:

- Develop new caregiver resources for the LGOA website.

- Partner with Area Agencies on Aging to demonstrate the positive impact of South Carolina's Family Caregiver Support Program and justify a request for additional funding.
- Continue development of a consumer-driven statewide service delivery system by conducting 6 technical assistance/training meetings per year with regional Family Caregiver Advocates.

5. Issue: State Health Insurance Information Program (SHIP)

Medicare offers a myriad of prescription plan options to offset the cost of prescription drugs.

- Prescription drug costs during the coverage gap are challenging to individuals with income above the 150% of federal poverty level.
- Ten percent of beneficiaries in SC are enrolled in Medicare Advantage plans (MA) and many do not understand the benefits.

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

- Searchable database for Medicare Part D drug plans and Medicare Advantage Plans.

  CMS offers a plan finder database that allows consumers, caregivers and professionals to enter drug information to locate a plan that corresponds to the consumer's needs.

- Trained counselors to provide objective and free information.

  The SHIP program is co-sponsored by the SC Department of Insurance. To avoid any Conflict of Interest, the Department of Insurance screens potential counselors for insurance licensures. The SHIP grant prohibits agents from becoming counselors.

  The SHIP training modules are Medicare Part A thru D, Medicare Supplement, Medicaid Eligibility and Medicare fraud. Medicare counselors are required to become certified by obtaining a proficiency of 70 or more on a final examination. Broader Medicare training opportunities are provided at annual conferences hosted by the State Unit on Aging (SUA) and CMS. Forty-eight new counselors were certified in 2007.

- Local help to learn about and/or enroll in Medicare programs

  The SUA allocates funds to the AAA to provide assistance in the local communities. Grant funds are allocated using the intrastate formula and can be used to hire coordinators.

Under Part D, Low-income Subsidies (LIS) are available based on low-income and resources. Some people will be automatically enrolled and others will be required to complete a lengthy application.

The state Gap Assistance Program for Seniors (GAPS) is available for those who do not qualify for the LIS program. GAPS is income based, state-funded and administered by the SC Department of Health and Human Services (DHHS) to cover 95% of the prescription cost during the donut hole phase. GAPS can be accessed by a DHHS list of Part D plans that coordinate with GAPS at www.dhhs.state.sc.gov.

People are enrolled in a Medicare Advantage plan that health care providers are not accepting. They are required to pay full cost of care if providers do not accept the plan for care.

Goals:

- Provide information and assistance to a greater number of beneficiaries unable to access other channels and who prefer locally based services.
- Enhance the SHIP counselor cadre and equip them to be proficient in educating, assisting and enrolling consumers.
- Increase targeted outreach to locate and enroll consumers eligible for Low-income subsidy.

Outcomes:

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

Strategies:

- Offer four Medicare basic and advanced trainings to counselors with regards to Medicare products.
- Offer educational and enrollment seminars to people in every region in South Carolina.
- Offer Medicare 101 to new Medicare beneficiaries to empower them to make options that suit their needs.

- Collaborate closely with CMS, Social Security and AoA as an active partner to provide the most current and accurate information to beneficiaries and the public.
- Identify and partner with colleges to use students in the health discipline to reach low-income consumers eligible for LIS.
- Increase targeted outreach to reach consumers eligible for LIS.

6. Issue: Evidence-Based Prevention and Wellness programs-In August 2006**,** the LGOA, in partnership with the SC Department of Health and Environmental Control (DHEC), received a grant from the Administration on Aging (AoA) to introduce and expand evidence-based health promotion and disease prevention programs (EBP) in South Carolina. Assistant Secretary Josephina Carbonell made these programs a priority in her Choices for Independence plan also introduced in 2006. As of May, 2008, the programs are available in 6 of the 10 regions of the state. All ten AAA regions will offer EB programs by July 1, 2008. Over 600 people have completed the programs through June, 2008. The LGOA is working with the University of South Carolina and the State Budget and Control Board, Office of Research and Statistics, to gather quantitative and qualitative program outcomes.

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

Goals:

The LGOA intends to expand the programs to all regions of the state no later than July, 2009 by implementing the following goals:

- Beginning July 1, 2008, all AAA regions must use their Title IIID funds only for evidence-based health promotion programs. This incentive has strongly encouraged local contractors and AAAs to identify evidence-based programs they would like to provide at their senior centers and meal sites.
- The LGOA will continue to identify partners that can support the sustainability of the program either through financial dedication or contribution of resources to assure the programs continue beyond the grant cycle.
- The LGOA is also exploring the use of state and other funds for home and community based services for partial reimbursement of contractors who track and report participant completers of the program. The LGOA will continue to explore additional grants to support the program. A complete progress report can be found on the LGOA website.

Outcomes:

- Policy makers will demonstrate support of evidence-based programming at the federal and state levels through allocation of additional resources and funding.
- Through evaluation, seniors will demonstrate a higher quality of life after completing the programs, as health care utilization decreases.
- New partnerships are developed because of increased interest in community-based evidence-based programming.
- Research will enable state, and local providers to have adequate resources to provide cost effective prevention services to seniors and their caregivers.
- Seniors and caregivers will be enabled to have choice and remain independent at home whenever possible

Strategies:

- Complete research related to program outcomes of AoA grant, including qualitative program analysis and quantitative Office of Research and Statistics data and the Senior Cube.
- Disseminate findings of the evaluation efforts and compare with other states' data.
- Partnership for Healthy Aging gains new membership, refines its vision, mission and goals for the next four years.
- Seek additional funding and/or resources for the sustainability and expansion of the EBP initiatives.

7. Issue: Long Term Care Planning

Most Seniors Have Failed to Plan for Long Term Care

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

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

Approximately 60 percent of individuals over age 65 will require at least some type of long-term care services during their lifetime. Despite the need for long-term care planning, most Americans still do not carry any form of coverage and fewer than two in five (37%) adults report that they have developed a plan to pay for their long-term care needs. Very few seniors spend money or time to plan for the event of long-term care.

No one knows why people beyond age 65 are not more concerned about preparing for long-term care. Perhaps they have seen it in their family or among friends and seen the effect that it has. Because of the unsavory aspect of receiving long-term care, perhaps seniors prefer to ignore it rather than embrace the need for it. Perhaps they mistakenly think the government will take care of them. Or they are assured that family and friends will provide the care when needed, but don't know how difficult it really is for loved ones to provide that care when the time actually comes. Whatever the case, without proper planning, the need for long-term care can result in the single greatest crisis in a senior's life.

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

Current Generation Needs to Plan for Long-Term Care

As if the current lack of planning for long-term care were not a great enough burden on the immediate or extended family, the failure to plan, for the current generation of baby boomers, could be even more devastating on spouse or family in the future. Here is a list of factors that will make long-term care in the future an even more pressing burden than it is today.

1. We are living longer. The population segment of the "very old", older than age 85, is the fastest-growing age group in the country. The older the person, the more likely the need for long-term care and the more likely a need for care which lasts not just months but years. Over 50% of the age group over 85 is receiving long-term care.
2. The older the person the more likely the risk of onset of dementia. The Alzheimer's Association estimates about 46% of people over the age of 85 have dementia or Alzheimer's.
3. The number of overweight and obese people in the United States is increasing dramatically. Obesity is a major contributor to disability and poor health in the seniors. Estimates are that the effects of obesity will increase nursing home enrollments by an additional 15% to 20% by the year 2020.
4. The ranks of seniors are growing larger. The population of seniors over 65 will double from about 37 million people today to about 77 million people in 2035, 30 years from now. Based on current estimates of the rate of long term care this means that in 30 years about 17 million senior Americans will be receiving long term care.

5. It is estimated that 6 out of 10 people will need long term care sometime during his/her lifetime.
6. With a large and growing number of single person households there is no spouse and oftentimes no children to provide care. About 40% of the population is single.
7. The birthrate is going down and families are getting smaller. The combination of fewer children, the increasing number of single person households and a growing number of seniors will eventually create a situation where there are more people needing care than there are available family caregivers.
8. Out of approximately 116 million women in this country who could be employed in the workforce about 60% or 69 million are employed. With women being the traditional caregivers, this means only about 40% of traditional caregivers are at home and able to provide long term care for loved ones without having to juggle a work schedule as well.
9. Children are moving far away or seniors are relocating after retirement and this makes it difficult or impossible to provide the resulting long-distance caregiving.
10. The number of seniors as a percent of the population is growing larger, putting a burden on the tax base and availability of money for government programs and the availability of younger caregivers. Over the next 50 years seniors will grow from about 12% of the population to over 20% of the population.
11. Medical science is preventing early sudden deaths which often results in a prolonged life with impaired health and a higher potential need for long-term care.
12. Government programs are already stretched thin for long-term care services and will experience even greater stress on available funds in the future.
13. Most healthy people in their 50s and early 60s prefer to ignore this future problem and their lack of planning will further burden public programs in the future.

The failure of the current pre-retirement generation to plan for long-term care will have an even greater future negative impact on our culture and our families than the lack of planning does today.

Why Plan Ahead for Long-Term Care Needs

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

Most people learn about long term care the hard way – when they or a loved one needs care. However, long term care needs are best met when they are planned

for. Planning ahead gives individuals time to talk with their family about preferences and concerns, to research care options in the community, and to give some thought to preferred types of services and providers. Furthermore, planning ahead gives individuals the time to plan for how they will pay for care – which can be very costly – in a way that does not deplete the financial resources available for a spouse or other family members.

Some of the specific advantages of planning ahead include:

- Preserving assets and income for uses other than paying for long term care services. This allows one to ensure quality of life for a spouse or other family member and allows one to preserve and pass on an estate to heirs.
- Providing choice over care options and control over where and how one receives long term care.
- Improving quality of life. This results in less emotional and financial stress on individuals and their families.
- Easing the burden of providing care by loved ones. Family members can still be involved in the daily care routine, but they can be a supplement rather than being the only source of care, which is emotionally and physically demanding.
- Maintaining independence. Choices for care outside a facility and being able to stay at home as long as possible are enhanced if individuals plan ahead, including a plan for how to pay for care options that are less likely to be covered by payers of last resort, such as Medicaid.

Why People Do Not Plan Ahead

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

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

What Motivates Planning

Overcoming the barriers outlined above is critical to support and enable planning behavior. One powerful factor is having some long term care experience, perhaps a close family member or friend who has needed long term care.

Attitudes appear more important in predicting who will and will not plan ahead than demographics. People who understand and acknowledge the risks and costs of needing long term care in the future, and who perceive the value of planning ahead, are much more likely to plan. People who plan ahead for long term care needs are also more likely to be "planners" in other aspects of their lives.

How We Have Addressed the Problem Thus Far in SC

The Lt. Governor's Office on Aging through ADRC Expansion grant funding began working in 2007 with the SC Partnership of Disability Organizations and Clemson University to develop two long term care planning curricula. One training module was developed for seniors and the other for seniors with a child with a disability. A total of twenty trainings will be conducted by the end of June 2008. There has been overwhelming response to the trainings and resource materials that have been distributed at the trainings. In addition, fact sheets on various long term care issues have been developed and posted on the SC Access "Learn About."

Goals:

Increase the Awareness of the Need for Long Term Care Planning Through Trainings and Public Awareness Campaigns

Outcomes:

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

Strategies:

- Seek to receive approval for the Lt. Governor to launch the "Own Your Own Future" Campaign
- Provide additional trainings as requested
- Post training modules and other resource materials on the Lt. Governor's website.

B. Modernization of Aging Services in South Carolina

1. Issue: Collaboration with other state health and human services agencies – As South Carolina continues to implement current initiatives and implement those key elements in its FY 2009-2012 State Plan on Aging, it will be

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

Goals:

- Create a core group of state agencies to build a working partnership to plan and implement cost effective programs for South Carolina's seniors and caregivers to meet their needs within limited resources.
- Coordinate and maximize services to seniors and their caregivers so that the greatest number of seniors and caregivers may be served within available resources.
- Work together to help educate South Carolinians to take personal responsibility for their retirement years and to utilize available services and information responsibly.

Outcomes:

- A state coordinating body of appropriate state health and human services agencies concerned with serving South Carolina's seniors and caregivers will be established.
- A statewide plan for these agencies will be developed and implemented.
- Services for seniors and their caregivers will be coordinated and cost effective to serve the maximum number of persons within available resource limits.
- South Carolina's related agencies will establish mechanisms to educate seniors and their caregivers to take personal responsibility for their senior years and to responsibly utilize information and services to make wise choices for their senior years.

Strategies:

- The Lieutenant Governor's Office on Aging will work to create a statewide coordinating body through legislative proviso or through collaborative approaches of appropriate health and human services agencies that provide services to seniors.
- The Lieutenant Governor will serve as Chair of this body in order to assure that Agency Heads and policy makers represent their organizations and address the needs of seniors.

- Key agencies in the coordinating body will be the SC Department of Health and Human Services, Department of Mental Health, Department of Transportation, Department of Social Services and the Department of Developmental Disabilities and Special Needs.
- Work with the above agencies to develop an assessment of the status of South Carolina's seniors and develop a coordinated plan to meet the needs of seniors and their caregivers.
- Leverage this working relationship to maximize the availability of services to South Carolina's seniors and their caregivers through cost effective service delivery and advocacy for resources on the state and federal levels.

2. Issue: Meaningful Senior Centers; Senior Centers as the Town Square

South Carolina, like the nation is facing the task of modernizing its senior centers to make them more relevant to today's mature adults and senior needs. Many senior centers are little more than group dining sites that have minimal or no programming or other offerings that would make today's seniors want to use them and participate in their activities. The Lieutenant Governor's Office on Aging needs to focus on South Carolina senior centers and the current aging network practices and operation in the state in order to achieve our ideal center: that of a well rounded and resourceful facility that attracts mature adults. Currently there are 149 senior centers and 77 nutrition sites. Changing the image of the traditional senior center and the perception that the community has of the facility is an important aspect to the transition, and acceptance of a "village square" senior center and an aging friendly community is at the forefront of focus. It is widely known that today's seniors and the "Baby Boomers" tend to avoid centers that operate as congregate sites as they are perceived to be for the less fortunate and low income seniors. Today's seniors and "the Boomers" will want activities, choices, and input into the programming and services that interest them and meet their needs.

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

Goals:

1. LGOA serves as the catalyst/guide to modernize senior centers and make them vital resourceful centers and make our senior centers synonymous with the services and programming that mature constituents can benefit from and use.

2. Implement the Vision of the model senior center-Incorporating the National Council on Aging established senior center standards and modeling our senior centers after their best practice facilities will result in accredited and successful senior centers.
3. To have an evolution of change and move our state to be the best in the nation in senior service, programs, and resources.

Outcomes:

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

Strategies:

- Statewide friendly visits are conducted for a "hands-on" assessment of facilities and a "snapshot" of centers' operation in terms of the LGOA vision for the centers.
- Develop a current and accurate database of contact and address information.
- Create state guidelines and an accountability process to assure the practices are being conducted each day in the centers.
- Develop effective partnerships with aging network and local communities. By partnering with Area Agencies, service providers, faith-based communities, and organizations, joint efforts and cooperation will move our states focus to better serving the mature adults and promote new opportunities, ideas and concepts to be implemented.
- The LGOA will provide technical and financial assistance to aging partners.
- The LGOA will build public awareness through marketing of senior center's and programs.
- Best Practices will be recognized and the National Council on Aging accreditation will be encouraged.

3. Issue: Increased Competition, Cost Control and Accountability - As the demographic section of this State Plan illustrates, the in-migration of older adults to South Carolina, the increasing longevity of all individuals over age 60, the

need to provide community based services to older adults will expand exponentially over the next decade. The issue is three part: a) how to assure that there will be enough service providers to handle the increased demand for consumer choice; b) how to control the cost of critical services; and c) how to determine the positive outcome of those service expenditures.

Goals:

- Develop the concept of aging and disability resource centers into effective operating entities in each region in South Carolina.
- Through comprehensive planning and resource coordination at the state level, focus statewide human service agencies to address both the preventive and care-providing services required to control long term care costs.
- Promote reporting client data though the Senior Cube to document specific outcomes of this coordinated effort.
- Generate economic support from both the public and private sector based on documented outcomes.

Outcomes:

- Increase competition and consumer choice in delivery of services to older adults.
- Effective strategies to build working relationships with entities providing goods and services to older consumers.
- Determine the fair market value for services and develop strategies to keep costs within the ranges.
- Provide case management at the regional level.

Strategies:

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

4. Issue: Information Technology During the past decade, technology has become extremely important in providing services to seniors. Two challenges that we have identified are 1) staff has to re-enter the same data multiple times in various databases (duplicate data entry) and 2) the public isn't aware that the e-form technology exists to help them.

4a. Issue: Building Bridges (duplicate data entry) - One of the overriding goals about data entry is that the same information should not have to be entered more than once. In the Aging Network, Information and Referral specialists and other staff (ADRC) are still entering the same client data multiple times in multiple systems. These include OLSA (Tapestry) which is the client tracking/case management system, eforms (AssistGuide), Caregiver, SHIP, AIM and RouteMatch. Ombudsman is unique in the information it collects and in privacy issues and therefore is not a part of the Bridges plan. RouteMatch is a transportation database that Lower Savannah will use as part of the Systems Transformation Grant.

Goals:

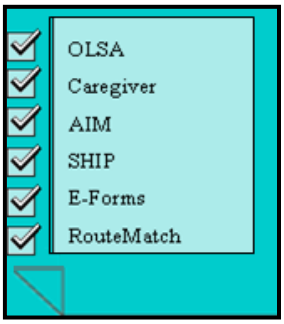
- To have one central point for entry of client data that can them be shared with other applications as needed. For example, everyone will use OLSA as the primary intake tool. If the information needs to be shared with Caregiver and GAPS (South Carolina's pharmacy program for seniors), you would check those boxes and common data fields would be mapped and relevant data shared. There would be a mechanism to check for existing clients so as not to duplicate clients and a mechanism for deciding which client data is the most current.

Outcomes:

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

Strategies:

- Create one central client intake screen
- Establish methodology to verify if the client already exists in one of the systems
- Allow data to be shared in both directions (OLSA to other applications and vice versa)
- Unique data fields will be available on subsequent screens for each program
- Create a checklist of programs with which to share common data



4b. Issue: - E-forms Built on the web-based system *SC Access,* the LGOA added a web-based consumer data collection and electronic forms management process to enable consumers to apply directly for Medicaid long-term care services (waiver and nursing home) and GAPS (SC pharmacy program for low-income seniors). This unique technology enables consumers to enter personal information only once to apply for multiple services (given the eform is available). The system guides the consumer through a series of questions (similar to the way TurboTax operates), gathering needed information. Once completed, the information added by the consumer populates the "official" form. Consumers can store their information and return later and edit forms, or apply for additional services if needed, without entering the same information again. The consumer can save the form to their own computer, send the form electronically (to be followed up with a signature page), or print and mail the application for processing.

There are several issues related to the eforms.

1) Marketing of the eforms has been minimal and therefore usage is low. The more forms processed, the less expensive the processing fee.
2) The signature page required for the eform to be processed is not being sent in for the majority of applications.
3) The grant that currently pays the monthly forms processing fee will end September 30, 2008.
4) More agencies such as DSS, DHHS, etc. should explore the eform technology to make applying for benefits much easier for clients.

Goals:

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

Outcomes:

1) Eforms remain part of SC Access after September 30, 2008.
2) Multiple eforms are available for seniors and adults with disabilities so they can apply for a variety of services and programs without having to duplicate the same information on every application.
3) Electronic signatures or other type signature is accepted by DHHS.

Strategies:

1) Work with DHHS to get them to assume the cost of processing the eforms.
2) Market the eforms to get the numbers up so the cost goes down.
3) Have AssistGuide market the eform technology to other agencies so more forms are added.

4) Work with DHHS to come up with a solution to decrease the number of applicants that never submit a signature page.

5. Issue: Expand and modernize nutrition services In recent years, nutrition group dining sites and senior centers have experienced a diminishing number of participants at the same time that food and gas prices have risen. Many states are looking at new ways to attract younger seniors to their facilities by providing more consumer choice and additional activities to keep seniors healthier longer.

Goals:

- In an effort to modernize the AoA nutrition program and revitalize senior centers, the LGOA has established the following two committees:

1. *The Nutrition Dream Team* will investigate ways to update nutrition sites, offer better meals at lower prices and attract a larger number of seniors to their facilities. The team is comprised of six AAA directors, three LGOA staff and a nutrition program/senior center consumer.

Outcomes:

1) Increased attendance at meal sites and senior centers
2) More evidence-based activities are available for adults at senior centers
3) Senior Center directors are more adept at marketing and outreach strategies
4) More competition in the procurement of meals from vendors
5) Consumers are more involved in the nutrition program/senior center planning process.

Strategies:

1) The Team will develop at least four meal voucher programs at restaurants, schools or hospitals.
2) Develop an incentive program to councils on aging for participation in the NCOA Senior Center Accreditation Program
3) Provide marketing training to council on aging directors and key staff
4) Solicit meal vendors from other states to increase competition among meal vendors
5) Explore a state level meal contract
6) Analyze the cost of frozen meals versus hot meals, including total unit cost
7) Reward organizations that actively recruit seniors as evidenced by re-vitalization of senior centers and meal sites.
8) Hold focus groups of consumers in at least four regions of the state.

3. The Systems Change Task Force *is* comprised of four AAA Directors, two Council of Government Directors and LGOA staff. The Task Force will develop pilot programs in four regions of the state to explore macro-system-development changes that will provide a platform of best practices for the rest of the state. Issues to be addressed include, but are not limited to, the need for a case management system and/or more in depth assessments than in the current system of service delivery, and vendor competition. Consumer choice will drive the delivery system by allowing seniors to determine the services they need and options on where they will receive the service, if possible.

Outcomes:

- A more comprehensive service delivery system that is consumer driven
- Cost containment due to increased competition
- Statewide improvement in service delivery

Strategies:

- Choose four regions of the state to test pilot programs
- Determine specific macro-system development changes to test
- Implement pilot programs
- Evaluate effectiveness of pilots
- Implement findings statewide

6. Issue: Energizing The Alzheimer's Resource Coordination Center. In 1994 legislation was enacted (SC Code of Laws 44-36-310) creating the Alzheimer's Resource Coordination Center (ARCC). The ARCC receives $150,000 annually through state appropriations for its activities. These funds also serve as matching funds for the Family Caregiver Support Program. The ARCC was tasked to provide specific services as outlined in the following goals. According to the *2008 Alzheimer's Disease Facts and Figures,* published by the Alzheimer's Association, in 2000 South Carolina had 67,000 people with Alzheimer's Disease or Related Disorders (ADRD). This number is projected to reach 80,000 by 2010. Additionally, the report indicates more than 159,000 caregivers are providing assistance to family or friends with ADRD. This represents more than 137 million hours of unpaid care per year, with an economic value of more than $1.4 billion. These statistics indicate the need for outreach, education, and collaboration between the public and private sectors to provide comprehensive services and resources to those directly impacted by ADRD.

Goals: The primary goals for the ARCC are to provide:

- statewide coordination
- service system development

- information and referral
- caregiver support services to individuals with ADRD, their families and caregivers
- continuing oversight of a grant program to assist communities and other entities in addressing problems relative to ADRD through education and respite programs

Outcomes:

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

Strategies:

1. The ARCC will work to expand the scope and mission as written in legislation
2. Continue to provide seed grants for education and/or respite programs, targeting underserved communities
3. Collaboration with the SC Alzheimer's Association on a state plan to assess current levels of activities and develop future strategies based on a global perspective of stakeholders
4. Collaboration with the Family Caregiver Support Program to obtain a comprehensive view of the need for assistance for caregivers specifically dealing with Alzheimer's disease
5. Collaboration with Aging and Disability Resource Centers (ADRC's) to coordinate centralized service delivery for persons with Alzheimer's disease and their caregivers

7. Issue: Building Partnerships with the Faith-Based Community To Serve Seniors - Since the beginning of 2007 the Lieutenant Governor's Office on Aging has refocused its efforts to reach out to the churches and the faith-based community to help provide services to seniors. During the initial phases of the Bush Administration there were a number of efforts to involve the faith-based community in the provision of social services. Success has been limited due to the fact that churches historically tend to focus on serving their own and many do not want governmental control over their activities and many small churches don't have the infrastructure, expertise or finances to utilize government funds effectively. The Lieutenant Governor's Office on Aging has begun to develop a number of efforts to expand its faith-based initiative in the future. These are as follows:

- Developed a fact list of the major denominations in order to bring them together to establish a means to serve South Carolina's senior population.
- The USC College of Social Work received a grant from the John A. Hartford Foundation to fund a project entitled "Geriatrics and Congregational Social Work". USC will use Master's level social work students to work in churches to develop meaningful programs for seniors. The Lieutenant Governor's Office on Aging will work with the College of Social Work in this effort.
- The Lieutenant Governor's Office on Aging received a grant in September, 2007 from the Administration on Aging to manage an Alzheimer's Disease Demonstration Grants to States Project (ADDGS). The ADDGS grant's goals are to improve access to home and community-based services for individuals with Alzheimer's disease and related disorders (ADRD) by targeting underserved minority and rural populations in the three-county area of Charleston, Berkeley, and Dorchester; and to expand consumer choice and consumer-directed long term care support for caregivers through the Aging and Disability Resource Center (ADRC), the Family Caregiver Support Program (FCSP), and the SC Alzheimer's Association (SCAA) to effect systems change. This effort will work with the AME churches in the Charleston area in order to enhance the success of the project to achieve greater success with minority and rural individuals and families. Additional funding will be necessary for this effort to continue past June, 2008.
- The Lieutenant Governor's Office on Aging has used supplemental state funds to provide services to seniors in rural areas with the assistance of churches in several regions of the state.
- The Lieutenant Governor's Office on Aging has worked with many churches through its evidence-based prevention and wellness programs "A Matter of Balance" and Living Well".

Goals:

- Establish an on-going working partnership with the state's various religious denominations to leverage the faith-based communities' infrastructure to serve seniors throughout South Carolina.
- Encourage the state's churches to be cost effective local service providers through competitive procurement.
- Expand Lieutenant Governor's Office on Aging efforts through churches to provide information, education and services throughout the state.

Outcomes:

- Churches from many religious denominations will have an on-going partnership with the Lieutenant Governor's Office on Aging to provide information, education and services to seniors throughout South Carolina.

- Seniors will have expanded options for services, education and assistance from their local community and organizations with which they have considerable trust.
- The Lieutenant Governor's Office on Aging will have additional new partners to assist it in carrying out its mission of serving seniors throughout South Carolina.

Strategies:

- Continue to develop a partnership with the major denominations and very large churches to establish a statewide database of the services provided to seniors and that may be available to other members of the community.
- Continue use of available state and federal funds for home and community-based services to have competitive procurement of services and to expand outreach to all parts of the state to serve seniors at a cost efficient rate.
- Build awareness of the knowledge, and services provided by the state's aging network.

C. Long Term Care Reform and Community Living Incentive Issues, Outcomes and Strategies

1. **Issue: Reform Medicaid/Medicare and provide choice and personal incentives-** South Carolina, like the nation, has recognized that with the passage of the reauthorized Older Americans Act, as amended 2006, the Medicare Modernization Act (2005), the Deficit Reduction Act, Choices for Independence and the New Freedom Initiative, the nation is moving toward a serious recognition that the nation will not have adequate resources to pay for the massive growth of the senior population over the next thirty years. SC likewise must craft a series of policies, initiatives, programs and services that move our service delivery system to one of providing choice, necessary information, guidance, prevention and wellness programs and incentives to help seniors remain independent as long as possible. With this also comes the recognition on the part of government that families and individuals must take personal responsibility for planning for their retirement and golden years. South Carolina must work with the federal and state government bodies to use the Medicaid and Medicare programs in the most efficient manner possible within the state environment. South Carolina must also advocate to the federal government through Centers for Medicare and Medicaid Services and the Administration on Aging on policies and initiatives that will work in South Carolina and benefit South Carolina's seniors and caregivers.

Goals:

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

Outcomes:

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

Strategies:

- The LGOA will work with other state health and human services agencies to implement the Long Term Care Partnership
- Work with the Governor and the General Assembly to provide tax incentive programs for purchasing long term care insurance.
- Work with the Governor and the General Assembly to enact tax incentives for Family Caregivers
- Work with other state and federal agencies and policymakers to provide payments to caregivers
- Work with South Carolina's citizens to educate them on incentives, options for community living and reverse mortgages.
- Expand the Systems Transformation Grant statewide
- Expand the Money Follows the Person Demonstration program to both aging related services and Medicaid where practical.

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

The Long Term Care Partnership Program was initiated in 1987 by the Robert Wood Johnson Foundation to encourage the purchase of private long term care insurance. California, Connecticut, Indiana, and New York implemented Long Term Care Partnership programs in the early 1990s and still operate programs. Individuals who purchase a private long term care insurance policy and use up its benefit, can then apply for Medicaid. If these individuals meet Medicaid income and level of care requirements, they can receive Medicaid-covered long term

care services while protecting some or all of their financial assets that would otherwise make them ineligible under Medicaid's mean testing requirements. The amount of protected assets equals the amount that the private long term care insurance policy paid out.

Under the Deficit Reduction Act (DRA) of 2005, states are allowed the option of enacting partnership policies without conducting estate recovery of Partnership-protected assets. The DRA, however, does not allow individuals with home equity exceeding $500,000 (or up to $750,000 at state option) to be eligible for Medicaid services, even if they have Partnership policies. New Partnership programs must meet specified criteria, including federal tax-qualification, identified consumer protections, and inflation protection provisions.

Since passage of the Deficit Reduction Act, at least 21 additional states have enacted authorizing legislation and/or submitted State Plan Amendments to the Centers for Medicare and Medicaid Services for approval. Work is currently underway by the Department of Health and Human Services and the Department of Insurance to develop and implement a program in South Carolina.

Consumer education is critical should SC implement a Long Term Care Partnership program. The addition of a partnership option will add a layer of complexity to an already difficult process of deciding whether to buy long term care insurance and, if so, which policy to purchase. Education, awareness, and understanding of long-term care needs and the potential role for private long-term care insurance are currently very limited and need to be expanded. The Lieutenant Governor's Office on Aging developed two curricula for long term care planning in 2007 through an ADRC Expansion Grant. One training program is designed for seniors and the other is designed for seniors with an adult child with a disability. A total of twenty trainings are planned to be provided by the end of June 2008. See Section A Implementation of Choices of Independence for further discussion.

A tax policy at the federal and state level that provides incentives for private long term-term insurance is one way to ease that pressure and increase the availability of long-term care coverage to those who need it. Cost is the primary impediment to both long term care insurance purchases and long term care insurance tax incentives. According to the Kaiser Family Foundation, twenty-six states and the District of Columbia offered state tax incentives for the purchase of long term care insurance in 2006. However, South Carolina currently does not. Of those states offering a tax incentive in 2006, 17 offer tax deductions, 8 offer tax credits, and 2 states offer both tax deductions and tax credits.

Tax incentives make the insurance more affordable, as well as lead to publicity and education, making the public more aware of the option of pre-funding their long term care risk. New state tax incentives would reduce the effective cost to the consumer of long term care insurance policies, making it more likely that such policies would be purchased. In turn, the long term costs of a larger portion of seniors in the state would be pre-funded and the rate of growth of future Medicaid long term care expenditures would be lowered.

Goals:

1. Support the state's efforts to develop, implement, and market a Long Term Care Partnership Program in South Carolina.
2. Encourage the development of reciprocal agreements with other states that have Long Term Care Partnership programs.
3. Continue to provide consumers training regarding long term care planning and information about the Long Term Care Partnership program.
4. Support passage of state legislation that would provide a tax incentive to those individuals purchasing long term care insurance.

Outcomes:

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

Strategies:

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

3. Issue: Systems Transformation Grant The Lt. Governor's Office on Aging represents one of the first ten states to receive a Systems Transformation Grant from the Centers for Medicare and Medicaid (CMS) for the five year period October 1, 2005 through September 30, 2010. This $2.97 million Systems Transformation grant provides the opportunity to continue reforms begun with earlier Real Choice Systems Change grants and the Aging and Disabilities Resource Center (ADRC) grant. The major grant partners include:

- South Carolina Department of Health and Human Services (DHHS)
- Three of the state's Regional Area Agencies on Aging (Lower Savannah in Aiken, Santee-Lynches located in Sumter, and Appalachia in Greenville)
- The University of South Carolina Center for Health Services and Policy Research

An advisory committee and five work groups (Developmental Disabilities, Transportation, Information Technology, Waiting Lists, and Evaluation) are providing input and oversight to the implementation of the project.

A strategic plan, developed with the assistance of the state and local agencies involved in the project and stakeholders from the senior and disability communities, was approved July 1, 2006 by CMS. The strategic plan for the grant includes the following mission statement, vision, and major goals and activities:

Mission statement:

We are a statewide partnership dedicated to helping older adults and adults with physical and/or developmental disabilities get reliable, comprehensive information and assistance to make informed choices about services.

We will –

- Inform consumers about available service options.
- Target community resources to those in greatest need of support.
- Demonstrate national leadership in how to use technology to link consumers to transportation and other services.

Vision:

We strive to create a long term care system that will result in "a community where informed older adults and adults with physical and/or developmental disabilities are linked to services they choose."

The broader vision for systems transformation in our state is a system that empowers and supports older adults and persons with disabilities living in the community through streamlined access to services and increased consumer choice. It is our intent to expand successful new system demonstration projects and models to serve the entire state as additional resources are identified and obtained.

Transportation as a Component of Access

South Carolina's Systems Transformation Grant was the only one of the ten grants awarded, which elected to address transportation as a major component of access. The portion of this five-year grant dedicated to work in the Lower Savannah Region is to help expand the Lower Savannah Aging and Disability Resource Center to include a broader target group of adults with disabilities and to help the Lower Savannah Council of Governments develop and add a mobility information, assistance and management center. This center will provide unique opportunities for local citizens and transportation providers in the six county Lower Savannah region, as well as serve as a model for both our nation and other AAA/ADRCs in our state. It will also serve the dual purposes of giving information and assistance to consumers, linking them to transportation resources, and to function as a centralized coordination center for the region, thus helping providers of transportation to operate more efficiently and enhance

their services to meet more un-met needs of consumers. Plans included using technology and building on the ADRC's infrastructure for providing information, referral and assistance to consumers. However, because funding in the Systems Transformation Grant is not adequate to provide the technology really needed to make the "transformation", Lower Savannah Council of Governments sought funding from the Federal Transit Administration's United We Ride and the US Department Of Transportation's Mobility Services for All Americans grants. The United We Ride grant, which concluded in June 2007, helped the Lower Savannah COG to employ some additional, needed consultant expertise to address roles and responsibilities of the center, as well as study best practices of human service coordination around the country, to prepare a plan for providing more coordinated transportation response to a disaster or emergency situation, and produce some base-line evaluation data that will be useful and helpful in the Travel Management Coordination Center design process and in evaluation of the center's effectiveness.

In 2006, LSCOG and its design team from the Systems Transformation and United We Ride grants decided to take the step of applying for the Mobility Services for All Americans (MSAA) grant, which addressed the same vision for the "mobility information, assistance and management center" as the Systems Transformation and United We Ride grants and would help provide opportunities for acquiring much-needed expertise in the technology aspects of center design and implementation.

LSCOG was selected as one of eight national grantees and now has the resources needed to develop a successful replicable and scalable model center for the region. Because the challenges of identifying and interfacing technology that will work in their rural setting, within budgets and within skill levels of local provider staff are significant, the MSAA planning project is helping to enlist the expertise from consultants who possess the knowledge and experience to help develop the needed solutions.

LSCOG's plan is to integrate the Travel Management Coordination Center with the Aging and Disability Resource Center, building on the work the agency has been doing in human services information, referral and assistance and their work in transportation coordination and development for the past six years.

Operations of the TMCC and increased coordination among providers of transportation services in the region will help address the following shortcomings:

- Lack of consumer knowledge of transportation resources and how to access them
- Unmet transportation (i.e. need to go to destinations other than service agency or medical)
- Limited areas of service, especially in rural parts
- Limited hours of service, especially for nights and weekends and for jobs
- Limited service for some trip purposes or target groups

- Trips are sometimes denied by shared seat providers if there is not a Medicaid trip to "piggy back" on
- Inefficiencies in coordination of trips throughout the region
- Need more coordination across county lines and for out of county trips
- New Medicaid brokerage system is reducing options for shared seat transportation
- Less than optimal automation of data, ridership, scheduling and reporting
- Need one-call information on transportation and regional mobility center
- Need door to door and door-through-door, as well as escorted transportation
- Could use more volunteer drivers if insurance were not a problem
- Park and ride and van pooling could help in some areas of the region
- Lack of scalable technology infrastructure

The major goal of the TMCC is to establish a regional mobility and information center that will handle incoming calls for service from consumers and agencies needing human services information or referral, and regional transportation. The TMCC will have visibility and access to all transportation resources available for the benefit of referring, scheduling and assigning consumers to transportation providers at the time and date of service requested. The TMCC will operate on a 24 hour, 7 day a week basis providing after-hours support and operational availability to the stakeholders in the region.

The TMCC is being designed to provide the following unique features:

- The center will provide consumer-focused information and assistance available to customers as both a telephone number and a website. Center staff will advocate, when necessary, for people to get rides for which they are eligible and negotiate with transportation providers to develop solutions where transportation needs remain unmet. Consumers will also be able to take advantage of human service information, referral and assistance from the same center that addresses their transportation needs.
- Consumers will be able to access web-based transportation information from *SC Access*.
- The center will serve as the coordination center for participating local public, private and human service transportation providers and purchasers of transportation.
- The center will work with local transit providers to coordinate service among funding sources, systems, and geographic boundaries thus offering more transportation service options using existing resources. The center will also work to help local providers acquire equipment needed to

participate fully in the coordination process among providers and with the TMCC.

- The target dates for the TMCC are as follows:
    1. Planning work concluded Summer 2008
    2. Incremental mobility center implementation is on-going
    3. Capital funds grant request Fall 2008
    4. Full Implementation early 2009
    5. Impact evaluation continues through 2010

Systems Transformation Goals:

1. Improve Access to Long-Term Support Services.
2. Transform Information Technology to Support Systems Change.
3. Create a System That More Effectively Manages the Funding for Long-Term Supports that Promote Community Living Options.

Outcomes:

1. Increased knowledge of: long-term care resources and service options; developmental/physical disability resources and service options; and, transportation resources and mobility options.
2. Increased access to user-friendly information on: long-term care resources and service options; developmental/physical disability resources and service options; transportation resources and mobility options; personal care workers through “Learn About”; and other “Learn About” topics as appropriate.
3. Increased mutual understanding among key partner agencies about each other’s eligibility, application and referral requirements and procedures.
4. Improved capacity and efficiency to provide information and assistance on: long-term care resources and service options; developmental/physical disability resources and service options; and transportation resources and mobility options, as well as making referrals to partner agencies.
5. Greater collaboration and ownership of the ADRC.
6. Improved utilization of transportation resources and mobility options.
7. Increased visibility of the: ADRC, including LTC and developmental/ physical disability service options; and mobility, information assistance and management center.
8. Reduced consumer frustration and burden in applying for Medicaid and other services as related to: long-term care resources and service options; developmental/physical disability resources and service options; transportation resources and mobility options.

9. Increased consumer and provider use of the Medicaid e-form and other forms as they become available in electronic format.
10. Increased capacity to integrate and increased integration of disparate data systems that manage eligibility processes.
11. Delayed entry into the LTC system, decreased utilization of acute/ER/in-patient services, and reduced nursing home admission rates.
12. Easier, faster, ADA compliant, and more user-friendly system of requests for transportation services for seniors and people with disabilities and application process to receive long-term care services.
13. Increase the level of consumer satisfaction related to the availability and accessibility of transportation services for seniors and people with disabilities.
14. More efficient and coordinated process for taking and matching consumer requests for: long-term care service options; and developmental/physical disability resources and service options, as well as managing and operating transportation and mobility service options.
15. More collaborative and streamlined service delivery system through: simplified and expedited application process for Medicaid eligibility and/or other services; simplified and expedited referral process to determine eligibility for Medicaid and/or other services; and, mobility information assistance and management center.
16. Successful adoption of the prioritization methodology through: consistent use; and, belief in its effectiveness.
17. More appropriate placement of individuals at risk of institutionalization who are eligible for and awaiting CLTC services.
18. A prioritization methodology that has been piloted and can be replicated statewide.
19. A mobility information, assistance and management center model that has been piloted and can be replicated elsewhere.

Strategies:

- Expansion of the existing Lower Savannah ADRC to serve adults with developmental disabilities, and four additional counties in the pilot area; as well as linking consumers with transportation needed to access long-term supports
- Expansion of the scope of activities to develop additional linkages with other agencies to use electronic systems to simplify application processes, reduce duplicative intake, and design and implement protocols for providing short-term interim assistance to seniors and adults with physical disabilities who are identified as being at high risk of institutionalization or re-hospitalization and are awaiting Medicaid's CLTC services.

- Expansion of the web-based directory of local long term care services, SC Access, and its Learn About Topics for the expanded target population and services
- Applying lessons learned from the implementation of the current ADRC to establish new ADRCs in Santee-Lynches and Appalachia regions
- Development of the technology needed to support consumer-oriented transportation access and to reduce duplicative application processes
- Development and implementation of a methodology for prioritization of individuals interested in receiving services from CLTC's home and community based waiver for seniors and adults with physical disabilities to promote more efficient utilization of Medicaid funding
- Development of a model one-stop/call mobility information, assistance, and management center in the Lower Savannah region to enhance consumers' access to community services and resources by better meeting their transportation needs.

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

Tax Incentives for Long Term Care

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

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

Many policy leaders argue that the cost savings to the government with a tax incentive program would be significant. The American Health Care Association calculates that, if the majority of persons over the age of 55 were covered with

private long term care insurance, the percentage of persons paid for nationally by Medicaid in nursing homes would fall from the current 67 percent to 25 percent within 25 years.

Numerous national policy organizations already are providing research and data on tax incentives so much of the research is in place. The Office on Aging will need to analyze the data and to make decisions that are in the best interests of South Carolina's senior citizens.

Goal:

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

Outcomes:

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

Strategies:

- Continue working with the Lt. Governor's Senior Estate Planning Roundtable to ensure that Office on Aging staff is well educated on the latest trends in long term care insurance
- Continue establishing a meaningful relationship with members of the General Assembly who are interested in senior financial issues so that legislators can make decisions for the future on long term care insurance tax incentives
- Continue to work with the public to educate them on the need for and best forms of long term care insurance to meet their individual and family's needs

Tax Incentives for Caregivers

As South Carolina's population ages, consideration must be given to providing tax incentives for caregivers. As healthcare and long term care costs skyrocket a large number of senior citizens will be unable to afford institutional care resulting in seniors remaining at home longer. The seniors who remain home will need caregivers, but many caregivers will not be able to afford retiring early or taking a less responsible job in order to serve as a caregiver. Family caregivers are a key

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

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

The Lt. Governor's Office on Aging plans to address tax incentives by following major trends in other states, working with the General Assembly, healthcare experts and national experts from credible public policy organizations. It will be the goal of the State Office to research the tax incentive plans already enacted in other states and to reach out to the lead tax policy experts, health care leaders and senior advocates in order to develop a tax incentive plan that serves South Carolina senior citizens and adequately funds care giving.

Goal:

- To enact meaningful policy so that South Carolina becomes an innovative leader in tax incentives for caregiving – while protecting and serving the needs of the state's senior population.
- Provide tax incentives to caregivers to enable them to help their loved ones remain at home and also to provide some tangible recognition of their efforts.
- **Outcomes:**
- By providing tax incentives, many South Carolina seniors would be able to continue to "Age in Place" with the grace and dignity they deserve.
- Caregivers would be able to continue in their role of helping their loved ones and not suffer the potential consequences of lost income and retirement benefits.
- Caregivers may be more able to purchase health insurance due to tax incentives being available.

Strategies:

- Continue establishing a meaningful relationship with members of the General Assembly who are interested in senior financial issues so that legislators can make decisions for the future on assisting caregivers through tax incentives.
- Continue to work with the public to educate them on caregiving and benefits available and services to meet their individual and family's needs.
- Work with the members of the General Assembly to provide tax incentives to caregivers in the future.

5. Issue: Payments for Family Caregivers Family caregivers keep families together, often preventing or delaying institutionalization.

The critical role of families, especially women, in providing care to elderly relatives (as well as relatives with disabilities) is well established. The challenges of family care are an increasing reality of daily life for America's families. In 2007, an estimated 560,000 informal caregivers provided 610 million hours of care in South Carolina at an estimated value of $5.5 billion dollars. Most seniors with long term care needs (65%) rely exclusively on family and friends to provide assistance. Another 30% supplement family care with assistance from paid providers. Care provided by family and friends can determine whether seniors can remain at home.

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

In recent years, changes in our health care delivery system—including shorter hospital stays—have transferred cost and responsibility for ongoing care onto families. As more and more long-term care is provided through home and community-based service programs rather than institutions, reliance on family and informal caregivers grows. Health care worker shortages, a highly fragmented and confusing array of programs, and soaring health and long-term care costs all limit families' access to helpful formal services such as in-home care or adult day services. In addition, we can expect the psychological and other costs of caregiving to rise as everyday care continues to shift to families.

Caregiving has short and long term financial consequences.

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

Payments to caregivers

This issue is especially important to consider for people who are most vulnerable to becoming impoverished in their later years – low-wage, minority women. These individuals are most likely to limit or forego employment for caregiving demands as their "opportunity costs" (i.e., lost or lowered salary) will be less than the costs for higher-wage workers. Thus, an opportunity to be paid for some of their caregiving labor (the same wage level as unrelated workers) could allow these women to provide needed care for a relative while addressing their current and future financial needs.

Paying family caregivers will attract some relatives who are outside the workforce, not currently assisting their needy family, and draw them into regular paid employment. For those family members who are employed, paying them for their personal assistance work will make it easier for them to make a commitment to that work, decrease the financial penalty associated with it, and legitimize their work at a modest public cost.

Providing payments to family caregivers (even excluding legally responsible relatives such as a spouse or parent of a minor child) continues to cause on-going controversy regarding quality, training and the ethics of paying for a service previously performed at no program cost. There is a growing body of research that supports the role of family caregivers in consumer-directed services, both as surrogate decision-makers for older relatives and as paid caregivers.

Medicaid waiver programs

Medicaid, mainly through its waiver programs, supplies the majority of public funding for home and community-based care. Medicaid has an enormous impact on our state's budget, with substantial implications for our state's policy overall and for our state's policy concerning family caregivers in particular. Although Medicaid services focus directly on the beneficiary, they indirectly sustain families in their caregiving role. Support of caregiving families will be crucial in assisting frail seniors and persons with disabilities to remain in or transition back to the community. Caregiver support can reduce the strain on Medicaid and other state-funded programs by keeping individuals in the home or community longer.

National Medicaid policyMedicaid allows states to provide respite care, training and family counseling through 1915(c) home and community based waivers. They may also pay legally responsible relatives to provide care that is "extraordinary". The services provided by the caregiver need to be necessary in order to prevent the beneficiary from being institutionalized. In addition, the relatives or friends must meet the qualifications for providers of care, and other criteria must be met.

SC Medicaid currently allows family caregivers (who are not legally responsible) to be paid for some home and community-based services.

The ability to hire whomever one wants, including a relative, to provide services empowers consumers by maximizing choice and contributing to their greater satisfaction of services. Through funding obtained through the Real Choice Systems Change grant received in 2002, South Carolina developed and implemented a consumer-directed long-term care waiver in six counties. *SC Choice*, the first Elderly/Disabled Medicaid Waiver of this kind under the President's new Independence Plus initiative, was approved by the Centers for Medicare and Medicaid Services on March 11, 2003. Participants in SC Choice were allowed to direct their own care,

manage their budget dollars, and serve as the employer of record for the personal care workers they selected to provide their care. Participants were allowed to hire family members who were not legally responsible to provide care. Prior to the implementation of SC Choice, SC DHHS did not allow payment for waiver services to legally responsible relatives, as well as members of the recipient's household who were related by blood or marriage unless there was supporting documentation that no other provider was available.

In an effort to foster more consumer direction and based on the experience from SC Choice, SCDHHS in 2004 amended its family caregiver policy for home and community based waivers, the Palmetto Senior Care Program, and children's personal care and nursing services; to allow family caregivers, who are not legally responsible, to be paid for providing personal care, attendant care, adult day health care, and nursing services. Family members, who are not the primary caregivers may be reimbursed for respite and companion services.

Based on the findings of SC Choice that consumers experienced greater satisfaction and actually spent less money when they had more control, SCDHHS merged SC Choice with its Elderly/Disabled waiver in July 2006 to create a new waiver, Community Choices. This new consumer-directed waiver allows participants four levels of consumer direction, as well as the option of selecting and paying family caregivers, who are not legally responsible to provide the services listed above.

SC and other states have found that implementing consumer-directed services can significantly expand the potential pool of workers by adding workers who, though willing to work for a relative or friend, would not join the staff of a provider agency. This has been particularly true for consumers living in rural areas who find it difficult to access traditional agency based workers. Those consumers who hire family and friends are highly satisfied and are less likely to be subjected to fraud or abuse. Allowing greater flexibility has also resulted in greater access to care, particularly in rural areas.

Medicaid Deficit Reduction Act changes impact family caregivers

On February 8, 2006, the Deficit Reduction Act (DRA) of 2005 was enacted into law (Public Law 109-171). Section 6087 of the DRA amended section 1915 of the Social Security Act to add new subsection (j). Section 1915(j) allows a State to furnish self-directed personal assistance services as a State Plan option. Section 6086 of the DRA amended section 1915 of the Act to add a new subsection (i). Section 1915 (i) allows States to provide home and community based services, as defined in Section 1915 (c) (4) (b) of the Act, under Medicaid State Plans. States may elect to offer individuals receiving services through 1915(i) the option to direct some or all of their services under that authority.

Section 1915 (i) of the Deficit Reduction Act (DRA) of 2005 enables States to provide home and community-based services as a State plan option. Under this option, States may provide some of the same services to caregivers that are available under 1915(c) waivers (see above).

Section 1915 (j) of the DRA enables States to offer a self-directed service delivery model for personal assistance services (i.e., cash and counseling programs) as a State plan option. These programs enable beneficiaries to pay legally liable relatives (parent,

spouses, and others) directly for personal assistance services identified in the service plan and budget.

South Carolina has not yet amended its Medicaid waiver family caregiver policy to allow legally responsible family members to be paid, even to provide "extraordinary" care, nor does it include personal assistance as a State plan option. While it is clear that our State cannot afford to compensate caregivers for all the informal support they provide in the community, meeting the needs of caregivers will facilitate their continued involvement in the caregiving relationship.

Goal:

- Compensate family caregivers, who are legally responsible, for "extraordinary care" as a way of recognizing and supporting them in their role.

Outcomes:

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

Strategies:

- Encourage SCDHHS to amend the state's waiver family caregiver policy to allow legally responsible family members to be paid for providing "extraordinary" care.
- Encourage SCDHHS to offer self-directed personal assistance as a State plan option under Section 1915 (j) of the Deficit Reduction Act.
- Work with advocacy groups for passage of these proposed amendments.

6. Issue: Reverse Mortgages In recent years, as the state's population has aged, the Lt. Governor's Office on Aging has closely followed the increasing popularity of Reverse Mortgages. As the popularity of Reverse Mortgages has grown, the opportunity for the industry to exploit, scam or target the senior community has grown immensely.

The Office on Aging believes that Reverse Mortgages can be an excellent tool which allows senior citizens to "age-in-place" at the family home they love so much. Nationally there were 107,558 federal government insured reverse mortgages, which was a 41 percent increase from fiscal year 2006. In South Carolina the number of reverse mortgages has increased sharply over the past six years, driven by a greater acceptance of this type of financing, an aging population and a phenomenon called the "sandwich generation." Many of the seniors who utilize the Reverse Mortgage concept benefit from having money in the bank and the security of knowing they can live comfortably without incurring debt. It provides seniors a safety net by utilizing their own hard earned equity.

Reverse Mortgages are currently addressed in the State Code under Chapter Four, Section 29-4-10. The State Code provides detailed rules on governing reverse

mortgage loans. However, the Office on Aging will work in the future to ensure that the public continues to be educated so that seniors can make decisions on what is in the best interests of their future and their family's futures. If necessary, the Office on Aging will work with the General Assembly to amend the State Code in order to better serve and protect seniors.

In 2007, the Office on Aging created the Lt. Governor's Senior Estate Planning Roundtable that meets often throughout the year. The roundtable is made up of members of the financial community and those who have an active interest in senior legal and insurance issues. The intent of the roundtable is to ensure that South Carolina's senior citizens are well informed and protected against unscrupulous loan and financial planners who prey upon vulnerable senior citizens.

Goal:

- The ultimate goal of the Office on Aging is to have the best Reverse Mortgage laws and regulations in the nation.
- It is our intent to keep the Reverse Mortgage industry on the cutting edge of industry trends nationally.

Outcomes:

- South Carolina's seniors will be protected
- South Carolina's seniors will have the tools to do what is in their best interest financially.

Strategies:

- The Office on Aging will follow national trends to ensure that South Carolina's senior citizens are not targeted by the Reverse Mortgage industry.
- Continue working with the Lt. Governor's Senior Estate Planning Roundtable to ensure that Office on Aging staff is well educated on the latest trends in the Reverse Mortgage industry.
- Continue establishing a meaningful relationship with members of the General Assembly who are interested in senior financial issues so that legislators have the tools necessary to successfully protect senior citizens who utilize the Reverse Mortgage option.

D. Senior Transportation

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

Transportation is critical for seniors and persons with disabilities, as well as low to moderate income members of South Carolina's population to maintain their independence and remain at home. South Carolina like many other states lacks a coordinated and affordable transportation system that currently meets the needs of its population. This system will be significantly lacking in the future as South Carolina

ages. There is a mix of transportation systems in South Carolina: large urban areas have public bus systems that are significantly under-funded and under-utilized. Each region of the state has RTA's (Regional Transportation Authorities) and over 60 separately funded systems that are program related. Many of them act as silos and are not coordinated with one another to take advantage of cost efficiencies and economy of scale. The two major transportation systems that serve the state's seniors and persons with disabilities are the Older Americans Act funded transportation services provided by the state's local contract providers and the state's new Medicaid brokerage system. During FY 2006-2007, 4,812 seniors in South Carolina received transportation services. This involved 1,800,858 trips for 10,805,148 miles. The cost of this service was $2,467,418 in Title III funds and a total expenditure of $6,881,960 from all sources. These transportation services primarily provide trips to group dining sites with some other services for shopping and medical facilities. As South Carolina ages, many seniors will not be able to drive and will require transportation to remain independent. Many will be able to pay for this service. South Carolina currently provides $5,864,000 in state funds for public transportation (FY 2004) as compared with other southeastern states such as North Carolina($154,680,000), Virginia ($140,100,000) and Tennessee ($38,532,000).

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

Coordination with the SC Department of Transportation

The Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU) created a requirement that a locally-developed, coordinated public transit/human service planning process and an initial plan be developed for South Carolina by 2007 as a condition of receiving funding for certain programs directed at meeting the needs of older individuals, persons with disabilities and low-income persons. Plans had to be developed through a process that included representatives of public, private, and non-profit transportation and human service providers, as well as the general public. Complete plans, including coordination with the full range of existing human service transportation providers, were required to be completed by federal Fiscal Year (FY) 2008.

The South Carolina Department of Transportation (SCDOT), through the consulting team of TranSystems/URS and in partnership with Councils of Governments (COGs) and interested stakeholders, developed regional coordinated plans that met the requirements of SAFETEA-LU and the Federal Coordinating Council on Access and Mobility (CCAM). While at a minimum projects funded under the Federal Transit Administration (FTA) formula programs for Sections 5310, 5316 and 5317 must be derived from a coordinated plan, the coordinated plans incorporate activities offered under other programs sponsored by federal, state and local agencies. The federal coordination initiative, called United We Ride, identified over 60 federal programs in addition to those sponsored by the FTA which included Temporary Assistance for Needy Families (TANF), Workforce Investment Act (WIA), Vocational Rehabilitation,

Medicaid, Community Action (CAP), Independent Living Centers, and Administration on Aging (AoA) programs among others.

SCDOT attempted to facilitate this by developing a plan in each region of the state and inviting all of the agencies that meet the letter and intent of this policy to the table and encouraging their participation throughout the plan development process.

Development and content of coordinated plans were designed to be specific to the needs and issues of each region. The coordinated plans address intra- and inter-regional needs and issues, and in a manner that allows the Council of Governments (COGs) to directly update the regional coordinated plan. Further, the coordinated plans have been developed in a manner that allows the COGs to adapt and expand the plans to incorporate programs and initiatives specific to their region.

SAFETEA-LU allowed two significant changes to the standard procedures defined by previous legislation. Under the new regulations, project proponents were allowed to use dollars from other federal programs as match to FTA funds and expenses related to mobility management can be considered a capital expense. These are two significant changes that allow greater flexibility for budgeting and financing human service transportation.

This statewide effort involved 20 focus groups with 207 participants and a statewide survey of 2,074 individuals. The surveys were designed specifically to obtain general public perceptions and views on transit. Community leaders saw the following destinations that needed to be served:

- Employment centers / business districts
- Hospitals / medical facilities
- Shopping areas

Residents saw the following destinations that needed to be served:

- Hospitals / medical facilities
- Employment centers / business districts
- Other major cities in SC

Both community leaders and individual members of the community had the following vision for the future:

- Expanded demand-response service in local communities
- More park-and-ride services to link residential areas with major employment centers
- Expanded hours of service
- Increased frequency of service
- More service in rural areas of the state

Both community leaders and individual members of the community saw the following barriers for transit:

- Widespread mindset that transit is only for the poor

- Lack of funding
- Cultural preference to drive
- Low population densities
- Lack of a coordinated statewide plan for transit
- Lack of reliable service
- High cost of providing transit in rural areas
- Cultural preference to drive
- Need to provide a variety of services to many destinations
- Perception that transit is not a top political priority

This effort led to the following stakeholder-expressed regional human services transportation needs:

- More hours of service for jobs, social service, recreation
- Expand geographic coverage of service, especially in rural areas
- Provide for personal attendants to accompany riders who need extra assistance
- Provide insurance to volunteer drivers/vehicles
- Better serve the elderly
- Need for door to door service (some people have difficulty in traversing even short distances to bus stops and to destination)
- More park and ride lots for car and vanpools as well as bus service
- One-stop shopping for transportation information (one number to call for information)
- Allow cross jurisdictional services (e.g., across county lines)
- Vehicle replacement (vehicles either taken out of service prematurely or after many years, both a burden on provider finances)
- Up-grading of communication equipment to support advanced technology (such as automated vehicle location systems)
- Increasingly older population putting a strain on future resources
- Loss of operating assistance as some areas increase in population
- Some areas with increasing population may need dedicated right of ways (e.g., for BRT or light rail transit); effort should be underway to address those future needs today.

Goal:

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

- Provide a coordinated public transportation system to meet the needs of South Carolina's citizens
- Expand the Lower Savannah pilot mobility transportation system statewide

Outcomes:

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

Strategies:

- Develop federally designated recipient strategy to better access operating assistance
- Review Medicaid brokerage and service provision processes to mitigate any negative impact that the new South Carolina Medicaid brokerage system may have in current coordination efforts throughout the state
- Rationalize conflicting policies and procedures which is part of efforts to mitigate the programmatic and pragmatic challenges associated with mixing varied funding sources
- Move forward with planning and implementation of regional mobility information, assistance and management/travel management coordination center now funded by national grants from the Centers for Medicare and Medicaid Services, FTA United We Ride and USDOT's Mobility Services for All Americans grants as being conducted in the Lower Savannah region
- Seek capital funding for ITS technology equipment for local coordinating providers and the center to make the center in Lower Savannah and other regions fully operational, once the design phase is completed
- Better understanding of trip origins and destinations addresses service overlap with other regions as well as how trips are made in each region to better determine common destinations
- Better understand trip origins and destinations addresses service overlap with other regions as well as how trips are made in each region in an attempt to better determine common destinations
- Education and staff development to address professional skill building and improve the delivery of resources
- Address access to medical services (for preventative health care measures)

E. Geriatric Trained Professional Workforce

Issue: Geriatric Loan Forgiveness Program Concerns about a shortage of geriatric-trained physicians are growing nationwide, as healthcare experts contemplate the

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

"We only have 30 geriatricians (currently) to treat the state's 500,000 patients over 65," said Lt. Governor André Bauer when he ratified the bill that created the program." We can now provide incentives for more doctors to undertake an extra year of intense training, thanks to this legislation authored by Rep. Nathan Ballentine and Sen. Ray Cleary."

The State Geriatric Loan Repayment Program has begun paying dividends already, with 14 geriatricians receiving awards since 2005.

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

GOAL:

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

OUTCOMES:

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

STRATEGIES:

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

F. Evidence-Based Research

1. **Issue: South Carolina Seniors' Cube** – During FY 2005-2006 and FY 2006-2007 the Lieutenant Governor's Office on Aging and the USC School of Public Health received a two year Duke Endowment grant for $130,000 with the University of South Carolina's Arnold School of Public Health to work with the Office of Research and Statistics to create the SC Seniors' Cube. The South Carolina Seniors' Cube is a nationally unique comprehensive web-based database of the senior population's health

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

Goal:

- Maintain and expand the South Carolina Seniors' Cube through annual updates of current information and addition of new program and demographic data on seniors in the future.
- Establish a partnership with the major colleges and universities to conduct research to drive state and national policy concerning senior services.
- Obtain grants to continue research to enhance the lives of seniors and to develop cost effective policies and programs to wisely use limited state and federal resources.
- Obtain additional state and federal resources through advocacy efforts resulting from use of the South Carolina Seniors' Cube.

Outcomes:

- Policy makers will support home and community-based services and reallocate institutional service resources
- Enable seniors and caregivers to have choice and remain independent at home whenever possible
- Research will enable state and local providers to document the need for and justify having adequate resources to provide cost effective prevention services to seniors and their caregivers.
- South Carolina will be recognized as a national leader in evidence-based research for seniors' healthcare.

Strategies:

- Negotiate with the Office of Research and Statistics for on-going maintenance and expansion agreement for the South Carolina Seniors' Cube.
- Develop final access/use protocols to allow public/private use of the South Carolina Seniors' Cube.

- Develop partnerships with South Carolina's major colleges and universities to use the SC Seniors' Cube for research and policy development.
- Request adequate resources through grants and internal funds to continue to develop the SC Seniors' Cube in order to fully utilize SC data capabilities.

2. **Issue: Evidence-Based Research- Advanced POMP/Medicare Grant** – A key area that the SC Lieutenant Governor's Office on Aging (LGOA) has been involved in during the last three years is in the area of evidence-based research through Advanced POMP, an AoA grant to determine "The Effects of Older Americans Act Nutrition Services on Medicare Utilization and Costs" and the creation of the SC Seniors' Cube. The LGOA has been a leader in the development of evidence-based research in order to advocate for additional state and federal resources to serve South Carolina's seniors, as well as for discovering different ways to provide the most cost effective services to our seniors. State resources are limited and intense competition for resources has required that we continue our work to maintain and obtain the necessary resources for our seniors. South Carolina managed the Advanced Performance Outcomes Measurement Project during FY 2004-2005 through FY 2006-2007, and found that there appears to be a threshold effect for nutrition services of four to five meals per week, and that this service over time may help to decrease hospital utilization for Medicaid services. We are now involved with an additional effort to use the same methodology to determine the impact of nutrition services on Medicare utilization and costs. Additionally, South Carolina partnered with the Duke Endowment, the University of South Carolina's Arnold School of Public Health and the Office of Research and Statistics to create the SC Seniors' Cube. This analytical cube allows users to sort millions of bits of data in seconds to look at trends of chronic disease to address with OAA services and resources in the future.

Goal:

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

Outcomes:

- Policy makers will support home and community-based services and reallocate institutional service resources
- Enable seniors and caregivers to have choice and remain independent at home whenever possible
- Research will enable state and local providers to document the need for and justify having adequate resources to provide cost effective prevention services to seniors and their caregivers.

Strategies:

- Complete the two year AoA project to determine the impact of nutrition services on Medicare utilization and costs in partnership with the USC Institute for Public Service and Policy Research, the USC Center of Health Services and Policy Research and the Office of Research and Statistics.
- Disseminate findings from the research effort
- Develop partnerships with South Carolina's major colleges and universities to use the SC Seniors' Cube for research and policy development.
- Request adequate resources through grants and internal funds to continue to develop the SC Seniors' Cube in order to fully utilize SC data capabilities.

3. **Issue: Prevention and Wellness Evidence-Based Research -** In addition to the POMP/Medicare grant, the LGOA will continue to expand its health promotion/disease prevention evidence-based programs and collect and analyze data to determine to what degree the programs are working in community-based settings. Those programs to be analyzed include the Chronic Disease Self Management Program (*Living Well* in SC), A Matter of Balance, a fall prevention program, and the Arthritis Foundation Exercise Program administered by the health department. Data from these programs will be entered in to the unique Senior Cube that is part of the Office of Research and Statistics to research the impact of the programs on hospitalizations and health care utilization. Data from these evidence-based programs will be analyzed by appropriate LGOA staff, USC and Office of Research and Statistics staff to determine the impact of these programs on reducing health care utilization and costs and to determine the impact and cost benefit factor in helping South Carolina's seniors remain independent and have choice in their senior years. The South Carolina Seniors' Cube will be utilized to help obtain further grants to conduct additional evidence-based studies and to use positive findings to obtain additional resources for prevention and wellness programs and services in South Carolina..

Goal:

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

Outcomes:

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

- New partnerships are developed because of increased interest in community-based evidence-based programming.
- Seniors and caregivers will be able to have choice and remain independent at home whenever possible
- More funding is available for evidence-based health promotion disease prevention programs
- Partnership for Health Aging membership grows and goals are achieved.

Strategies:

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

4. Issue: Alzheimer's Disease Demonstration Grants to States (ADDGS) Recent studies suggest that the prevalence of dementia is greater among African Americans than Caucasians. Paradoxically, although at greater risk for Alzheimer's disease, African Americans often go undiagnosed and/or receive care late in the course of the disease process. The results of an Alzheimer's Foundation of America survey released in March 2007 showed minority populations who identified themselves as being religious are more likely to turn to their religious leaders for support and let their religion influence their healthcare decisions. To address the needs of the minority population the ADDGS grant is structured to expand services to the minority and/or rural population through the faith-based community. Trusted members of the congregations are recruited and trained as volunteers to bridge the gap between the provider community and the minority population in need of services. In addition, with the inception of the ADDGS grant two Native American communities have expressed interest in the program being expanded to their populations.

Goal

- The ADDGS grant outlines two goals for the project:

  1. Improve access to home and community-based services for individuals with Alzheimer's disease and related disorders (ADRD) by targeting

underserved minority and rural populations in the three-county area of Charleston, Berkeley, and Dorchester

2. Expand consumer choice and consumer-directed long term care support for caregivers through the Aging and Disability Resource Center (ADRC), the Family Caregiver Support Program (FCSP), and the SC Alzheimer's Association (SCAA) to effect systems change

Outcomes

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

Strategies:

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

G. Emergency Preparedness

1. **Issue: Updating the LGOA Emergency Preparedness Program** The emergency preparedness program for the Lieutenant Governor's Office on Aging is a necessary and important function of the agency that insures that we assist in serving and protecting South Carolina's vulnerable senior population.

Under the current design, the emergency preparedness program allows that staff from the LGOA supplement or replace the staff and function of an impacted AAA in the event of a disaster or emergency. This is based on findings from the Hurricane Hugo response in the fall of 1989. Since that time, there have been many changes to emergency management practices in South Carolina that do not seem to have been taken into account in the LGOA emergency preparedness program.

In order to have a program consistent with state and federal emergency management standards, the LGOA should try to mirror state and federal practices of the bottom up approach to our program where COAs asks AAAs for assistance and AAAs ask LGOA for assistance.

Goal:

- Redesign emergency preparedness program in such a way that it more closely resembles that of state and federal plans, with requests for assistance working through the Aging Network from the bottom up.
- Encourage COAs to make and keep contact with their county emergency management directors so that their needs and resources can be discussed prior to an actual emergency or disaster.

- Encourage AAAs to make contact and establish a relationship with the SC Emergency Management Division's (SCEMD) Regional Emergency Managers so that their needs and resources can be discussed prior to an actual emergency or disaster.
- Encourage COAs and AAAs to participate in county and state level training exercises so that staff will be familiar with plans and procedures.
- Encourage COAs and AAAs to create or reaffirm mutual aid agreements with each other to make the process of requesting and rendering assistance as simple and effective as possible.

Outcomes:

- The emergency preparedness program will be more consistent with standardized emergency management programs in South Carolina. Under the new program, COAs and AAAs would backfill each other providing the support necessary where possible to help an impacted area get back on its feet and return to normal status.
- COAs and county emergency managers would have a relationship established prior to a cry for assistance during an emergency.
- AAAs and Regional Emergency Managers would have a relationship established prior to a cry for assistance during an emergency.
- COAs and AAAs would be familiar with plans, personnel and procedures prior to a disaster or emergency allowing them to better deal with their responses.
- Mutual aid agreements would allow for those that already know how to work in a COA or AAA to go in and get the system up and running rather than sending down staff from the LGOA to struggle through something with which others are already familiar. Barriers such as liability and reimbursement would have already been addressed at least on a basic level allowing a faster response to seniors needing help. The LGOA would also be able to concentrate on their task of interacting with state and federal partners to insure that COAs and AAAs get the help they need in a timely manner.

Strategies:

- Rewrite emergency preparedness plan to reflect the bottom up approach to response operations.
- Meet with SCEMD to review and make recommendations on changes to the LGOA emergency preparedness program.
- Meet with all AAAs to determine where they stand with their plans and explain proposed changes and provide support and guidance where necessary to help them make changes to their plans.
- Meet with AAAs and their COAs by region to help facilitate discussion and action on emergency preparedness programs.
- Facilitate a meeting between COAs and county emergency managers.
- Facilitate a meeting with AAAs and Regional Emergency Managers.

- Encourage participation in training and exercises at the county and regional level.
- Assist with the development of a mutual aid system among the AAAs and COAs.

2. Issue: Pandemic Flu Response and Continuity of Operations at the LGOA

The threat of an outbreak of pandemic flu is an issue of great concern at both the state and national level. In relation to the LGOA the primary concern will be continuity of operations and the health and safety of the seniors that we serve. The Department of Health and Environmental Control (DHEC) holds the lead on primary responsibility for the development of a plan for pandemic flu preparedness and response, and the LGOA is responsible for providing input on the senior aspect of the plan.

Goal:

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

Outcomes:

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

Strategies:

- Develop a plan as to how the LGOA will maintain regular operations during an outbreak of pandemic flu. The plan should potentially include the option for staff to work in non-traditional settings such as through telecommuting rather than working out of the main office.
- The risk of exposure and cross contamination is increased through the close quarters contact of a traditional office environment, consequently management should monitor the health of staff members and encourage them to take sick

leave if they are symptomatic and telecommute during the period of time that they are or could be contagious after exposure to pandemic flu.

- Encourage AAAs and COAs to make contact with their DHEC regions to assist them in monitoring potential outbreaks of pandemic flu and how they can best protect the seniors they serve and maintain their daily operations without risking further exposure to seniors through daily activities such as congregate feeding and home meal delivery.

H. ELDER RIGHTS AND RELATED ISSUES

America's expanding elderly population affects every segment of the social, political, and economic landscape. As individuals age, there are often changes in their living patterns and conditions which sometimes contribute to the deterioration of their rights. Issues surrounding the changing needs of the approximately 44 million persons in this country age 60 years and over have heightened national awareness and concern. It is no surprise that elderly people with physical and mental frailties are more likely to be vulnerable to abusive behavior from those whom they depend upon to provide care and support. Especially vulnerable to abuse, neglect, and exploitation are elderly persons unable to care for themselves. State and local organizations must mobilize to recognize these potential problems and provide support. Given the large number of incidents of abuse and neglect that are reported, service providers, caregivers, and all citizens who relate to seniors need to be alerted to the problem of abuse and neglect, taught to recognize it, and encouraged to report it. As a result, public policies relating to issues such as health care, health care insurance, retirement, affordable long term care, and quality of life are changing to meet the unique needs of the aging population.

Issues for Elder Rights and Related Issues:

Prevention of Abuse, Neglect and Exploitation:

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

Mistreatment or abuse can either be physical, psychological or both. It occurs in both the community and in long-term care settings. Nationally, studies indicate elder abuse is grossly underreported in the community. Statistics show as few as one in four cases of abuse are ever reported to the proper authorities. Although long-term care facilities are heavily regulated and monitored by both federal and state statutes, abuse can also occur in this setting. Residents of long-term care facilities may be extremely frail, cognitively impaired and totally dependent on caregivers for their needs. Because of these conditions they may be at risk for abuse. Nationally, and in South Carolina, physical abuse is the most common type of abuse reported in long term care facilities. The highest risk factor may be the presence of dementia (which may be present in 50 -

75% of nursing home residents). Residents with dementia, especially if they have disruptive or violent behaviors, may have an increased risk for being abused.

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

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

Neglect. The failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult is likely to increase with the growing numbers of the age 80+ population. *Self-neglect* includes the inability of a vulnerable adult without a caregiver to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death. The situation is aggravated when the older person lives alone, often without family or friends to observe the deterioration in functioning or to be available to intervene. Given the concomitance of Alzheimer's disease with advanced age, the probability of increased numbers of elders requiring a caregiver becomes a more realistic specter for the future.

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

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

Nursing homes provide care to over 1.7 million people every year. However, many individuals and family members find it a challenge to select a facility and to ensure appropriate care will be provided. Generally, a nursing home or residential care facility offers daily assistance to individuals who are physically or mentally unable to live independently.

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

In South Carolina, unlike most other states, the Long-Term Care Ombudsman Program has two distinct roles. The first role is to be an advocate for residents in long-term care facilities as required by the federal Older Americans Act. The second role as defined under the South Carolina Omnibus Adult Protection Act is to be the mandated investigator for abuse, neglect and exploitation in facilities. In contrast to regulators,

whose role is to apply laws and regulations, ombudsmen seek to identify and resolve problems on behalf of residents before intervention is needed by the regulatory agency. The Ombudsman program does not have direct enforcement authority and cannot sanction facilities for violations; however, it does have the authority to refer cases to the proper regulatory agencies for enforcement action, and refer all cases of abuse, neglect, and exploitation to local law enforcement or to the Attorney General's Office for investigation and prosecution. In 2006, the Omnibus Adult Protection Act was amended and all abuse, neglect and exploitation complaints in facilities operated or contracted for operation by the Departments of Mental Health and Disabilities and Special Needs must be reported directly to the Vulnerable Adult Investigative Unit (VAIU) at the State Law Enforcement Division. The VAIU vets the complaints and refers all "non-criminal" abuse, neglect and exploitation complaints to the Long Term Care Ombudsman Program for investigation.

The State Long Term Care Ombudsman Program, located in the SUA, has the responsibility for directing the program and oversees the investigation of complaints by its ten (10) Regional Programs. While the Ombudsmen do not have direct authority to require action by a facility, they have the responsibility to negotiate on the resident's behalf and to work with other state agencies for effective enforcement. The ten Regional Ombudsman Programs are located throughout the state. The administration of these regional programs is through the local Area Agency on Aging. These agencies employ a total of 19 full time ombudsmen to investigate complaints and provide assistance to all nursing home and residential care facility residents.

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

In FY 2007, the Ombudsman Program completed 5,837 complaint investigations. Often a single complaint affects more than one resident. For example, complaints regarding lack of staff to assist with meals could reasonably affect a single resident or the entire facility depending on the circumstances. This information is tracked over the reporting year to yield the number of people the ombudsman affects by conducting complaint investigations. The majority of the complaints to the ombudsman come from facility staff or families and friends of the resident.

However, in addition to investigating complaints and advocating on behalf of residents, Ombudsmen also serve as a valuable resource for residents, families, facility staff and community members. Ombudsmen are able to provide education on resident's rights, provide information or assistance with family and resident councils, share information about community groups and activities available to improve life and care for nursing home residents, offer advice about how to select a nursing home and answer questions about long term care

Many of South Carolina's nursing homes have enrolled in the Advancing Excellence initiative, a two year, voluntary, coalition-based campaign concerned with how we care for elderly and disabled citizens. Several facilities have instituted "Culture Change" initiatives such as The Eden Alternative□, which recognizes that being institutionalized

often breaks the spirit and ultimately the health of many formerly vibrant people. The Eden Alternative counters boredom, loneliness, and helplessness with animals, plants, and children, and requires an entire shift in management philosophy that brings decision-making authority closer to the residents and staff.

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

Decisions Regarding Health Care and End-of-Life:

The right to receive quality health care, to refuse care, and to execute advance directives regarding desired health care continues to grow in importance as the older population increases and as medical technology makes it increasingly possible to extend life. Studies within the state indicate a significant number of South Carolinians have primary end-of-life concerns about pain, comfort, and dignity. The SUA has partnered with members of the Carolinas Center for Hospice and End of Life Care to better understand and increase public awareness about end-of-life issues.

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

Legal Services:

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

During the last three years, the SC Lieutenant Governor's Office on Aging (LGOA) has been an advocate for Elder Rights in the areas of legal services, legislation/legislative initiatives, and financial exploitation/scam and fraud protection.

Legal issues that seniors and other vulnerable adults face run the gamut from financial exploitation to predatory lending practices, from contract disputes to disagreements

over real estate, from estate issues and family conflict to treasury and banking issues, and from domestic violence to physical, mental, and emotional abuse.

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

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

Scams and frauds that target vulnerable adults are increasing almost daily. According to the Federal Trade Commission, the latest published statistical compilation (2005) indicates that two thousand eight hundred ninety three (2,893) cases of fraud were reported in South Carolina in the fifty (50) years old and older demographic. Only seven hundred fifty one (751), or twenty six percent (26%), of those cases disclosed the amount of their losses, which totaled one million, nine hundred twenty eight thousand, two hundred eighty five dollars ($1,928,285). This is an average of two thousand, five hundred sixty eight dollars ($2,568) per fraud incident where the amount was reported.

In 2006, thirty seven percent (37%) of all complaints came from the 50 and over age group. Forty six percent (46%) of those complaints came from the 60 and over age group. If national averages hold true, that would indicate that of the complaints filed in South Carolina, one thousand, three hundred thirty-one (1,331) of the complaints came from the 60 and over age group, accounting for eight hundred eighty seven thousand, eleven dollars ($887,011) in losses. According to information published by the US Administration on Aging's National Center on Elder Abuse, however, "current estimates put the overall reporting of financial exploitation at only 1 in 25 cases..." By extrapolating the data, this would suggest that the unreported fraud in South Carolina in the sixty (60) year old and older population could reach as high as thirty three thousand, two hundred seventy five (33,275) cases annually. If the dollar amounts remain consistent, using the average of $2,568 lost per fraud case, this would suggest that losses may potentially reach more than eighty-five million, four hundred fifty thousand, two hundred dollars ($85,450,200) from this age group annually.

Financial exploitation, even when no illegal activity occurs, is on the rise as well. Unfair business practices in the private financial sector such as selling inappropriate annuities to seniors are occurring with increasing frequency. Class action suits have occurred or are in process in numerous states, including Minnesota, California, Pennsylvania, Florida, and Iowa where companies have targeted seniors for sales of products that reach maturity long after the life expectancy of the purchaser. Early withdrawal of money to provide for critical life needs such as in-home care or residential facility care imposes penalties that may range upwards of 20% of the amount invested. Predatory lending practices also fall into the category of financial exploitation and seniors as well as various minority groups are prime targets.

The Lieutenant Governor's Office on Aging provides referrals to seniors for obtaining legal resources through the South Carolina Center for Equal Justice, the National Elder Law Foundation, and the South Carolina Bar Association. General information and documents for Living Wills and Health Care Powers of Attorney are provided on the website and educational sessions are offered to all interested organizations throughout South Carolina. The agency has recently begun the process of creating Pareto charts that define all of the services available to seniors and vulnerable adults from all of the Adult Protective Services Providers. Efforts to address scams and frauds are underway with the Lieutenant Governor's Office on Aging spearheading the coordination of effort from these agencies.

Participation on the South Carolina Elderlaw Committee provides better oversight of legislation that targets issues that affect seniors and vulnerable adults. Guardianship initiatives are being developed in conjunction with organizations such as the Junior League and efforts of the Bar to establish a pilot program to provide pro bono guardianship in Lexington County.

Volunteer Program:

The SC Lieutenant Governor's Office on Aging (LGOA) instituted a Volunteer Ombudsman Program in 2005; however, when the coordinator for the program stepped down due to health issues, the program did not experience the desired growth. New leadership for the program was found in 2007 and a new approach is currently underway.

The program was met with challenges because facilities viewed “Volunteer Ombudsmen” as “junior Ombudsmen” and perceived that these workers would lack neutrality, focusing on finding even the smallest flaws within the long term care facilities. Since participation is voluntary for facilities, the response was underwhelming. Because having volunteers is a quality of care issue, for the facilities participation is desirable from a public relations standpoint; for the residents, the program is a lifeline that gives much needed support and caring, and contact may help alleviate the depression and decline that is often experienced in long term care settings.

New management has redefined the program’s purpose and quality standards. The program has been renamed “The Friendly Visitor Program” and emphasis is placed on being the contact point for seniors and vulnerable adults who lack friends and family or other visitors within the long term care environment. New marketing materials have been produced and a quarterly newsletter is being generated that highlights one volunteer, one Region in the Aging Network, and one facility every quarter.

The program has increased from a handful of volunteers to a significant number of recruits. In five months, over two hundred potential volunteers have been identified and are in the recruitment process. The process is lengthy, time consuming, and requires in-depth reviews of background information since volunteers work with vulnerable adults.

Facilities have also been recruited for participation in all areas of the state and numbers have doubled. While the response has been excellent, the facility base still needs to be expanded.

Mental Health:

In an article printed in the Journal of American Medicine (JAMA), the prevalence of mental illness among the elderly is approximately 20%. Suicide is the third leading cause of injury death among adults 65 and older in South Carolina. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) older individuals experience serious mental health and/or substance abuse (MH/SA) problems that affect their quality of life as well as their ability to function independently in the community. The incidence rates vary among older adults, however studies suggest that older adults experience high rates of depression and anxiety disorders, as well as alcohol abuse and dependence.

As the Baby Boomers age and this population group increases, it will become increasingly imperative to insure both the clinical and policy communities are well informed as to the nature and effectiveness of different service delivery models for treating MH/SA problems. In SC, there is sparse data on the prevalence of mental illness and substance abuse. SAMHSA is conducting a study that includes SC and the preliminary results should be available for review by the end of 2008. This will allow the SUA to effectively plan for new initiatives surrounding seniors who have mental illness and/or substance abuse problems.

Program Goals for Elder Rights and Related Issues:

- To reduce the prevalence of elder abuse, neglect and exploitation in home and institutional settings.
- To improve the quality of care in facilities through increased participation in the Advancing Excellence and Culture Change programs.
- To empower residents to know and exercise their rights, voice their concerns and, to the extent possible, act on their own behalf or to seek outside assistance
- To identify and resolve resident problems relating to poor facility practices
- To identify and represent the interests of residents and seek appropriate remedies
- To improve access to legal assistance services for older adults who have no other legal resources
- To increase awareness and promote the use of advance directives for health care planning in the community and long term care facilities through training and education
- To increase partnering and collaborative opportunities to increase knowledge of advance directives for health care providers
- To increase the awareness of the occurrence of mental illness and substance abuse in the older adult population
- Create process maps of Adult Protective Services Providers' services for vulnerable adults to include legal services information
- Develop a gap analysis of services including legal support available for and needed by vulnerable adults
- Compile statistical information that documents and supports the need for the development of legal services or legislative initiatives to fill existing gaps

- Develop partnerships with organizations such as the Junior League to create programs for vulnerable adults who lack capacity
- Develop partnerships with organizations such as AARP to recruit volunteers on an ongoing basis
- Utilize partnerships to create a dynamic base of volunteers to provide an ongoing pool of visitors for residents of long term care facilities
- Develop a complete system of centralized secure files and records to maintain comprehensive information on volunteers statewide
- Input information and compile statistical information that documents the visits made by Friendly Visitors
- Solicit facilities to participate in the program with a goal of 60% participation within three years

Strategies for Elder Rights and Related Issues:

- To increase public awareness about issues of elder abuse, neglect and exploitation including causes, profiles of victims and perpetrators, warning signs, reporting, and strategies for prevention through work with member agencies of the Adult Protection Coordinating Council
- To increase professional understanding of physicians and other health care and social service professionals and educate them about the Omnibus Adult Protection Act through work with member agencies of the Adult Protection Coordinating Council
- To develop methods for standardized collection, reporting, and coordination of data related to adult abuse, neglect and exploitation through work with member agencies of the Adult Protection Coordinating Council
- To improve the coordination with law enforcement, solicitors and the judicial system to increase prosecution of adult abuse, neglect and exploitation through the work of the Adult Protection Coordinating Council
- To ensure timely and responsive access to the services of the long term care ombudsman program for all residents in long term care facilities
- To support the statewide Long Term Care Ombudsman program through training and technical assistance
- To expand the advocacy capacity of the ombudsman program by increasing the number of community outreach connections, increasing the profile and visibility of the ombudsman program, and by improving effective networking
- To develop and nurture effective self-advocacy of nursing home residents by supporting the development of family councils through collaboration with the long term care ombudsman program
- To ensure the health, safety, welfare and rights of residents by working more vigorously with long term care providers and related health and human services agencies toward a level of care that is responsive, individualized, and of high quality
- To provide collective and analytical data concerning complaints, trends, patterns and

condition of residents in long term care facilities and identify and present essential information to appropriate public policymakers

- To provide ongoing training and public information about advance directives for the public and professionals who serve older adults
- To support the network of trained volunteers to provide ombudsman witness services to persons who are in hospitals and long term care facilities
- Identify the services provided by various agencies that target the needs of vulnerable adults and disseminate the information to agencies throughout South Carolina
- Identify the resources available to meet specific support requirements and create a needs assessment that establishes service gaps
- Compile findings from latest surveys and program initiatives nationally and in South Carolina and disseminate findings from statistical research effort to the Bar Association and members of the Adult Protection Coordinating Council as well as to the Joint Legislative Committee on Aging
- Develop partnerships with resources within South Carolina for financial and legislative support of issues involving vulnerable adults.
- Use AARP mailings; public presentations at fraternal, community, and religious organizations; mass media; participation in wellness events, health fairs, senior events, and other public gatherings to solicit participation in the program.
- Establish centralized confidential files on program participants and recruitment efforts
- Regional staff will require and retain visit records from all participants and enter the data in the Ombudsman database system
- Create and employ a strategic plan of facility solicitation, including meetings with directors of facilities and officials of the South Carolina Health Care Association.

Desired Outcomes for Elder Rights and Related Issues:

- Reports will be produced on a regular basis identifying unduplicated crimes of abuse, neglect and exploitation of vulnerable adults through the Adult Protection Coordinating Council.
- Public awareness of factors related to abuse, neglect and exploitation will result in increased reporting.
- Residents, families and agencies contact the ombudsman program for information and assistance to resolve problems with long term care facilities.
- Residents and families initiate and participate in resident and family councils.
- Complaints are analyzed to identify major issues impacting residents and strategies are developed based on identified issues.
- Needed regulatory and law enforcement actions are initiated.
- Citizen groups and other advocates push the long term care ombudsman's

advocacy agenda.

- Consumers' quality of care and quality of life are improved.
- Residents, families and the public understand the need for systems change, make comments and provide testimony on legislative and regulatory proposals.
- Knowledge and public understanding of advance directives will increase.
- Partnership with the Dept. of Mental Health, PAMI and substance abuse organizations will result in increased awareness and resultant policy changes and increased services to older adults.
- Agencies, police authorities, and groups that serve vulnerable adults will be able to quickly ascertain where support services can be located. Clients, consumers, and their caregivers will be referred to the appropriate services to enhance their quality of life.
- Document the need for expanded services for vulnerable adults
- Justify having adequate resources for the provision of cost effective protective services for vulnerable adults and their caregivers.
- Establish a public guardianship program for vulnerable adults who lack capacity.
- Older adults will have more pro bono or sliding fee scale legal assistance services available.
- The Friendly Visitor program will become dynamic in nature, so that new volunteers are always entering the program as experienced volunteers retire from service. This will prevent service gaps in the participating facilities.
- Centralized documentation provides much needed documentation of participant credibility and will also allow long term tracking of program effectiveness and results, as well as help in establishing challenges to program success.
- Friendly Visitor data meets some of the mandated statistical requirements placed on the agency by funding sources.
- Establish greater outreach to residents and improve quality of life in facilities.

I. Volunteer and Employment Opportunities

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

The trend toward earlier and longer retirement creates some new challenges for South Carolina's seniors. While the majority of senior "transplants" tend to be of middle income or above, many of South Carolina's lifelong residents have lived in rural communities with below-the-national-average income levels. Many native South

Carolina seniors are ineligible for federal financial assistance, and with skyrocketing health care costs, must continue to work in order to afford the basics.

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

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

Programs currently utilizing a sizeable number of volunteers are the home delivered meals program, State Health Insurance Program (SHIP), Advance Directives, Five Wishes and the Friendly Visitor Program. The Lieutenant Governor's Office on Aging continues to build partnerships with community organizations and other parts of state government in order to increase volunteer efforts. With the implementation of the Living Well and Alzheimer's Disease Demonstration Grant to States, the SUA continues to explore ways to utilize volunteers for expanding the outreach of its programs.

J. Education and Training

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

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

K. Resource Allocation:

The methods used by the SUA to allocate funds to the area agencies are described in Chapter 8. OAA funds and most state funds, except when otherwise directed by law are allocated based on a multi-factored formula. The factors include an equal base, percent of population 60+ below poverty, percent of minority population 60+, percent of population who are moderately or severely impaired, and the percent of state rural population. An examination of the recipients of services through the Aging Network shows that those populations in greatest economic and social need and minorities are served in numbers greater than their general representation in the population. No further targeting measures are indicated at this time.

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

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

CHAPTER 8: RESOURCE ALLOCATION PLAN

A. Background:

Section 305 (a)(2)(C) of the OAA and Section 1321.37 of the Title III regulations require that each SUA, after consultation with all area agencies in the State, shall develop and use an intrastate funding formula for the allocations of funds to area agencies. The SUA is required to review the Intrastate Funding Formula whenever it develops a new State Plan on Aging.

B. Philosophy of the Intrastate Funding Formula

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

C. Goals of the Intrastate Funding Formula

The Intrastate Funding Formula is intended to address the following goals:

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

D. Assumptions of the Intrastate Funding Formula

The OAA defines *greatest economic need* as the need resulting from an income level at or below the poverty levels established by the Office of Management and Budget. This definition is applied to the formula by including the number of people age 60 and over, with incomes at or below the poverty level, as a factor.

The OAA defines *greatest social need* as the need caused by non-economic factors which include physical and mental disabilities, language barriers, and cultural, social, or geographic isolation including that caused by racial or ethnic status which restrict an individual's ability to perform normal daily tasks or which threaten such individuals' capacity to live independently. Since this definition is not specific, it is much more difficult to apply to a funding formula. Therefore, several factors have been included in order to apply this definition to the formula.

- Since the definition is broad and non-specific, it is assumed that many individuals age 60 and over who do not fit into a specific category are in greatest social need. Therefore, the number of people age 60 and over is included as a factor.
- The definition refers to racial or ethnic status as a cause of isolation that causes need. Therefore, the number of minority individuals age 60 and over is included as a factor.

- The definition refers to geographic isolation as cause of need. It is assumed that persons who reside in rural areas are more geographically isolated, relative to those who reside in urban areas. Therefore, the number of people with a rural residence is included as a factor.
- The definition refers to physical and mental disabilities and restricted ability to perform normal daily tasks. The US Census collected data on disabilities for the first time in 2000 from individuals who received the long form. The questions involved data on limitations in performing ADL; therefore, the FY 2009 – 2012 State Plan includes a factor based on individuals 60+ with impairments affecting 2 or more ADL, as reported in the 2000 Census.

The final assumption made in determining factors to be included in the formula is that a minimum level of funding is needed to support a viable service system in each area, regardless of the presence of other factors; therefore, an equal funding base has also been included as a factor.

The OAA provides that particular attention should be paid to low-income minority individuals; however, this term is not defined. Over 60 percent of those at or below the poverty level are minority individuals and approximately one third of the minority individuals are at or below the poverty level. Therefore, by including age 60 and over at or below the poverty level and age 60 and over minority individuals as factors, it is assumed that particular attention has been paid to low income minority individuals.

In establishing the weights for the factors, it was assumed that maintenance of an equal funding base is still the most critical factor in ensuring statewide access to services; therefore, the equal base factor was given a 50 percent weight.

Although the OAA requires that resources be directed toward those in greatest economic or social need, with particular attention to low-income minority individuals, it does not provide for specific eligibility requirements. The definition of greatest social need is so broad that virtually any individual age 60 and over is eligible; therefore, the age 60 and over factor has been given a weight of 20 percent.

Of the remaining factors that have been included, age 60 and over at or below poverty, and age 60 and over minority, are the most directly related to the language in the OAA and the most easily quantifiable; therefore, these two factors have each been given weights of 10 percent respectively.

The final two factors, moderately and severely impaired and rural residents are related to the language in the OAA but are not as easily quantifiable; therefore, these two factors have been given weights of 5 percent each, respectively.

Numerical Statement of the Formula

A = Planning and Service Area (PSA) Allocation

T = Total Federal Funds Available for Allocation

E = Equal Base; **Weight: 50%***

S = PSA Proportion of State 60 plus Population; **Weight: 20%**

P = PSA Proportion of State 60 plus Population at or Below Poverty; **Weight: 10%**

M = PSA Proportion of State 60 plus Minority Population; **Weight: 10%**

I = PSA Proportion of State 60 plus Moderately or Severely Impaired Population; **Weight: 5%**

R = PSA Proportion of State Rural Population; **Weight: 5%**

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

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

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

SOUTH CAROLINA INTERSTATE FUNDING FORMULA

NUMBERS OF PEOPLE IN EACH REGION FOR EACH FROMULA CRITERIA

PLANNING AND SERVICE AREA	AGE 60+ *	AGE 60+ POVERTY	AGE 60+ MINORITY*	AGE 60+ 2+ ADL	TOTAL POPULATION RURAL SCALE
Appalachia	200,338	19,434	25,474	72,718	348,000
Upper Savannah	42,088	5,321	9,985	17,490	139,173
Catawba	54,852	5,204	9,956	19,539	139,032
Central Midlands	100,074	8,783	24,089	34,260	155,547
Lower Savannah	59,158	8,621	19,006	23,059	165,209
Santee-Lynches	38,874	5,937	13,963	15,739	117,435
Pee Dee	59,358	10,002	19,785	25,393	176,000
Waccamaw	73,016	6,332	11,314	21,222	134,806
Trident	96,359	9,047	25,572	32,480	116,500
Lowountry	48,314	4,079	10,359	12,885	93,186
TOTAL	**772,431**	**82,760**	**169143**	**274,785**	**1,584,888**
Source:	2000 Census, * 2006 American Community Survey				

EACH REGION'S PERCENTAGE OF THE STATE TOTAL FOR EACH FORMULA FACTOR

PLANNING AND SERVICE AREA	AGE 60+ *	AGE 60+ POVERTY	AGE 60+ MINORITY *	AGE 60+ 2+ADL	TOTAL POPULATION RURAL SCALE
Appalachia	25.94%	23.48%	15.06%	26.46%	21.96%
Upper Savannah	5.45%	6.43%	5.90%	6.36%	8.78%
Catawba	7.10%	6.29%	5.67%	7.11%	8.77%
Central Midlands	12.96%	10.61%	14.24%	12.47%	9.81%
Lower Savannah	7.66%	10.42%	11.24%	8.39%	10.42%
Santee-Lynches	5.03%	7.17%	8.26%	5.73%	7.41%
Pee Dee	7.68%	12.09%	11.70%	9.24%	11.11%
Waccamaw	9.45%	7.65%	6.69%	7.72%	8.51%
Trident	12.47%	10.93%	15.12%	11.82%	7.35%
Lowcountry	6.25%	4.93%	6.12%	4.69%	5.88%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Source:	2000 Census, * 2006 American Community Survey				

SC American Indian/Alaskan Native And Hispanic Population 60+ By PSA - 2006

Appalachia:	AIAN	Hispanic	Upper Savannah:	AIAN	Hispanic	Catawba:	AIAN	Hispanic
Anderson	43	161	Abbeville	6	21	Chester	10	25
Cherokee	12	48	Edgefield	13	26	Lancaster	16	51
Greenville	189	1320	Greenwood	11	103	Union	12	37
Oconee	29	117	Laurens	27	88	York	158	345
Pickens	26	119	Mccormick	2	14	**Total:**	**196**	**458**
Spartanburg	76	497	Saluda	6	46	**Santee-Lynches:**	**AIAN**	**Hispanic**
Total:	**375**	**2262**	**Total:**	**65**	**298**	Clarendon	9	51
Central Midlands:	**AIAN**	**Hispanic**	**Lower Savannah:**	**AIAN**	**Hispanic**	Kershaw	22	73
Fairfield	5	40	Aiken	104	270	Lee	4	24
Lexington	105	323	Allendale	2	20	Sumter	30	140
Newberry	14	63	Bamberg	4	31	**Total:**	**65**	**288**
Richland	141	812	Barnwell	11	34	**Trident:**	**AIAN**	**Hispanic**
Total:	**265**	**1238**	Calhoun	7	22	Berkeley	85	313
Pee Dee:	**AIAN**	**Hispanic**	Orangeburg	90	105	Charleston	138	658
Chesterfield	20	64	**Total:**	**218**	**482**	Dorchester	105	158
Darlington	20	82	**Waccamaw:**	**AIAN**	**Hispanic**	**Total:**	**328**	**1129**
Dillon	79	43	Georgetown	13	77	**Lowcountry:**	**AIAN**	**Hispanic**
Florence	39	130	Horry	97	488	Beaufort	26	500
Marion	11	29	Williamsburg	18	39	Colleton	41	43
Marlboro	121	37	**Total:**	**128**	**604**	Hampton	7	24
Total:	**290**	**385**				Jasper	9	50
						Total:	**83**	**617**
Total American Indian/Alaskan Native Population 60+ In SC:				**2013**				
Total Hispanic Population 60+ In SC:				**7761**				

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

STATE UNIT ON AGING PARTICIPATION OF TARGET GROUPS BETWEEN 7/1/2006 AND 6/30/2007					
Target Group	Title III-B	Title III-C-1	Title III C-2	Title III-D	All Titles
# Low Income	4,117	5,516	4,361	2,853	11,271
% Low Income	52%	58%	63%	55%	57%
# Minorities	4,137	5,210	3,712	2,395	10,137
% Minorities	53%	55%	53%	46%	51%
# Low Income Minorities	2,574	3,269	2,269	1,475	6,103
% Low Income Minorities	33%	34%	33%	28%	31%
# Rural	4,770	6,034	4,361	3,085	12,128
% Rural	61%	64%	63%	60%	61%
# Social Need	3,746	4,648	3,493	2,327	9,024
% Social Need	48%	49%	50%	45%	45%
# Frailty/Disabled	2,901	2,380	4,554	1,290	7,833
% Frailty/Disabled	37%	25%	66%	25%	39%
All Clients Served	7,875	9,497	6,952	5,176	19,946
% Served	39%	48%	35%	26%	100%

Note: Minorities include African-Americans, Hispanic Origin, American Indian/Native Alaskan, Asian-American/Pacific Islander. Also, Title III-E data not yet available; will be collected in new system beginning July 1, 2004.

STATE UNIT ON AGING

STATE FISCAL YEAR: 2008-2009

ALLOCATION FOR AREA AGENCY ON AGING OMBUDSMAN SERVICES AS OF MARCH , 2008

PLANNING AND SERVICE AREA	TITLE III-B OMBUDSMAN	STATE 5% Match	LOCAL 10% MATCH	Total Title III Ombudsman	Title VII Elder Abuse	Title VII Ombudsman	Total OAA Ombudsman	State Ombudsman	Medicaid Ombudsman	TOTAL OMBUDSMAN Services
APPALACHIA	$85,819	$5,048	$10,096	$100,963	$28,561	$78,217	$207,741	$70,686	$74,942	$353,369
UPPER SAVANNAH	$14,497	$853	$1,706	$17,056	$4,681	$13,143	$34,880	$3,394	$33,412	$71,686
CATAWBA	$13,440	$791	$1,581	$15,812	$4,166	$12,154	$32,132	$23,894	$18,694	$74,720
CENTRAL MIDLANDS	$48,358	$2,845	$5,689	$56,892	$9,667	$33,098	$99,657	$54,533	$132,830	$287,020
LOWER SAVANNAH	$13,706	$806	$1,612	$16,124	$4,191	$12,384	$32,699	$21,821	$30,098	$84,618
SANTEE-LYNCHES	$9,418	$554	$1,108	$11,080	$2,942	$12,438	$26,460	$5,391	$21,536	$53,387
PEE DEE	$17,863	$1,051	$2,102	$21,016	$5,362	$16,124	$42,502	$43,594	$11,700	$97,796
WACCAMAW	$15,232	$896	$1,792	$17,920	$3,194	$13,763	$34,877	$31,416	$11,902	$78,192
TRIDENT	$69,556	$4,092	$8,183	$81,831	$7,108	$21,578	$110,517	$54,058	$26,492	$191,067
LOWCOUNTRY	$7,604	$447	$895	$8,946	$2,749	$12,031	$23,726	$1,216	$23,924	$48,866
TOTALS	$295,493	$17,382	$34,764	$347,639	$72,621	$224,930	$645,190	$310,000	$385,530	$1,340,721
STATE OMBUDSMAN	$160,000	$28,235								$188,235
TOTAL	$455,493	$45,617								$1,528,956

STATE UNIT ON AGING

STATE FISCAL YEAR: 2008-2009

ALLOCATION FOR AREA AGENCY ON AGING **PLANNING, ADMINISTRATION AND PROGRAM DEVELOPMENT** AS OF MARCH , 2008

PLANNING AND SERVICE AREA	Title III P&A (B,C 1&2)	Program Dev	State 5% Match	Local Match	Subtotal AAA P&A B,C 1 & 2	State General Revenue	State Cost of Living	SSBG Admin	Total for P&A and PD Activities
APPALACHIA	$209,392	$0	$0	$69,797	$279,189	$5,000	$14,746	$0	$298,935
UPPER SAVANNAH	$102,775	$41,112	$2,418	$39,095	$185,400	$5,000	$4,734	$6,594	$201,728
CATAWBA	$106,966	$36,362	$2,139	$39,933	$185,400	$5,000	$86,500	$5,215	$204,265
CENTRAL MIDLANDS	$142,346	$0	$0	$47,449	$189,795	$5,000	$18,783	$15,840	$229,418
LOWER SAVANNAH	$122,589	$18,655	$1,098	$43,058	$185,400	$5,000	$7,681	$6,334	$204,415
SANTEE-LYNCHES	$104,383	$39,289	$2,311	$39,417	$185,400	$5,000	$7,017	$5,828	$203,245
PEE DEE	$126,345	$14,399	$847	$43,809	$185,400	$5,000	$4,332	$7,464	$202,196
WACCAMAW	$116,198	$25,900	$1,523	$41,779	$185,400	$5,000	$6,065	$6,026	$202,491
TRIDENT	$140,656	$0	$0	$46,885	$187,541	$5,000	$14,031	$3,503	$210,075
LOWCOUNTRY	$100,299	$43,918	$2,583	$38,600	$185,400	$5,000	$6,842	$12,368	$209,610
TOTAL	$1,271,949	$219,635	$12,919	$449,822	$1,954,325	$50,000	$92,881	$69,172	$2,166,378

Allocations for Direct Regional Service Provision - Area Plan Period 2008-2009

Planning and Service Area	Legal Assistance III-B	Case Management	1 R&A III B	Title III-E Family Caregiver Support Services	P&A III-E	I-Care	Senior Medicare Patrol	SMP Local Match	Total Ins Counseling	Total AAA Direct Services **
Appalachia				$295,034	$32,782	$45,702	$5,815	$5,272	$66,789	$394,605
Upper Savannah				$144,810	$16,090	$24,020	$7,707	$2,569	$34,296	$195,196
Catawba				$150,715	$16,746	$25,867	$8,220	$2,740	$36,827	$204,288
Central Midlands				$200,567	$22,285	$29,622	$10,250	$3,417	$43,289	$266,141
Lower Savannah				$172,729	$19,192	$27,615	$8,950	$2,983	$39,548	$231,469
Santee-Lynches				$147,076	$16,342	$24,345	$7,819	$2,606	$34,770	$198,188
Pee Dee				$178,020	$19,780	$27,775	$9,644	$3,215	$40,634	$238,434
Waccamaw				$163,723	$18,191	$23,919	$8,277	$2,759	$34,955	$216,869
Trident				$198,185	$22,021	$27,108	$9,459	$3,153	$39,720	$259,926
LowCountry				$141,328	$15,703	$21,297	$7,385	$2,462	$31,144	$188,173
Total	0	0	0	$1,792,185	$199,132	$277,270	$93,526	$31,176	$401,972	$2,393,289

** The Title III-E share of the Regional 1, R&A Specialist and the staffing for the Care Giver Advocate(s) not paid with P&A Funds must be deducted from this allocation before determining the amount available for direct Caregiver services.
*** Match for IIIE Staff and III-E P&A and any Title III-B service delivered by the AAA must be added to this total

ESTIMATED FLOW -THROUGH ALLOCATIONS FOR SERVICE PROVISION

STATE FISCAL YEAR 2008 – 2009

ALLOCATION FOR SERVICE PROVISION – AREA PLAN PERIOD 2008-2009

PLANNING AND SERVICE AREA	Title III Supportive Services	Title III-C-1 Group Dining	Title III C-2 Meals Delivered to Home	Title III-D Evidence Based Wellness Program	Total Title III Federal	State 5% Match	Local 10% Match	Total Title II	Bingo Revenue	State Funded Home and Community Based Services	SSBG Meals	Total Revenue for Services
APPALACHIA	$555,937	$777,743	$393,967	$33,242	$1,760,889	$103,582	$207,163	$2,071,634	$117,361	$607,818	$12,000	$2,808,813
UPPER SAVANNAH	$272,867	$381,740	$193,372	$16,315	$864,294	$50,840	$101,681	$1,016,815	$55,743	$298,335	$88,505	$1,459,398
CATAWBA	$283,994	$397,305	$201,254	$16,981	$899,534	$52,914	$105,827	$1,058,275	$47,227	$310,500	$69,999	$1,488,001
CENTRAL MIDLANDS	$377,930	$528,716	$267,822	$22,598	$1,197,066	$70,416	$140,831	$1,408,313	$64,827	$413,200	$212,654	$2,098,994
LOWER SAVANNAH	$325,475	$455,333	$230,650	$19,462	$1,030,920	$60,643	$121,285	$1,212,848	$62,215	$355,849	$85,033	$1,715,945
SANTEE-LYNCHES	$277,139	$387,708	$196,394	$16,571	$877,812	$51,636	$103,272	$1,032,720	$41,343	$303,000	$78,216	$1,455,279
PEE DEE	$335,448	$469,281	$237,715	$20,058	$1,062,500	$62,500	$125,000	$1,250,000	$62,463	$366,750	$100,206	$1,779,419
WACCAMAW	$308,506	$431,593	$218,624	$18,447	$977,170	$57,481	$114,981	$1,149,612	$47,442	$337,296	$80,688	$1,615,038
TRIDENT	$373,446	$522,440	$264,642	$22,330	$1,182,855	$69,580	$139,159	$1,391,594	$56,899	$408,293	$46,773	$1,903,559
LOWCOUNTRY	$266,300	$372,538	$188,709	$15,923	$843,470	$49,615	$99,231	$992,316	$44,480	$291,145	$166,545	$1,494,486
TOTAL	$3,377,037	$4,724,397	$2,393,149	$201,927	$10,696,510	$629,207	$1,258,410	$12,584,127	$600,000	$3,692,186	$940,619	$17,816,932

STATE UNIT ON AGING

Projected State Unit on Aging Operating Budget Fiscal Year 2008

South Carolina State Plan on Aging 2009 - 2012

(4)

(1), (5)

Budget Category	Title III - OAA	Title V - OAA	Other Federal	State Revenue	Other Funds	Total
Saleries	$543,493	$61,184	$325,027	$1,257,318	$9,247	$2,196,269
Fringe Benefits	$158,372	$17,743	$105,999	$365,632	$2,621	$650,367
Direct Operating Costs	$234,244	$9,341	$449,280	$580,801	$346,591	$1,620,257
Total	$936,109	$88,268	$880,306	$2,203,751	$358,459	$4,466,893
	-2	-3	-4	(1), (5)		

(1) Excludes Lt. Governor's Office - Statehouse - $415,379.

(2) Includes only the federal share of Title III State Administration and the federal share of Title III funding for the Long-Term Care Ombudsman.

(3) Includes only the federal share Title V State Administration.

(4) Includes Social Services Block Grant, Insurance Counseling (CMS), and the federal share of Medicaid, Medicare Fraud Patrol (AoA), and Demonstration Grants from CMS and AoA.

(5) Includes required match for all federal grants administered by the SUA ($304,435) plus additional state general revenue to support state mandated responsibilities of the State Unit on Aging ($1,831,285)

Effective Date: 10-01-2008

OFFICE ON AGING					
State Fiscal Year 2008 - 2009					
Allocation to Area Agency on Aging for BINGO FUNDED SERVICES as of March , 2008					
Estimated Bingo Tax Allocation: $600,000					
APPALACHIA: $117,361		**UPPER SAVANNAAH: $55,743**		**CATAWBA: $47,227**	
Anderson	$20,109	Abbeville	$8,594	Chester	$9,010
Cherokee	$10,285	Edgefield	$8,109	Lancaster	$11,035
Greenville	$34,262	Greenwood	$11,642	Union	$8,981
Oconee	$12,975	Laurens	$11,768	York	$18,201
Pickens	$14,247	McCormick	$7,614	**SANTEE-LYNCHES: $41,343**	
Spartanburg	$25,483	Saluda	$8,016	Clarendon	$9,270
CENTRAL MIDLANDS : $64,827		**LOWER SAVANNAH : $62,215**		Kershaw	$10,637
Fairfield	$8,335	Aiken	$17,874	Lee	$7,864
Lexington	$21,701	Allendale	$7,271	Sumter	$13,572
Newberry	$9,455	Bamberg	$7,786	**TRIDENT: $56,899**	
Richland	$25,336	Barnwell	$8,182	Berkeley	$15,113
PEE DEE: $62,463		Calhoun	$7,721	Charleston	$28,875
Chesterfield	$9,635	Orangeburg	$13,381	Dorchester	$12,911
Darlington	$11,314	**WACCAMAW: $47,442**		**LOWCOUNTRY: $44,480**	
Dillon	$8,501	Georgetown	$12,246	Beaufort	$19,130
Florence	$15,547	Horry	$28,084	Colleton	$9,489
Marion	$8,989	Williamsburg	$9,112	Hampton	$7,977
Marlboro	$8,477			Jasper	$7,884

Services to Low Income and Minority Older Individuals

According to the 2000 Census 82,759 minority individuals age 60 and older were below the poverty level in South Carolina, comprising approximately 13.0 percent of the total population age 60 and older. Approximately 23 percent of the minority population age 60 and older is below the poverty level.

The methods used to satisfy the service needs of minority older individuals, with respect to the fiscal year preceding the year for which the plan is prepared, were the same as those used to satisfy the service needs of all older individuals. Since the limited federal funds available through the Older Americans Act do not come close to making it possible to satisfy the service needs of all older individuals, minority or otherwise, an effort is made to identify those most in need. The SUA has implemented a uniform Client Intake and Client Assessment Information System statewide to aid the Area Agencies on Aging and local service providing agencies in determining those most in need of services. An effort has been made by all Area Agencies on Aging to ensure that nutrition sites, senior centers and other service delivery sites are located in areas that are easily accessible to low-income minority older individuals. Minority individuals comprise a much higher proportion of Title III program participants than their proportion of the total 60 and older population.

Services to Older Individuals in Rural Areas

According to the 2000, Census approximately 40% of South Carolina's population resides in rural areas. With respect to the fiscal year preceding the fiscal year for which the plan is prepared, the methods used to satisfy the service needs of older individuals who reside in rural areas included efforts to make services accessible in rural areas. Efforts have been made by the Area Agencies on Aging in rural areas of the state to decentralize the location of congregate nutrition sites to the extent that it is feasible to do so. Many congregate nutrition sites and other service delivery sites are located in rural areas. In addition, statewide, 57.4%

of the Title III-B funds have been allocated and spent on transportation services for FY 2007 in order to provide access to services for those older individuals residing in rural areas.

Title III-B Minimum Percentage Requirement

Section 307 of the Older Americans Act was amended in 1987 to require that the State Plan shall specify a minimum percentage of Title III-B funds which each Area Agency on Aging will expend, in the absence of a State Agency waiver, for access services, in-home services and legal assistance. Program Instruction-88-04 from the Administration on Aging indicates that minimum percentages must be specified in this plan. Therefore, minimum percentages were established with participation and input from Area Agencies on Aging and local service providing agencies. The minimum percentages of Title III, Part B funds which each Area Agency on Aging will expend, in the absence of a State Agency waiver, for access services, in-home services and legal assistance are:

Access Services:	15 Percent
In-Home Services:	10 Percent
Legal Assistance:	1 Percent

The table below shows the amount of funds expended in each category statewide during the fiscal year most recently concluded.

TOTAL III-B EXPENDITURES FOR FISCAL YEAR 2006 – 2007

CATEGORY	EXPENDITURES	PERCENTAGE
Access Services	$2,971,790	71%
In-Home Services	$1,108,902	27%
Legal Services	$77,169	2%
TOTAL	**$4,157,771**	**100.0%**

Preference for Greatest Economic or Social Need

As required by the Older Americans Act, the SUA gives preference to providing services to older individuals with the greatest economic or social needs, with particular attention to low-income minority individuals. Since the use of means tests is prohibited, the service providers must use their discretion in determining that potential participants are economically needy. The US Bureau of Census poverty thresholds are used as guidelines for determining economic need.

Social needs are determined through a client needs assessment process that considers factors such as physical and mental disabilities, cultural or social isolation, or other factors that restrict an individual's ability to perform normal daily tasks or that threaten his or her capacity to live independently.

The SUA allows the Area Agencies on Aging flexibility in determining the specific process that will be used to assess needs in each Planning and Service Area; however, all Area Agencies are required to use a uniform Client Intake and Client Assessment information form. This is monitored using the Program Performance Report, and by periodic on-site monitoring and assessment of the Area Agencies on Aging. Current statistics indicate that 72% of participants are below the poverty threshold, 56 percent live in rural areas, and 51 percent are minorities (Fiscal Year 2006-2007). According to the 2000 Census, 13% percent of those over age sixty

are below the poverty threshold, 60% live in rural areas, and 23% percent are minorities. These figures demonstrate that the target population is receiving preference because they are being served in greater proportions than their percentages of the total population over age sixty in South Carolina. Therefore, it has not been deemed necessary to add additional procedures to target these groups.

APPENDIX A: ASSURANCES

Listing of State Plan Assurances

Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and required activities.

ASSURANCES

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

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

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

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

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

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

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

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

Sec. 306(a), AREA PLANS

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

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

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

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

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

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

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

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

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

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

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

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English

proficiency, and older individuals residing in rural areas within the planning and service area; and

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

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

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

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

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

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

(6)(F) Each area agency will:

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

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

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

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

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

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

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

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

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

(ii) the nature of such contract or such relationship.

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

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

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

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

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

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

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

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

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

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

not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

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

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

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

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

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

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

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

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

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

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

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

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

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

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

(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and

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

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

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

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

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

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

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

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

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

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

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

(21) The plan shall

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

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

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

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

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

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

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

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

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

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

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

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this

paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

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

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

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

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

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

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

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

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social

service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

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

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

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

(2) The State agency:

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

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

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:

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

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

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

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

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

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

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

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

_____ _____

Signature and Title of Authorized Official Date

APPENDIX B: LIEUTENANT GOVERNOR'S – OFFICE ON AGING MISSION, VISION AND VALUES STATEMENTS

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

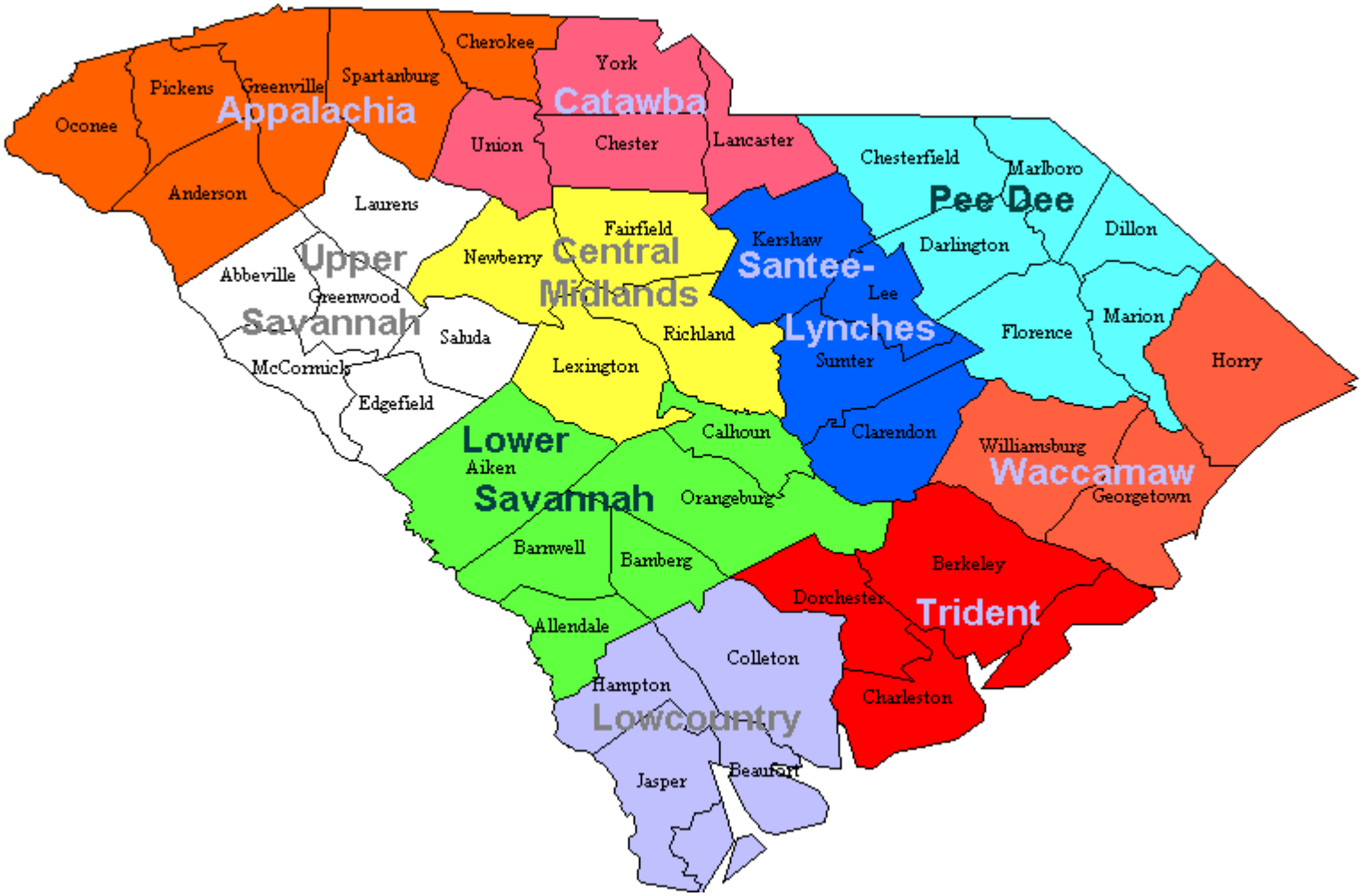
The ***vision*** of the Lieutenant Governor's Office on Aging is to provide leadership, advocacy and collaboration to assure a full spectrum of services so that South Carolina senior and / or adults with disabilities can enjoy an enhanced quality of life, contribute to their communities, have economic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

Our Values**:** Our value statements are based on mutual respect for internal and external audiences and define: 1) how people want to behave with each other in the organization; 2) how the organization will value external customers and 3) they form the foundation for everything that happens in the workplace. Our value statements describe actions that are the living enactment of the fundamental values held by most individuals within the organization and are traits or qualities that are considered worthwhile; representative of an individual's highest priorities and deeply held driving forces.

- We accept ***personal responsibility*** to efficiently use organization resources, improve our systems, and collaborate with others to improve effectiveness.
- We maintain ***credibility*** by making certain our actions always match our words.
- We are ***truthful in all matters***; present truth in an appropriate and helpful manner; ***keep confidences***; and admit mistakes seeing them as learning opportunities.
- We are dedicated to meeting the expectations and requirements of internal and external customers; getting first-hand customer feedback, if possible, and use it for improvements in services and products; ***act with customer in mind***; establish and maintain effective relationships with customers to gain their trust and respect.
- We are committed to bringing creative ideas, ***innovative services*** and suggestions for quality improvement to the attention of others after we have projected how potential ideas play out in the community, organization and impact the individuals we serve.
- We will strive to relate well to all people, inside and outside the organization, build constructive and ***effective relationships***, use diplomacy and tact, and to diffuse situations comfortably.
- We will demonstrate strength, moral principals, honesty and ***ethics*** that warrant the trust of those we serve.
- We will focus on ***successful teamwork*** to set and accomplish goals because we all share the same mission.
- We will foster a climate of ***mutual respect*** and positive change at all levels.
- We respect the unique contributions of each individual and treat one another with ***respect and dignity***.

- We are thoughtful ***stewards*** of our human/financial resources and provide the best value for every dollar spent because we're taxpayers, too.
- We will honor our ***commitments*** because we believe in integrity.
- We will be committed to ***open/transparent communication*** given freely and share as appropriate.

APPENDIX C: SOUTH CAROLINA PLANNING AND SERVICE AREAS



AREA AGENCIES ON AGING AND SERVICE PROVIDERS

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REGION III - CATAWBA

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For Krystle Stephens – krystle.stephens@catawba-aging.com

COUNTIES SERVED: Chester, Lancaster, York, & Union

REGIONAL OMBUDSMAN: Melissa Morrison
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bmauldin@centralmidlands.org
For Sharon Seago sseago@centralmidlands.org

COUNTIES SERVED: Fairfield, Lexington, Newberry, and Richland

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MS. LYNNDA BASSHAM, Human Service Director
MS. MARY BETH FIELDS, Aging Unit Director
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COUNTIES SERVED: Aiken, Allendale, Bamberg, Barnwell, Calhoun, and Orangeburg

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MR. SHAWN KEITH, Aging Unit Director
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COUNTIES SERVED: Clarendon, Kershaw, Lee, and Sumter

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COUNTIES SERVED: Georgetown, Horry, and Williamsburg

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COUNTIES SERVED: Beaufort, Colleton, Hampton, and Jasper

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APPENDIX D: STATEWIDE SUPPORT OF OLDER AMERICANS ACT SERVICES

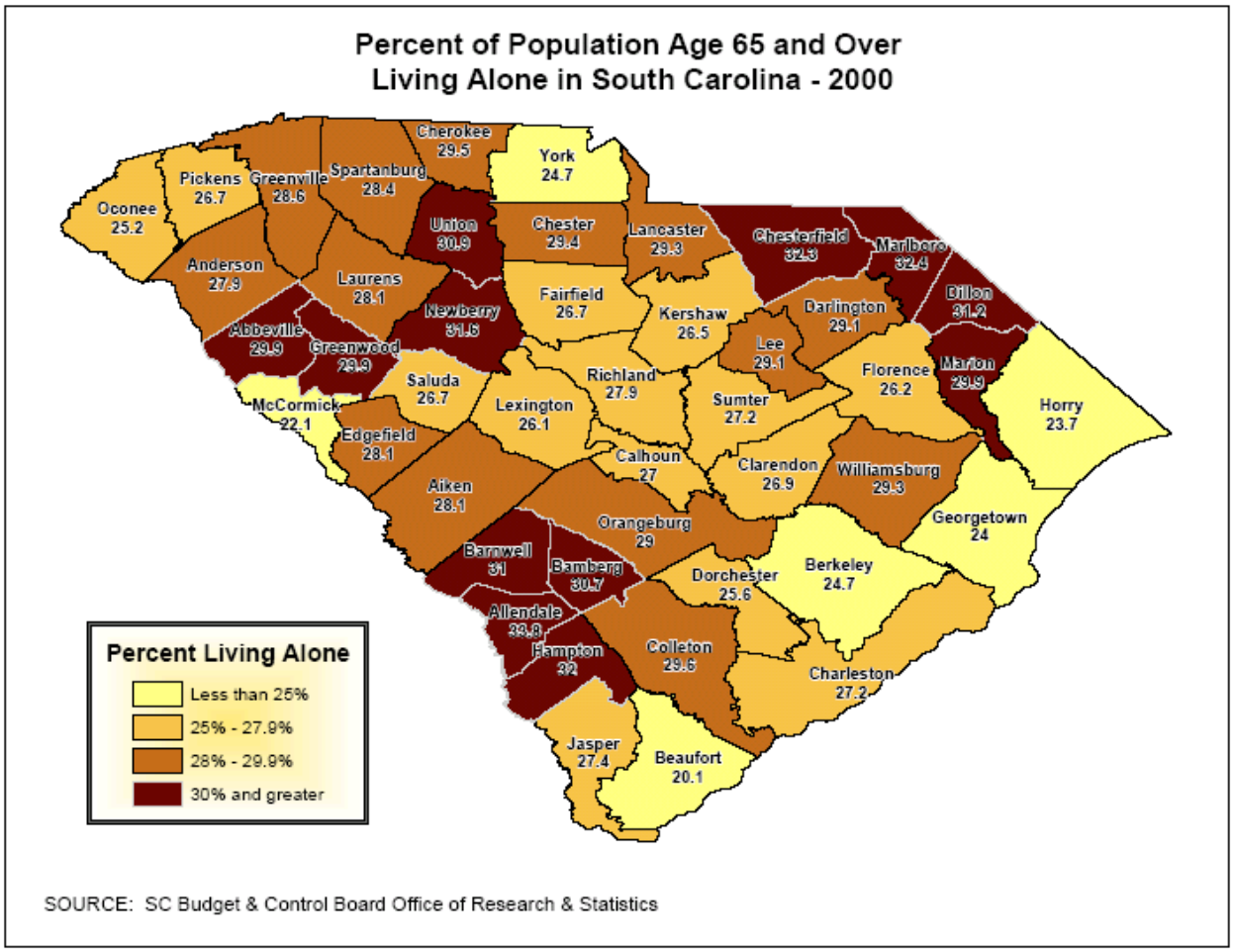
	Adult Day Care	Care Mgmt	Congregate Meals	Education/Info	Family Caregiver	Health Screening	Health Promotion	Home Del. Meals	Homebound Support	Home Living Support Support	Income/Material Aid	Info & Assistance	Legal Assistance	Level I Home Care	Level II Home Care	Home Maintenance	Nutrition Education	Physical Fitness	Respite	Social Support	Transportation
REGION 01																					
Anderson-Oconee	X	X	X					X						X				X			X
Cherokee			X				X	X				X		X		X	X	X	X		X
Greenville		X	X	X		X	X	X						X	X		X	X		X	X
Pickens		X	X					X				X		X		X		X			X
Spartanburg		X	X				X	X						X				X			X
SC Ctrs for Equal Justice			X					X					X								
Appalachia AAA					X							X									
REGION 02																					
Abbeville			X					X	X			X						X		X	X
Edgefield	X		X					X				X		X				X			X
Greenwood			X					X				X						X		X	X
Laurens	X		X					X										X			X
McCormick			X					X										X			X
Saluda			X					X						X	X			X			X
Health Related Personnel														X							
Upper Savannah AAA					X					X		X	X			X					
REGION 03																					
Chester			X					X						X				X			X
Lancaster			X	X		X		X						X				X	X		X
Union			X					X						X				X			X
York			X	X		X		X						X				X			X
Catawba AAA					X							X									
REGION 04																					
Fairfield			X				X	X						X			X				X

	Adult Day Care	Care Mgmt	Congregate Meals	Education/Info	Family Caregiver	Health Screening	Health Promotion	Home Del. Meals	Homebound Support	Home Living Support Support	Income/Material Aid	Info & Assistance	Legal Assistance	Level I Home Care	Level II Home Care	Home Maintenance	Nutrition Education	Physical Fitness	Respite	Social Support	Transportation
Lexington			X			X		X						X							X
Newberry	X		X			X		X		X				X	X					X	X
Richland			X				X	X						X							X
Irmo-Chapin			X			X		X													X
Columbia Urban League													X								
Home Care Solutions														X	X						
Central Midlands AAA	X				X							X									
REGION 05																					
Aiken			X				X	X			X			X	X		X				X
Allendale			X					X		X				X							X
Bamberg			X					X		X				X							X
Barnwell			X	X		X	X	X							X		X				
Calhoun			X					X		X		X		X				X			X
Orangeburg			X					X						X				X			
Lower Savannah AAA					X							X									
REGION 06																					
Clarendon			X			X		X						X				X	X		X
Kershaw			X					X	X					X				X			X
Lee			X					X						X				X			X
Sumter			X					X						X				X	X		X
Santee-Lynches AAA		X			X							X									
Empowered Care								X													
Greater Faith			X																		X
REGION 07																					
Chesterfield			X			X		X						X							X
Darlington			X					X						X				X			X
Dillon			X					X						X				X			X
Florence			X				X	X						X	X			X			X

	Adult Day Care	Care Mgmt	Congregate Meals	Education/Info	Family Caregiver	Health Screening	Health Promotion	Home Del. Meals	Homebound Support	Home Living Support Support	Income/Material Aid	Info & Assistance	Legal Assistance	Level I Home Care	Level II Home Care	Home Maintenance	Nutrition Education	Physical Fitness	Respite	Social Support	Transportation
Marion			X					X						X	X			X			X
Marlboro			X					X		X				X		X		X			X
SC Ctrs for Equal Justice													X								
Vantage Point AAA					X						X	X		X							
REGION 08																					
Georgetown			X				X	X						X			X				X
Horry		X	X				X	X						X			X				X
Williamsburg			X				X	X						X			X				X
Waccamaw AAA					X							X									
REGION 09																					
Berkeley			X					X						X							X
Charleston			X					X													X
Dorchester			X					X													X
Sea Island			X					X													X
South Santee			X					X													X
HCBS															X						X
Roper St. Francis																		X			
SC Ctrs for Equal Justice													X								
Trident AAA					X							X									
REGION 10																					
Beaufort			X				X	X						X							X
Colleton	X		X				X	X						X							X
Hampton			X				X	X							X						X
Jasper			X					X						X	X			X			X
Lowcountry AAA					X							X									

APPENDIX E: HISTORICAL DEMOGRAPHICS

PERCENT OF 65+ POPULATION LIVING ALONE IN 2000



	POP	#	%	PSA	POP	#	%	PSA	POP	#	%
APPALACHIA				**UPPER SAVANNAAH**				**CATAWBA**			
Anderson	22,627	6,314	27.9	Abbeville	3,842	1,149	29.9	Chester	4,317	1,271	29.4
Cherokee	6,517	1,923	29.5	Edgefield	2,669	750	28.1	Lancaster	7,413	2,172	29.3
Greenville	44,573	12,768	28.6	Greenwood	9,075	2,717	29.9	Union	4,670	1,443	30.9
Oconee	10,311	2,598	25.2	Laurens	9,168	2,576	28.1	York	17,072	4,217	24.7
Pickens	12,616	3,373	26.7	McCormick	1,645	363	22.1	**SANTEE-LYNCHES**			
Spartanburg	31,740	9,027	28.4	Saluda	2,778	743	26.7	Clarendon	4,538	1,221	26.9
CENTRAL MIDLANDS				**LOWER SAVANNAH**				Kershaw	6,796	1,804	26.5
Fairfield	3,094	827	26.7	Aiken	18,287	5,139	28.1	Lee	2,504	729	29.1
Lexington	21,989	5,734	26.1	Allendale	1,421	480	33.8	Sumter	11,760	3,201	27.2
Newberry	5,323	1,683	31.6	Bamberg	2,314	710	30.7	**TRIDENT**			
Richland	31,475	8,772	27.9	Barnwell	2,962	917	31.0	Berkeley	11,261	2,787	24.7
PEE DEE				Calhoun	2,102	567	27.0	Charleston	36,858	10,016	27.2
Chesterfield	5,120	1,656	32.3	Orangeburg	12,091	3,508	29.0	Dorchester	8,791	2,254	25.6
Darlington	8,158	2,376	29.1	**WACCAMAW**				**LOWCOUNTRY**			
Dillon	3,545	1,107	31.2	Georgetown	8,354	2,001	24.0	Beaufort	18,754	3,774	20.1
Florence	14,837	3,881	26.2	Horry	29,470	6,984	23.7	Colleton	4,928	1,460	29.6
Marion	4,298	1,287	29.9	Williamsburg	4,856	1,423	29.3	Hampton	2,595	831	32.0
Marlboro	3,550	1,149	32.4					Jasper	2,269	622	27.4
SC Totals: Total Population Over 65 = 485,333; Total Over 65 Living Alone = 132,302; Percent of Over 65 Living Alone = 27.3											
Source: Office of Research and Statistics based on Census 2000 data.											

POPULATION OVER AGE 60 IN 2000

PSA	TOTAL	60+	%	PSA	POP	#	%	PSA	POP	#	%
APPALACHIA				**UPPER SAVANNAH**				**CATAWBA**			
Anderson	165,240	30,240	18.1	Abbeville	26,167	5,005	19.1	Chester	34,068	5,751	16.9
Cherokee	52,537	8,672	16.5	Edgefield	24,595	3,568	14.5	Lancaster	61,351	10,107	16.5
Greenville	379,616	59,563	15.7	Greenwood	66,271	11,781	17.8	Union	29,881	6,139	20.5
Oconee	66,215	14,116	21.3	Laurens	69,567	12,222	17.6	York	164,614	23,395	14.2
Pickens	110,757	17,034	15.4	McCormick	9,958	2,286	23.0	**SANTEE-LYNCHES**			
Spartanburg	253,791	42,408	16.7	Saluda	19,181	3,671	19.1	Clarendon	32,502	6,197	19.1
CENTRAL MIDLANDS				**LOWER SAVANNAH**				Kershaw	52,647	9,095	17.3
Fairfield	23,454	4,047	17.3	Aiken	142,552	24,112	16.9	Lee	20,119	3,244	16.1
Lexington	216,014	30,215	14.0	Allendale	11,211	1,844	16.4	Sumter	104,606	15,809	15.1
Newberry	36,108	6,892	19.1	Bamberg	16,658	3,014	18.1	**TRIDENT**			
Richland	320,677	41,607	13.0	Barnwell	23,478	3,840	16.4	Berkeley	142,651	16,280	11.4
PEE DEE				Calhoun	15,185	2,804	18.5	Charleston	309,969	48,734	15.7
Chesterfield	42,768	6,933	16.2	Orangeburg	66,215	16,065	21.3	Dorchester	96,413	12,353	12.8
Darlington	67,394	11,101	16.5	**WACCAMAW**				**LOWCOUNTRY**			
Dillon	30,722	4,773	15.5	Georgetown	55,797	11,434	20.5	Beaufort	120,937	25,040	20.7
Florence	125,761	19,986	15.9	Horry	196,629	40,104	20.4	Colleton	38,264	6,711	17.5
Marion	35,466	5,753	16.2	Williamsburg	37,217	6,405	17.2	Hampton	21,386	3,392	15.9
Marlboro	28,818	4,656	16.2					Jasper	20,678	3,084	14.9
SC Totals: Total Population = 4,012,012; Total Over 60 Population = 651,482; Total % = 16.2											
Source: Office of Research and Statistics based on Census 2000 data.											

SOUTH CAROLINA POPULATION BY AGE 2000 – 2025: AGE 60+ By PSA						
	2000	2005	2010	2015	2020	2025
Appalachia PSA	**172,033**	**186,440**	**212,860**	**241,230**	**278,140**	**307,320**
Anderson County	30,240	32,420	36,850	40,930	47,540	51,610
Cherokee County	8,672	9,150	10,300	11,540	13,220	14,530
Greenville County	59,563	63,770	72,600	82,280	95,630	107,090
Oconee County	14,116	16,770	19,930	23,260	26,910	29,630
Pickens County	17,034	18,810	21,460	24,570	28,130	31,370
Spartanburg County	42,408	45,520	51,720	58,650	66,710	73,090
Upper Savannah PSA	**38,533**	41,940	**48,530**	**56,020**	**64,880**	**73,210**
Abbeville County	5,005	5,150	5,870	6,540	7,490	8,250
Edgefield County	3,568	3,970	4,870	6,110	7,590	9,110
Greenwood County	11,781	12,300	13,560	14,840	16,470	17,750
Laurens County	12,222	13,450	15,470	17,870	20,570	23,200
McCormick County	2,286	3,110	4,290	5,610	7,050	8,510
Saluda County	3,671	3,960	4,470	5,050	5,710	6,390
Catawba PSA	**45,392**	**49,080**	**56,810**	**65,170**	**76,780**	**87,110**
Chester County	5,751	6,080	6,940	7,790	8,960	9,860
Lancaster County	10,107	10,360	11,780	13,220	15,290	16,410
Union County	6,139	6,370	6,900	7,310	8,050	8,340
York County	23,395	26,270	31,190	36,850	44,480	52,500
Central Midlands PSA	**82,761**	**91,810**	**109,480**	**129,110**	**152,480**	**172,400**
Fairfield County	4,047	4,260	5,040	6,130	7,200	8,300
Lexington County	30,215	35,680	43,450	51,510	61,070	70,340
Newberry County	6,892	7,270	8,240	9,380	10,740	11,930
Richland County	41,607	44,600	52,750	62,090	73,380	81,830
Lower Savannah PSA	**51,679**	**67,970**	**67,710**	**79,520**	**94,280**	**108,090**
Aiken County	24,112	27,960	32,880	38,880	46,590	54,450
Allendale County	1,844	2,110	2,530	2,880	3,410	3,600
Bamberg County	3,014	3,020	3,480	3,880	4,520	4,530
Barnwell County	3,840	4,290	5,040	6,000	7,250	8,550
Calhoun County	2,804	3,020	3,720	4,540	5,620	6,570
Orangeburg County	16,065	17,570	20,060	23,340	26,890	30,390
Santee-Lynches PSA	**34,345**	**38,390**	**45,430**	**53,160**	**64,090**	**72,220**
Clarendon County	6,197	7,140	8,900	10,790	13,080	14,730
Kershaw County	9,095	9,810	11,590	13,380	16,120	18,430
Lee County	3,244	3,490	4,180	4,920	6,040	6,450
Sumter County	15,809	17,950	20,760	24,070	28,840	32,610
Pee Dee PSA	**63,202**	**55,710**	**64,390**	**73,630**	**85,920**	**92,210**
Chesterfield County	6,933	7,200	8,380	9,510	10,930	12,130
Darlington County	11,101	11,680	13,480	15,510	18,000	19,420
Dillon County	4,773	4,730	5,280	5,980	6,840	7,660
Florence County	19,986	21,680	25,210	29,370	33,900	37,470
Marion County	5,753	5,880	7,010	7,940	10,080	9,380
Marlboro County	4,656	4,540	5,030	5,320	6,170	6,150
Waccamaw PSA	**57,943**	**69,030**	**85,870**	**105,770**	**129,770**	**153,420**
Georgetown County	11,434	13,800	17,640	22,100	17,940	32,490
Horry County	40,104	48,470	60,420	74,460	91,060	109,060
Williamsburg County	6,406	6,760	7,810	9,210	10,770	11,870
Trident PSA	**77,367**	**92,870**	**114,490**	**139,130**	**167,866**	**180,640**
Berkeley County	16,280	22,110	29,430	37,340	46,370	42,300
Charleston County	48,734	54,520	63,770	74,880	88,090	98,260
Dorchester County	12,353	16,240	21,290	26,910	33,400	40,080
Lowcountry PSA	**38,227**	**46,460**	**59,320**	**74,710**	**93,280**	**112,500**
Beaufort County	25,040	32,230	42,320	54,650	69,260	85,220
Colleton County	6,711	7,200	8,470	9,950	11,600	12,870
Hampton County	3,392	3,570	4,360	5,120	6,350	7,040
Jasper County	3,084	3,410	4,170	4,990	6,070	7,370
South Carolina Totals	**651,482**	**729,700**	**864,890**	**1,017,450**	**1,207,480**	**1,359,120**

SOUTH CAROLINA POPULATION BY AGE 2000 – 2025: AGE 75+ By PSA						
	2000	2005	2010	2015	2020	2025
Appalachia PSA	**58,533**	**59,070**	**60,990**	**62,100**	**76,650**	**88,520**
Anderson County	10,289	10,280	10,750	10,600	13,580	14,830
Cherokee County	2,947	2,940	2,940	2,800	3,520	4,020
Greenville County	20,747	20,930	20,970	20,840	25,550	30,430
Oconee County	4,074	4,570	5,640	6,580	8,040	8,940
Pickens County	5,857	5,990	6,230	6,630	7,840	9,120
Spartanburg County	14,619	14,360	14,460	14,650	18,120	21,180
Upper Savannah PSA	**13,403**	**13,780**	**14,350**	**14,810**	**17,650**	**21,676**
Abbeville County	1,784	1,780	1,900	1,810	2,050	2,460
Edgefield County	1,195	1,220	1,280	1,350	1,700	2,260
Greenwood County	4,245	4,250	4,150	4,080	4,680	5,670
Laurens County	4,194	4,280	4,490	4,630	5,590	6,610
McCormick County	681	860	1,070	1,380	1,840	2,460
Saluda County	1,304	1,390	1,460	1,560	1,790	2,110
Catawba PSA	**14,920**	**15,120**	**15,900**	**16,140**	**19,820**	**23,469**
Chester County	1,954	1,880	2,030	1,850	2,450	2,919
Lancaster County	3,279	2,930	2,990	3,050	3,930	4,170
Union County	2,180	2,260	2,360	2,300	2,550	2,870
York County	7,507	8,050	8,520	8,940	10,890	13,510
Central Midlands PSA	**28,365**	**29,770**	**31,060**	**31,700**	**38,980**	**49,380**
Fairfield County	1,405	1,340	1,350	1,340	1,610	2,230
Lexington County	9,764	11,290	12,550	13,610	16,450	20,220
Newberry County	2,661	2,490	2,480	2,550	3,120	3,720
Richland County	14,536	14,650	14,680	14,200	17,800	23,210
Sub Total						
Lower Savannah PSA	**17,557**	**19,130**	**20,400**	**20,670**	**24,980**	**30,590**
Aiken County	7,943	9,350	10,220	10,320	12,210	15,360
Allendale County	707	770	770	760	1,080	1,210
Bamberg County	1,092	920	970	810	1,240	1,090
Barnwell County	1,336	1,480	1,580	1,570	1,860	2,410
Calhoun County	949	880	950	950	1,290	1,570
Orangeburg County	5,530	5,730	5,910	6,260	7,300	8,950
Santee-Lynches PSA	**11,335**	**11,950**	**13,560**	**13,840**	**7,960**	**19,850**
Clarendon County	1,869	1,940	2,300	2,580	3,450	4,230
Kershaw County	2,946	3,000	3,350	3,240	4,020	4,800
Lee County	1,169	1,220	1,440	1,290	1,750	1,730
Sumter County	5,351	5,790	6,470	6,730	7,960	9,090
Pee Dee PSA	**17,950**	**17,220**	**17,270**	**16,890**	**22,290**	**24,790**
Chesterfield County	2,203	2,030	2,180	2,160	2,690	3,220
Darlington County	3,704	3,530	3,470	3,520	4,580	5,200
Dillon County	1,603	1,520	1,380	1,410	1,610	2,080
Florence County	6,897	7,020	7,110	7,320	8,970	11,260
Marion County	1,944	1,750	1,830	1,440	2,780	1,490
Marlboro County	1,599	1,370	1,300	1,040	1,660	1,540
Waccamaw County PSA	**16,614**	**19,550**	**23,450**	**26,850**	**33,330**	**40,940**
Georgetown County	3,476	3,910	4,770	5,350	7,480	8,730
Horry County	11,011	13,560	16,540	19,330	23,290	28,970
Williamsburg County	2,127	2,080	2,140	2,170	2,560	3,240
Trident County PSA	**24,905**	**28,610**	**31,780**	**35,570**	**45,800**	**59,510**
Berkeley County	4,288	5,800	7,440	9,360	12,500	16,690
Charleston County	16,828	18,010	18,420	18,930	23,760	30,340
Dorchester County	3,789	4,800	5,920	7,280	9,520	12,480
Lowcounty PSA	**11,703**	**13,760**	**17,120**	**20,410**	**26,730**	**32,090**
Beaufort County	7,425	9,640	12,460	15,600	19,580	14,970
Colleton County	2,134	2,020	2,210	2,260	2,910	3,380
Hampton County	1,148	1,040	1,260	1,250	1,670	1,700
Jasper County	996	1,060	1,190	1,300	1,570	2,040

South Carolina Totals	215,285	227,960	245,880	258,980	322,410	390,709
SOUTH CAROLINA POPULATION BY AGE 2000 – 2025: AGE 85+ By PSA						
	2000	**2005**	**2010**	**2015**	**2020**	**2025**
Appalachia PSA	**14,010**	**13,520**	**16,310**	**11,860**	**17,550**	**14,090**
Anderson County	2,344	2,110	2,890	1,640	3,300	1,820
Cherokee County	721	650	820	560	780	670
Greenville County	5,009	4,870	6,010	4,320	5,630	5,450
Oconee County	848	880	1,080	1,000	1,750	1,050
Pickens County	1,504	1,640	1,720	1,490	1,970	1,780
Spartanburg County	3,583	3,370	3,790	2,850	4,120	3,320
Sub Total						
Upper Savannah PSA	**3,462**	**3,580**	**3,980**	**3,620**	**4,020**	**4,380**
Abbeville County	488	380	610	380	580	470
Edgefield County	293	350	360	330	400	390
Greenwood County	1,041	1,060	1,100	1,000	950	1,160
Laurens County	1,121	1,130	1,230	1,080	1,360	1,210
McCormick County	178	240	300	320	380	520
Saluda County	341	420	380	510	350	630
Catawba PSA	**3,476**	**3,440**	**4,250**	**3,110**	**4,680**	**3,850**
Chester County	446	310	550	280	490	490
Lancaster County	752	650	450	440	1,000	400
Union County	505	510	640	460	680	540
York County	1,772	1,970	2,310	1,930	2,480	2,420
Central Midlands PSA	**6,840**	**7,520**	**9,100**	**7,620**	**9,690**	**8,830**
Fairfield County	344	640	320	340	340	280
Lexington County	2,412	3,170	3,950	3,930	4,500	4,620
Newberry County	706	660	680	520	780	610
Richland County	3,376	3,350	4,150	2,830	4,070	3,320
Lower Savannah PSA	**4,089**	**4,430**	**6,440**	**4,680**	**5,790**	**5,020**
Aiken County	1,782	2,070	2,650	2,520	2,660	2,820
Allendale County	189	190	240	140	300	110
Bamberg County	240	150	260	40	400	-220
Barnwell County	301	350	440	390	450	450
Calhoun County	242	180	260	160	280	180
Orangeburg County	1,335	1,490	1,590	1,430	1,700	1,680
Santee-Lynches PSA	**2,704**	**2,610**	**3,660**	**2,510**	**4,460**	**2,700**
Clarendon County	433	380	550	390	740	590
Kershaw County	703	590	890	580	960	610
Lee County	287	230	420	220	540	10
Sumter County	1,281	1,410	1,800	1,320	2,210	1,490
Pee Dee PSA	**4,378**	**4,010**	**5,000**	**2,940**	**5,750**	**2,510**
Chesterfield County	516	410	470	350	580	340
Darlington County	843	810	1,000	550	1,110	590
Dillon County	353	330	360	290	240	560
Florence County	1,797	1,880	2,150	1,660	2,260	2,110
Marion County	470	290	590	0	1,050	-1,040
Marlboro County	399	290	430	90	510	-50
Waccamaw PSA	**3,170**	**3,650**	**5,070**	**4,620**	**6,870**	**5,910**
Georgetown County	657	650	1,140	660	1,630	750
Horry County	2,041	2,540	3,410	3,570	4,610	4,790
Williamsburg County	472	470	520	390	630	370
Trident PSA	**5,604**	**6,730**	**8,640**	**7,960**	**10,600**	**11,120**
Berkeley County	879	1,240	1,770	2,030	2,720	3,040
Charleston County	3,855	4,170	5,060	3,990	5,160	5,110
Dorchester County	870	1,320	1,810	1,940	2,620	2,970
Lowcountry PSA	**2,537**	**2,840**	**3,870**	**4,220**	**5,630**	**5,720**
Beaufort County	1,512	2,060	2,830	3,410	4,260	5,090
Colleton County	493	380	500	350	610	350
Hampton County	274	180	280	150	490	-70
Jasper County	258	220	260	310	270	350
South Carolina Totals	**50,269**	**52,340**	**65,320**	**53,140**	**74,900**	**64,130**

Lieutenant Governor's Office on Aging

Supplemental State Funds Expenditures

Calendar Year 2007

January 1, 2007-December 31, 2007

5,476 seniors served at a cost of $2.8 million, an average of $511.32 per person

County	# of seniors served from January – December 2007 with State Supplemental Funding	County	# of seniors served from January – December 2007 with State Supplemental Funding
Abbeville	39	Greenwood	115
Aiken	475	Hampton	67
Allendale	34	Horry	139
*Anderson	102	Jasper	113
Bamberg	43	Kershaw	108
Barnwell	48	Lancaster	86
Beaufort	81	Laurens	102
Berkeley	122	Lee	28
Calhoun	84	Lexington	139
Charleston	211	McCormick	170
Cherokee	115	Marion	56
Chester	79	Marlboro	28
Chesterfield	81	Newberry	54
Clarendon	92	*Oconee	101
Colleton	61	Orangeburg	135
Darlington	200	Pickens	122
Dillon	110	Richland	69
Dorchester	89	Saluda	63
Edgefield	30	Spartanburg	498
Fairfield	49	Sumter	463
Florence	157	Union	125
Georgetown	115	Williamsburg	51
Greenville	87	York	140

* Anderson and Oconee counties are served by a single agency.

Lt. Governor André Bauer has written each of the 5,476 recipients, asking for their evaluation of services.

All will have received a survey form by February 2008.

The survey responses to date indicate:

96.4% thought the quality of the service was very satisfactory or satisfactory

98.6% thought the service met their needs

88.2% thought the service helped them stay at home

The Lt.Governor's Office on Aging has also reviewed its AIM reporting information system for a profile of the services provided South Carolina's seniors.

Findings:

- 52% are receiving home delivered meals
- 24% are receiving congregate (group) meals
- 9% are receiving home care/home living support
- 6% are receiving transportation
- 1% are receiving adult day care/respite services
- 5% are receiving other services

Of the 5,476 seniors receiving the new home and community based services we see the following:

- 54% are nutritionally at risk
- 91% lack support (needs help or someone to check on them during evacuation or disaster, needs caregiver assistance or lives alone)
- 53% have incomes less than the federal poverty level
- 49% live alone
- 62% live in rural areas
- 55% are 75 and older
- 20% are 85 and older
- 25% are between 60 and 74

Permanent Funding of $2.9 Million is Priority for This Year

Priority of Lt. Governor André Bauer, Lt. Governor's Office on Aging, AARP SC, and Silver Haired Legislature

History of program: $2.9 million in supplemental funding authorized in state budget that began July 1, 2006 but supplemental funds could not be released until November 2006. Funds were to be spent in calendar year 2007.

In the interim, 10 Area Agencies on Aging prepared regional plans and arranged funding for county programs.

Program was planned, implemented and evaluated within one year.

No administration funds were withheld at either the state or regional level: 97% of the $2.9 million supplemental appropriation was used to purchase services at the local level during calendar year

2007; the remaining 3% will be spent for local services during January-June 2008.

The Legislature authorized an additional $1.4 million in supplemental funds in state budget that began July 1, 2007. These funds were not available until November 2007, and will be spent in the six months from January through June 2008. Less than $100,000 remaining from the original $2.9 million and the $1.4 million in new supplementary funds will be spent for local services during January-June 2008.

All funding will be exhausted by June 30, 2008. If the Legislature supports Lt. Governor Bauer's budget request for $2.9 million in permanent funding for the fiscal year that begins July 1, 2008, programs will continue through 2008 and 2009. Another round of supplementary funding means the program would have to halt between July and November, when the supplemental funds would be released.

APPENDIX F: STATE PLAN PUBLIC HEARINGS

2005-2008 State Plan on Aging

Minutes
Public Hearing

FY 2009-2012 State Plan on Aging

South Carolina Lt. Governor's Office on Aging

Friday, June 20, 2008
Dept. of Health and Environmental Control
Columbia, South Carolina

Presiding: Bruce E. Bondo

Mr. Bondo opened the hearing at 10:20 a.m. and introduced Lt. Governor Andre' Bauer. Lt. Governor Bauer welcomed the attendees and discussed the State Plan on Aging and the office's accomplishments over the past year. Mr. Bondo explained that the hearing would be in compliance with Federal law requiring that the Lt. Governor's Office on Aging prepare a state plan every four years and sponsor hearings to elicit public comment on the draft plan. Mr. Bondo introduced Ms. Joanne Metrick and other presenters for the hearing.

The State Plan Process

Mr. Bruce Bondo, serving as Senior Policy and Planning Consultant, explained that the State Plan, which identifies how South Carolina will use federal funds received through the Older Americans Act, is completed on a four-year cycle. Drafters of the Plan incorporate information from a variety of sources, including census data, surveys of recipients, Area Agencies on Aging, local service providers; the regional Area Plans for FY 2006-2008 by the ten AAAs. Input was received from the State AARP, the Silver Haired Legislature, the Joint Legislative Committee on Aging. Issues identified by the SC White House Conference on Aging and the US White House Conference on Aging were included in addition to requirements from the Administration on Aging and the Centers for Medicare and Medicaid Services. Following public review at three hearings around the state, the Plan will be submitted to the Lt. Governor and the Governor for final approval. The plan will then be forwarded to the US Department of Health and Human Services' Administration on Aging.

Overview of the State Plan

Mr. Bruce Bondo reviewed the content of the State Plan and the Executive Summary. He explained the purpose of the State Plan to be the mechanism to bring Older Americans Act funds to South Carolina over the next four years and to provide a blueprint for their use. He explained the vision and the mission of the State Unit on Aging, and the specific services provided and the sources of funding that support it.

The Intrastate Funding Formula

Ms. Joanne Metrick explained the funding formula that South Carolina will implement to fulfill the federal requirements of the Older Americans Act. This multi-faceted formula allocates federal funds to each economic development district according to the following:

- Fifty (50) percent is allocated equally to provide a viable operating base for service delivery.
- Twenty (20) percent is allocated based upon the proportion of the State's population sixty years old and older.
- Ten (10) percent is allocated based upon the proportion of the state's population sixty years old and older below the poverty level.
- Ten (10) percent is allocated based upon the proportion of the state's minority population sixty years old and older.
- Five (5) percent is allocated based upon the proportion of the state's moderately or severely impaired population that are 60 and older and have two or more limitations in activities in daily living.
- Five (5) percent is allocated based upon the proportion of the state's rural population

Characteristics of SC's Senior Population and Impact on Health Care Costs

Mr. Bruce Bondo discussed the characteristics of the senior population in South Carolina and the impact of these demographics on health care costs in the state. Mr. Bondo commented that South Carolina's senior population grew from 286,272 seniors in 1970 to 651,482 in 2000, an increase of 128 percent over thirty years. Statistics indicate that an additional 123 percent increase in seniors may be anticipated over the next thirty years from 651,482 to 1,450,487 by 2030. He additionally indicated that the growth of persons 85 and older have grown from 11,830 to 50,269 from 1970 to 2000 for a growth rate of 325 percent. It is anticipated that this population group will increase to 141,286 by 2030 for an additional 181 percent. Given the impact of both inflation and the growing number of seniors over the next thirty years, the effects on the already rising costs of nursing home care costs should prove considerable. Mr. Bondo further indicated that the older seniors would be susceptible to Alzheimer's disease and dementia, and would have a significant impact for health care costs for individuals, families and society. Mr. Bondo indicated that governmental officials on both the state and national level recognized that our citizens must recognize that the government will not have the necessary resources to cover the cost of long term care services and that we must plan for choice and personal incentives, as well as individuals taking personal responsibility for planning for their retirement and senior years.

Mr. Bondo indicated that the LGOA had undertaken a number of efforts to determine the major needs that should be addressed in the major initiatives for the next four years and beyond. The major needs discussed were as follows:

1) Transportation
2) Increased funds for home and community-based services
3) Strengthen Family Caregiver Support Program
4) Long Term Care Reform/Restructure Medicare/Medicaid/Provide Choice with Personal Incentives
5) Implement ADRC's with focus on Building a Case Management System
6) Expand and Modify Nutrition Services

7) Support Geriatric Education

8) Expand and Modernize Senior Centers

Major Initiatives Addressed in the FY2009-20012 State Plan
LGOA staff highlighted the issues and initiatives that the plan seeks to address:

- Modernization of Aging Services in South Carolina – Joanne Metrick
- Long Term Care Reform and Community Living Incentives – Deborah McPherson
- Senior Transportation – Deborah McPherson
- Implementation of Choices for Independence – Denise Rivers
- Geriatric Trained Professional Workforce – Denise Rivers
- Energizing the ARCC – Anne Wolf
- Elder Rights and Related Issues – Dale Watson and Catherine Angus

Staff discussed the above initiatives in detail and suggested that anyone interested in the significant detail review the draft State Plan.

Comments:

- One individual representing a local service provider expressed her concern that we needed to provide more funding to accomplish the proposed initiatives, and that adult day care was needed. She indicated that she liked efforts to modernize and expand senior centers and provide focal points or case management, but at the local level and not the regional level. She expressed concern over our requirement to have seniors provide their Social Security numbers, and she also expressed her concern over the high cost of fuel and the impact that it was having on service delivery.
- One individual representing the reverse mortgage industry thanked us for addressing the issue of reverse mortgages and expressed the need to provide education on reverse mortgages and warned of the possibility for using them as scams. He also indicated that there are significant benefits to reverse mortgages, and provided his experiences where he had helped seniors avoid delinquencies and foreclosures.
- One individual representing a local service provider thanked the Lt. Governor's Office on Aging for addressing the key issues. She expressed her concern over not having input in the State Plan development, and the fact that it would be difficult if not impossible to accomplish the initiatives without additional resources. Some services are not provided adequate resources to make it economically feasible to deliver the required services. She indicated that local service providers needed to be on the Nutrition Task Force and that she saw the need for increased communication, collaboration and improved relationships in the future.
- One individual representing a community residential care facility in Orangeburg thanked the Lt. Governor's Office on Aging for all that it does, and was excited about the rural PACE program. He cited his concerns about Dept. of Health and Environmental Control regulations and requested our assistance in our office helping DHEC to understand that his facility had no intent to harm the facility's seniors. DHEC regulations were causing undue expense in making modifications to their facility and they requested assistance in this area.

- One individual representing an Area Agency on Aging thanked us for all of our efforts, and expressed her concerns about how the Area Agencies on Aging and the local providers were to accomplish our initiatives without additional funding. She indicated that SC's citizens could not afford long term care insurance and that we needed to help family caregivers who work in order that they didn't have to retire early. She also indicated that legislation needed to be passed to make Area Agencies on Aging ADRC's (Aging and Disability Resource Centers).
- Mr. Larry Reed requested that his comments be made in writing. They are included below:

My name is Larry Reed and I am the Southeast Regional Manager for Mortgage Advocates, a company specializing in Reverse Mortgages in South Carolina and other states. I am also a Board Member with the SC Gerontology Society and a member of the Advisory Committee for the Central Midlands Area Agency on Aging. Our company was licensed in South Carolina in August, 2006 and by the end of October we had grown to become number four in the state in the Reverse Mortgage business. We accomplished that by focusing on our customers, supporting their needs, and educating them on Reverse Mortgages among their other options.

I applaud the undertaking required to prepare a plan such as we are reviewing today. It is very important work and no matter what we do today, we will not be fully prepared for the changes taking place in our aging society. The plan must focus on meaningful action steps that are measurable and quantitative. My comments will reflect on three critical issues facing our older adult population involving Reverse Mortgages and today's mortgage climate of historically high delinquency and foreclosure.

Critical issue #1

Reverse Mortgages, offered properly, are about education, education, education. I speak to groups about Reverse Mortgages as often as time permits. My attention is focused on independence, freedom, and control, the three emotions that are at the foundation of the decisions made by all seniors. When they are informed and educated about their options for choosing how and where they live, seniors have the freedom to make the decision correct for their situation with as much independence and control as possible. The result may or may not be a Reverse Mortgage, and they are prepared to make the decision for themselves.

Regarding Reverse Mortgages, the State Draft Plan says it will ensure that the public continues to be educated so that seniors can make decisions on what is in their best interest. I strongly support that statement and recommend expanding it with specific action steps to accomplish this most important of all tasks as it relates to our senior population and Reverse Mortgages.

I speak to individuals constantly who have never heard of Reverse Mortgages. Others are afraid because of something negative said by an uninformed friend or family member. And it is not just the senior home owners who are unaware or fearful. I spoke with a financial planner attorney recently. He called me at the request of his mother in law. He opened by saying he was very much against Reverse Mortgages. We agreed he would

keep an open mind while we talked. Our discussion ended with him saying he did not realize the breadth of the program, the protections in the program, nor the many benefits. He indicated he would reconsider the use of the program for his clients and recommend it to his mother in law.

Critical issue #2

Lt Governor Bauer's top priority this year is to protect our state's seniors from scams. I applaud that decision. On page 115 of the draft document it says "As the popularity of Reverse Mortgages has grown, the opportunity for the industry to exploit, scam or target the senior community has grown immensely." There are two considerations that develop from that statement.

The first is the Reverse Mortgage business is not a business to dabble in. That is why most banks and financial institutions do not offer it. The CEO of one of the state's largest credit unions said they would not offer the product because it is too much of a niche market. He is correct. To offer this product properly and support the customer, a company must understand the senior client and the life changes they face. Reverse Mortgages are not just another product or a business to treat superficially. This is not a business to escape to while the mortgage industry cleanses itself from its problems. It requires a unique commitment and it must include professionals dedicated to it.

The second consideration is to rephrase the first strategy on page 116 to read, ensure that South Carolina's senior citizens are not…coerced by pressure tactics and products that target Reverse Mortgages as the financing vehicle for their purchase. Virtually all negative press about Reverse Mortgages is because another industry chose this product to finance their sales process. And the Reverse Mortgage Industry is not perfect. There are some individuals attempting to participate who are not committed to the ethics required to work with our senior clients.

Seniors will be targeted for Reverse Mortgages as they are the only ones who qualify for them. However, the business should be offered by professionals who will educate, inform, and protect the senior. It should not be offered by those individuals whose purpose it is to close a loan as fast as possible or to create finances for another product where they will make additional profits.

Critical Issue #3

Today's climate of very high delinquency and foreclosure is attacking the senior population. The incidence of bankruptcy has experienced the highest growth among the older adult population.

Some banks, thrifts, credit unions and mortgage companies offered loans to seniors they could not afford and made no sense from a historical credit perspective. Add those situations to the normal change of circumstance as we age, and there is currently a mini disaster taking place here and across the nation.

I will sight two examples. One is a lady in Moncks Corner who is 67 and has lived in her home for 35 years. She contacted us in mid April indicating she was having a problem making her mortgage payment. After some digging and a couple of conversations, it turned out she had a foreclosure sale scheduled in approximately 30 days. A Reverse Mortgage was virtually her only alternative and they normally take about 60 days to complete. Resources were marshaled and the loan funded two weeks ago on the morning the sale was scheduled. The lender refused to reschedule the sale and if it had not funded that day, she would have lost her home. The lender would have taken her home appraised for $115,000 (in today's soft market) for a debt of approximately $30,000. And this lender, owned by one of the largest banks in the world, is one of the worst to obtain information from or to deal with during the delinquency and foreclosure process.

A second example is a call received in our office two weeks prior to a scheduled foreclosure sale on a Batesburg property. Fortunately this lender would communicate, listen to reason, and agreed to delay the sale for 30 days. Still it has been a very stressful process. It probably will be cleared to close today or Monday, and we should close the middle to the end of next week. It must close by next Friday or she will lose her home.

In both instances, these loans were in foreclosure in two of the legal foreclosure factories that operate in our state. In both instances these ladies (I am assuming Batesburg will be completed) will have their homes to enjoy for the rest of their lives if they pay their taxes, insurance, and maintain their properties. And they will never have to make another mortgage payment.

How many others situations are in process just like these throughout the state? How many others could be saved if they only knew? How many other lenders are set to profit from the remaining equity in a home owned by a senior citizen?

Mr. Bondo thanked everyone for their participation and their comments. He noted that those who were concerned about necessary resources should contact their legislators and congressmen to help us advocate for additional funding. He noted that we were trying to comply with federal mandates and initiatives as well as our own. He reminded those who did not wish to present where they could mail their written comments on the State Plan.

The meeting was adjourned at 12:30 p.m.

STATE PLAN PUBLIC HEARINGS
2009-2012 State Plan on Aging

Friday, June 20, 2008
10:00 -12:00 P.M.
Columbia, SC

10:00 A.M.	Welcome	Lt. Gov. Andre' Bauer
	Overview of the State Unit on Aging and Review Of the State Plan	Bruce E. Bondo Senior Policy & Planning
	Intra-State Funding Formula	Joanne Metrick Senior Consultant
	Discussion of Initiatives:	
	Modernization of Aging Services	Joanne Metrick
	Long Term Care Reform & Community Living Incentives	Deborah McPherson
	Senior Transportation	Deborah McPherson
	Choices for Independence	Denise Rivers Crystal Strong
	Geriatric Workforce	Denise Rivers
	Energizing the ARCC	Anne Wolf
	Elder Rights and Related Issues	Dale Watson or Catherine Angus
	Comments	
12:00 P.M.	Adjournment	

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Friday, June 20, 2008

	Name	Organization	Address	Will Speak
1.	Curtis Loftis	LGOA	1301 Gervais Street, Columbia SC.	
2.	Bruce Bendo	"	"	
3.	Jeanne Patrick	"	"	
4.	Anne Wolfe	"	"	
5.	Gerry Dickinson	"	"	
6.	Andrea Bauer	Lt. Governor	State Capitol	
7.	Frank Adams	LGOA	1301 Gervais Street	
8.	John Legere	"	"	
9.	Anna Hendley	"	"	
10.	Denise Rivers	"	"	
11.	Kevin Pendley	"	"	
12.	Susan Theriot	"	"	
13.				
14.				
15.				

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Friday, June 20, 2008

Name	Organization	Address	Will Speak
1. Kim Bowers	ICRC	200 Leisure Lane, Cola	N
2. Jessica Abbott	"	"	
3. Lynn Stedman	Nby COA	1300 Hunt St Nby SC	Y
4. Norman Whitaker	Central Midlands COG	236 Stoneridge Dr	N
5. Shirley Baker	Sumter Senior Services	P.O Box 832 Sumter	N
6. KAREN SHarpe	Care Improvement Plus	3700 Forest Drive Ste 204 Columbia 29204	N
7. Naomi Butler	BCDRTMA	305 Heatley St. Moncks Corner, SC	N
8. DarlyNN Thomas	SCPDSN	Columbia SC	N
9. Patricia Thomas	SC DHEC	1751 Calhoun St Box101106 - Cola, SC	N
10. Vicki Young	SC Primary Health Care Assn.	2221 Alpine Rd, Ext - Cola, SC	N
11. Marie [illegible]	DHHS LTC	PO Box 8206	N
12. Brenda Hyleman	" "	" "	N
13. Dr. Roland [illegible]	Univ. of South Carolina	Columbia, SC	NO
14. Robin [illegible]	PDA	1218 Holly Hill Dr. W. Cola 29169	NO
15. [illegible] Lee	Catawba AAA	PO Box 4618 Rock Hill	NO

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Friday, June 20, 2008

Name	Organization	Address	Will Speak
1. Dr. [illegible]	[illegible]	2417 [illegible], West Col[illegible]	
2. Jean R. Bridges	SHL+ AAA	1101 Saluda Chase Way W Col[illegible]	
3. Donna [illegible]	Kershaw CoA	Camden, S.C	
4. Vickie Moody	SCanpha	2711 Middleburg DR Colu SC	
5. Stacey Pierce	The Oaks	Orangeburg	
6. Rev McGee	The Oaks	"	
7. [illegible]	Midlands Council A & A	Area Agency Columbia	NO
8. [illegible]	CMCOG-AAA	236 Stoneridge Dr. Columbia	[illegible]
9. [illegible]	ACOG	30 Century Circle, Greenville	
10. Denice Crumpton	Senior Resources	2817 Millwood Avenue	
11. Angela [illegible]	FCCOA	210 E Washington St Winnsboro	
12. Earley Reed	Mortgage Advocate	1 Windsor Court #210 Columbia 29223	✓
13. Joan Bainer	LLR - Bd of Nursing	110 Centerview Dr. Suite 202 - Colu 29210	
14. Cynthia McDuffie	Palmetto Senior Care	5110 Fairfield Rd Cola SC 29203	✓
15. Vernon Anderson	Palmetto Senior Care	" "	✓

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Friday, June 20, 2008

Name	Organization	Address	Will Speak
1. Georgia Bookert	Senior Resources	2517 Blueridge Terrace	
2. Vera Belcher	Senior Resources	2140 Heyward Brockington Road	
3. Barbara Braxtee	Senior Resources	231 Lakeside Ave	
4. Jen Hatton	LTG	St. Capitol	
5. Deborah McPherson	LGOA		
6. Susan Heintz	LGOA	Newsstand.	
7. Shawn Keith	SLAAA	34 West Liberty St Sumter	
8. Ray Cannon	The Woodlands at Furman		
9. Lynda Chastain	LCRAC	125 Parker St Lexington	✓
10. [illegible]	Senior Resources	Millwood Ave	
11. Abbie Pruitt	Senior Resources	Millwood Ave	
12. Mavis Burton	SCZLC	Dutch Sq.	
13.			
14.			
15.			

COMMENT SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Friday, June 20, 2008

Name: James R. McGee

Organization: The Methodist Oaks

Address: P.O. Box 327, Orangeburg, SC 29116-0327

Comment(s):

1. Appreciation for what the office does
2. Moving our services into the community

PACE
Home Services
Technology

COMMENT SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Friday, June 20, 2008

Name: Vernon Anderson & Cynthia McDuffie

Organization: Palmetto Senior Care

Address: 5110 Fairfield Rd Cola. SC 29203

Comment(s): The hearing was very informative. It presents an excellent opportunity to network for this great cause: Our seniors.

Minutes
Public Hearing

FY 2009-2012 State Plan on Aging

South Carolina Lt. Governor's Office on Aging

Tuesday, July 8, 2008
Greenville County Council Chambers
Greenville, South Carolina

Presiding: Tony Kester, Interim Director

Mr. Kester opened the hearing at 10:00 A.M. and introduced Lt. Governor André Bauer. Lt. Governor Bauer welcomed the attendees and discussed the State Plan on Aging and the office's accomplishments over the past year. Mr. Kester explained that the hearing would be in compliance with Federal law requiring that the Lt. Governor's Office on Aging prepare a state plan every four years and sponsor hearings to elicit public comment on the draft plan. Mr. Kester introduced Ms. Joanne Metrick and other presenters for the hearing.

The State Plan Process
Mr. Kester, serving as Interim Director, explained that the State Plan, which identifies how South Carolina will use federal funds received through the Older Americans Act, is completed on a four-year cycle. Drafters of the Plan incorporate information from a variety of sources, including census data, surveys of recipients, Area Agencies on Aging, local service providers; the regional Area Plans for FY 2006-2008 by the ten AAAs. Input was received from the State AARP, the Silver Haired Legislature, the Joint Legislative Committee on Aging. Issues identified by the SC White House Conference on Aging and the US White House Conference on Aging were included in addition to requirements from the Administration on Aging and the Centers for Medicare and Medicaid Services. Following public review at three hearings around the state, the Plan will be submitted to the Lt. Governor and the Governor for final approval. The plan will then be forwarded to the US Department of Health and Human Services' Administration on Aging.

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Mr. Kester reviewed the content of the State Plan and the Executive Summary. He explained the purpose of the State Plan to be the mechanism to bring Older Americans Act funds to South Carolina over the next four years and to provide a blueprint for their use. He explained the vision and the mission of the State Unit on Aging, and the specific services provided and the sources of funding that support it.

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Ms. Joanne Metrick explained the funding formula that South Carolina will implement to fulfill the federal requirements of the Older Americans Act. This multi-faceted formula allocates federal funds to each economic development district according to the following:

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Characteristics of SC's Senior Population and Impact on Health Care Costs

Mr. Kester discussed the characteristics of the senior population in South Carolina and the impact of these demographics on health care costs in the state. Mr. Kester commented that South Carolina's senior population grew from 286,272 seniors in 1970 to 651,482 in 2000, an increase of 128 percent over thirty years. Statistics indicate that an additional 123 percent increase in seniors may be anticipated over the next thirty years from 651,482 to 1,450,487 by 2030. He additionally indicated that the growth of persons 85 and older have grown from 11,830 to 50,269 from 1970 to 2000 for a growth rate of 325 percent. It is anticipated that this population group will increase to 141,286 by 2030 for an additional 181 percent. Given the impact of both inflation and the growing number of seniors over the next thirty years, the effects on the already rising costs of nursing home care costs should prove considerable. Mr. Kester further indicated that the older seniors would be susceptible to Alzheimer's disease and dementia, and would have a significant impact for health care costs for individuals, families and society. Mr. Kester indicated that governmental officials on both the state and national level recognized that our citizens must recognize that the government will not have the necessary resources to cover the cost of long term care services and that we must plan for choice and personal incentives, as well as individuals taking personal responsibility for planning for their retirement and senior years.

Mr. Kester indicated that the LGOA had undertaken a number of efforts to determine the major needs that should be addressed in the major initiatives for the next four years and beyond. The major needs discussed were as follows:

5) Transportation
6) Increased funds for home and community-based services
7) Strengthen Family Caregiver Support Program

8) Long Term Care Reform/Restructure Medicare/Medicaid/Provide Choice with Personal Incentives

5) Implement ADRC's with focus on Building a Case Management System

6) Expand and Modify Nutrition Services

7) Support Geriatric Education

8) Expand and Modernize Senior Centers

Major Initiatives Addressed in the FY2009-20012 State Plan
LGOA staff highlighted the issues and initiatives that the plan seeks to address:

- Modernization of Aging Services in South Carolina – Joanne Metrick
- Long Term Care Reform and Community Living Incentives – Deborah McPherson
- Senior Transportation – Deborah McPherson
- Implementation of Choices for Independence – Denise Rivers
- Geriatric Trained Professional Workforce – Denise Rivers
- Energizing the ARCC – Denise Rivers
- Elder Rights and Related Issues – Dale Watson and Catherine Angus

Staff discussed the above initiatives in detail and suggested that anyone interested in the significant detail review the draft State Plan.

Comments:

- Only one individual presented comments in Greenville. Ms. Becky McDade, Director of the McCormick County Council on Aging, spoke about the concerns she has regarding the "bundling" of services to seniors.
- Another submitted comments by email: ebird@truvista.net was concerned about evaluating senior's ability to be physically mental fit to drive cars and to maintain drivers licenses. Also wrote about hearing aid exploitation and senior financial exploitation.

Mr. Kester thanked everyone for their participation and their comments. He also thanked the staff of the Greenville County Council and County Administrator's Office for assisting with the coordination of the hearing. He reminded those who did not wish to present where that they could submit written comments to the Lt. Governor's Office on Aging at gdickinson@aging.sc.gov.

The meeting was adjourned at 12:00 p.m.

STATE PLAN PUBLIC HEARINGS
2009-2012 State Plan on Aging

Tuesday July 8, 2008
10:00-12:00 P.M.
Greenville, SC

10:00 A.M.	Opening Comments	Tony Kester Interim Director
	Welcome	Lt. Gov. André Bauer
	Overview of the State Unit on Aging and Review Of the State Plan	Tony Kester
	Intra-State Funding Formula	Joanne Metrick Senior Consultant

Discussion of Initiatives:

Modernization of Aging Services	Joanne Metrick
Long Term Care Reform & Community Living Incentives	Deborah McPherson
Senior Transportation	Deborah McPherson
Choices for Independence	Denise Rivers
Geriatric Workforce	Denise Rivers
Energizing the ARCC	Denise Rivers
Elder Rights and Related Issues	Dale Watson or Catherine Angus

	Comments	
12:00 P.M.	Adjournment	

Anyone wishing to submit comments by email should do so by 5:00PM on July 9, 2008. Send comments to gdickinson@aging.sc.gov.

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Tuesday, July 8, 2008

Name	Organization	Address	Will Speak
1. Brenda Whitehurst	Retired	610 Tanager Ct, Greer 29650	Maybe
2. Bobby R. Bridges	Amber Star	P.O. Box 4452 Spty S.C. 29305	
3. Margaret Wade	Retired	143 Morton Rd Simpsonville SC 29681	
4. Jenada Thompson		12 Owens Street Greenville	
5. GILBERT SCACO	RETIRES	107 YORKSHIRE DR. GREENVILLE, SC 29615	
6. Kayin C. James	SCDOT-MassTransit	955 Park St. Cola, SC 29202	
7. Sue Dhand	Retired	102 Creekside ct. Greer SC 29650	
8. LEONA CROUCH	citizen	206 Bordeaux Dr, Simpsonville SC	NO
9. ED JENSON	WORD Radio	Greenville	
10. Michael Stogner	retired	103 Stonewall Ct, Easley, SC 29642	NO
11. WALT DAHLGREN	"	Bx 5661 - GREENVILLE, SC 29606	NO.
12. Suzanne Englemann	citizen	340 Rocky Top DR. G'ville	
13.			
14.			
15.			

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Tuesday, July 8, 2008

Name	Organization	Address	Will Speak
1. Glenda Manigault	Appalachian AAA		
2. MARY ELLENBURG	DHEC	220 McGee rd. Anderson SC 29625	
3. Becky McDade	McCormick County Senior Center	PO Box 684 McCormick SC 29835	Maybe
4. Juanita Wideman	Upper Savannah	AAA PO Box 1366 Greenwood SC	
5. Barbara Wright	Upper Savannah	AAA	
6. Kimberly Snider	Central Clemson Young at Heart	Central Town Hall PO Box 549 Central, 29630	
7. Gina Stegall	~~ACOG~~ ACOG	Century Dr	
8. Nikki Robertson	SCARCH	Columbia SC	
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SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Tuesday, July 8, 2008

Name	Organization	Address	Will Speak
1. [illegible] Meyer		201 Grand Mt. Rd	
2. Susie Madden	DHEC-Region I	1736 S. Main St. Greenwood SC 29646	
3. Nancy Hawkins	Appalachian Council of Governments		
4. Sandy Dumas	"	P.O. Box 16068, Greer, SC	
5. Liz Seaman	Meals On Wheels		
6. DARIUS NOURI	MAXIM Healthcare	555 N. Pleasantburg Dr Greenville, SC	
7. AC PARSONS	PICKENS CO SENIORS UNITED	P.O. Box 1373 Pickens SC 29671	
8. JOAN WOOD	Sr Center Cherokee Cty	499 W. Rutledge Ave Gaffney 29341	
9. Carol Goldsmith	SCDHHS-Greenville County	301 University Ridge Ste 6700 Greenville SC 29601	
10. [illegible]	ACOG	31 Century Dr.	
11. Doreen Arnold	AARP-SC	1201 Main St Col SC 29201	
12. Benico Gonzales			
13. Fanny Gonzales			
14. Michael Hudson	Greenville Police	4 McBee St. Greenville S.C. 29601	
15. Catherine Gilstrap	Westminster Garden Club	23 Salida Lake Ct. Greenville SC 29611	

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Tuesday, July 8, 2008

Name	Organization	Address	Will Speak
1. Frank R Walker	Senior Action Inc		
2. Von Hallman			
3. Carolyn Eigel	Stroke Club	#10 Lily St, Greenville, S.C. 29617	
4. Lillie Burrell		308 Rickbaum Rd Gville 29615	
5. Carlos Burrell		" "	
6. Pauline Farr		68 westbrook Dr Mauldin S.C. 29662	2nd
7. Andrea Smith	Senior Action		
8. Doug Wright	Senior Solution's		
9. Lamar Batty	SCSHL		
10. Helen Brown	SC ACOG - FCSP	P.O. Box 6668 Greenville SC 29650	
11. R H Patterson Jr	PAPA INC. ORG	2140 Pinney Mtn Rd Greenville SC 29609 244-4968	
12.			
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14.			
15.			

Minutes
Public Hearing

FY 2009-2012 State Plan on Aging

South Carolina Lt. Governor's Office on Aging

Wednesday, July 9, 2008
Winthrop University – McBryde Hall
Rock Hill, South Carolina

Presiding: Tony Kester

Mr. Kester opened the hearing at 2:00 P.M. and introduced Lt. Governor André Bauer. Lt. Governor Bauer welcomed the attendees and discussed the State Plan on Aging and the office's accomplishments over the past year. Mr. Kester explained that the hearing would be in compliance with Federal law requiring that the Lt. Governor's Office on Aging prepare a state plan every four years and sponsor hearings to elicit public comment on the draft plan. Mr. Kester introduced Ms. Joanne Metrick and other presenters for the hearing.

The State Plan Process

Mr. Kester, serving as Interim Director, explained that the State Plan, which identifies how South Carolina will use federal funds received through the Older Americans Act, is completed on a four-year cycle. Drafters of the Plan incorporate information from a variety of sources, including census data, surveys of recipients, Area Agencies on Aging, local service providers; the regional Area Plans for FY 2006-2008 by the ten AAAs. Input was received from the State AARP, the Silver Haired Legislature, and the Joint Legislative Committee on Aging. Issues identified by the SC White House Conference on Aging and the US White House Conference on Aging were included in addition to requirements from the Administration on Aging and the Centers for Medicare and Medicaid Services. Following public review at three hearings around the state, the Plan will be submitted to the Lt. Governor and the Governor for final approval. The plan will then be forwarded to the US Department of Health and Human Services' Administration on Aging.

Overview of the State Plan

Mr. Kester reviewed the content of the State Plan and the Executive Summary. He explained the purpose of the State Plan to be the mechanism to bring Older Americans Act funds to South Carolina over the next four years and to provide a blueprint for their use. He explained the vision and the mission of the State Unit on Aging, and the specific services provided and the sources of funding that support it.

The Intrastate Funding Formula

Ms. Joanne Metrick explained the funding formula that South Carolina will implement to fulfill the federal requirements of the Older Americans Act. This multi-faceted formula allocates federal funds to each economic development district according to the following:

- Fifty (50) percent is allocated equally to provide a viable operating base for service delivery.
- Twenty (20) percent is allocated based upon the proportion of the State's population sixty years old and older.
- Ten (10) percent is allocated based upon the proportion of the state's population sixty years old and older below the poverty level.
- Ten (10) percent is allocated based upon the proportion of the state's minority population sixty years old and older.
- Five (5) percent is allocated based upon the proportion of the state's moderately or severely impaired population that are 60 and older and have two or more limitations in activities in daily living.
- Five (5) percent is allocated based upon the proportion of the state's rural population

Characteristics of SC's Senior Population and Impact on Health Care Costs

Mr. Kester discussed the characteristics of the senior population in South Carolina and the impact of these demographics on health care costs in the state. Mr. Kester commented that South Carolina's senior population grew from 286,272 seniors in 1970 to 651,482 in 2000, an increase of 128 percent over thirty years. Statistics indicate that an additional 123 percent increase in seniors may be anticipated over the next thirty years from 651,482 to 1,450,487 by 2030. He additionally indicated that the growth of persons 85 and older have grown from 11,830 to 50,269 from 1970 to 2000 for a growth rate of 325 percent. It is anticipated that this population group will increase to 141,286 by 2030 for an additional 181 percent. Given the impact of both inflation and the growing number of seniors over the next thirty years, the effects on the already rising costs of nursing home care costs should prove considerable. Mr. Kester further indicated that the older seniors would be susceptible to Alzheimer's disease and dementia, and would have a significant impact for health care costs for individuals, families and society. Mr. Kester indicated that governmental officials on both the state and national level recognized that our citizens must recognize that the government will not have the necessary resources to cover the cost of long term care services and that we must plan for choice and personal incentives, as well as individuals taking personal responsibility for planning for their retirement and senior years.

Mr. Kester indicated that the LGOA had undertaken a number of efforts to determine the major needs that should be addressed in the major initiatives for the next four years and beyond. The major needs discussed were as follows:

9) Transportation

10) Increased funds for home and community-based services

11) Strengthen Family Caregiver Support Program

12) Long Term Care Reform/Restructure Medicare/Medicaid/Provide Choice with Personal Incentives

5) Implement ADRC's with focus on Building a Case Management System

6) Expand and Modify Nutrition Services

7) Support Geriatric Education

8) Expand and Modernize Senior Centers

Major Initiatives Addressed in the FY2009-20012 State Plan
LGOA staff highlighted the issues and initiatives that the plan seeks to address:

- Modernization of Aging Services in South Carolina – Joanne Metrick
- Long Term Care Reform and Community Living Incentives – Denise Rivers
- Senior Transportation – Denise Rivers
- Implementation of Choices for Independence – Denise Rivers
- Geriatric Trained Professional Workforce – Denise Rivers
- Energizing the ARCC – Denise Rivers
- Elder Rights and Related Issues – Dale Watson and Catherine Angus

Staff discussed the above initiatives in detail and suggested that anyone interested in the significant detail review the draft State Plan.

Comments:

- Scott Middleton of Agape Senior spoke about the LGOA Ombudsman Program and Volunteer Program. He spoke about the need for additional or alternative funding for vulnerable adults. Who will monitor abuse in homes if LTC Ombudsman don't? Since we are pushing Home and Community Based services, there will be more in-home abuse and exploitation. Wants LGOA to look in to alternative placements. OSS programs in Assisted Living facilities are declining rapidly.

- Jim Griffith of the Edgefield Council on Aging noted that the Lt. Governor's Office on Aging had done an "excellent job on the State Plan" and said "it was very easy to read and understand." Evidence Based Programs in SC won't work. People need to exercise to improve quality of life. Life expectancy is now 78. Arthritis is the most common ailment. LGOA needs a committee to study evidence based vs non-evidence based programs. Committee should consist of: 3 MD's, 1 Sports Medicine, 1 AAA Director, 1 LGOA staff (didn't get the rest)

- Sally P. Sherrin of the Lancaster County Council on Aging requested that her written comments be included in the comments section. They are included below:

Thank you for the opportunity to review and give comment to the draft State Plan on Aging 2009-2012. It is obvious that much thought and planning has gone into the creation of this plan and I compliment you on your hard work.

As a local provider of aging services, I agree with the central theme of the draft plan, there are currently more seniors than resources can provide care for and the situation will continue to worsen as the baby boomers age. Across this state and nation, additional funding must be accessed to continue to serve seniors who are able to stay in their homes as a result of current services and to serve the baby boomers.

I would also support Chapter 7, Issue 2, page 91. Meaningful Senior Centers; Senior Centers as the Town Square. Senior facilities in South Carolina over the past several years have vastly improved due to the establishment of funding by the State Legislature and the additional revenues that have been accessed by local providers as a result of the matching abilities of these state funds. Activities and services need to be increased and modernized, but additional funding will be necessary to accomplish this goal.

I support Chapter 7, Issue 7, page 96 & 97. Expand and modernize nutrition services. The two committees referenced in this issue, The Nutrition Dream Team and the System Change Task Force can establish recommendations and put forth ideas from across the state and nation to the aging network in South Carolina. However, I would suggest that individuals from the local provider level be included on these committees to offer input from those providing services. The findings of these committees should be shared with the aging network.

Chapter 7, F. Evidence Based Research, Issue 1, page 122. South Carolina Seniors' Cube discusses as a strategy the development of final access/use protocols to allow public/private use of the South Carolina Seniors' Cube. I suggest that within that protocol a method of notification of the intended use of client information be developed so that seniors whose information is placed into the cube have full knowledge of how and when their private information is shared.

Chapter 3, Key Outcomes and Strategies, A, Implementation of Choices for Independence, 2, page 6. Implement ADRC's statewide with a focus on building case management system. My comment to this strategy would be that as demonstrated in this plan, there are not enough resources to currently meet the needs of senior in South Carolina. To take resources from a system that is currently unable to meet urgent needs to develop a system that is for the dissemination of information and not services, does not further the goal of maintaining the independence of seniors. Careful consideration needs to be given to the implementation of case management from a regional approach so that what seems to be a cost effective approach does not become a more expensive duplication of efforts. Service management will have to continue at the local level, duplicating these efforts at the regional and local level.

My final comment to the plan is that throughout the plan is discussion of how to develop the aging network to allow for a competitive environment that produces the best costs in service delivery. However, there is no discussion of how to foster competition in the services that are provided at the regional level such as family caregiver, I R and A and Insurance Counseling. I suggest that consideration be given on how to foster competition and allow for innovations within all services provided in the aging network in South Carolina.

Thank you for the opportunity to comment on this plan.

Sincerely,
Sally P. Sherrin
Executive Director

Wendy Duda, Executive Director of the York County Council on Aging, made several comments. She applauded the LGOA staff for the "enormous about of work they have done to put together this plan and their vision for services for the next three years as we are challenged to find ways to serve the growing elderly population in South Carolina. She specifically commented on the Statewide Meal Contract and noted her facilities had no problem attracting seniors to her meal sites. Don't overlook COA's like hers when LGOA puts out the nutrition bid. Regional Case Management will be more costly. Seniors will have to wait for an assessment. If seniors are assessed at the Regional level and there is no Older American Act funds available, what local funding is available? Current case management staff have multiple duties.

- Jim Gerald who had previously served in local (elected) government in Florida before retiring to Rock Hill questioned how the Lt. Governor's Office on Aging could have made a 20 percent savings in administrative expenses without impacting services.

Mr. Kester thanked everyone for their participation and their comments. He thanked the staff of the President's Office at Winthrop University, specifically Rebecca Masters, for everything that they had done to assist with the coordination of the public hearing. He reminded those who did not wish to present that they could email their written comments to the LGOA in care of gdickinson@aging.sc.gov.

The meeting was adjourned at 4:00 p.m.

STATE PLAN PUBLIC HEARINGS
2009-2012 State Plan on Aging

Wednesday July 9, 2008
2:00 – 4:00 P.M.
Rock Hill, SC

2:00 P.M.	**Opening Comments**	**Tony Kester** **Interim Director**
	Welcome	**Lt. Gov. André Bauer**
	Overview of the State Unit on Aging and Review Of the State Plan	**Tony Kester**
	Intra-State Funding Formula	**Joanne Metrick** **Senior Consultant**
Discussion of Initiatives:		
	Modernization of Aging Services	**Joanne Metrick**
	Long Term Care Reform & Community Living Incentives	**Denise Rivers**
	Senior Transportation	**Denise Rivers**
	Choices for Independence	**Denise Rivers**
	Geriatric Workforce	**Denise Rivers**
	Energizing the ARCC	**Denise Rivers**
	Elder Rights and Related Issues	**Dale Watson or Catherine Angus**
	Comments	
4:00 P.M.	**Adjournment**	

Anyone wishing to submit comments by email should do so by 5:00PM on July 9, 2008. Send comments to gdickinson@aging.sc.gov.

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Wednesday, July 9, 2008

	Name	Organization	Address	Will Speak
1.	Deb Lewis	Catawba AAHT	PO Box 4618 Rock Hill SC 29732	
2.	Jim Teicher	Personnel	803 LAKE CLUB RD, ROCK HILL	
3.	Brenda D. Wilson	citizen	1919 Sharonwood Dr Rock Hill	
4.	Jill Bryant	DHHS	1890 Neely's Creek Rd RHSC	
5.	Virginia Cruz	DHHS	" "	
6.	Barbara Robinson	Catawba AAA	P.O. Box 4618 Rock Hill SC 29732	
(2) ✓ 7.	James R. Griffith	ECSCC	15 Center Spring, Edgefield SC	Maybe
8.	Larry Booe	ECSCC	15 Center Spring Rd, Edgefield SC	
(3) 9.	Wendy Ruda	YCCOA	PO Box 115-G Rock Hill SC	maybe
10.	Marion Cirilo	AARP	1717 Matthews Dr. Rock Hill 29732	no
11.	Allison Matthews	Westminster Towers	1330 India Hook Rd Rock Hill	
12.	Ruth Pierce	" "	" " " " " "	
13.	Lisa Perez	" "	" " " " " "	YES
14.	Jackie Thompson	CMCOG/AAA	236 Stoneridge Dr Cola SC 29210	not a chance
15.	Tony Fountain	Westminster Towers	1330 India Hook Rd Rockhill	

SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Wednesday, July 9, 2008

	Name	Organization	Address	Will Speak
1.	G. Scott Middleton	Aging Services		yes
2.				
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SIGN-IN SHEET

SC Lieutenant Governor's Office on Aging

STATE PLAN PUBLIC HEARING

Wednesday, July 9, 2008

	Name	Organization	Address	Will Speak
1.	[illegible] Sherrer	Lancaster COA	PO Box 1296 Lancaster SC 29720	Yes
2.	Barbara T. Smith	York County Adult Day	care 359 Park Ave, Rock Hill SC. 29730	
3.	Ann Barton RVC	"	"	maybe
4.	Amy Laughlin	Westminster Towers	1330 India Hook Rd. Rock Hill SC 29732	
5.	Jennifer Solomon	Wil-Gerontology	601 Pena Lake Rd Chester, SC	?
6.	Eddie Bied	NON	2901 State Hwy. 901 Blacksteak	
7.	Catherine Beard	Senior matters		
8.	Brenda Perryman	SCDOT - Mass Transit	955 Park St Columbia SC	?
9.	Danielle Henderson	Agape Senior	159 Sedgewood Dr Rock Hill, SC	
10.	Jim Gerald			yes
11.				
12.				
13.				
14.				
15.				

Appendix G: Acronyms

The following abbreviations have been used in the FY 2009-2012 State Plan on Aging:

- **AAA** - Area Agency on Aging
- **AARP** – American Association of Retired Persons
- **ACE** – Alternative Care for the Elderly
- **ADA** – Americans with Disabilities Act
- **ADDGS** – Alzheimer's Disease Demonstration Grant to States
- **ADRC** – Aging and Disability Resource Center
- **ADRD** – Alzheimer's disease and related disorders
- **AIRS** – Alliance of Information and Referral Systems
- **AoA** - Administration on Aging
- **ARCC** – Alzheimer's Resource Coordination Center
- **CCAM** – Coordinating Council on Access and Mobility
- **CLTC** – Community Long Term Care
- **CMS** – Centers for Medicare and Medicaid Services
- **COA –** County Councils on Aging
- **COG –** Council of Governments
- **DRA –** Deficit Reduction Act
- **EBP –** Evidence-Based Prevention programs
- **FCSP –** Family Caregiver Support Program
- **FTA –** Federal Transit Administration
- **GAPS –** Gap Assistance Program for Seniors
- **I-CARE –** Insurance Counseling Assistance and Referral for Elders
- **I&R –** Information and Referral
- **I R & A –** Information, Referral and Assistance
- **JAMA –** Journal of American Medicine
- **LTC –** Long Term Care
- **LGOA –** Lieutenant Governor's Office on Aging
- **LTCO –** Long Term Care Ombudsman
- **MFP –** Money Follows the Person
- **MMA –** Medicare Modernization Act
- **MSAA –** Mobility Services for All Americans

- **NAMI –** National Association of Mental Illness
- **NAPIS -** National Aging Program Information System
- **NSIP –** Nutrition Services Incentive Program
- **OAA** – Older Americans Act
- **OLSA** – On-Line Support Assist
- **PSA -** Planning and Service Area
- **RAAC –** Regional Aging Advisory Council
- **SAMHSA –** Substance Abuse and Mental Health Services Administration
- **SCDHEC** – South Carolina Department of Health and Environmental Control
- **SCDHHS –** South Carolina Department of Health and Human Services
- **SDC –** Service Delivery Contractor
- **SCDOI –** SC Department of Insurance
- **SMP –** Senior Medicare Patrol
- **SSBG –** Social Services Block Grant
- **SHIP -** State Health Insurance Assistance Program
- **SUA -** State Unit on Aging
- **TMCC –** Travel Management Coordination Center
- **USDA** - United States Department of Agriculture
- **USDHHS** - U. S. Department of Health and Human Services
- **USDOL** – United States Department of Labor

Statement from Governor Mark Sanford's Office

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

Gerry --

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

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

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

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

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

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

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

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