PUBLIC HEARING

JOINT LEGISLATIVE COMMITTEE ON AGING

Columbia, September 14, 1988

420 W. Bridge St.
St. Matthews, SC

August 29, 1988

Keller H. Barron
Director of Research
212 Blatt Building
P.O. Box 11867
Columbia, SC 29211

The subjects coming up on September 14 - are indeed very important issues, but there is one more, "Living With Dignity"? I have recently learned there is no place to turn when you're 65 and need some type of help for survival. I'm not talking about free hand outs, but some way to continue on with dignity in society. Due to cancer surgery I lost about a year from working. When I talk to all the agencies that are to help I find no one really puts their teeth into the problem.

I wanted to start a small in-home business offering my home as collateral. I'm a business woman and have records to prove the need of my prudent - am on S.S. which is not enough to survive. My tracking ability is slowing down to what it was. I did put in 12-14 hours daily - now would like to work from the home.

I also wanted to get my house winterized needed $20,000 against a $50,000 piece of property Farmers' home "Told me I was too old". One bank - because I was single and no charge cards - Some would not even listen.

I also find if I sell my house it will almost be impossible for me to get a loan to buy another home. Example: The State Housing Authority is not for singles. Another: You have to make at least $20,000 per year.

There should be some type of loans at our interest and long term so we could handle payments and live in society like other people - you can't "Die With Dignity" if you can't live with Dignity. It isn't everyone's fault because they find themselves in a financial problem. One agency told me, quote - "Why with your income $551.00 Social Security not you should be entitled to a Farm Home Grant" she

sends me a blanket, but no one tells me how to break thru the red tape. When Seabrook Carter here in St. Matthews, swings around in his chair and tells me - "At your age I don't want to get involved." Please see some of these issues are addressed at the Sept. 14 - meeting.

Sincerely,
Margaret Lovell
420 W. Bridge St.
St. Matthews, SC 29135
1-800-655-5837

I would like to see action on:
"Living with Dignity" - Don't push us in the gutter.

"Loans with payments we can afford" - Not free housing.

"The Notch Babies" - Get us our deserved Social Security.

We pay the same utilities as anyone else.
We pay the same for gasoline.
We pay the same for groceries.

/1125/

PUBLIC HEARING

BY

JOINT LEGISLATIVE COMMITTEE ON AGING

Columbia, SC - September 14, 1988

Representative Patrick B. Harris, Chairman

Joint Legislative Committee on Aging
212 Blatt Building
P. O. Box 11867
Columbia, SC 29211
Telephone - (803) 734-2995

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ADDITIONAL WRITTEN STATEMENTS SUBMITTED:

The Annual Public Hearing of the Joint Legislative Study Committee on Aging was held in the Blatt House Office Building, Room 101, in Columbia, South Carolina, on Wednesday, September 14, 1988.

Committee members present: Chairman Patrick B. Harris, Vice-Chairman Dave Waldrop, Representative Dill Blackwell, Senator Peden McLeod, Ms. Gloria H. Sholin, Mr. Tom Stilwell, and Mr. Robert Wasson.

Staff members present: Keller H. Barron, Director of Research, Sherri L. Craft, Research Assistant, and Beth Mitchell, Legislative Clerk.

There were 150 persons present throughout the day. The hearing began at 10:30 a.m., recessed for lunch from 1:00 - 2:00 p.m., and adjourned at 4:00 p.m.

OPENING REMARKS

Chairman Patrick B. Harris called the meeting to order at 10:30 a.m. and requested Mr. Ollie Johnson, Executive Assistant to the SC Commission on Aging, to open with prayer.

After welcoming the attendees to the 26th Annual Public Hearing, Chairman Harris reminded the presenters of their ten minute time frame and requested that they refrain from exceeding that limit.

Members present included Vice-Chairman, Representative Dave Waldrop of Newberry; Mrs. Gloria Sholin, gubernatorial appointee from Hilton Head; Mr. Thomas Stilwell, gubernatorial appointee from Inman; and Mr. Robert Wasson, newest appointee from Laurens. Representative Harris commented on the time he and Mr. Wasson spent together at Presbyterian College and in the House of Representatives. Mr. Wasson also served in the Senate and spent many years as Chief Commissioner at the S.C. Tax Commission.

Representative Dill Blackwell sent notice that he would attend the Hearing following a sub-committee meeting on the rural hospital crisis with Senator Leatherman. Senator Peden McLeod and Senator Isadore Lourie had also informed the Committee to expect their attendance.

Senator Nell Smith was unable to attend due to an unavoidable conflict.

Chairman Harris recognized Carolyn Schmitt, a volunteer who assisted the Committee with the sign-in sheet. Display materials were also available to attendees.

Presenters were requested to leave a written copy of their testimony with Sherri Craft, Research Assistant, to be included in the transcript.

Dr. C.M. Johnson, Chairma
SC Commission on Aging
400 Arbor Lake Dr.
Suite B-500
Columbia, SC 29223

REMARKS BY DR. C.M. JOHNSON, CHAIRMAN
SOUTH CAROLINA COMMISSION ON AGING
to the
JOINT LEGISLATIVE COMMITTEE ON AGING
PUBLIC HEARING, SEPTEMBER 14, 1988

Representative Harris and members of the Committee...

I am C. M. Johnson, Chairman of the Commission on Aging. I am pleased to have the opportunity to speak with you this morning about our agency and the issues and concerns of South Carolina's older citizens.

In our presentation last year, several recommendations were made from the Commission's "Action Plan for the Elderly" to address long term care issues.

I would like to express my personal appreciation and that of our agency to this Committee and to the General Assembly for the commitment and support that resulted in several pieces of legislation being passed this session.

Among them:

Long Term Care Insurance Act
Home Equity Conversion
Retirement Benefit Adjustment
Amendments to the Death with Dignity Act

You have also worked closely with our Commission on numerous other bills that have a direct impact on the elderly, and we sincerely appreciate you and your staff always remembering to call us and asking our opinion and inviting us to participate in the discussion.

Also, we thank Keller Barron and her staff for their cooperation and support on behalf of the elderly.

We have a long way to go to meet the long term care needs of South Carolina's rapidly growing aging population, which is expected to increase by 45% in this decade.

This growth in the elderly population is placing increasing demands on our Commission staff. We urge the Committee's strong support of the Commission's budget.

Other priorities include:

- Protection for maintaining financial independence of older South Carolinians.

- Establishing state policy that assures adequate public transportation.

and

- Strong support for family caregivers in the form of tax credits.

I appreciate the caring and concern of the Joint Legislative Committee on Aging and ask your continued efforts and support in providing solutions to the problems facing our senior citizens.

Mrs. Ruth Seigler, Executive Director of the Commission, will now provide further detail on our priorities and goals.

Ruth Seigler, Executive Director
SC Commission on Aging
400 Arbor Lake Dr.
Suite B-500
Columbia, SC 29223

(2)

PRESENTATION
before the
JOINT LEGISLATIVE COMMITTEE ON AGING
September 14, 1988

It is a real pleasure to have the opportunity to present issues and concerns from the South Carolina Commission on Aging for consideration for legislative priority setting and funding over the next year. I would like to take a few minutes to express my sincere appreciation for the outstanding accomplishments made this year through your commitment and concern. I would also like to recognize Representative Patrick Harris, "Mr. Pat," as the 1988 Outstanding Older South Carolinian. Mr. Pat was recognized at the Aging Network Training Conference in May, and this is the plaque which hangs at the Commission on Aging with his name engraved.

Rep. Harris - **I have the plaque on the wall. Thank you, Ruth.**

Rep. Waldrop - **Mr. Chairman and Mrs. Seigler, this fellow here has received an honor which he dearly deserves. This gentleman has worked very hard for this Committee since it's beginning, before I became a member of the General Assembly, and I only wish that a number of legislators could model ourselves after him.**

Rep. Harris - **Thank you!**

Dr. Johnson has already referred you to the green document with the summary of the actions for which you provided leadership. Let me express appreciation as well. As we look at the statistical charts in your yellow packet, you will see the continued growth of the older population in South Carolina. This certainly is exciting as well as offering all of us many challenges. The Commission has worked closely this year with the Aging Network, with the Council on Elder Affairs, and many other groups to identify priorities for action.

I would like to direct your attention to the white document which we list the budget priorities of the Commission and very quickly review several areas of importance that may need some elaboration. I would also like to ask your continued consideration for increasing the line item in the budget for expanding the community services funds for in-home and community based services. You are currently providing $250,000 in this line item and that combined with the bingo revenue of approximately $500,000, we are this year initiating a number of new services across the state. Please continue to assist us in the search of additional money for this program. These funds provide vital dollars to keep older persons independent and functioning as vital contributing members of our society.

The Aging Network continues to have waiting lists for most services. We also have an urgent need to initiate a study on the status of senior centers across the state and to continue our efforts to assure adequate public transportation. The study and research of Alzheimer's Disease and related dementias is another important area for appropriate funding and legislative support. Area Agencies on Aging and local service providers have a great need to attract and retain qualified staff who are experts in programs and services for older persons. Funding to offer a 5% cost of living increase to these staff would stabilize and strengthen these valuable human resources.

The administrative operating budget of the Commission continues to be strained and we would urge the restoration of the $69,000 from last year's budget cuts as well as the 3% ($59,000) reduction mandated this year. The restoration of this $128,000 would provide important match dollars for local services, and help the agency administer the aging program in a planned manner rather than as crisis management.

We would also urge your support for the staffing and program request of the Commission. The Commission is experiencing a tremendous increase in the public demand for information and referral. We also have an important need to provide training for a variety of staff that work with older persons including nursing assistants, van drivers, nutrition site staff, homemakers, etc.

The Commission supports the Legislative Priorities developed by the Advisory Council on Elder Affairs. This group represents most organizations and groups in which we interact and importantly the Council strongly represents older persons themselves. We have worked closely with the Council and you will hear specifically from them as well as individual members of the Council on these priorities.

There will continue to be challenges and opportunities for growth and improvement in meeting the statutory and public mandates for the Commission on Aging. This year we experienced some of those. The Commission will be facing important decisions later this year with the report of the S.N.A.P. Committee (this is the Committee which is studying the number and placement of Area Agencies on Aging for the state.) The Commission will also be addressing quality assurance measures that are required of Area Agencies on Aging and local service provider agencies. We are initiating a committee to study the impact of Performance Based Contracting.

All of this reflects the commitment of the Commission toward the objective that all older people should have the opportunity to live independent, meaningful and dignified lives in their own home and community as long as possible. That every community should have a system of services and opportunities to help older people serve and be served where they live. Older people, their family and friends must be familiar with the system and feel that it responds to them. We know we can depend on the Joint Legislative Committee on Aging to champion this objective. Thank you.

RUTH Q. SEIGLER
Executive Director

Betty H. Park
Advisory Council on Elder Affairs
1800 Main St., 3C
Columbia, SC 29201

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1988-89
LEGISLATIVE PRIORITIES
ADVISORY COUNCIL ON ELDER AFFAIRS

Issues surrounding the ability of the elderly to maintain an independent and productive life on into their very eldest age, frame the legislative priorities of the Council on Elder Affairs and the various constituent organizations in which the Council coordinates and collaborates.

There are a number of important areas in which the Joint Legislative Committee on Aging and the General Assembly began to address last year, and we are most appreciative of those efforts. However, we must keep the momentum moving forward in order to appropriately respond to the impact of rapidly changing demographics of the elderly population.

With this very brief introduction, we have taken a number of legislative issues and organized them into several major priority categories. Our coalition efforts will provide testimony that centers around these priorities:

I. Strong Commitment and Support for the Budget Request of the Commission on Aging

II. Protection for Maintaining/Sustaining Financial Independence of Older South Carolinians

III. Establishing State Policy that Assures Adequate Public Transportation

IV. Strong Support for Family Caregivers

V. Initiating Studies to Evaluate Current Programs and Services and Develop Appropriate Legislation to Address the Needs of Older South Carolinians.

In PRIORITY I, we would urge your careful review of the budget requests of the Commission. The Commission is a small state agency with a total budget of $13,333,569 which includes $10,777,307 in Federal funds. Of these funds $11,918,408 is distributed across the state to provide programs and services. Two years ago the state budget was reduced by $69,342; this year's mandated 3% reduction will result in an additional reduction of $59,363, for a total reduction of $128,705. With the dramatic growth in the number of elderly and especially the unprecedented growth of the very old elderly, any reduction in funds will have an adverse impact on programs and services to this critical population. We urge the restoration of these funds as well as allocating $1,029,418 to fund the new budget request of the Commission.

PRIORITY II includes maintaining or sustaining financial independence for the elderly. This priority is so important to our state. By investing in legislation that promotes this concept, you allow older persons to maintain their dignity and integrity while at the same time continue to pay their way for their needs.

Legislative areas that address this priority include:

1. Develop legislation to provide a $6,000 state income tax exemption on retirement income for those who are 62 years of age, and at age 65 provide a total tax exemption on retirement income.

2. Increase the Homestead Exemption.

3. Increase funding for the provision and expansion of community-based and in-home services. Of the Commission's original request for 1.5 million dollars, currently $250,000 is appropriated through the Commission's budget and $500,000 revenue is anticipated from bingo tax. Should new sources of state revenues be developed, such as, from a lottery, an increase in marriage license fees, etc., providing additional community-based and in-home services should be considered as a priority for these funds.

4. Develop programs through the State Housing Authority in coordination with the Commission on Aging, innovative Housing Options for low and middle income elderly.

5. Pass legislation (Senate Bill S-1276) to assure the protection of elderly persons who purchase living arrangements through life care communities.

PRIORITY III urges the strengthening of the state's commitment to allocating resources to assure adequate and appropriate public transportation. Two years ago, the General Assembly increased the gasoline tax 1/4 of one cent which was to be designated for public transportation (Act No. 197, 1987). Due to permissive wording in the legislation, the funds were not totally allocated for these purposes. This language needs to be amended to assure these funds are allocated to public transportation purposes. All across South Carolina elderly persons are suffering because they can not access needed services or in many instances just meet basic needs such as grocery shopping. We also advocate a pilot project to test the use of public school buses being used for elderly transportation, such as the system that has been developed in the state of Florida.

PRIORITY IV addresses the need to recognize through progressive legislation that families are the cornerstone of care for the frail elderly and they need support to continue to bear the burden of this care:

1. Develop and pass legislation to give a $300.00 tax credit for families who provide at least six months of continuing home/community based care for a frail elderly family member who has been certified by a physician as nursing home eligible.

2. Increase monthly personal needs allowance for individuals in residential care facilities from $25.00 to $30.00.

3. Develop initiatives or pilot projects to test the establishment of Adult Day Care services for a frail elderly person as a fringe benefit for public and private sector employees.

4. Ask Human Resource Management through Carolina Health Styles Wellness Program to offer support groups and resources for state employees who are caregivers for disabled and handicapped family members.

5. Provide state funding for the continuation of the Dementia Registry. (This is Priority #10 of the SCCOA Budget Request.)

PRIORITY V - There are several areas of aging programs and services that would benefit from studies initiated by the Legislature, they include:

1. Initiate a study of the current status of senior centers and nutrition sites across the state to establish priority areas for strategic placement and/or renovation of centers/sites.

2. Initiate a study of Adult Foster Care services similar to programs in other states.

3. Medical Durable Power of Attorney.

4. Expanded use of friendly visitors (Volunteer Ombudsman) services in local nursing homes.

Rep. Harris - **Thank you very much Betty. I commend you for all your work and particularly your volunteer work because it's volunteer work that keeps most of our programs going. We do appreciate you so much.**

Park - **Thank you!**

Rep. Harris - **Any questions? If not, I want to take a moment of time and present to you, Senator Ryan Shealy, he's come in along with Representative Candy Waites. We welcome you both to the program. And Ryan, if the Lottery bill passes, we only want half the money.**

Sen. Shealy - **We will work on that.**

David Sojourner
Advisory Committee on Legal Advocacy
1901 Gadsden St.
Columbia, SC 29201

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DAVID C. SOJOURNER, JR.
HARRY B. GREGORY, JR.

FROM: David C. Sojourner, Jr.,Esquire
Advisory Committee for Legal Advocacy
for the Elderly

TO: Joint Legislative Committee on Aging

RE: Proposal for Family Consent Statute and Health Care Power of Attorney

DATE: September 14, 1988

The South Carolina Commission on Aging's Advisory Committee on Legal Advocacy for the Elderly serves as an advocate for the elderly while focusing upon legal issues affecting the livelihood and status of senior citizens in institutions and in the community.

In discussing legal problems which effect the elderly, the S.C. Department of Social Services and the State Long Term Care Ombudsmen have discovered the need for a mechanism for providing consent for health care for the incompetent patient. The Ombudsmen's Office has related one incident where an elderly patient in a facility fell and broke her hip. Since she was not able to sign a consent for treatment, her physician refused to operate until her condition became life-threatening. Five days passed in the interim. While this example may seem extreme, it is easy to imagine this type of problem arising in light of the recent activity in the area of medical malpractice litigation.

The normal procedure in this type of situation is for the Department of Social Services to petition the probate court for the appointment of a Guardian. This procedure is costly as well as time-consuming.

Our committee proposes that you consider two options for providing a means to insure that the elderly of this state are provided prompt medical attention when the time comes that they are no longer able to act on their own behalf.

First, we believe that the enactment of a Family Consent Statute would alleviate many of the problems discussed. South Carolina has already adopted a statute allowing a parent to consent to treatment on behalf of a minor child. Our proposal is for a statute authorizing a child or spouse to consent to medical treatment on behalf of an incompetent parent or spouse.

While, a Family Consent Statute would apply in many situations, it would not help those patients who do not have a spouse or children. For those patients without a family, we propose a statute authorizing the use of a Health Care Power of Attorney. The Health Care Power of Attorney would allow an individual to designate an agent to consent to medical treatment on his or her behalf. This power could be drafted so that it would be a "springing power." That is, it would not become active until the patient was no longer competent to act on his or her own behalf.

Under current South Carolina law it is unclear whether an agent under a general durable power of attorney can consent to medical treatment. [See, Drafting the Durable Power of Attorney, Moses (1985)]. If there is uncertainty you can be sure that a cautious physician will be reluctant to act solely on the consent of the patient's agent under a general power of attorney.

Merely enacting a Health Care Power of Attorney Statute will not correct the problem. It will however provide a mechanism of dealing with the problem. Once enacted, the Commission on Aging, the Aging Network, and the South Carolina Bar would work to publicize the availability of this simple and inexpensive method of insuring that health care will be provided in a timely manner.

If these two proposals were implemented, we believe that the majority of our elderly will eventually be covered under one of the options. The only group who will not be assisted by these measures are those who are already incompetent and do not have a spouse or children.

Rep. Harris - Do you have copies of this proposed legislation that you could provide us with?

Sojourner - We have some copies of a health care power of attorney statute from other states.

Rep. Harris - How about the consent for the incompetent?

Sojourner - There are some in other states. Yes sir, we could present those to you.

Rep. Harris - Would you make those available to the Committee so we could see what the other states are doing?

Sojourner - Certainly!

Rep. Waldrop - This program would be free to people that qualify for it. Will lawyers be able to collect the usual one-third?

Sojourner - I'm sorry. There's no tort recovery in these situations. This consent statute would allow a spouse to automatically be able to consent for a parent.

Rep. Waldrop - I understand that, but I understand that an attorney would probably handle this. Am I correct?

Sojourner - Under the power of attorney statute - Yes sir, they would I'm anticipating that we could provide a form in that statute similar to our Living Will that the Commission on Aging or the Bar could make available.

Rep. Harris - Thank you! Welcome Representative Dill Blackwell who I told you earlier had a prior commitment but I knew he would be here.

Michael J. Stogner
Appalachian Council of Governments
P. O. Drawer 6668
Greenville, SC 29606

PUBLIC HEARING TESTIMONY

JOINT LEGISLATIVE COMMITTEE ON AGING

SEPTEMBER 14, 1988

S. C. ASSOCIATION OF AREA AGENCIES ON AGING

Mr. Pat, Members and staff of the Joint Legislative Committee on Aging, and interested friends, my name is Michael Stogner. I am the Aging Unit Director of the Appalachian Council of Governments and am here today presenting testimony on behalf of the South Carolina Association of Area Agencies on Aging.

Today the South Carolina Association of Area Agencies on Aging, along with the entire Aging Network, wishes to express our sincere appreciation to you for your many significant accomplishments during the last session and throughout the years. As the "Summary of Legislation Enacted through 1988 Related to Aging Interests" publication so graphically illustrates, your efforts have positively impacted the quality of life for all the citizens of South Carolina, including the elderly. We applaud your efforts to date, look forward to the upcoming session, and pledge our continued support as we mutually endeavor to insure the highest quality of life for our older citizens.

The Older Americans Act intends that the area agency on aging shall be the leader relative to all aging issues on behalf of all older persons in the planning and service area. This means that the area agency shall proactively carry out, under the leadership and direction of the State agency, a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems in, or serving, each community in the planning and service area. 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 overall goal of the Area Agency on Aging is to develop, coordinate and promote a comprehensive area-wide aging network system that will enable the older people of their area to lead independent lives in their own homes in dignity for as long as possible. In developing this community based service delivery system, the Area Agency undertakes annual planning activities to obtain updated information on the status and needs of the older citizens and prioritize those needs; inventory the resources and

services available from public and private sources to meet the identified needs and evaluate their effectiveness; develop and administer a comprehensive area plan for their region; sub-contract program funds obtained by the Area Agency to local providers for the delivery of services; secure additional resources to assist local providers in developing new, innovative programs to benefit the older citizens of their region; provide technical assistance to local governmental jurisdictions and other human service provider agencies; and, serve as an advocate to enhance awareness by service providers, community leaders, civic groups, the corporate and voluntary sectors, and elected officials regarding the identified needs and issues impacting the older citizens of the State. The key words in all of this are planning and administration - the best use of the limited resources available to provide the maximum number and type of quality services to those older citizens most in need of them.

As you are aware, South Carolina's population is growing older. The forecasts of people 65 and older in SC show a 21% increase for the period 1990 to 2000, while that for the nation is 10.2%. At present we are still a largely rural state with high rates of illiteracy (25% of the elderly), poverty (24.3% of the elderly, while the national average is 14.1%), and a significant minority population (26% of the elderly are black, while nationally the average is 8%). Consideration must be given to emphasizing and

refining the continuum of care of health and human services which are available to respond to the multiple and diverse needs of well, able elderly to chronically and terminally ill persons.

The Area Agency is only one part of a total Aging Network which includes many diverse agencies including the Commission on Aging, county councils on aging and other local service providers, DSS, Health and Human Services Finance Commission, DHEC, mental health, social security, the private sector, etc. All of those agencies must work in concert to meet the ever increasing needs of the older citizens of our state. In meeting these needs, none of these agencies can stand alone. There must be inter and intra-agency coordination and memorandums of agreement that are implemented, not just signed, at all levels of the network. This necessitates planning, coordination and advocacy for the most effective continuum of care possible.

It is in this advocacy role that we appear before you today. We request your support of the restoration of State Grant Funds for Planning Districts ($128,705). These funds are used by Area Agencies and County Councils on Aging primarily for matching funds for other Federal programs. These fund reductions now have to be replaced by local sources which have been used and are needed to maintain and expand services. Restoration of just the FY 87-88 reductions of $69,342 would allow the provision of an additional

2,300 units of homemaker services; 3,003 meals; and, 79,690 units of transportation service to the elderly. Last year we asked for your support in the establishment of the S. C. Registry for Dementing Illness. The registry was established in 1988 and has a private foundation award plus state matching funds to operate. It provides information that will enable an increasing amount of research, education, and service for demented individuals. It holds a position of national leadership as the prototype of optional demention registry methodology. We strongly urge state budget support of the registry.

The Commission on Aging's original budget request for the provision and expansion of community-based, in-home services was $2.5 million. Of the original request, currently $250,000 is appropriated through the Commissions's budget and $500,000 is anticipated from the bingo tax. Should new sources of state revenue be developed, or windfalls be experienced, providing additional community-based, in-home services should be considered as a priority for these funds - as earlier demographics and current waiting lists for these services illustrate that current funding only scratches the surface of meeting this need.

Two years ago the General Assembly increased the state gasoline tax and 1/4 of one cent was designated for public transportation activities. These monies need to be made available on an on-going

basis. In the Appalachian region alone, the requests for transportation service-assistance was more than twice the amount of the assistance that could be provided and we believe many other agencies would have applied for this assistance had more lead time been provided. We encourage your support of the continuation of 1/4 of one cent earmarking of the state gasoline tax for public transportation activities.

The Area Agencies also support legislation to:

1) assure the protection of elderly persons who purchase living arrangements through life care communities;

2) provide resources for the State Housing Authority to develop innovative housing options for low and middle income elderly;

3) give a $300 tax credit for families who provide in-home care for a frail, elderly family member who has certified as nursing home eligible;

4) increase personal needs allowance for nursing home residents.

The Area Agencies support studies initiated by the legislature to:

1) study current status of senior centers and nutrition sites across the state regarding placement and/or renovation of the same;

2) study of Adult Foster Care services similar to programs in other states.

As Winston Churchill stated, " A civilization will be judged by how it treats its elderly." The challenge is before us. We pledge to join with you in our continuing partnership to successfully meet the challenge.

Thank you.

Michael J. Stogner
S. C. Appalachian Council of Governments
P. O. Drewer 6668
Greenville, SC 29606

Rep. Blackwell - Mr. Stogner, I followed with interest what you are saying, I hear you indicating that there needs to be a responsibility to work together among all of the folks. Do you see any duplication of effort in any of the planning activities or service delivery?

Stogner - There is responsibility at all three levels of the network. The type of planning that takes place at the state level is designed to be more for policy to present to you and the Commission itself for the state as a whole. The planning that takes place at the Area Agency is designed for the communities within its service and planning area. The planning that takes place at the local county council on aging or service provider is within the jurisdiction of the people it serves in the community of that county. Hopefully these are not duplications. Hopefully they flow into one another and build upon each other. I would venture to say that there may be some duplication in some of these activities by virtue of the fact that we don't have the full coordination and cooperation among all agencies that we need.

Rep. Blackwell - Why do we not have that cooperation and coordination? It seems to me that these folks of all people ought to be cooperating. What's the problem?

Stogner - I'm speaking in the broad base not just the Aging network. I'm also including the Department of Social Services, Mental Health, Department of Health and Environmental Control and Finance Commission. It appears to me, and this is a personal opinion, that we have not yet figured out how to get beyond the "turf" responsibilities and even though we each have responsibilities in our own jurisdiction, we must recognize that we do not have unlimited resources.

Rep. Blackwell - I wish we had more time.

Rep. Harris - I do, too, Michael. We appreciate you coming.

Rep. Waldrop - Make sure he's here for the Committee meeting.

Mary Gail Douglas, Presider
SC Association of Council
Aging Directors
210 E. Washington St.
Winnsboro, SC 29180

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JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

TESTIMONY

SEPTEMBER 14, 1988

MARY GAIL DOUGLAS, PRESIDENT
S. C. ASSOCIATION OF COUNCIL
ON AGING DIRECTORS
210 E. WASHINGTON STREET
WINNSBORO, S. C. 29180

ISSUES NOTED IN THE PRESENTATION:
BINGO MONEY
GASOLINE TAX FOR ELDERLY & HANDICAPPED
MEDICAID BED SITUATION
ASSURANCE OF FOCAL POINTS IN EACH COUNTY
(i.e. COUNCILS ON AGING, ETC.)

MR. CHAIRMAN AND MEMBERS OF THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING:

MY NAME IS MARY GAIL DOUGLAS AND I AM HERE TODAY REPRESENTING THE S. C. ASSOCIATION OF COUNCIL ON AGING DIRECTORS. LET ME BEGIN BY TAKING A MINUTE TO EXPRESS TO YOU OUR GRATITUDE FOR THE WORK THAT WAS DONE ON THE BINGO MONEY. WE WANT YOU TO KNOW THAT THIS MONEY HAS ALREADY BEEN PUT TO WORK AT THE SERVICE DELIVERY LEVEL AND IS ASSISTING US IN SERVING THOSE IN NEED OF HOMEMAKER SERVICES, PERSONAL CARE SERVICES AND RESPITE CARE. RESPITE CARE IS THAT SERVICE WHICH HAS BEEN DEVELOPED TO RENDER BRIEF PERIODS OF "REST" FOR THE CAREGIVER OF AN OLDER PERSON WHO HAS THE TOTAL RESPONSIBILITY OF THAT OLDER PERSON DAY IN, DAY OUT. THROUGHOUT THE STATE, THERE CONTINUES TO BE WAITING LISTS FOR THESE SERVICES, BUT THE BINGO MONEY HAS HELPED TREMENDOUSLY TO BEGIN TO MEET THESE NEEDS.

WE ALREADY KNOW THAT YOU SUPPORT THE IDEA OF GETTING THE DOLLAR DOWN TO THE LEVEL WHERE PEOPLE ARE SERVED. WE REALIZED THIS AGAIN THROUGH THE EFFORTS SHOWN IN THE PASSAGE OF THE ¼ OF ONE CENT GASOLINE TAX FOR THE PURPOSE OF PURCHASING CAPITAL EQUIPMENT USED IN THE TRANSPORTATION OF ELDERLY AND HANDICAPPED INDIVIDUALS. THESE DOLLARS ARE ALREADY AT WORK AND HAVE BEEN AWARDED TO TRANSPORTATION PROVIDERS WHO MEET THE UNIQUE NEEDS OF ELDERLY AND HANDICAPPED INDIVIDUALS IN THIS STATE. IT IS (6) CITED OVER AND OVER AGAIN THAT TRANSPORTATION IS A MAJOR PROBLEM FOR THIS SEGMENT OF THE POPULATION. SERVICE PROVIDERS SEE THIS SOURCE AS A REMEDY TO REPLACING WORN OUT EQUIPMENT. WE ENCOURAGE YOU TO SUPPORT THE CONTINUATION OF THIS TAX FOR THIS PURPOSE IN THE COMING LEGISLATIVE SESSION. - 20 -

THE ASSOCIATION OF COUNCIL ON AGING DIRECTORS CONTINUES TO DEAL WITH PROBLEMS ASSOCIATED WITH THE SHORTAGE OF MEDICAID NURSING HOME BEDS IN THIS STATE. THIS HAS BEEN A PROBLEM FOR QUITE SOME TIME AND THE PROBLEM IS GROWING. ADDITIONAL MEDICAID BEDS ARE NEEDED DESPERATELY. WE ARE SEEING MORE AND MORE PEOPLE IN NEED OF 24 HOUR A DAY CARE AND HAVING TO SETTLE FOR 4 HOURS A DAY CARE BECAUSE OF THE LIMITED NUMBER OF BEDS. HOSPITALS ARE DISCHARGING PATIENTS EARLIER DUE TO THE WAY THAT THEY ARE REIMBURSED. THIS CAUSES AN EVEN GREATER BURDEN ON THE PROVIDERS WHO ARE INVOLVED IN THE CONTINUITY OF CARE; BUT ARE NOT ABLE TO MEET THIS 24 HOUR A DAY NEED. WE ASK THAT MUCH CONSIDERATION BE GIVEN TO THIS ISSUE IN THE NEXT LEGISLATIVE SESSION.

I SAVED OUR MOST PRESSING ISSUE AND PLEA TO YOU FOR LAST AND IT IS PROBABLY THE MOST SERIOUS CHALLENGE THAT IS FACING OUR STATE TODAY--THAT IS THE CHALLENGE OF ASSURING APPROPRIATE AND ADEQUATE PROVISION OF PROGRAMS AND SERVICES FOR THE STATE'S ELDERLY POPULATION. IN 1900, THE AVERAGE LIFESPAN WAS 46 YEARS. OBVIOUSLY IN 1900, THERE WERE FEWER ELDERLY CITIZENS. TODAY, THE AVERAGE LIFESPAN IS 76 YEARS. IT'S A FACT THAT ELDERLY ARE HERE TO STAY AND STATISTICS POINT THAT THEY ARE HERE TO STAY LONGER. WE ARE ALSO SEEING MORE SINGLE ELDERLY, MORE ELDERLY WHO HAVE NO CHILDREN AND MORE ELDERLY WHO ELECT TO CONTINUE TO LIVE INDEPENDENTLY IN THEIR OWN HOMES AS LONG AS POSSIBLE. STUDIES SHOW THAT S. C. IS THE THIRD LARGEST GROWING RETIREMENT STATE. MANY ELDERLY ARE RE-LOCATING TO OUR STATE WITHOUT THE SUPPORT OF ANY FAMILY. FOR THESE REASONS AND MANY OTHERS, THE AGING NETWORK OF SOUTH CAROLINA IS FACED WITH AN OVERWHELMING TASK IN TRYING TO MEET THE NEEDS OF THIS SEGMENT OF OUR POPULATION THAT IS CALLED ELDERLY. WE ARE ALREADY REALIZING THAT THE OLD WILL GET OLDER AND THERE WILL BE MORE OF THEM. BY THE YEAR 2030, ONE-FIFTH OF THE ENTIRE POPULATION OF THE UNITED STATES WILL BE OVER THE AGE OF 65.

IN FACING THIS CHALLENGE, IT IS REALIZED THAT ONE OF THE GREATEST PROBLEMS OF THE ELDERLY AND FAMILY MEMBERS OF THE ELDERLY IS ACCESSING THE SERVICE DELIVERY SYSTEM. THIS NEEDS TO BE DONE WITH AS LITTLE DIFFICULTY AS POSSIBLE FOR THEM. THIS CAN ONLY BE ACHIEVED THROUGH THE DESIGNATION AND RECOGNITION OF COMMUNITY FOCAL POINTS. (i.e. COUNCILS ON AGING, SENIORS UNLIMITED, SENIOR ACTION AND OTHERS) THESE FOCAL POINTS SHOULD PROVIDE THE LEADERSHIP WITHIN THE COMMUNITY TO BRING ABOUT COORDINATION OF SERVICES, DEVELOPMENT OF NEW SERVICES, IMPROVE EXISTING SERVICES, AND PARTICIPATE IN NEEDS STUDIES AND ADVOCACY EFFORTS IN REGARD TO THE ELDERLY. ACCESSING SERVICES FOR THE ELDERLY DEMANDS THAT THE FOCAL POINT BE A RECOGNIZABLE AND VISIBLE AGENCY TO THE COMMUNITY AS WELL AS TO SENIORS THEMSELVES. A FOCAL POINT FOR THE ELDERLY SHOULD CONCENTRATE ALL EFFORTS TOWARD THE NEEDS OF THE ELDERLY. NO OTHER TASKS OR RESPONSIBILITIES SHOULD OCCUPY THE AGENCIES' ATTENTION. THE BASIS FOR THE OLDER AMERICANS' ACT WAS ESTABLISHED UPON THIS CONCEPT.

DONALD F. REILLY, SENIOR VICE PRESIDENT, NATIONAL COUNCIL ON AGING, MADE THIS STATEMENT IN A TESTIMONY BEFORE THE SUB-COMMITTEE ON AGING OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON APRIL 30, 1987, "A COMMUNITY FOCAL POINT SHOULD BE A HIGHLY VISIBLE ONE-STOP LOCATION FOR OLDER PERSONS AND THEIR FAMILIES TO GET INFORMATION ON THE SERVICES AND OPPORTUNITIES AVAILABLE, WITH PROVISION OF NEEDED SERVICES ON-SITE WHEREVER FEASIBLE, REFERRAL TO OTHER APPROPRIATE SERVICE PROVIDERS, AND COORDINATION OF SERVICES AS NECESSARY." THIS IS OUR ASSOCIATION'S VISION OF APPROPRIATE AND ADEQUATE PROVISION OF SERVICES TO OUR STATE'S ELDERLY.

BY NO MEANS CAN ANY AGENCY OR SHOULD ANY AGENCY EXPECT TO BECOME THE SINGLE PROVIDER OF ALL AGING SERVICES. THIS TYPE OF SUPER-AGENCY WOULD DAMAGE THE PROGRESS BEING MADE IN THE AGING FIELD TO PROVIDE A BROAD BASE OF SUPPORT. THE AGENCY SHOULD BE A MULTI-SERVICE AGENCY ACQUAINTED WITH ALL AVAILABLE SERVICES AND PROGRAMS FOR THE ELDERLY. IT IS THROUGH THIS AVENUE THAT OLDER PEOPLE AND FAMILIES OF THE ELDERLY ARE GUIDED TO RECEIVE NEEDED SERVICES. AS YOU CAN WELL IMAGINE, THIS PROCESS COULD BECOME QUITE COMPLEX IF THERE IS NO SINGLE POINT OF ENTRY FOR OLDER PEOPLE TO ACCESS SERVICES. WE SOLICIT YOUR CONTINUED SUPPORT OF THIS CONCEPT AND ASK THAT CONSIDERATION BE GIVEN TO ASSURE THE ESTABLISHMENT OF MULTI-PURPOSE CENTERS, OR FOCAL POINTS, IN EACH COUNTY. THIS APPROACH WOULD ASSURE AN EFFECTIVE, COMPREHENSIVE AND APPROPRIATE SERVICE DELIVERY SYSTEM TO OUR STATE'S ELDERLY. COUNTIES THAT HAVE DEVELOPED FOCAL POINTS HAVE ESTABLISHED RELATIONSHIPS THAT ENCOURAGE ADDITIONAL RESOURCES FOR THE EXPANSION OF PROGRAMS FOR THE ELDERLY. THIS OFFERS THE OPPORTUNITY TO FILL SOME OF THE GAPS THAT ARE LEFT AS A RESULT OF LIMITED FUNDING FROM THE FEDERAL LEVEL.

AS DIRECTORS OF FOCAL POINTS IN THE COUNTIES THROUGHOUT THE STATE, WE PLEDGE OUR COMMITTMENT TO PROVIDE PROGRAMS AND SERVICES TO THE ELDERLY OF SOUTH CAROLINA IN ORDER TO ENHANCE THE QUALITY OF LIFE FOR THEM. WE APPRECIATE YOUR CONSIDERATION OF OUR CONCERNS AND LOOK FORWARD TO YOUR SUPPORT AND WORKING WITH YOU IN THIS NEW LEGISLATIVE YEAR.

RESPECTFULLY,

MARY GAIL DOUGLAS, PRESIDENT
S. C. ASSOCIATION OF COUNCIL ON AGING DIRECTORS

Rep. Blackwell - Ms. Douglas you made a very informative statement and your demonstration here of the lovely folks brings it home. Do you see a duplication of effort or do you see anything that could be done in the configuration of the State programs that would improve or bear on what you are talking about.

Douglas - I think the reconfiguration study that is currently underway will further define what the responsibilities of each role should be. I think that if there is a duplication factor, it will be answered and corrected through that process.

Wasson - How many counties have focal points that you've mentioned here?

Douglas - We have 43 members in our association. Two of those counties serve two counties. So whenever we talk about focal points, we want a visual community focal point that doesn't get swallowed up in the local offices such as Department of Social Services or wherever it is located. An example that I can give to best clarify that is the Fairfield County Council on Aging at one time was housed in the Recreation Commission Building. We were not as visible as we are now since we have been able to have our own building. The community now associates elderly needs and elderly services with the Council on Aging as opposed to recreation activities as before.

Al Reynolds
Rt. 2, Box 151
Keithwood Lane
Blythewood, SC 29016

(1)

Mr. Chairman, ladies and gentlemen, on September 13, 1910, I discovered America. Thank God for the United States of America, the greatest country on Earth, and all those who had a part in making our nation what it is today.

Hoping that everyone present agrees with me on this point, I would like to say that of the fifty states, South Carolina is the most special in so many ways. I wish to thank each and everyone who has helped make our lives here in South Carolina as comfortable as they are.

When I was a "country boy" in Lexington County standing on the side of the road "thumbing" - hitch-hiking, if you please, Mr. Edgar Brown and Mr. Sol Blatt came by in a chauffeur driven automobile, picked me up, and brought me to Columbia. They were men that had compassion on others.

Another statesman who has compassion for and a desire to help his fellowman is the Honorable Senator Strom Thurmond. We also have our present Governor and Congress working together for our benefit. The Democratic Donkey and the Republican Elephant must work together for the good of all concerned. How do you spell cooperation? W E . We should work together for suffering humanity.

Today I have a few requests for you to kindly consider. These requests are for the low-income handicapped, the low-income disabled, the low-income elderly, and the other low-income bracket people of our state. As an example, if you own an automobile and pay for the license tag, and you receive a tax notice in the mail for over seventy dollars, it strains your meager budget. You can see, before your very eyes, it's draining away at your monthly income, especially when that income for you and your spouse (two people, mind you) is only $541.00 per month. Especially is this true when there are taxes on everything you purchase, except prescription drugs. It would be very helpful to all the low-income brackets of citizens mentioned above if our legislators would rule to eliminate completely taxes on their homes, automobiles, and sales taxes on their groceries, dry cleaning, gasoline, and any other commodities. I believe this could be done if some-

one had a vision and would follow through with it.

Another suggestion that I would like to mention is about the dire need for all people of our great state to be more mindful of the litter that is along the highways and byways. The trash and litter that passersby of South Carolina view is filthy and unfit to be seen. There are laws against littering and they could be enforced if someone were man or woman enough to strictly enforce them. Our legislature is helping us but there is much more that needs to be done. The inmates in our state prisons could clean up the litter all over the state instead of just sitting around on taxpayers money if someone who is a good statesman would see to this.

Also, I have a plan to help the poor alcoholics that would enable them to function as sober reliable citizens. It would put the alcoholic back in society so to speak. It would give me great pleasure to talk with anyone interested and to share this plan with them. I firmly believe that it would put 50% of the alcoholics who want help back of their feet.

May the Lord bless each and everyone of you. Keep up the good work and thank you.

Al Reynolds
Rt. 2 Box 151
Keithwood Lane
Blythewood, S. C. 29016

Telephone 803-786-0631

Harold W. Pasch
Rt. 3, Box 547
St. Matthews, SC 29135

I. The Notch Act of 1977 extenuates my Social Security Benefits by approximately twenty-five per cent. I am informed that there are elderly Puerto Ricans in Puerto Rico collecting a comprehensive benefit who have not paid anything into the Social Security Fund. Is this an equitable Congressional Act when I have worked many years paying into the fund?

II. I and everyone to whom I have spoken never heard of a medical doctor who would stand in the way as a barrier to a patient's getting proper medical care. Betty Guerry, M.D., at Crafts-Farrow State Hospital has done this to me once in 1980 and again in 1983 when I needed neurological care. The question is: why does the Department of Mental Health hire an obdurate physician? I feel that the only reason she holds her position is that she is in collusion with E.A. Hall. Dr. Vallini at Hall Institute told me they (Medlin-Guerry team) never sent any neurological patients to his ward. If patients are to receive optimum care they should be under the care of a neurologist and a psychiatrist and not a medical neophyte whose incipient medical training was in pediatrics.

While I was a Patient At Crafts-Farrow State Hospital I received Prolixin Decanoate, a derivate of a trifluoromethyl phenothiazine ester. This was administrated by intra-muscular injection and this almost caused my expiration. The following are excerpts from the "Physicians' Reference".

1. Patients with mitral (Pertains to heart valve on left side of heart between upper and lower chambers) insufficiency appears to be particularly prone to hypotensive reactions with phenothiazine derivatives and should therefore be monitored closely when the drug is administered. Phenothiazine derivatives can cause hypotension severe enough to cause fatal cardiac arrest.

2. If signs and symptoms of tardive dyskinesia (delayed impairment of any muscular movements) appear in a patient on prolixin decanoate the drug should be discontinued.

3. Physicians should be alert to the possibility that severe adverse reactions may occur which require immediate medical attention.

4. Sudden and unexplained deaths have been reported in hospitalized patients receiving Prolixin Decanoate.

Dolores Macey
William Hall Psychiatric Institut
2100 Bull St.
Columbia, SC 29201

TESTIMONY

Presented to the State of South Carolina

Joint Study Committee on Aging

by

Dolores Macey

Chairperson

South Carolina Commission on Aging

State Advisory Committee on Alzheimer's Disease and Related Disorders

Representative Harris and other distinguished members of the Committee:

I speak to you as chairperson of the Statewide Advisory Committee on Alzheimer's Disease and as a former caregiver of my mother who died from Alzheimer's Disease over three years ago.

I speak to you for the 24-30,000 people in South Carolina who have Alzheimer's Disease and for the 80% of families who provide for their care. Yes, there are two casualties of this dreadful disease: the patient and the family. Alzheimer's Disease is the fourth leading cause of death in adults in this country. It affects over 2.5 million in the USA. Before I go any further, however, I should like to take this opportunity to thank members and staff of this committee who were supportive of the development of model legislation for long term care insurance which is long overdue in this country.

This year, we are asking for your support of the following:

1) Development and passage of legislation to give a $300.00 tax credit to families who provide at least 6 months of continuing home or community-based care for a frail elderly family member who has been certified by a physician as eligible for nursing home placement.

I have traveled around the State of South Carolina, speaking to support groups and have never met any family members who had as their first priority placing their loved one in a nursing home. A primary factor leading to nursing

home placement is exhaustion of financial resources and the overwhelming burden on family caregivers. The legislation I am asking for was introduced in the Senate and House last term but did not get out of committee (H 3414 & S-968).

2) Families need in-home health services and adult day care centers. We are very appreciative of the Alzheimer's Day Care Project the Department of Mental Health now operates at the Hall Institute. This pilot project allows family members to continue to be employed and provides respite from the long and exhaustive care needed by the Alzheimer's patient. This project is unique in many ways. It is the result of a collaborative effort of local county councils on aging, an area agency on aging, the University of South Carolina School of Medicine, the South Carolina Commission on Aging and the South Carolina Department of Mental Health. This project needs statewide replication.

Families also desperately need in-home health care services. When the patient is no longer able to attend a day care program, but can function outside of a nursing home with the support of some health services in the home, then such services should be made affordable. In 1985, less than 4% of Medicare funds were spent for home care.

When patients have reached the last stages of Alzheimer's Disease, most families must inevitably turn to nursing homes for placement and care of their loved ones. Families need to know that this resource is available to them. The stress and burden of the caregiver are overwhelming. The disease can last from 2 to 25 years and we know of caregivers who died before the victim of Alzheimer's Disease expired.

3) We are asking you to increase the personal needs allowance for Medicaid nursing home residents from 25.00 to 30.00 per month. These funds are used to

purchase personal items such as toothpaste, hair products and services and other necessities for daily care. Let us help preserve human dignity.

4) We ask that Human Resource Management of the State of South Carolina and the South Carolina Chamber of Commerce be encouraged to survey employees to determine the number who are providing care for elderly parents or other relatives. In December 1987, a New York Times survey indicated 20-40% of full time employees were caring for elderly parents or other relatives. We expect South Carolina has a large group of caregivers in this category. Projected figures for the over 65 group in South Carolina increases 46% for the period 1980-1990 and 21% for the period 1990-2000. The growth rate in South Carolina during 1980-1990 is much higher than the US rate of 24.7%. The projected rates for South Carolina for the period 1990-2000 are also higher than the US rate of 10.2%.

Let me say in closing that Alzheimer's Disease patients do not belong to any one state agency--they belong to the total community, both the private and the public sector. I pray we will not have groups representing different diseases competing with each other for funds and services. Alzheimer's patients have for the most part been productive, tax-paying citizens who had the misfortune to contract this dreadful disease that robs the patients of all human dignity. Let us not forget them.

Thank you for giving me the opportunity to speak to you. I shall be happy to answer any questions you might have.

Jean Hutson
Alzheimer's Disease and Relate
Disorders Association, Inc.
511 Old Chapin Road
Lexington, SC 29072

Mr. Chairman, Ladies and Gentlemen:

Columbia Chapter for Alzheimer's Disease and Related Disorders heartily supports the continuance of the Dementia Registry and Study Center at the University of South Carolina.

There have been no hard statistics on the number of people with Alzheimer's Disease or other dementia related illness in South Carolina. With the establishment of the Resistry and DHEC making Alzheimer's Disease a reportable disease, we now have a means for a statistical base. The Registry will provide numbers, locations with largest needs, service providers, and available services for families. Cases can be followed from diagnosis thru demise with informed consent from patient/families.

The South Carolina Dementia Registry is unique in that it is one of approximately 7 in the United States that has the blend of features of which it is capable. It is only the third in the nation that will carry Statewide statistics. The South Carolina Registry has already been recognized nationally and articles authored by the director, Dr. Rona Sayetta have been published in the American Journal of Alzheimer's Disease and Research. The Dementia Study Center at the University, in conjunction with the Registry will enhance the image of University of South Carolina in being among the first dedicated to this cause.

The members of Columbia Chapter for Alzheimer's Disease and Related Disorders are aware of the tremendous need for hard statistics on dementia related illnesses. Longevity has added to the fast growing population of dementia victims. Families of these victims are dependent upon the Department of Mental Health, the Commission on Aging and other health related State agencies to aid them in providing services in various ways. The private sector is called upon for services also. In order to plan for the needed services, the Registry will prove to be the most valuable tool todate. Long term projection is a must if our population is to be served adequately.

Ladies and Gentlemen, I ask you to consider these needs carefully. The Registry must have the means for continuance in the 1989/90 budget. Present funding will allow its continuance thru December 1989. In Januar 1990 there have to be funds to continue the work. A break in service will mean the end of a project that has been needed in this State for many years. Please support the request of the Commission on Aging for funds to guarantee the continued funding of the Dementia Registry. The familie of the demented elderly of this State are dependent upon your support.

Jean Hutson

Dr. Rona B. Sayetta
SC Registry for Dementing Illnesses
USC - Public Health
Suite 206 - Benson Building
Columbia, SC 29208

TESTIMONY BEFORE THE
JOINT LEGISLATIVE COMMITTEE ON AGING

SUBJECT: Support for the South Carolina Registry for Dementing Illnesses to continue operating

DATE: September 14, 1988

PRESENTER: Rona B. Sayetta, M.D., Sc.D., M.P.H., Director
The South Carolina Registry for Dementing Illnesses
Research Assistant Professor of Epidemiology
University of South Carolina School of Public Health

I'm Dr. Rona Sayetta, a faculty member at the University of South Carolina School of Public Health and the Director of the new South Carolina Registry for Dementing Illnesses which is housed there. I appreciate the opportunity to come before you today to ask for your support for continuation of the registry.

A case registry is a system for recording, storing and updating standardized information about all individuals with a particular disease or class of disorders--or at least all such individuals who come to medical attention--from a specified date onwards. The South Carolina Registry for Dementing Illnesses is a data system for information about Alzheimer's disease, multi-infarct (vascular) dementias, the alcohol-related dementias, Huntington's disease, and similar disorders. These chronic dementing illnesses are characterized by a global decline in cognitive abilities in clear consciousness (such as loss of memory or the use of language) and there is often associated physical deterioration during the course of illness. There are more than 70 such conditions in all, although Alzheimer's disease

and the vascular dementias (the result of multiple small strokes) together account for about 80 percent of the total. The South Carolina Registry for Dementing Illnesses will identify newly diagnosed cases of all these conditions and then track them over time. We expect to identify and register most of the 7,500 new dementia cases that we think are occurring each year.

Dementia is important because it is a major cause of disability, dependence, institutionalization, and impoverishment in old age. These diseases become terminal. But before the death of the person comes the death of the personality. We have an estimated 67,500 cases of all types of dementing illness in existence in the state right now.

Among the nine members of the Joint Legislative Committee on Aging sitting here, three or four of you can expect to become demented before you die. If you live into your nineties, you may have as much as a 50-50 chance of developing one of these dread diseases. It is the same for all the citizens of our state; there but for the grace of God go I. The motto of the South Carolina Registry for Dementing Illnesses is, "Knowledge to Help Families."

South Carolina's dementia registry is not just another university-based research project. I want to explain to you how its significance is much greater for our state. Then you will understand why the consortium that supports the registry is asking you through me to enable it to continue to operate.

The South Carolina Registry for Dementing Illnesses has two

major objectives. The first is to serve all the state's health and social service agencies by producing statistics they need to plan and evaluate the effectiveness of program services and to prepare their budgets. At the present time, it is impossible to produce an accurate, unduplicated count of the number of dementia cases in South Carolina, or even the number of affected nursing home occupants. We don't know who they are, where they're located, what their stage of illness is, what services they need, or which services they are presently unable to obtain.

The second purpose of the dementia registry is research. Qualified investigators with approved projects now have almost no way to identify cases in the state to carry out their proposed studies. The registry is a confidential database that can be of immeasurable assistance to researchers who are trying to locate cases--of course, only with the informed consent of the patients or their representatives. The major dementing illnesses have no known cause or cure. The registry can help scientists and clinicians to discover risk factors, useful treatments, and strategies for prevention. The registry can also be a tool for investigating patients' needs for care and ways of assisting them and their families to cope better with the progressive onslaughts of illness.

The South Carolina Registry for Dementing Illnesses was funded beginning April 1, 1988, through a combination of monies from a private foundation, discretionary and in-kind assistance from the involved state health and human service agencies, and

federal dollars. Most of the start-up money will run out at the end of calendar year 1989, right after we have produced our first complete year of good statistics. The registry is ready to conduct statewide data collection beginning this October 1.

The registry has a full- and part-time staff of about 25 people (including both those who are salaried and those who are donating services). This large number is necessary because the registry includes professional and public relations activities, statewide field staff operations, computer systems, physician oversight committees, a User Policy Council, and several other elements to make it work. Our dementia registry is unique in the country because it is the national prototype of active chronic disease surveillance systems for difficult-to-diagnose conditions. There are only two other public health dementia registries already operating in the United States, and several additional ones are being designed. We are the only public health dementia registry that is not located inside and operated by a state health department, although in South Carolina we are an agent of DHEC and collaborate very closely. We carry out active rather than passive surveillance of cases by sending research nurses to doctors' offices throughout the state to abstract relevant medical data directly from their records. The other registries depend on reportable disease requirements, and when the doctors don't send in all the reports, their registries get severe undercounts of the number of cases to be served.

We are asking for $465,779 to continue the dementia registry

operation in the latter part of fiscal year 1989. This will cover some remaining start-up expenses plus six months of operation. Detailed budget breakdowns are available upon request. The projected cost for all of fiscal year 1990 is $656,133. The expense is high, but the registry is the single vehicle that will meet all of the state's needs in this area. If adequate funding cannot continue, all the time, effort, and money already invested in the registry will be wasted and we shall have no choice but to shut it down. It is impossible to keep the registry operating indefinitely on a piecemeal basis with limited available research grants. All the other public health dementia registries in the United States are funded through continuing appropriations by their legislatures to their state health departments.

The list of supporters of our registry is still growing and at present includes all the state agencies, universities, professional societies and lay groups shown on the last sheet in your handout. The registry was planned by the South Carolina Commission on Aging and involves the Department of Health and Environmental Control, the Health and Human Services Finance Commission, the Department of Mental Health, the South Carolina Commission on Alcohol and Drug Abuse, the Medical University of South Carolina, and the University of South Carolina, as well as professional associations of doctors, nurses, pharmacists, social workers, the Alzheimer's Association, and other organizations. They will be writing and testifying on behalf of our consortium

effort as this year's legislative process progresses. I represent the whole consortium, without whose dedicated support there would be no dementia registry.

The South Carolina Registry for Dementing Illnesses is a recognized national leader in this registry movement. We have one of only two population-based genetic registries in existence in the United States to study dementing disorders that run in families. We are the only dementia registry to cover a significant proportion of blacks--a segment of the population that is virtually unstudied with respect to Alzheimer's disease and multi-infarct dementias. We are a technical resource for consultation on registry methodology to the rest of the world. We have already made considerable progress in attempting to identify and aid the afflicted, most of whom are elderly. I hope that, with your support, we can continue this worthwhile effort long enough to realize its full benefits.

I will be glad to answer your questions or furnish any additional information that you may want. Thank you.

THE REGISTRY CONSORTIUM

A growing consortium of public and private agencies and professional associations supports the South Carolina Registry for Dementing Illnesses. At present these agencies include:

Alzheimer's Disease and Related Disorder Association, South Carolina Chapter
American Association of Retired Persons, South Carolina Chapter
American Heart Association, South Carolina Chapter
Central Midlands Regional Planning Council
Medical University of South Carolina
    Department of Neurology
    Department of Psychiatry
    Department of Medicine, Geriatrics Division
National Association of Social Workers, South Carolina Chapter
South Carolina Academy of Family Physicians
South Carolina Center for the Study of Aging
South Carolina Commission on Aging
South Carolina Commission on Alcohol and Drug Abuse
South Carolina Department of Health and Environmental Control
South Carolina Department of Mental Health
    William S. Hall Psychiatric Institute
South Carolina Gerontology Center
South Carolina Gerontological Society
South Carolina Health and Human Services Finance Commission
South Carolina Nurses' Association
South Carolina Psychiatric Association
South Carolina Society of Hospital Pharmacists
South Carolina Society of Internal Medicine
South Carolina Society of Pathologists
South Carolina State Budget and Control Board
    Division of Research Statistics
University of South Carolina School of Medicine
    Department of Neuropsychiatry and Behavioral Science
University of South Carolina School of Public Health
    Department of Epidemiology and Biostatistics
    Department of Health Administration
    Department of Health Promotion and Education
    Department of Environmental Health Sciences

Kenneth White
AARP State Legislative Com.
676 Lakepoint
Mt. Pleasant, SC 29464

STATEMENT OF

THE AMERICAN ASSOCIATION OF RETIRED PERSONS

AT THE PUBLIC HEARING OF

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

PRESENTED BY

KENNETH W. WHITE, CHAIRMAN

SOUTH CAROLINA AARP STATE LEGISLATIVE COMMITTEE

COLUMBIA, SOUTH CAROLINA

SEPTEMBER 14, 1988

MY NAME IS KENNETH WHITE AND I AM THE CHAIRMAN OF THE SOUTH CAROLINA STATE LEGISLATIVE COMMITTEE OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS. MY COMMITTEE SPEAKS FOR THE SOUTH CAROLINA AARP MEMBERSHIP ON STATE LEGISLATIVE OR REGULATORY MATTERS. OUR PRINCIPAL RESPONSIBILITY IS TO PROPOSE, SUPPORT OR OPPOSE LEGISLATION OR REGULATION IN THE INTEREST OF THE STATE'S SENIOR CITIZENS. AARP HAS ABOUT 315,000 MEMBERS IN SOUTH CAROLINA.

SOUTH CAROLINA IS IN A CATCH 22 VISE. WHILE ITS INDUSTRIAL AND TOURIST BASE IS GROWING IT IS STILL REGARDED AS ONE OF THE POOREST STATES IN THE NATION. BUT ITS 65 AND OVER POPULATION IS GROWING RAPIDLY - TWICE AS FAST AS THE NATION AS A WHOLE. ALSO, THE PROVERTY LEVEL IN THE STATE - 23 PERCENT OF THE POPULATION - IS HIGHER THAN THE NATIONAL AVERAGE. SUCH A HIGH POVERTY LEVEL INCREASES THE IMPACT ON THE STATE'S MEDICAID FUNDS. IN ADDITION, MORE OLDER AGE PERSONS ARE CHOOSING TO LIVE IN SOUTH CAROLINA IN THEIR RETIREMENT YEARS.

THE BIG QUESTION IS - HOW IS THE STATE GOING TO COPE WITH THE CURRENT AND GROWING DEMAND FOR ESSENTIAL SERVICES FOR ITS OLDER POPULATION WITH SUCH A SLIM REVENUE AND CURRENT SERVICES BASE? THIS IS A QUESTION THAT CANNOT BE ADDRESSED FULLY IN THESE HEARINGS. BUT AARP WOULD LIKE TO ENGAGE IN FURTHER DIALOGUE WITH THE JOINT COMMITTEE AND OTHER MAJOR GROUPS REPRESENTING THE INTERESTS OF THE AGING SO THAT THE QUESTION CAN BE ADEQUATELY ADDRESSED. IN THE MEANTIME OUR STATE LEGISLATIVE COMMITTEE SEEKS

TO EXAMINE MAJOR CONCERNS FACING OLDER PERSONS IN SOUTH CAROLINA. EACH YEAR THE COMMITTEE CONDUCTS A STATEWIDE SURVEY AMONG MEMBERS LIVING IN THE STATE TO HELP DETERMINE THEIR PRINCIPAL CONCERNS. GUIDED ON THIS YEAR'S SURVEY, OUR COMMITTEE HAS IDENTIFIED FOUR MAJOR LEGISLATIVE PRIORITIES. WE URGENTLY PROPOSE THAT THE JOINT LEGISLATIVE COMMITTEE ON AGING JOIN WITH AARP IN SUPPORT OF THE FOLLOWING PRIORITIES:

1. EXPAND IN-HOME AND COMMUNITY-BASED SERVICES TO DELAY OR PREVENT INSTITUTIONALIZATION OF FRAIL ELDERLY. SERVICES MAY INCLUDE HOME HEALTH CARE, TRANSPORATION, HOMEMAKER SERVICES, HOME-DELIVERED MEALS, RESPITE CARE, AND ADULT DAY CARE.

2. SUPPORT REFORMS IN MEDICAID, INCLUDING INCREASING ELIGIBILITY ROLLS AND PREVENTION OF SPOUSAL IMPOVERISHMENT.

3. HELP RESTRAIN THE RISE OF HEALTH CARE COSTS IN SOUTH CAROLINA.

4. SUPPORT AN INCREASE IN THE HOMESTEAD TAX EXEMPTION FOR HOMEOWNERS OVER 65 FROM $20,000 TO $30,000.

I WOULD LIKE TO COMMENT BRIEFLY ON EACH PRIORITY.

EXPANDING IN-HOME AND COMMUNITY-BASED SERVICES

THE GREATEST FEAR OF THE ELDERLY IS HAVING TO LEAVE THEIR HOMES TO ENTER A NURSING HOME. THE HIGH COST, THE LOSS OF INDEPENDENCE, AND THE EMOTIONAL TRAUMA OF LEAVING FAMILIAR SURROUNDINGS ARE OF MAJOR CONCERN TO THEM AND THEIR FAMILIES. AARP FEELS THAT INCREASING THE AVAILABILITY AND AFFORDABILITY OF IN-HOME AND COMMUNITY-BASED SERVICES WILL ALLEVIATE THIS MAJOR CONCERN AND DECREASE THE NEED FOR EXPENSIVE NURSING HOME CARE.

SOUTH CAROLINA HAS A COMMUNITY-BASED LONG-TERM CARE NETWORK IN PLACE.

THE HEALTH AND HUMAN SERVICES FINANCE COMMISSION HAS DEVELOPED, FOR MEDICAID-ELIGIBLE PERSONS, A SYSTEM DESIGNED TO OFFER CASE MANAGEMENT, PERSONAL CARE, PHYSICAL AND SPEECH THERAPY, MEDICAL SOCIAL SERVICES, HOME-DELIVERED MEALS, RESPITE CARE, AND MEDICAL DAY CARE SERVICES.

THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL (DHEC) PROVIDES IN-HOME SKILLED NURSING, THERAPIST SERVICES, CASE MANAGEMENT, MEDICAL SOCIAL SERVICES, ASSESSMENT, MEDICAL SUPPLIES, ETC. TO HOME-BOUND INDIVIDUALS.

THE SOUTH CAROLINA COMMISSION ON AGING (SC COA), PROVIDES AN

ARRAY OF COMMUNITY-BASED SERVICES TO ALL ELDERLY PERSONS. SUCH SERVICES INCLUDE CONGREGATE AND HOME DELIVERED MEALS, ADULT DAY CARE, TRANSPORTATION, HOME SERVICES, ETC., FUNDED PRIMARILY BY THE OLDER AMERICANS ACT.

THE BIG PROBLEM IS THAT THIS NETWORK IS FRAGMENTED, UNDERFUNDED, UNKNOWN AMONG VAST NEMBERS OF OLDER CITIZENS, AND NOT AVAILABLE IN SOME AREAS, ESPECIALLY RURAL AREAS.

OUR RECOMMENDATIONS ARE:

FIRST, THE BUDGET REQUEST OF THE SOUTH CAROLINA COMMISSION ON AGING FOR COMMUNITY-BASED PROGRAMS (ACE) SHOULD BE SUPPORTED. (THIS BUDGET REQUEST IS IN ADDITION TO REVENUES EXPECTED FROM BINGO TAX MONIES.)

SECOND, THE STATE SHOULD ENCOURAGE THE EXPANSION OF PRIVATE SECTOR INVOLVEMENT IN APPROPRIATE WAYS.

THIRD, GREATER EFFORTS SHOULD BE MADE TO PUBLICIZE AND TO EDUCATE THE PUBLIC ON SERVICES AVAILABLE.

<u>SUPPORT REFORMS IN MEDICAID</u>

SOUTH CAROLINA IS MISSING A GREAT OPPORTUNITY BY LIMITING THE STATE MONIES IT APPROPRIATES FOR ITS MEDICAID PROGRAMS.

THE FEDERAL GOVERNMENT MATCHES STATE FUNDS THAT ARE APPROPRIATED IN VARYING AMOUNTS DEPENDING ON THE PROGRAM. FEDERAL MEDICAID MATCHING FUNDS HELP RELIEVE THE STATE OF HAVING TO PAY FOR MANY SERVICES AND EXPENDITURES WHICH WOULD OTHERWISE BE PAID FOR SOLELY WITH STATE DOLLARS.

BECAUSE OF INCREASING INFLATION, MORE SENIOR CITIZENS FIND THEMSELVES DENIED MEDICAID BENEFITS WHEN THEIR INCOME IS A FEW DOLLARS MORE THAN ALLOWED BY THE STATE-ESTABLISHED POVERTY LEVEL. IT IS HIGHLY RECOMMENDED THAT THE POVERTY LEVEL BE ESTABLISHED AT A HIGHER POINT TO INCREASE THE NUMBER OF FRAIL ELDERLY WHO WILL BE ELIGIBLE FOR BENEFITS.

ON ANOTHER POINT, THE RECENTLY ENACTED FEDERAL CATASTROPHIC HEALTH CARE LEGISLATION PROVIDES BOTH AN INCOME AND AN ASSET PROTECTION FOR THE SPOUSE OF A MEDICAID NURSING HOME RESIDENT IN ORDER TO PREVENT SPOUSAL IMPOVERISHMENT OF THE SPOUSE REMAINING AT HOME. SOUTH CAROLINA IS GIVEN THE OPTION TO INCREASE THE MINIMUM AMOUNT OF THE ASSETS THAT A COUPLE MAY RETAIN. THE FEDERAL ACT ALLOWS A COUPLE TO KEEP AT LEAST $12,000 IN ASSETS IN ADDITION TO THEIR HOME. THE STATES ARE ABLE TO INCREASE THE AMOUNT OF ASSETS RETAINED UP TO $60,000. WE URGE THE LEGISLATURE TO PROPERLY IMPLEMENT AN INCREASE IN THE AMOUNT OF ASSETS THAT MAY BE RETAINED BY CITIZENS.

RESTRAINING THE RISE IN HEALTH CARE COSTS

IN 1965, HEALTH CARE EXPENDITURES REPRESENTED 6.1% OF THE GROSS NATIONAL PRODUCT (GNP). AT THE PRESENT RATE OF SPENDING, HEALTH CARE EXPENDITURES ARE EXPECTED TO CONSUME MORE THAN 15% OF THE NATIONAL ECONOMY BY THE YEAR 2,000. ESTIMATES ARE THAT MEDICAL PRICES WILL CONTINUE TO INCREASE MUCH MORE RAPIDLY THAN GENERAL INFLATION FOR HOSPITAL CARE, PHYSICIAN SERVICES, AND PRESRIPTION DRUGS. ONGOING EFFORTS MUST BE PURSUED TO HELP CONTAIN THE RATE OF INCREASE.

AARP CONTINUES TO BE REPRESENTED ON THE HEALTH INFORMATION ADVISORY COMMITTEE OF THE JOINT LEGISLATIVE HEALTH CARE PLANNING AND OVERSIGHT COMMITTEE. LAST YEAR, THE HEALTH INFORMATION ADVISORY COMMITTEE DEVELOPED POLICY AND PROCEDURAL RECOMMENDATIONS FOR COLLECTING, ANALYZING, AND DISSEMINATING HOSPITAL DATA RELATED TO COSTS OF CARE. THE RESULTING HEALTH CHOICES BULLETIN WAS PUBLISHED IN APRIL, 1988. THE BULLETIN PROVIDES GENERAL INFORMATION ON HOSPITALS IN THE STATE AND SHOWING DIFFERENCES AMONG HOSPITALS IN THEIR CHARGES AND LENGTH OF STAY FOR PATIENTS WITH TWENTY-FIVE OF THE MOST COMMON PROCEDURES AND DIAGNOSES. AARP SUPPORTS CONTINUING EFFORTS TO UPDATE AND DISSEMINATE THESE DATA TO CONSUMERS, PROVIDERS, INSURERS, GROUP PURCHASERS, AND STATE GOVERNMENT AS REQUIRED BY THE MEDICALLY INDIGENT ASSISTANCE ACT OF 1985.

WE BELIEVE THAT THE OPEN PUBLICATION OF HOSPITAL FEE SCHEDULES SHOULD BE GIVEN A FAIR TRIAL AS A COST CONTAINMENT INCENTIVE BEFORE RESORTING TO MORE RESTRICTIVE MEASURES.

HOWEVER, AARP PROPOSES A STUDY OF AN INDEPENDENT HOSPITAL COST CONTAINMENT COMMISSION TO SERVE THE DUAL FUNCTIONS OF CONTAINING HOSPITAL COSTS AND APPROVING CERITIFCATE OF NEED APPLICATIONS.

AARP CONTINUES TO SUPPORT LEGISLATIVE EFFORTS TO OBTAIN MORE ADEQUATE FUNDING FOR ALL COMPONENTS OF THE MEDICALLY INDIGENT ASSISTANCE ACT SO THE NEEDS OF THE MEDICALLY INDIGENT MAY BE MORE ADEQUATELY ADDRESSED, AND THE COST SHIFTING STRAIN ON HOSPITALS AND OTHER HEALTH SERVICE PROVIDERS, HEALTH CARE INSURANCE COMPANIES, AND PAYING PATIENTS MAY BE RELIEVED.

COST CONTAINMENT EFFORTS MUST GO BEYOND SCRUTINY OF HOSPITAL COSTS TO INCLUDE OTHER MEMBERS OF THE HEALTH PROVIDER COMMUNITY. AARP WILL SUPPORT OTHER INTERESTED CONSUMER GROUPS IN ADDRESSING THE PROBLEMS OF COST CONTAINMENT OF SUCH HEALTH CARE PROVIDERS AS NURSING HOMES, IN-HOME HEALTH CARE SERVICES, PHYSICIANS, AND HEALTH CLINICS.

INCREASING THE HOMESTEAD TAX EXEMPTION

THE TAX EXEMPTION FOR HOMEOWNERS OVER 65 HAS BEEN $20,000 SINCE 1984. IN THE MEANTIME INFLATION HAS CAUSED FURTHER STRAIN ON FIXED INCOMES; ALSO PROPERTY VALUES AS WELL AS PROPERTY TAXES HAVE RISEN. ALMOST ALL STATES HAVE SIMILAR LAWS, AND MANY HAVE INCREASED THE EXEMPTION FROM TIME TO TIME.

MOST AGREE THAT THE PROPERTY TAX IS REGRESSIVE; THEREFORE RELIEF IN THE FORM OF THE HOMESTEAD EXEMPTION IS JUSTIFIED. THE TAX EXEMPTION PROTECTS CAPITAL INVESTMENT AND HOMEOWNERSHIP. IT HELPS OLDER CITIZENS TO MAINTAIN THEIR QUALITY OF LIFE. OLDER HOMEOWNERS NOW COUNT ON IT. IN TODAY'S WORLD IT SHOULD BE INCREASED.

WE URGE THE JOINT COMMITTEE TO INTRODUCE LEGISLATION TO RAISE THE HOMESTEAD EXEMPTION TO $30,000.

IN ADDITION WE UNDERSTAND THAT SOME COUNTIES RESTRICT THE HOMEOWNER WHO HAS JUST TURNED 65 TO A CERTAIN TIME PERIOD IN WHICH TO APPLY FOR HIS EXEMPTION. IF HE OR SHE DOES NOT APPLY WITHIN THAT DESIGNATED TIME PERIOD THERE WILL BE NO EXEMPTION FOR THAT YEAR. THIS IS GROSSLY UNFAIR AND WE URGE THE JOINT COMMITTEE TO CONSIDER LEGISLATION OR PROPOSED REGULATION TO MAKE THE APPLICATION FOR HOMESTEAD EXEMPTION

UNIFORM THROUGHOUT THE STATE.

ONE LAST NOTE:

AARP JOINS WITH THE COMMISSION ON AGING AND OTHER STATE GROUPS ON AGING IN SUPPORT OF LEGISLATION TO PROTECT THE CONSUMER AND HIS OR HER FINANCIAL RESOURCES IN ANY DEALING WITH LIFE CARE COMMUNITIES IN THE STATE. LAST YEAR S.1276 BY SENATOR LEATHERMAN WOULD PROVIDE SUCH CONSUMER PROTECTION. WE UNDERSTAND THE BILL WILL BE REINTRODUCED IN JANUARY AND WE URGE ITS ADOPTION.

MR. CHAIRMAN, THESE ARE BUT A FEW OF THE MANY ISSUES FACING OLDER CITIZENS IN SOUTH CAROLINA. AS THE LEGISLATIVE YEAR BEGINS WE WILL TAKE POSITIONS ON OTHER MAJOR ISSUES.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS OUR VIEWS.

McLeod - So what you are saying is that we need to do something further to increase the capital a spouse can own.

White - That's right! The federal law recently passed allows a minimum limit of $12,000 which an individual can have in his domain before he is qualified for Medicaid. This protects the income of the spouse. Now the state has the option of going beyond the $12,000 capital up to $60,000. In other words they could protect assets of individuals up to $60,000 plus the ownership of their home.

McLeod - Do you have a handle on all that?

Barron - We are working on it. Health and Human Services Finance Commission is working on it as well. We will have some more information to present to you in terms of what the Health and Human Services Finance Commission would anticipate.

McLeod - The Indigent Care Act that requires hospitals to report on cost containment, how is that part coming along?

Barron - I can't answer that. Betty Carnes can you answer that regarding the Medical Insurance? Indigent Act?

Carnes - I can't but Mr. Benny Clark will be here shortly and he would be able to.

Harris - We will get that information, Peden.

Carl May, Chair
Legislative Forum/SCFOA
6506 Satchel Ford Road
Columbia, SC 29206

SOUTH CAROLINA FEDERATION OF OLDER AMERICANS
101 CAROLINA CIRCLE
WEST COLUMBIA, SOUTH CAROLINA 29169

REPORT TO: Joint Legislative Committee on Aging
September 14, 1988

RE: Recommended Legislative Priorities for 1988-1989

FROM: Legislative Forum/S. C. Federation of Older Americans

1. Encourage at-home care of the frail elderly to enable them to remain in their homes.

   a. Giving a tax credit for families who provide for a frail elderly family member;

   b. Developing Adult Day Care services; and

   c. Developing programs through the State Housing Authority for innovative housing options, such as "Granny Flats" ("Echo Housing") already successful in Canada and PA.

   RATIONALE: a - Most elderly prefer to remain at home or near family as long as possible, and b - this care is much less expensive than institutional care.

2. Increase Homestead Exemption from $20,000 to $30,000.

   RATIONALE: Inflation and tax increases.

3. Amend the Guardianship laws to provide greater protection for the older person, requiring that the affected person have the right and opportunity to be present at a guardianship hearing and to have access to legal counsel.

   RATIONALE: Older persons must be protected from the unscrupulous who seek to control their resourses under the guise of protecting them.

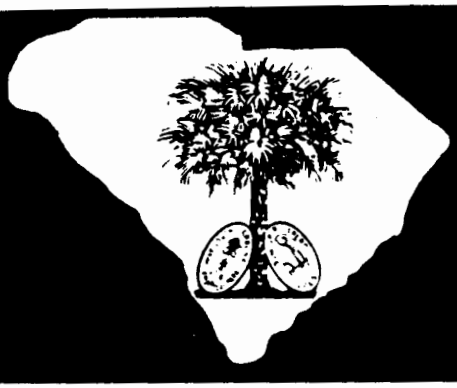
4. Increase the S. C. Income Tax Exclusion from $3000 to $6000 for all retirees.

   RATIONALE: a - S. C. is losing potential retirees, with their dollars, because other states have greater tax incentives; and b- this will help the elderly maintain their independence.

Respectfully submitted,
Carl May
Carl May, Chair, Legislative Forum
Claude Vaughn
Claude Vaughn, Vice-Chair

Diana B. Jones
SC Episcopal Home
at Still Hopes, Inc.
100 7th St. Extension
W. Columbia, SC 29169-7151

AAHA



THE SOUTH CAROLINA ASSOCIATION
OF NON-PROFIT HOMES FOR THE AGING

JOINT LEGISLATIVE COMMITTEE ON AGING
Public Hearing on Senate Bill S1276
September 14, 1988

Ladies & Gentlemen:

I wish to speak in favor of Senate Bill S1276 concerning Continuing Care Retirement Communities in the State of South Carolina.

My name is Diana Jones, and I have been Executive Director of the S. C. Episcopal Home at Still hopes, a "CCRC" or Continuing Care Retirement Community in West Columbia, South Carolina for seven years. I appear before this committee as State President and representative of SCANPHA, the South Carolina Association of Non-Profit Homes for the Aging. SCANPHA is the State Chapter of a national professional organization, the American Association of Non-Profit Homes for the Aging. Our 31 members in the State include the Presbyterian Homes, the Lutheran Homes, Baptist Homes, the Methodist Homes, the Episcopal Homes, and various other nondenominational not-for-profit CCRC's, HUD projects, and nursing homes providing accommodations for over 3000 older South Carolinians.

A CCRC, as its name implies, is a <u>community</u> rather than just a nursing facility, providing several levels of housing for older individuals, generally including what is termed independent living (cottages and apartments), residential care (a room with bath with some health care and meals and other amenities provided), and nursing care (intermediate or skilled or a combination of both). This type of living provides many advantages: a continuum of care on one campus, a single administration over all levels of care, suitable care for couples with differing health needs with minimum physical separation, and, perhaps most importantly, an atmosphere that encourages individual dignity and freedom.

For thirty years and more, SCANPHA's group of facilities has comprised all of the continuing care communities in the State of South Carolina. However, with the growth of the elderly population, the popularity of the Carolinas as a retirement choice, and the emergence of powerful national chains of retirement communities eager to participate in a growth industry, many new for-profit facilities have been constructed and a type of CCRC heretofore not existent in South Carolina has appeared: the life care communities.

Life Care Continuing Care Communities are based on a philosophy different from non-life care communities, in that they embody an insurance principle in this way: an individual pays up front for care he may or may not need. He gambles he will need it, and has the comfort of knowing he's already paid for it. Life Care CCRC's generally cost from $60,000 to $150,000 for an individual to enter a facility exactly--except for the contractual arrangement--like the CCRC I described to you earlier. The monthly cost is usually set at one figure, no matter what level of care is required then or in the future, thereby assuring the individual that his monthly income is sufficient to cover his costs at any time. The facility gambles he will not need expensive nursing care: the individual gambles he will. Any danger to the consumer lies in the fact that if his up-front fee may be used for construction or other costs, and there is no legal constraint, the facility may bankrupt, and he will lose his life savings.

Non life care on the other hand, does not embody an insurance principle; it is a pay-as-you-go care plan, with an individual's monthly cost matching the cost of the care he is receiving. Entrance fees are minimal or non existent. In most cases care is taken to provide a fund from which to support those whose money runs out. Money for construction is raised from gifts or borrowed on such funds raised.

This legislation, although requiring similar reporting of financial status for both types of CCRC's, addresses this difference in philosophy. SCANPHA supports the necessity for financial reporting and thanks the legislators and staff for their interest and attention to the differences between Life Care and non life care.

Again, SCANPHA supports this bill, and thanks those involved in this legislation for their courteous attention to our concerns as well as their interest in protecting the financial status of elderly consumers.

In closing, I would like to state that housing for the elderly is part of a continuum of necessary services for our aging citizens and I hope is viewed so. As housing specialists, we are not in competition with state services to the elderly, but neither are we part of them. Housing is a complex and ever changing issue and, like most growth industries, working in it is almost a necessity for comprehending its many facets. I respectfully suggest, therefore, that you consider allowing those who labor in its fields to assist you in your deliberations when elderly housing issues are at stake in this state.

Thank you.

Diana Jones, President
S. C. Association of Non-Profit Homes
for the Aging, Inc.
Post Office Box 3727
West Columbia, SC 29171

Harris - **What happened to my ARP home in Due West?**

Jones - **They are a member.**

Harris - **Alright. You had me frightened there for a minute. Thank you very much.**

James R. Rider
40 Inlet Oaks
Village, SC 29576

STATEMENT PRESENTED TO
JOINT LEGISLATIVE COMMITTEE
OF THE AGING
STATE OF SOUTH CAROLINA

"OWNER MOBILE HOMES ON LEASED LOTS, I.E., MOBILE HOME PARKS"

SEPTEMBER 14, 1988

PHONE: 1-803-651-6016

JAMES R. RIDER
MURRELLS INLET, S.C.

September 14, 1988

On December 16, 1986, I appeared before the South Carolina Federation of Older Americans. To this body I presented the woes, as I perceived them, of people living in mobile home parks. The people I was speaking about owned their mobile homes but leased the land from the mobile home park developer. The Federation felt that my presentation had merit and passed the material I had given them to this Committee in January 1987. Attached is a response from Mr. Patrick Harris, dated January 12, 1987. It is short, I'll read it.

I use this information to begin my presentation to remind you that I am not presenting an entirely new thought to you. Since the initial presentation, I was informed that S-115 was in the works. As I see it, S-115 would simply be an amendment to the landlord - apartment dweller act. I feel that there are so many differences between an apartment dweller and a mobile home owner that a separate bill should be offered as a Mobile Home Act.

An apartment dweller's financial involvement in renting an apartment is usually an outlay for furniture. Most apartments have expensive extras such as stoves and refrigerators as part of the apartment's fixed items (such as sinks, tubs, outlets, etc.). But a mobile home owner could have as much as $40,000 tied up in his home. No business man would go into business, lay out that much money for equipment to operate the business, and not expect a lease for the store he rents of at least five years. Mobile home owners on leased land, from my observations, have no leases; one year leases; we presently have a twenty month lease - one place I know has a twenty year lease. So if the mobile home park was to become a shopping mall in the near future, those with no lease, or short term leases, would have a large problem.

Where do you go? Do you have the cost of moving? Moving costs could run a thousand to two thousand dollars. I am old - I want the comfort and security that neighbors provide, yet no park will take me because my unit is too small, being 12' wide; my unit is too old; I can only get in the park if I buy a mobile home from park's operators. I can buy an inexpensive lot in the hinterlands but where are the neighbors if I'm alone and sick? Where is the social relationships that keep my days from being lonely?

You can buy a deeded lot and a home (both from the park operator) for nearly $60,000. This is the picture at a park next to mine. True, the location determines the ultimate price - you can buy a deeded lot and a mobile home inland for $20,000 less. But if you are living on a restricted income, twenty-nine percent of retirees live on social security benefits alone, the purchasing of land and a unit is prohibitive.

And the senior citizen is not alone. Who else lives in a mobile home? Young marrieds, beginning careers and on a bottom salary step. Low income people - all they can afford is an old mobile with an air conditioner in a window. The enlisted career military person - it is well-known that they are not over paid. You do have some who use the mobile as a second home, a vacation home. The South Carolina Mobile Home Mfg. Association claims that 45% of all new homes sold in South Carolina are mobile homes, so lots of people need a legislative umbrella.

Well, senior citizen, if living in a mobile home is such a burden, why not get out? Some put together a budget - a mobile home was all they could afford. Others, coming from a large, permanent house, don't want to maintain such a large unit anymore - the children have left, the parents can no longer do the work to maintain a large home.

Now, some history. Park opened, rent sixty dollars a month. If you paid eleven months rent then and there, the twelfth month rent was waived. Free water and sewerage from the park's plant. Free lawn mowing; free garbage pick-up from in-ground containers; a roving security patrol at night; a swimming pool; a clubhouse with a laundry room; tennis courts to be built. And a two year lease.

Around 1980, park sold their water and sewer system to Georgetown County Water and Sewer District when it came into being. Park's tenants now paid for these services.

When I arrived in Spring 1983, I received a lease for one month. Lease wasn't discussed again. I paid quite a bit of money for an older unit, but since the park was a class act, the location of the mobile unit helped determine its selling price. But unlike regular homes, the value of a mobile home decreases with age. There are some exceptions to this remark.

A new lease was offered in August 1986. My initial rent was $100, then raised to $110. The August 1986 lease called for $130 in rent plus six dollars for garbage collection. The park would no longer offer free collection. Tenants had no choice - must take service from contractor park dealt with. Whether a year round home or a vacation home, everyone had to pay this additional monthly charge. Being one person, I don't have much garbage - could easily drive five minutes to a county trash collection - not allowed!

At this time, without saying so, the part-time night security was dropped. The laundry room was taken away - made into a park office. You now had to cut your own grass. If you couldn't, you could get someone to do it. I pay $12 a cutting during the growing season. So you might say that at that time my rent was $130

plus $6 for garbage plus $24 for mowing - total $160 - a rise of fifty dollars over prior conditions. You could keep a dog or cat, no more than 25 pounds - no more than two, for $5 apiece a month. You now had to pay 12 months rent - the discount was taken away. The two employees who did the lawn work and trash collections were told they'd be kept on until January 1. A minor point, Christmas baskets of fruit from the park owners were replaced by a Christmas card.

So oldsters had to carry their trash to the front of the property. My neighbor does it twice a week for people too ill or weak to do it for themselves. He also cares for their lawns. Some do not have a washer/dryer arrangement in their mobiles - they either drive to a laundermat (if they drive) or wait on the goodness of a friend or neighbor to take them. And you either buy a lawn mower, or pay to have lawn cut.

Not only does all this put a strain on someone living on a small income but does tremendous damage to the resale value. If you wanted to sell, no longer can you suggest such inducements as free water, lawn care, garbage pick-up, etc. Some homes in the park have been for sale for more than a year. Others have gone to the expense of moving out rather than face more of the same with a new lease in March 1990.

It is your home, but you must register guests at the park office. If my 94 year old mother was to visit, I'd have to let the office know. They may enter your home at will if they feel a problem is in the making.

Also in the August 1988 lease, a new thought enters. In Garden City, South Carolina, the nation's major mobile home park operator insists that older units, when sold, have to be removed. The older, 12' mobiles are boxy - even if well maintained, lack eye appeal. So the park says, "Get rid of them!" My park copied the idea in the new lease, but has not set a specific age as the cut-off point. There are other factors that could cause removal. The owners of the park still have all copies of the new lease in the hands of their lawyers so I can't list the other factors. Can you imagine trying to sell your unit and receiving a price close to your initial costs under these conditions?

If the legislative bodies of South Carolina act, I can think of the following suggestions that would alleviate some of the present inequities.

1. Lease of at least five years with a five year option. Escape clause with both parties in agreement.

2. Any bona fide offer to buy the park for whatever purpose a new owner might have in mind must be brought to the tenants. If they, as a body, can meet the offer, they get the first chance to buy the property at the price offered by prospective purchaser.
3. Tenants do not have the ability to buy the park and a new owner takes over and wants the tenants out, they must be offered 80% of insured value for their homes in the park. As I stated earlier, finding a place to move would be impossible for many.
4. If tenant(s) prefer to move, they should have ~~18~~ 12 months from date of notification to move.
5. Park leases should be standardized and in compliance with all federal, state, county laws. A new lease should be available two months prior to lease change.
6. When established procedures are taken back by park owner, a reduction in rent based on value of that which was removed should be made. (A formula for this could be arrived at.) I'm speaking about loss of water and sewer, trash pick-up, etc.
7. Prospective tenant does not have to purchase new home from park's owners. Any new home meeting federal, state, county standards should be allowed access.
8. Older homes; homes of various sizes (10', 12', 14', double-wide) - thought needs completion - I don't have it now.
9. A tenant's association must be recognized by park's owners. Any changes should be presented to the association for their input. Landlord can then act (within the law).
10. Evictions - tenants being evicted should receive notice in writing from park's owner(s) or his agent at least six months before eviction can be acted upon. Notice should contain reason(s) for eviction along with possible remedies.
11. Deposit money (if exists) should draw interest at prevailing rates and said monies shall be returned to tenant within 30 days of leaving, provided penalties aren't called for.
12. If contents of the state's laws for mobile homes are in conflict with local statutes, the local statutes are expressly repealed.

I hope to have the most recent compilation of Florida's mobile home laws soon. I say Florida because Florida has dealt with seniors for years. People have been retiring to South Carolina for years but the recent years have seen a great increase in retirees moving here. So I'm borrowing from Florida's long experience.

When the apartment dweller - landlord act was signed, the tenant's ombudsman remarked, "Landlord-tenant law goes to 300 years ago and the land grants of the King." I'd say it is time to change.

Thank you,

James R. Rider

James R. Rider
Murrells Inlet, South Carolina
Phone: 1-803-651-6016

Harris - If you will leave that address we will write and get copies of the Florida law.

Rider - I'll give that to Sherri.

Blackwell - Mr. Chairman, I just wanted to say to Mr. Rider that I think this is government-in-action. We appreciate you, you made a very good presentation, sir.

William P. Simpson
HHSFC
P. O. Box 8206
Columbia, SC 2920

STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION

William P. Simpson, Chairman

TESTIMONY

To The

Joint Legislative Study Committee on Aging
September 14, 1988

Representative Harris and members of the Committee, my name is William Simpson. I am chairman of the State Health and Human Services Finance Commission (SHHSFC).

The SHHSFC was established in 1984 and is responsible for the planning, financing, and administration of the Medicaid and Social Services Block Grant (SSBG) programs. As an administrative agency, though we do not deliver direct services, the federal government holds this agency accountable.

My purpose today is to present to you the Commission's future direction in the provision of long term care services for the elderly and disabled citizens of South Carolina. By virtue of this agency being shouldered with the responsibility of financing long term care services through the Medicaid and Social Services Block Grant programs, the Commission pays for 80% of the long term care services provided in South Carolina; and we anticipate that this percentage will increase. Government involvement in

health services is no longer regarded as a welfare program but as a necessity. The expenditures of this agency touch not only the lives of 265,000, but also impact directly most of the state's 4,500 physicians, 2,700 pharmacists, 72 general hospitals, and 160 or so nursing homes.

We have opted for a collaborative approach in both the planning and provision of community-based long term care services. This approach is even more vital in view of the mandate of the Omnibus Budget Reconciliation Act (OBRA) of 1987. The main thrust of OBRA mandates far reaching changes in the assurance of quality. This theme manifests itself in new statutory requirements in every long term care program administered by the Finance Commission. These changes are having a substantial impact on the financing and delivery of long term care services in South Carolina.

I will highlight for you a few of the major impacts of the Act on the long term care system. OBRA mandates far reaching changes in preadmission screening criteria and requirements related to the development of a plan of care for residents admitted to a mental health, mental retardation, or a nursing care facility. Preadmission screening is mandated for all persons entering a long term care institution regardless of payor source which includes all private pay persons. This will be a considerable change and will impact us as well as private industry. The

changes in OBRA require that after admission, an extensive assessment must be completed at least annually on all long term care residents and the plan of care updated. By comparing the annual assessment to the previous assessment and plan of care, quality of care can be monitored in each facility. An extensive data system is required for reporting and monitoring.

All facilities must eventually meet all the criteria for skilled licensure as there will not be a distinction between skilled or intermediate level of care. These and other mandated changes can best be met through a system of case-mix reimbursement and case management for all long term care residents. Also, OBRA's theme of better quality of care impacts home health and the training of all nursing assistants providing care for the elderly in home health as well as long term care institutions.

The Medicare Catastrophic Coverage Act of 1988 further increases our needs for new resources. This act expands the population which will become eligible for Medicaid. Because of new regulations related to Spousal Impoverishment, it will increase the state's portion of reimbursement for Medicaid sponsored long term care clients. The state will also be responsible for the deductibles which are included under broader coverages.

All these initiatives will require extensive evaluations of the current long term care system and the resources now available to it. It is very likely that we will see a sweeping restructuring of the long term care system, which will enhance the quality of the services provided. Quality is important to the Commission and we are pleased that OBRA leads in this direction. The implementation of these initiatives has a high price tag and will require the reallocation of current resources and the appropriation of new resources. The alternative to not implementing these initiatives will ultimately cost more, not only in suffering, pain, and physical deterioration but in actual cash outlay.

We want to involve health and social service agencies, aging organizations, and advocacy groups in our efforts to enact these reforms. In keeping with the mission of our agency we will continue to foster partnerships with our sister agencies and organizations in planning and implementing these initiatives.

Thank you for the support that you have given to our agency in the past. We would like your continued support as we take our request before the General Assembly in the next Legislative session. Staff members are present to answer any questions that you might have.

TESTIMONY

JOINT LEGISLATIVE COMMITTEE on AGING

SEPTEMBER 14, 1988

Patricia C. Rowe
RSVP Programs of South Carolin
5290 Rivers Avenue, Suite 300
Charleston, SC 29418

Presented By: Patricia C. Rowe representing the Retired Senior Volunteer Programs in South Carolina.

Chairman Harris, ladies and gentlemen:

In South Carolina, there are eight Retired Senior Volunteer Programs. They are a part of the Federal Volunteer Agency ACTION's Older American Volunteer Programs. There are over 700 RSVP programs throughout the fifty United States, Guam, Puerto Rico, and the Virgin Islands. Just recently the RSVP concept has spread to London, England and Mexico. As you can see we are not an isolated group working with seniors.

The RSVP programs are committed to the spirit of people helping people, encouraging local volunteer efforts by channelling the energies, innovative spirit, experience and skills of the senior volunteers into meeting the needs of their community.

Presently, there are over 4,050 RSVP volunteers in South Carolina, who last year contributed 705,317 hours of service to the community. Traditionally, these volunteers perform services for their community valued in the millions of dollars, annually, if we were to estimate the value of their time as low as minimum wage. This is a conservative figure. Today's senior volunteer possesses highly needed skills and experience in management, education, medicine, etc....the list is endless.

RSVP volunteers have to be classified as non-traditional volunteers. There assignments take them to many fascinating and interesting areas of the community that the traditional volunteer never sees. From courts, schools, museums, libraries, hospitals, hospices, nursing homes, in-home care projects, day care centers, nutrition sites, and other service centers as requested by the community. Volunteers serve without compensation, but may be reimbursed for transportation expenses.

The programs continue to expand their efforts to match resources to the diverse needs of the communities of South Carolina by providing increased opportunities for retired persons aged 60 and older to serve their communities on a regular basis in a variety of settings. The sixty year old, today, is not the sixty year old we worked with in the seventies. Their flexibility, experiences and professionalism has far surpassed the expectations of the original guidelines set forth by ACTION in the founding of the RSVP Program.

Special Initiatives are introduced annually, by ACTION, to help communities solve their ever increasing problems, by the use of senior volunteers. Initiatives

emphasizing service to Youth, Literacy, Drug Abuse, In-Home Care, Consumer Education, Crime Prevention, and Management Assistance to private non-profit and public agencies. The above mentioned initiatives are presently incorporated into the RSVP grants throughout South Carolina.

This year a cost of living allowance was granted to the RSVP projects, the first increase since 1980. This amounted to 2.60 per volunteer, consequently RSVP sponsors, their Advisory Councils and staffs have had to use their imagination and varied approaches to attract cash and in-kind contributions to match the Federal Funds given by ACTION. For the rural projects this has been a most difficult effort due to the limitations of their community resources.

With grants from the Laubach Literacy Foundation and corporations such as EXXON, many RSVP projects were able to expand their services to their community, but these grants were seed grants to be absorbed by the community in subsequent years.

For many years RSVP programs have kept a low profile in their communities. This is not the case today. The skills of the volunteers have made an impact on their respective communities, to the point they are an integral part of the over all plan for services needed by their community.

It has been well founded that you can only go so far with so much. The talent and skills of the volunteers are in constant demand but the expense to maintain the high quality of service they provide is forever increasing. Mandated by the Federal grant to insure, train, feed (when necessary) and transport the volunteers, plus recognizing each and everyone of them, has put an extreme burden on many of the projects. Within the next year or so this report will not be a status of volunteers report but a genuine request for funds to continue services to the communities now being served by RSVP projects.

Presently twelve counties of this state are being served by RSVP volunteers. The requests from other counties to expand the exisiting programs, has been a problem, that cannot be solve readily. Federal Funds are not available for expansion.

More than 28 states have appropriated funds in their budgets for RSVP program assistance. Each year the number of states supporting RSVP grants has grown.

The RSVP projects in South Carolina hope in the near future, when definite guidelines and needs of the various projects are clearly defined, that a request for assistance will be granted by this Study Committee. Until then we will continue to serve the state to the best of our abilities.

Thank You !

Harris - **I thank you very much. I stated earlier that volunteers mean so much to many of our programs. We do appreciate them.**

Maggie Hope
c/o Foster Grandparent Program
1800 Main St., Suite 3C
Columbia, SC 29201

JOINT LEGISLATIVE COMMITTEE ON AGING - PUBLIC HEARING

Wednesday, September 14, 1988

My name is Maggie Hope and I am a Foster Grandparent Volunteer with the Foster Grandparent Program which is sponsored by the Council on Aging of the Midlands. I serve as a Foster Grandparent Volunteer at the South Carolina Department of Youth Services, Birchwood Campus in a classroom and Santee Lockup Unit, for two days a week. Three days a week I am a Foster Grandparent at the Sistercare shelter for abused women and their children.

The Foster Grandparent Program is a National Program which began 23 years ago across the United States. Foster Grandparents are individuals who are 60 and older and live on limited incomes. Foster Grandparents volunteer 20 hours per week with children that have special or exceptional needs. Such as abused children, troubled teenagers, mentally and physically handicapped youngsters, sick children and the list goes on. We receive a small stipend of $2.20 an hour for our volunteer work. For many of us this helps us to be able to volunteer. Other benefits we receive include a physical each year; volunteer insurance to cover us while driving to and from our volunteer stations, as well as accident insurance while volunteering; assistance with transportation, if needed; a nutritious meal at our volunteer stations and annual and sick leave and holidays. The primary benefit we receive is giving and receiving love from the children we work with each day.

As I mentioned, the Foster Grandparent Program is sponsored by the Council on Aging of the Midlands. We receive most of our funding from ACTION, the

Federal Domestic Volunteer Agency. We also depend on support from the community and donations from individuals.

Here in Columbia, our program serves both Richland and Lexington Counties. Today we have 61 active Foster Grandparent Volunteers. The Foster Grandparents volunteer in 12 volunteer stations. These include South Carolina Department of Youth Services, Richland Memorial Hospital, Wil Lou Gray Opportunity School, Midlands Center, Greenview Elementary School, Sistercare, and six others. The Program is 21 years old here in Columbia. We are one of 250 Foster Grandparent Programs across the United States, Puerto Rico, the Virgin Islands and the District of Columbia. There are two other programs in South Carolina - Charleston and Aiken and we are the largest, here in Columbia.

Last year the Foster Grandparents in the Columbia area gave over 62,000 hours of volunteer service to over 700 children with special or exceptional needs. That is a lot of hours of love and attention given to the children in the Midlands area.

I have been a Foster Grandparent for 1 year. I am a Foster Grandparent because I enjoy working with children. I feel my presence at both Birchwood and Sistercare helps the children who are so troubled. At the Department of Youth Services I work with teenagers, mostly boys, who are 14 to 17 years old. The children have so many different problems and some days it takes a lot of patience to work with them but every morning, Monday through Friday, I look forward to being with the children and sharing of myself with them. I work in a classroom with Viola Laurie, the classroom teacher at Birchwood High School. In addition to giving a lot of love, attention and advice to

the children I help them with their classroom work. The classroom I work with teaches living skills - that is, how to apply for a job, find a place to live, write checks and so on. I try to help the children see that they can take charge of their lives and make positive changes in their behavior and attitudes.

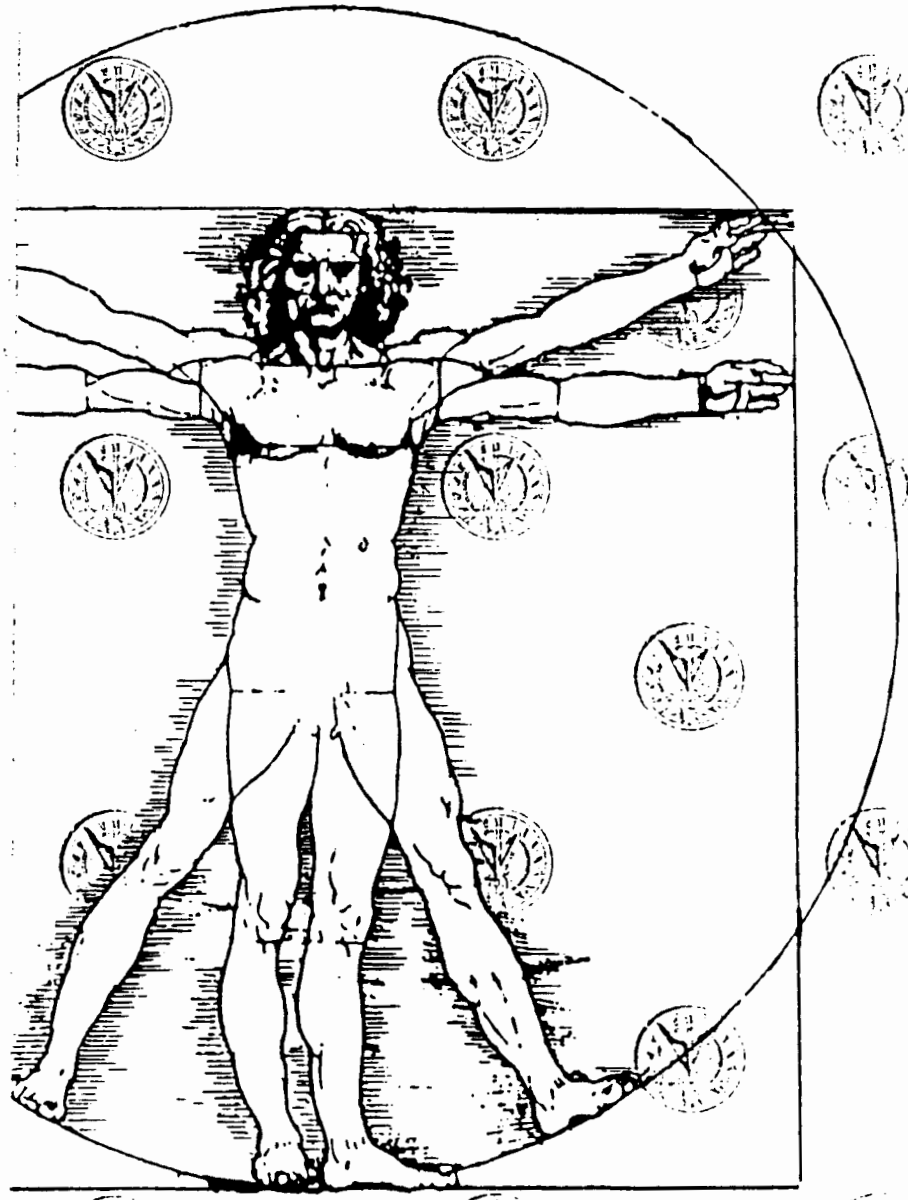
At Sistercare, I go to the shelter and play with the children. These children need a sense of security and love because their small worlds have been turned upside down. We read books, play games and just talk.

I appreciate the opportunity to share with you what I do as a Foster Grandparent Volunteer and welcome you to come visit me at South Carolina Department of Youth Services. The Foster Grandparents are making a difference in the lives of many children in our community, state and nation.

Harris - **I want to commend you for your volunteer work. As I have said earlier if it weren't for our volunteers I don't know what we would do in so many of our programs. Thank you again!**

Purvis Collins
SC Retirement System
1122 Lady St., 2nd Floor
P. O. Box 11960
Columbia, SC 29211

LONG TERM CARE INSURANCE



A protection plan
sponsored by the
South Carolina
Retirement Systems
For active employees
of state agencies and
public school districts

Introducing Long-Term Care Insurance

Long-term care refers to a wide range of personal services - such as help with eating, walking, and dressing - provided to people who suffer from a chronic disease or long-lasting disability. Whether these services are provided in a nursing facility, an adult day care center, or in a private home, the annual costs can be staggering.

Unfortunately, most health benefits plans and Medicare aren't designed to pay for long-term care expenses, and Medicaid will only cover those expenses once the patient has exhausted all other financial resources.

That's why the South Carolina Retirement Systems (SCRS) is sponsoring a new Long-Term Care (LTC) Insurance Plan from Aetna Life Insurance Company. It's specifically designed to protect you, your spouse, and everything you've worked so hard for from the expenses of long-term care.

How much can long-term care cost per year?

Long-term care can cost from $20,000 to $40,000 per year in a skilled nursing facility - and from $5,000 to $10,000 if you receive the care in a home setting.

AETNA'S LONG-TERM CARE PLAN

What advantages does Aetna's program offer?

Aetna's Long-Term Care Insurance Plan offers you a combination of 7 advantages you won't find in other plans available today.

1. **You don't have to be confined in a nursing home beforehand** to receive benefits.
2. **You receive care where it's most convenient for you** -whether that's in a private home, an adult day care center, or a nursing facility.
3. **You choose your own coverage level** - from $30 to $100 per day - in $10 units.
4. **You won't have to fill out a lot of forms,** collect paperwork, or submit receipts.
5. **If you die before using your benefits, your premium can be returned** to your beneficiary -depending on your status at the time you die.
6. **You may apply to change your coverage up or down** to keep pace with inflation or your own financial need.
7. **Your plan is backed by a strong, financially stable insurer** - Aetna Life Insurance Company.

Who is eligible to participate in the program?

All active employees and their spouses may enroll in this LTC plan with **no medical questions asked** from September 1 — October 31, 1988. Those who enroll during this period will have the opportunity to apply for Long-Term Care coverage for their parents at a later date. Parents applying for coverage will have to meet certain medical criteria to be accepted.

Who is eligible to receive benefits under Aetna's Long-Term Care Plan?

Under the SCRS / Aetna Long-Term Care Insurance Plan, you are eligible to receive disability benefits if you are unable to carry out **any two** of the daily living activities listed below because of a chronic condition caused by illness or accident - without continual help from another person:

- **Eating**
- **Dressing**
- **Toileting** and related hygiene
- **Walking** or using a wheelchair
- **Transferring** between your bed and a chair or wheelchair

What does the plan pay?

The SCRS / Aetna Long-Term Care Plan can pay benefits ranging from $30 - $100 per day for care in a nursing facility. If you choose to receive care in a home setting, the plan can pay from $15 - $50 per day. That's half the amount of the nursing facility benefit.

The amount you receive depends on how many $10 coverage units you buy. For example, if you purchase 7 coverage units, your benefit would be $70 per day for nursing facility care, or $35 per day for home care. The following chart shows the daily, annual, and lifetime benefits you can receive - whatever coverage level you choose.

COVERAGE LEVEL CHART

Number of $10 units	Nursing facility benefit daily	annual	Home care benefit daily	annual	Lifetime maximum benefit
3	$ 30	$10,950	$15	$ 5,475	$ 54,750
4	$ 40	$14,600	$20	$ 7,300	$ 73,000
5	$ 50	$18,250	$25	$ 9,125	$ 91,250
6	$ 60	$21,900	$30	$10,950	$109,500
7	$ 70	$25,550	$35	$12,775	$127,750
8	$ 80	$29,200	$40	$14,600	$146,000
9	$ 90	$32,850	$45	$16,245	$162,450
10	$100	$36,500	$50	$18,250	$182,500

When does the plan begin paying?

If your claim is accepted, benefit payments will begin after a **90-day waiting period.** The waiting period begins the day you can no longer perform two of the daily living activities outlined above.

This waiting period helps hold costs down by eliminating short-term care, which is often covered under Medicare, your regular SCRS health care plan, or other health insurance you may have.

What if I die before I can use my LTC benefits?

If you enroll **as an active employee or the spouse of an active employee,** and you (or your spouse) die while still actively at work and contributing to the plan, the contributions you have made will be returned (minus some administrative costs) to the beneficiary you designate.

Your beneficiary will receive 100% (minus administrative charges) of your contributions if you die while still an active employee. That percentage will decrease to 90% if you retire or leave your employment and take your coverage with you. Each year after that, the percentage would decrease by another 10%. So if you die two years after you retire, your beneficiary would receive 70% of your contributions back.

What doesn't the plan pay for?

No insurance plan can cover everything. But as you look through the following list, you'll see that the exceptions to coverage under this plan are few and reasonable. This plan will not pay for medical expenses that are due to:

- **A pre-existing condition** - any condition which was diagnosed or treated within 90 days before the effective date of coverage.
- **Treatment in government nursing facilities**
- **Group Policy Duplication** - This plan will not pay for any loss payable under the South Carolina Retirement Systems' group policy for hospital, convalescent or hospice facility confinements, or home health care.
- **Mental Illness** - such as schizophrenia.
- **War**
- **Self-inflicted Injuries**
- **Hospital Confinements**
- **Treatment Outside the U.S.**

What conditions would terminate coverage?

As an active employee, your group coverage in the Long-Term Care Insurance Plan will last until any of the following events happen:

- you fail to pay the premium amount when due,
- you become ineligible for our plan,
- you die,
- you terminate your employment.

Is the Long-Term Care Plan portable?

Yes. If you terminate employment or if SCRS discontinues the plan, you can continue your coverage and any coverage you have on your spouse and eligible parents. Aetna would then bill you directly. To continue coverage without SCRS, you'd just have to pay the premium you had been paying, plus a small monthly administrative fee. (That fee is $2.25 this year.)

How will I pay for this plan?

You pay the entire cost of Long-Term Care coverage for yourself and your spouse. If you and your spouse choose to participate in this plan, your cost will be based on your age at the time your coverage becomes effective - and will be paid through the salary reduction method of the state's cafeteria plan each pay period.

Your premiums will never increase just because you get older or use your benefits.

How do I enroll?

You and your spouse may apply for coverage under this LTC plan between September 1 and October 31, 1988, as long as:

- you are actively at work
- your spouse has not been confined in a hospital, a nursing facility, or at home within the 90 days before the enrollment period.

Your spouse may not participate unless you do. Coverage for anyone who enrolls during this enrollment period will become effective on January 1, 1989.

What are the maximum lifetime benefits?

If you need Long-Term Care, your benefits will continue for up to:

- **5 full years** if you receive all your care in an eligible nursing facility.
- **10 full years** if you receive all your care at home.

Or, you can combine both types of care until you reach the maximum lifetime dollar amount. Under this plan, your lifetime maximum dollar benefit can range from $54,750 for three $10 daily coverage units to $182,500 if you purchase ten $10 coverage units. (See coverage level chart.)

How are the benefits paid?

Payments will come directly to you, the active employee, at the end of each month - even if your spouse is the one receiving the care.

Does this plan provide a premium waiver?

Yes! After you have received benefits for 90 consecutive days, you will no longer have to make premium payments. And that's the way it will stay until you get better. As soon as you stop receiving benefits, you will be expected to start paying premiums again on the next premium due date.

Does the plan offer a way to keep up with inflation?

Whenever SCRS conducts an enrollment period for this LTC plan, you will have the opportunity to apply to increase your protection by one or more $10 coverage unit. To get the increase, you'll have to meet certain medical standards. However, in years ending in a zero or a five (such as 1990 and 1995), you may add one coverage unit with **no medical questions asked.**

Premium Rates

The following premium rates are based on $10 units of daily benefits. Premiums may be calculated by multiplying the number of desired units times the monthly premium for the applicant's age (as of the

applicant's effective date of coverage).

For example: Age 42 = $2.15 per unit x ten (10) units or $100 per day of benefit = $21.50 montly premium.

A minimum purchase of three units or $30 of daily benefit is required. Maximum purchase is ten units or $100 of daily nursing facility benefit.

If both you and your spouse enroll, you must each purchase the same amount of benefit units of coverage.

The plan pays:

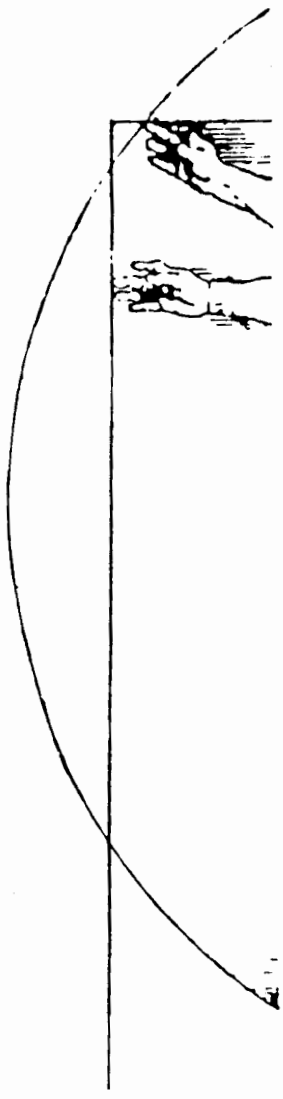
100% of the daily benefit amount for care received in a nursing facility.

50% of the daily benefit amount for care received at home or in an adult day care center.

There is a lifetime maximum of $18,250 per $10 of daily benefit amount.

SCRS LONG-TERM CARE PLAN MONTHLY CONTRIBUTION RATES PER BENEFITS UNIT ($10 OF DAILY NURSING FACILITY BENEFITS)

Age	Monthly Deduction Per $10 Unit	Age	Monthly Deduction Per $10 Unit
Less than 25	$ .69	61	$ 9.45
25-29	.93	62	10.36
30-34	1.27	63	11.37
35-39	1.75	64	12.46
40	1.87	65	13.66
41	2.01	66	14.97
42	2.15	67	16.40
43	2.30	68	17.96
44	2.48	69	19.68
45	2.65	70	21.54
46	2.85	71	23.61
47	3.07	72	25.74
48	3.31	73	28.11
49	3.56	74	30.76
50	3.83	75	33.81
51	4.14	76	37.36
52	4.47	77	41.00
53	4.83	78	44.61
54	5.23	79	48.05
55	5.65	80	51.06
56	6.13	81	53.27
57	6.66	82	54.57
58	7.24	83 & Over	54.70
59	7.89		
60	8.63		



Both the Aetna insurance premium and the SCRS recordkeeping fee will be payroll deducted. The insurance premium portion will be remitted to Aetna and the fee portion will be retained by SCRS.

The coverage features of the Long-Term Care Plan are abbreviated and summarized because of space limitations. For a complete description of the plan and detailed information on the determination of benefits payable, employees should consult the plan booklet certificate issued by the Aetna Life Insurance Company.

Harris - **On behalf of the Committee, I want to thank you for the interest you've taken in the program to helping us get it established. We are grateful to you for that.**

Col. Angelo Perri
SC Council of Chapter, Retired
Officer's Association
6108 Belterdale Dr.
Columbia, SC 29209

SOUTH CAROLINA COUNCIL OF CHAPTERS

THE RETIRED OFFICERS ASSOCIATION

PRESENTATION TO THE JOINT LEGISLATIVE COMMITTEE ON AGING
Public Hearing September 14, 1988 - Room 101/109
Blatt Building

Presentor: Colonel ANGELO PERRI, USA Retired Vice-President
South Carolina Council of Chapters Retired Officer's Association

As you may be aware, there are 37,759 military retirees, plus their families, who live in South Carolina. The value of that payroll is over 440 million dollars per year. The United States Department of Commerce considers that an income dollar turns over 2.5766 times and each additional resident creates 1.44 jobs. Thus, the retired military segment of our population equates to a $1 billion per year "industry" and creates 100,000 jobs.

In addition to bringing their military pension income to this state, many military retirees also bring valuable technical and management skills; the majority embark on second careers, and thus pay state income tax not only on their retired military pay, but on the salary or wages earned in their second career, plus purchasing homes, motor vehicles, large appliances, etc. They add no burden to the public school systems, health care or welfare systems. They are mature, responsible, and law abiding.

In recognition of the desirability of attracting military retirees as permanent residents, most states grant them partial or total exemption from paying state income tax on their military pensions. The following table illustrates the situation in the Southeast:

RETIRED MILITARY PERSONNEL
INCOME TAX COMPARISON - SOUTHERN STATES

	STATE	TAX EXEMPTION	NUMBER OF MILITARY RETIREES
	Texas	No tax	142,457
	Alabama	$ 10,000 Excluded	36,640
*	Georgia	$ 4,000 Excluded	55,222
	Mississippi	$ 5,000 Excluded	19,249
	Arkansas	$ 6,000 Excluded	20,488
	Florida	No tax	141,487
**	Louisiana	$ 6,000 Excluded	25,021
***	North Carolina	$ 4-3,000 Excluded	49,318
****	South Carolina	$ 3,000 Excluded	37,759
			527,641

* Over 62
** Over 65
*** Bill in Legislature to raise to $6,000
**** Was $1,200 until 1985

The amount of state income tax exemption obviously has some effect on the number of retired military personnel that a state has in residence. For example, from 1983-1987, 82,408 persons retired from military service. Of these, 12,187 went to Florida; 4,561 to North Carolina; 4,177 to Georgia and 2,879 to South Carolina. As attractive as South Carolina has been to military retirees, there is a downward trend. We had 34,880 military retirees in 1983 and only went to 37,759 in 1987.

We believe, that the current $3,000 state income tax exemption needs to be raised. Attached is a proposed bill that would:

Leave the $3,000 exemption for military retirees upon retirement from active duty. Raises the exemption to $6,000 at age 62 and also grants the $6,000 to all citizens -- retired from any endeavor, and totally exempts retired pay at age 65 for all citizens.

This bill would have a minor impact on state revenues; that, we believe, would be more than offset by attracting quality retirees to South Carolina, especially civilian retirees who generally retire at age 62 -- and will make one last move. The total exemption at age 65 is desirable, but is certainly negotiable if the revenue lost is larger than anticipated.

The South Carolina Council of Chapters, Retired Officers Association, on behalf of over 37,000 military retirees in the state urges the adoption of the proposed bill as a revenue enhancement measure, as well as providing tax relief for all citizens at age 65. We thank you for your courtesy and the opportunity to make this presentation.

Attachment

A BILL

TO: AMEND SECTION 12-7-435, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976 RELATING TO DEDUCTIONS SO AS TO INCREASE TO SIX THOUSAND DOLLARS ANNUALLY THE DEDUCTIONS ALLOWED FROM TAXABLE INCOME FOR CERTAIN RETIRED PAY FOR RETIREES WHO ATTAIN THE AGE OF SIXTY-TWO BEFORE THE CLOSE OF THE TAXABLE YEAR AND TO ALLOW THE DEDUCTION OF ALL RETIRED PAY FROM TAXABLE INCOME FOR RETIREES WHO ATTAIN THE AGE OF SIXTY-FIVE BEFORE THE CLOSE OF THE TAXABLE YEAR.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1: Item (c) of Section 12-7-435 of the 1976 Code, as added by Act 101 of 1985, is amended to read:

(c) Any retired person, or his surviving spouse, who attains the age of . . sixty-two before the close of the taxable year and who receives income under one or more qualified pension programs is allowed to deduct from taxable income . . six thousand dollars of the pension income received in each taxable year. Upon attaining the age of sixty-five retired persons or surviving spouses are allowed to deduct from taxable income all amounts received from qualified pension programs. If the pension income also qualifies for a deduction from taxable income under the provisions of items (a) or (b) of this section . such deductions from taxable income . . must be subtracted from the deductions authorized under the provisions of this item.

Harris - You said that although we show a downward trend, we showed an increase numerically. Is that what you are talking about?

Perri - Yes sir.

Harris - Don't you think the death rate would have some factor in that. Maybe the increase is really more than we might think because the factor of death at this age would take some away who have made this a permanent residence. I'm greatly in favor of your proposal and I hope we can do something about it and we do appreciate your coming.

Mary Mace
SC Retired Educators Association
421 Zimalcrest Dr.
Columbia, SC 29210

The South Carolina Retired Educators Association
Legislative Program
1989

Improving the quality of life for its members continues to be among the major concerns of the South Carolina Retired Educators Association. Those among our ranks whose benefits are small because of circumstances beyond their control are the focus of our efforts this year.

Most retirees have received the substantial raise voted by the legislature in its last session. Without a doubt, this is highly appreciated and elicits our warm gratitude. However, those who retired before 1972 continue to suffer from a very low base pay. Ten, or even fourteen percent of their small amount still leaves a substantial difference between their income and that of those who retired later. A bonus will not improve the base for them at all.

The SCREA is dedicated to continue the effort to close the gap. This means that our legislative proposal will seek to realize that portion of last year's request that was not achieved last year.

I. COMPENSATION

To provide an increase in the base retirement benefit for members of the South Carolina Retirement System who retired prior to July 1, 1972, with the increase to commence with the July 1, 1989 monthly check. The increase is to be an amount equal to one dollar for each year of service plus one dollar for each full year that the retiree has received benefits under the system. This increase is not to affect the cost of living adjustments or earning ceilings provided by law.

II. HOMESTEAD EXEMPTION

To increase the homestead exemption for homeowners 65 years of age and above from the current $20,000 to $30,000.

III. NEEDS OF THE ELDERLY

To keep abreast, informed and alert to the general needs of the elderly, and to promote legislation beneficial to this group.

Blackwell - Would your organization support a movement to allow the counties and cities of South Carolina to collect property taxes on a monthly rather than annual basis. This is something that was suggested by the Municipal Association last week before the Budget and Control Board.

Mace - I'm going to refer that to Mr. Willis.

Willis - Mr. Blackwell, I'm not in a position to speak for the Association on that matter because it hasn't been presented to us.

Blackwell - I wish you folks would take a position on that because I think that this is perhaps something that will be introduced this year. The idea being that you could pay it just as you pay your light bill or water bill and that way you would not have a high one-time tax rate. Also both the cities and school districts would not have to do tax anticipation notes which might save them some money.

Willis - It would be pro-rated over twelve months.

Blackwell - Yes sir.

Willis - How would it be collected?

Blackwell - A person could go to a bank or have electronic funds transferred or mail it in or pay to Duke Power Company when they pay their light bill. It would be something that would be put into place by the counties and municipalities. It would not be something which is maintained by the State.

Willis - Is that in any way tied to our recommendations?

Blackwell - No sir. But you were talking about taking positions and I was interested in whether you had a position on that.

Willis - We will respond.

Mace - We certainly will discuss that. It's new to us and we have no position on it.

Harris - Thank you very much. I think we might look into that on a Committee level, Keller.

Center for Developmental Disabilities
Benson Building - USC
Columbia, SC 29208

WRITTEN TESTIMONY PROVIDED TO THE JOINT LEGISLATIVE COMMITTEE ON AGING BY THE ELDERLY ASSISTANCE LINE

Public Hearing - September 14, 1988

For over six years, the **South Carolina Handicapped Services Information System (SCHSIS)** has actively and effectively served the citizens of South Carolina as a statewide system providing information on services available to persons with disabilities of all ages. In 1987, Mr. John Winthrop, a philanthropist from Charleston was interested in seeing a statewide system similar to SCHSIS be developed for senior citizens. He saw a tremendous need to provide all senior South Carolinians, both disabled and non-disabled, with a central source of information about exactly what services are available to them. The need for such a system becomes more critical considering the projected rate of growth in South Carolina's elderly population during the coming years.

In response to a proposal and as a result of Mr. Winthrop's vision and influence, the Center for Developmental Disabilities was awarded a one-year grant of $23,000 from the Brookdale Foundation of New York to develop the ***Elderly Assistance Line*** as an add-on component to SCHSIS. Since November 1987 our staff has been actively involved in collecting data on agencies all over the state that provide services to persons who are elderly. This information on available services supplements the SCHSIS database.

The ***Elderly Assistance Line***, as a component of the SCHSIS, is a statewide, computerized information and referral system providing easy access to needed information through the use of a toll-free telephone number. This approach maximizes the economy of scale and provides a comprehensive I & R system at a fraction of the total cost. The ***Elderly Assistance Line*** is designed to serve all persons in South Carolina over the age of 55. The information in the database includes service listings from a wide variety of organizations such as state agencies, hospitals, private associations, voluntary organizations, support groups and much more. A wide variety of services including, but not

limited to, retirement and adapted housing, meals, homemaker services, transportation, recreation, peer and family support, medical services, and special equipment are also contained in the computer database of the ***Elderly Assistance Line.***

The goal of this computerized information and referral system is to provide callers with the most current, complete and pertinent information to access needed services. Therefore, updating present information on providers and adding new providers as they are identified is a tedious, yet an on-going process.

When we receive a call, a trained counselor assists the caller to determine the service(s) needed. Based on the service needed and the county in which the caller resides, the counselor uses the computer to search the computer files to obtain information on providers offering that service. The counselor is then able to provide the caller with a detailed description of the services, the name, address and phone number of the provider offering the service, and the name of a contact person with whom to speak. Additionally, information on hours of operation, accessibility, transportation, eligibility, etc. is also available.

Another important benefit of the ***Elderly Assistance Line*** is its ability to identify gaps in services available in the local community as well as on the county and state level. Identifying what services are not available is, often, as important and useful as identifying what is available. Such information can be especially useful to those who are responsible for providing and planning services to the elderly population of South Carolina.

The ***Elderly Assistance Line*** is a valuable resource to South Carolina's senior citizens, their family members, and agency representatives interested in their well-being. Needing services and not knowing where or how to find them is a most frustrating and confusing experience. The ***Elderly Assistance Line*** exists to make the experience of locating services for senior citizens an easier task.

South Carolina's Elderly Assistance Line looks to the future by meeting the needs of its senior citizens TODAY!

Do you or someone you know experience...

- *loneliness or social isolation?*
- *difficulty getting to appointments?*
- *frustration in finding someone to care for your elderly parents?*
- *grief over losing someone you love?*
- *concern over where you will live after retirement?*

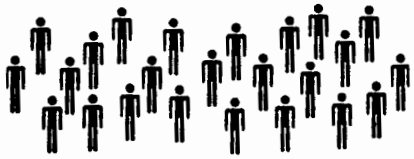
As a statewide, computerized information & referral system, the Elderly Assistance Line is a clearinghouse of information on services available to persons over 55 in South Carolina. Details on services offered by state and other public agencies, regional and local offices on aging, private organizations and many other service providers are maintained, with frequent updates, to ensure that you receive the most current and accurate information possible.

When you call, you will speak with a trained counselor who cares and understands the needs of persons who are elderly. During the call, the counselor will use the computer to list agencies offering the services you request, in the county in which you need the services. The counselor then will immediately provide you with detailed descriptions of the service offered by each agency, the name, address, and telephone number of each facility, as well as the name of a person at each location with whom you may speak.

CALL FREE
1-800-922-1107
Columbia Area 777-5732
Voice & TDD

Elderly Assistance Line offers information on a vast array of services designed to meet the diverse needs of senior citizens.

- *meals*
- *housing*
- *discounts*
- *home health*
- *medical care*
- *transportation*
- *case management*
- *homemaker services*
- *reassurance activities*
- *& other similar services*



BY THE YEAR 2000

The most rapidly growing segment of our population is the elderly. It is estimated that by the year 2000, one in four Americans will be over the age of fifty-five. By the year 2020, the entire "Baby Boom" generation will be over the age of fifty. Such an increase in the elderly population will surely result in a growing demand for services which must be met in new and innovative ways.

May we help you locate services for yourself, spouse, parent, friend or client?

Receiving information about the services you need is as easy as dialing the telephone

A Note to Service Providers

We are also interested in identifying new service providers. If you or the agency for which you work provide services to persons over the age of 55 and would like to be part of our system, please call the ELDERLY ASSISTANCE LINE and let us know. There is no charge to your agency for our referral services.

CALL FREE
1-800-922-1107
Columbia Area 777-5732
Voice & TDD

Benson Building
Columbia, SC 29208

The Elderly Assistance Line is a program of the Center for Developmental Disabilities at the University of South Carolina School of Medicine and is funded through the Brookdale Foundation.

Harris - Do you work with vocational rehabilitation?

Yajnik - Yes, we do. Very Actively.

Sholin - What type services do you offer?

Yajnik - There are a variety of services and unlimited training of these that are listed in my testimony but these are related to retirement and adaptive housing, meals, homemaker services, medical transportation, recreation, family support, and many more.

Blackwell - Do you provide information and referrals?

Yajnik - Yes we are an information and referral system.

Blackwell - If I called you from Travelers Rest, SC, you would link me to what's going on in Travelers Rest.

Yajnik - That is correct.

Harris - That's great. Mr. Blackwell doesn't even know what goes on in Travelers Rest. Thank you!

Margaret Wickenberg
SC Hospital Association
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P. O. Box 6009
W. Columbia, SC 29171-6009

South Carolina Hospital Association · Post Office Box 6009 · West Columbia, SC 29171-6009 · (803) 796-3080

STATEMENT OF THE SOUTH CAROLINA HOSPITAL ASSOCIATION
presented to the
JOINT LEGISLATIVE COMMITTEE ON AGING
by

Margaret Wickenberg, SCHA Liaison to Older South Carolinians

September 14, 1988

Mr. Chairman and members of the Committee, I am Margaret Wickenberg, and I serve as the South Carolina Hospital Association's Liaison to Older South Carolinians.

The South Carolina Hospital Association is a not-for-profit organization representing 92 hospitals and nursing homes across the state where tens of thousands of South Carolinians earn their living. I appreciate the opportunity to be here today to discuss with you the South Carolina Hospital Association's concerns regarding the growing elderly population.

Our association has been working with the Commission on Aging, its Council on Elder Affairs and other concerned organizations, and we fully support the five priority categories and recommendations identified by Betty Park of the Council on Elder Affairs earlier today. I would like to detail a few other related concerns, which hospitals have.

One is the inadequacy of the Medicare Program, which was implemented in 1966 to help finance health care for millions of older and disabled Americans. An adequate Medicare program is important to all of us. It's important to the senior citizens, many living on fixed incomes, who rely on it for their health care services. It's important to the soon-to-be senior citizens who expect to rely on it in a few years. It's important to the children, friends and neighbors of senior citizens. It's important to employers who pay the unpaid portion of Medicare bills through a cost shift to privately insured patients. And it's important to hospitals, as partners with the state and federal governments in providing care.

In states such as South Carolina, where the growth of our over-65 population is outpacing the national average, it becomes perhaps an even more critical issue to all involved. The future of the Medicare program is being jeopardized by Congress' tendency to cut the Medicare budget disproportionately in its attempt to reduce the deficit.

During the last fiscal year, Congress made up 36 percent of the federal budget savings on the backs of Medicare beneficiaries. Between 1984 and 1988, the costs of goods and services purchased by hospitals to provide care increased 22 percent. During that same period Medicare rates increased 11 percent. Hospitals cannot afford to continue treating patients for less than the cost of treatment.

Pat Mason, Executive Director
SC Retirement Communities Association
4201 Blossom St.
Columbia, SC 29205

SOUTH CAROLINA RETIREMENT COMMUNITIES ASSOCIATION

Leaders Committed To Quality, Service, Integrity

Request Proposed
by the
South Carolina Retirement Communities Association
to the
Joint Legislative Committee on Aging
Public Hearing

Wednesday, September 14, 1988

That the Committee investigate and support the process whereby reciprocal agreements are made with other states allowing for tax exemptions on pension income going to retired state employees who have relocated here. South Carolina Tax Commission records show that we already have such reciprocal agreements with 26 of the 43 states that have a state income tax.

Respectfully Submitted,

Patrick Mason
Executive Director

Attachments: SCRCA Background Data Sheet
Senior Living Industry Network

PM/jkd

SOUTH CAROLINA RETIREMENT COMMUNITIES ASSOCIATION

Leaders Committed to Quality, Service, Integrity

PRESS INFORMATION

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BACKGROUND AND STATUS OF THE ORGANIZATION

S.C.R.C.A. was formed on March 20, 1987 after seven months of dialogue among private and public sector leaders who recognized the benefits from a cooperative effort to manage the growth of the Senior Living Industry in South Carolina. The non-profit trade association (chartered as a 501-C6) has adopted the root mission, "to strengthen the state's competitive position among traditional destinations (Florida and Arizona) as an excellent retirement destination today and for the next ten decades".

The group recognizes they are in the infant stage of a 50-year growth cycle fueled by the 5,000 Americans who turn 65 everyday and by South Carolina's low cost of living, temperate 4-season climate and attractive mix of lifestyle options. It's time leaders in the Senior Living Industry organize to assure a reputation for excellence.

The S.C.R.C.A. is made up of Associate Members (CEO developers) actively marketing residential resort and retirement community properties that appeal to pre-retirees and retirees. An Allied Membership is available for vendors offering products and services to the senior living developers and their "resident customers".

The S.C.R.C.A. enjoys support in the public sector from the State Development Board, Parks, Recreation and Tourism Department, the State Commission on Aging and the Joint Legislative Study Committee on Aging.

(Over)

In support of its root mission, the Board of Directors adopted four objectives to accomplish i the first two years:

1) Fund a longitudinal research program that will build an econometric model of the industry tracking housing starts, jobs created, taxes paid, number of real estate transactions, revenues transacted($270 million in 1988) and the associated multipliers. The data will be used as a basic working tool to develop awareness and rapport with our state government officials and legislative leadership.

2) Establish an effective marketing cooperative program that will: a) build awareness of the advantages and benefits of living in South Carolina, b) work as a year-round demand generator, c) speak to potential buyers and to those who influence the buyers, d) deliver a stream of high quality inquiry-leads, e) make maximum use of low cost marketing channels (see SOUTH CAROLINA MATURE LIFESTYLES - Publication Release).

3) Develop cost reduction opportunities for Member communities and benefit packages (in the form of high value group insurance and mortgage plans) for their "resident customers".

4) Formulate an effective Code of Ethics that will set integrity standards for the senior living industry in South Carolina.

The S.C.R.C.A.'s formation was spearheaded by Patrick Mason, President, American Lodging Resources Inc. (ALRI), a Columbia firm offering business management consulting services to the Hospitality and Real Estate Development industries in the areas of marketing, operations and publishing. ALRI currently manages S.C.R.C.A. under contract with the Board of Directors.

END

SOUTH CAROLINA SENIOR LIVING INDUSTRY NETWORK

Private Sector

Aberdeen Place*
Anderson Place
Arlington Village
Atrium at Forest Park
Beachwood At The Heritage
Bradford Village*
Cardinal Retirement Villages
Clemson Area Retirement Center*
Colonial Charter*
Covenant Towers*
Cooper Hall
Countryside Manor
Dataw Island
DeBordieu
Eagle Landing Retirement Community
East Port Marina Country Club
Golf Villas at Sigfield
Greenbrier Retirement Village
Heather Lakes
Heritage Plantation
Heritage U.S.A.
Highland Valley*
Hilton Head Plantation
Hulon Greene*
Hunters Landing
Island Green*
Kalmia Landing
Keowee Key*
Kiawah Island
Laurel Creek
Links O'Tyron
Litchfield By The Sea
Magnolia Grove*
Moss Creek
Myrtle Trace*
Pawleys Plantation*
PawPaw Village
Plantation Pointe
Presbyterian Homes Of S.C.
Rolling Green Village
Rosehill Plantation
S.C. Baptist Ministries
S.C. Episcopal Home at Still Hopes
Sandpiper Village
Seabrook Island
Seabrook of Hilton Head
Seaside Village*
Savannah Lakes Village*
Sigfield Golf Resort
Skylyn Place
South Creek
Springdale Village
Spring Forest*
Southern Palms
Swansgate
The Calhoun
The Carolinian*
The Cottages of Santee
The Cypress of Hilton Head
The Elms Of Charleston*
Timberlake Pantation*
Trinity Place*
Walnut Creek
Westminster Towers
White Oak Estates
Wild Dunes
Willow Run
Woodlake Village*
Woodside Plantation*

*S.C.R.C.A. Associate Community Members

S.C.R.C.A. Allied Members

Brookgreen Gardens
C&S Bank
Duke Power
Kingstree, SC
SCN Bank
Sears MATURE OUTLOOK
Financial Integrity Corporation
S.C. Association of Non-Profit Homes For The Aging
Thomas Realty
McLeod Marketing, Ltd.
SCANA Corporation

S.C.R.C.A. Support Network

Governor Carroll Campbell
Terry Collier - S.C. Tourism Council, Inc.
Bill Cork - Joint Tourism Caucus
Ruth Seigler - Commision On Aging
Dr. David Rembert - U.S.C.
General John Blount - U.S.C.
Patrick Harris- Joint Legislative Study Committe Aging
Grace McKown - State Development Board
Mac McIlroy - State Chamber of Commerce
Fred Brinkman - Parks Recreation & Tourism
Ashby Ward - Travel & Tourism Forum
James Timmerman - Wildlife & Marine Resources Dept.
George W. Settles - Abbeville Development Board
Harold Lesselbaum - State Development Advisory Comm.
Alice Hite - "Old 96" Tourism Commission
Baron Holmes - State Budget Division
Dill Blackwell - South Carolina House of Representatives
Gene Foxworth - South Carolina House of Representatives
Jim Wedding - SCANA Corporation
Bud Long - South Carolina Senate
Charles Bundy - P.R.T. Commission

MATURE LIFESTYLES - Distribution Partners

Aberdeen Place
Bradford Village
Chambers of Commerce:
- Greater Abbeville
- Greater Aiken
- Barnwell
- Calhoun County
- Greater Cheraw
- Clemson
- Columbia
- Greater Easley
- Greenville
- Hilton Head
- Kingstree
- Marlboro County
- Myrtle Beach
- Greater York

Columbia Convention & Visitors Bureau
Commission on Aging
Clarks Hill Russell Authority
C&S Relocation Kit
Duke Power
Financial Integrity Corporation
Fort Jackson Retirement Services
Georgetown Development Commission
Governor Campbell's Office
Highland Valley
Joint Legislative Committee on Aging
Keowee Key Realtec
Lexington Medical Center
Loris Community Hospital
Patriot's Point
Pedro's South of the Border
Pendleton District Historical & Recreational Comm.
10 P.R.T. Interstate Welcome Centers
Santee Cooper Visitors Bureau
SCN Relocation Kit
South Carolina Association of Realtors
South Carolina Federation of Older Americans
South Carolina Hospital Association

Database maintained by:
South Carolina Retirement Communities Association - August 1988

Waldrop - I like the idea, sir. On your reciprocal agreement would it be based on what is in South Carolina versus North Carolina or will it be based on if you come from North Carolina to South Carolina.

Mason - It will go both ways. If a retired policeman in Columbia or a state employee went to Ohio, he would enjoy equal benefits that an Ohio state employee coming to South Carolina would enjoy. It's an equal thing.

Waldrop - Do you have a draft of this particular piece of legislation?

Mason - No, we are suggesting that we develop a draft and move in that direction.

Waldrop - I wish you would and get it back to us.

Blackwell - Has the Tax Commission made any indication of what the revenue impact of this would be?

Mason - There may be some documents to that effect. What we are suggesting is that we look closely at that impact; update it, and aggressively make some moves to make those agreements with other states.

Blackwell - Sounds good.

Hilton P. Terrell, MD, PhD.
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Think Comprehensively in Planning Medical Legislation for the Elderly

Hilton P. Terrell, M.D., PhD.
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Florence, S.C. 29504-3231

This committee is receiving public testimony in order to better consider wise and helpful laws for S.C., especially as those laws relate to the elderly.

Laws are one manifestation of the collective ethical judgments of a political entity, in this case S.C.

Many people in S.C. attempt to base ethical judgments on the Bible. I do not pretend to speak for all, or even most, of those who so use the Bible. I offer only one of the perspectives so derived. I recognize that many represented by our legislature reject the Bible outright and base their ethics on other foundations. They are fortunately free to present not only their conclusions, but also the foundations which underpin them and lend coherence to their viewpoint. While not trying to convince anyone here today of the validity of my foundation in the Bible, what I have to say has more coherence (even if no more acceptability) if presented as principles, rather than specific conclusions. As to specific conclusions, I believe South Carolinians would agree on many issues, even coming from different worldviews.

My motivation came as I reviewed a synoptic report of legislation recently considered in S.C. Many of the bills enacted or considered by state and federal legislatures in recent years are spoken to by Biblical norms for ethics. Without trying to address any particular bill that

may be forthcoming, I appreciate the opportunity to offer a few principles for such bills as they relate to the elderly and to medicine. Some of these principles are drawn from sources not often cited in health legislation, probably because they run counter to the notion that more is better, which notion the medical profession has promoted with less than excellent evidence.

I. Medical care has a much more tenuous relationship with the health and longevity of the elderly than is generally believed.1 Though it is true that the average life expectancy has dramatically increased in the U.S. in this century, most of that increase is due to improvements in the health of infants and children. Once a person makes it to late middle age, the likelihood of living to age 75 - 85 is not greatly different from what it was in 1900.2 Maximum life span has changed hardly at all in a century. In the later years of life, the proper goal of medicine should be to help us live better. Too often it has focused upon helping us live longer. The two goals can be contradictory, especially in the elderly.

II. The expense of medical care has increased beyond all proportion to the improvements in longevity. "...the precipitate and still unrestrained rise in medical care expenditures began when nearly all (92%) of the modern decline in mortality this century had already occurred."3 Just what are we purchasing with all the money? Are the purchases worthwhile?

III. Expensive and highly technical medical skills are often developed and applied to the elderly without adequate evidence that they are truly

helpful. Such medical maneuvers are very often distressing to the elderly:4

A. Hospitalization is undertaken without adequate regard to the separation from family and friends and the often consequent disorientation.

B. Drug therapy more often has side effects in the elderly, and is more difficult due to multiple drugs.

C. Screening tests, which are not without some discomfort and hazard, are done in the elderly without any proof that they increase the length or the quality of life.

D. All of these things are done, naturally, at substantial expense, often with state involvement, supporting a medical-industrial complex at the financial expense of all and at the expense of the well-being of the elderly.

Why burden this committee with these things? Why not address these concerns within the medical profession? They are being addressed, but too slowly. A generation of elderly is at risk of being consumed by the overly materialistic view of health and disease to which the medical profession has succumbed in recent decades. The profession is too easily driven by the availability of financing. We may soon be approaching a point at which the health of the elderly will be <u>improved</u> by <u>less</u> medical care, until medical care is redefined to provide more caring and less emphasis on use of "aggressive" medical attempts to try to overcome the 100% mortality rate of being human. Since my profession has not yet been effective in redefining its goals in the treatment of the elderly, we may need a little help in the form of less financial help from civil government.

IV. The primary locus of authority for a person's health resides first with the person, second with the family, third with the church. The first stop I just made (the individual) squares not only with the Bible, but also with common sense. From whatever ethical foundation, most South Carolinians would probably agree with the second stop, the family. I won't venture to the third stop, nor to those not mentioned such as civil government or employers. There is experimental evidence that the individual and family are in more powerful control of their health than any other entities.5 If this be true, then whatever legislation is passed to augment the health of the elderly should not adversely influence either the individual's inalienable contribution to his/her health, nor weaken the family.

The connection between, say, an antibiotic and health seems obvious. (It, in fact, is more questionable than most realize.6 The connection between an individual's belief system and his/her health is less obvious but immensely more powerful.7 A generation which looks to civil authority to decide who will look after their health, where it will be done, what treatments will be administered is essentially a slave to the state as regards its health. The Bible recommends against a person's choosing slavery.(I Cor. 7:21, 23) Politically, this state is likewise now committed against slavery. Medical "help" for the competent elderly which flows through innumerable agencies, qualifications for providers and other barriers is, by one viewpoint, a condescension for the recipient. The recipients are so inept in their judgment of value received for value given, that father state must do it for them. I urge you in all your deliberations to avoid unnecessary condescension to the elderly.

Still less obvious but intuitively reasonable is the connection between the strength of a family and the health of its members.8 While not disputing that help from outside the family is sometimes needed, a state or any other "third party" which makes its assistance too freely available cannot avoid teaching a generation that a given task is not a family responsibility. The more we legislatively provide, the more we may be expected to provide in the future. Since the state's resources are taken from its citizens in the form of direct and indirect taxes, the provision is disproportionately at the expense of the producing members of society, conceivably weakening their ability and motivation to provide for their own. (I Tim. 5:3-13, esp. vs. 8)

I know of no studies on such. No one does studies that last 30 - 60 years. One does, however, think of Sweden, whose social welfare programs for all ages are in some jeopardy. Families there have been literally weakened, shriveled in size, perhaps due in part to past government actions which encouraged a very low birth rate. Improving the lot of today's geriatric group through tax-supported programs could conceivably burden working families so that responsible child-bearing and nurture becomes less desirable. A future geriatric cohort could be faced with a demographic dilemma, not to mention the troubles of an ill-nurtured group itself. Sound legislation should consider <u>future</u> generations of elderly, not today's only.

V. No tax-supported medical programs for the elderly should be justified on the basis of compassion or charity (love). They may be justified, but not by appeal to compassion or charity. Compulsion, one of the core features of taxation, has no part of compassion. ~~Those who know of~~

God's requirement that His people be compassionate, can obey or disobey Him, as they wish, with their own funds. Legislation can coerce others to financially support medical programs for the elderly (or any other group), but no legislature can truly coerce compassion, nor should it. Compassionate coercion is an oxymoron. God sometimes coerces, but even He does not coerce compassion.(Acts 5:4)

One of medicine's problems today is a lack of compassion in the midst of technical proficiency. A substantial number of physicians are soured on many features of medical care - especially the heavy-handedness of third parties, prominently including civil government. My profession richly deserves the unsavory restraints put upon it by the fact of having accepted third party money eagerly for more than three decades. Our elderly patients, however, do not so deserve the fruit of physician disenchantment with medicine. Patients have to put up with such results as brevity of contact with physicians or suffer as the physician resorts to procedural medicine where mere listening would have been more productive.

Medicine is peculiarly susceptible to reduction in quality through subtle shifts in physician behavior. As an example, a physician can hand an elderly patient a drug prescription rather than spending 20 extra minutes to really hear the problem. What incentives are there to do this? As an example, you can, in the name of compassion, lock in the legal charge for a service. Fail to change the cost of providing the service. State that physicians are notoriously inefficient, and that the cap on the charge will force efficiency. It may work to cap expenditures, but it will often be at the expense of true compassion.

In an inchoate way, patients will recognize that they are not receiving fully what they desire. They will probe the medical care system at multiple points trying to receive the compassion they know they want but which they cannot articulate. Rather than compassion, they too often receive CAT scans, rather than love, liver profiles. Costs can actually go up as real benefits go down.

No private or public agency can adequately police individual health care delivery so as to reduce such shifts. A better approach is to reduce the incentive for physicians to reduce quality. Help the elderly and the medical profession. Do not try to legislate compassion. Rather, in legislation, try to leave place for compassion. Leave place for the individual to exercise his/her responsibility. Leave place for the family to to likewise.

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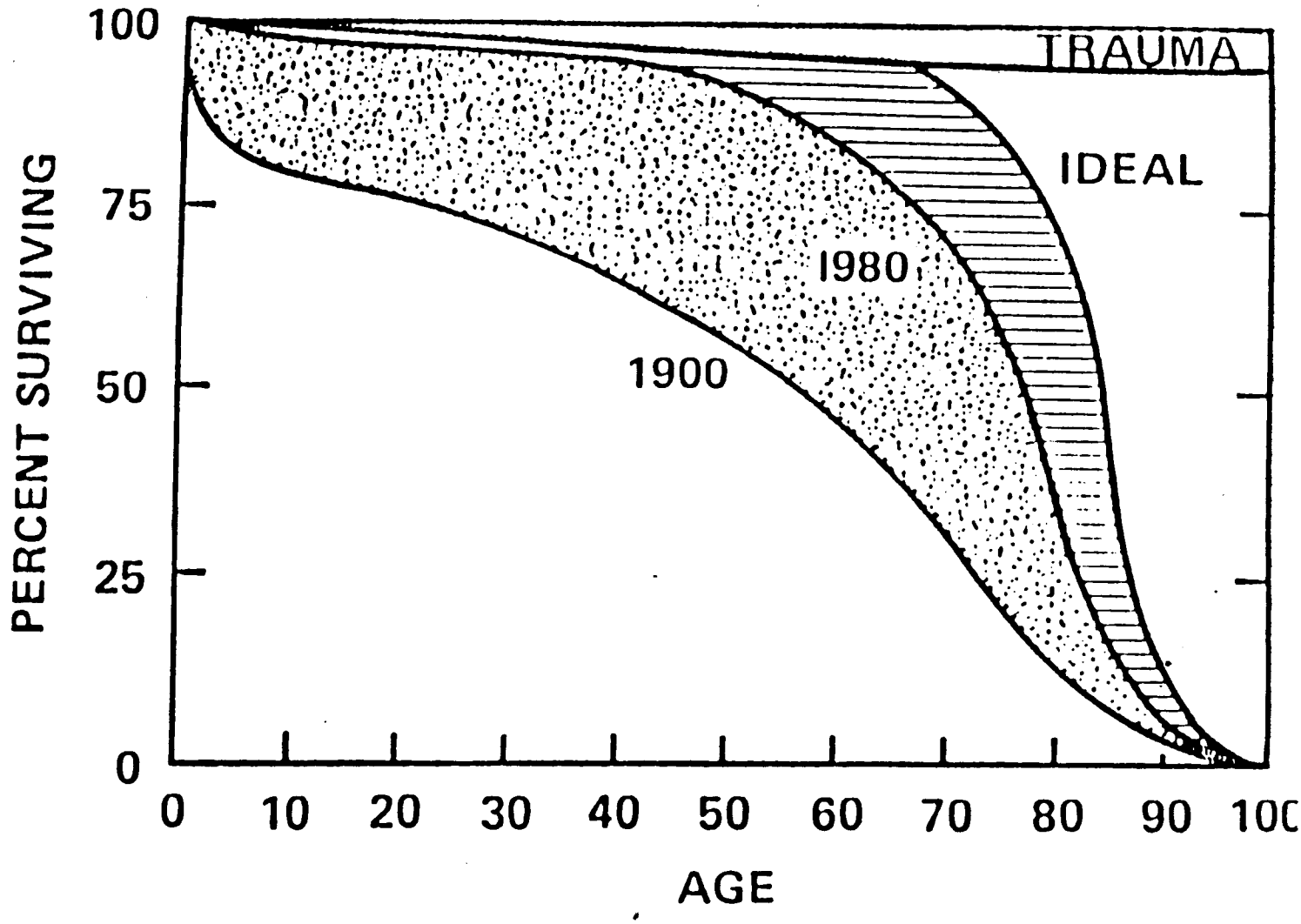


Figure 2. The Increasingly Rectangular Survival Curve. About 80 per cent (stippled area) of the difference betwee the 1900 curve and the ideal curve (stippled area plu hatched area) had been eliminated by 1980. Trauma is nov the dominant cause of death in early life.

into the future, at some point in the 21st century th
average life expectancy as projected at birth will ex
ceed average age of death as projected at age 75
A white woman aged 70 may now expect to live 1

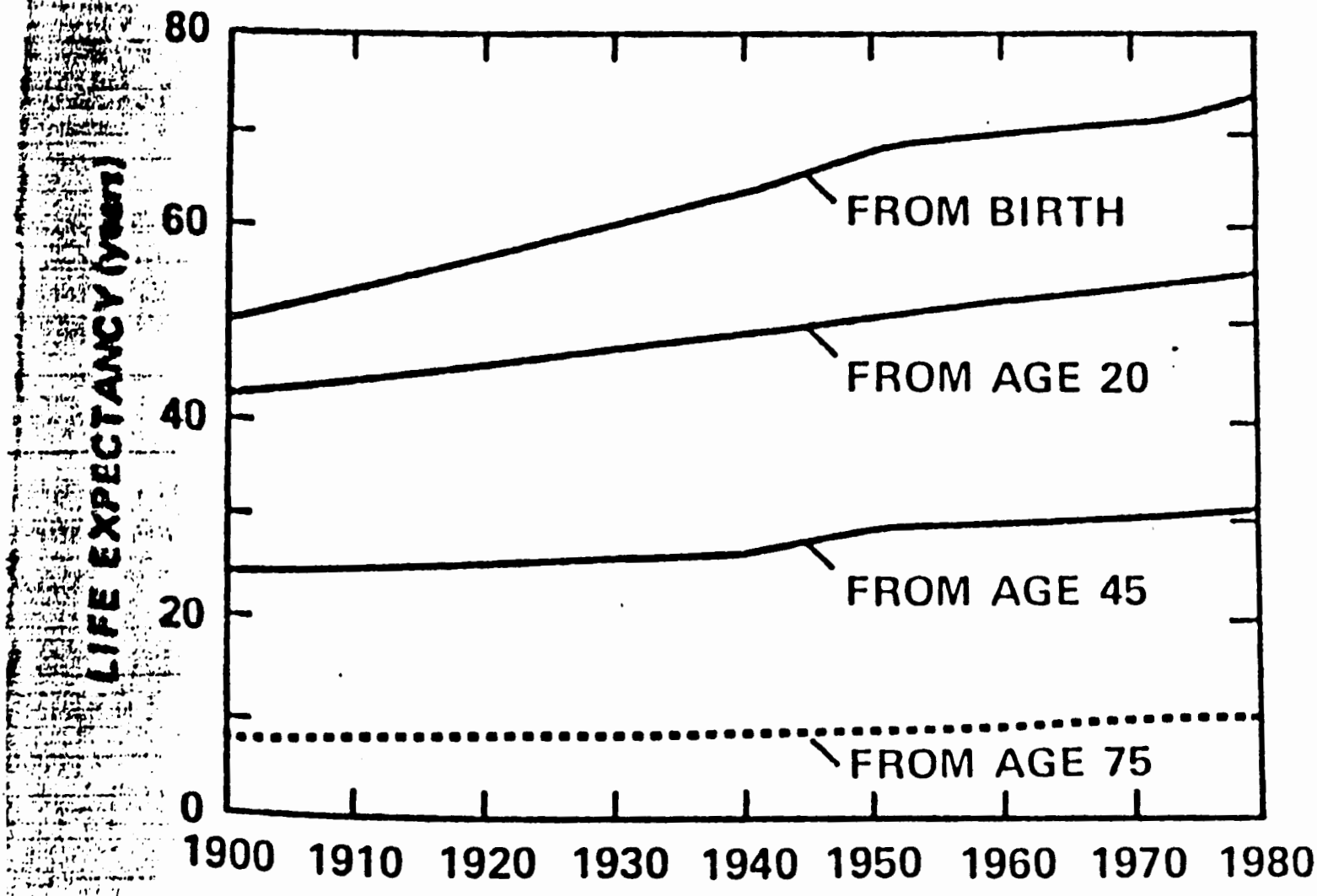


Figure 1. Life Expectancy Trends in the United States. Life expectancy at birth has increased by 26 years in this century, and expectancy at 75 (broken line) by only three years. The slope decreases as the life span is neared.

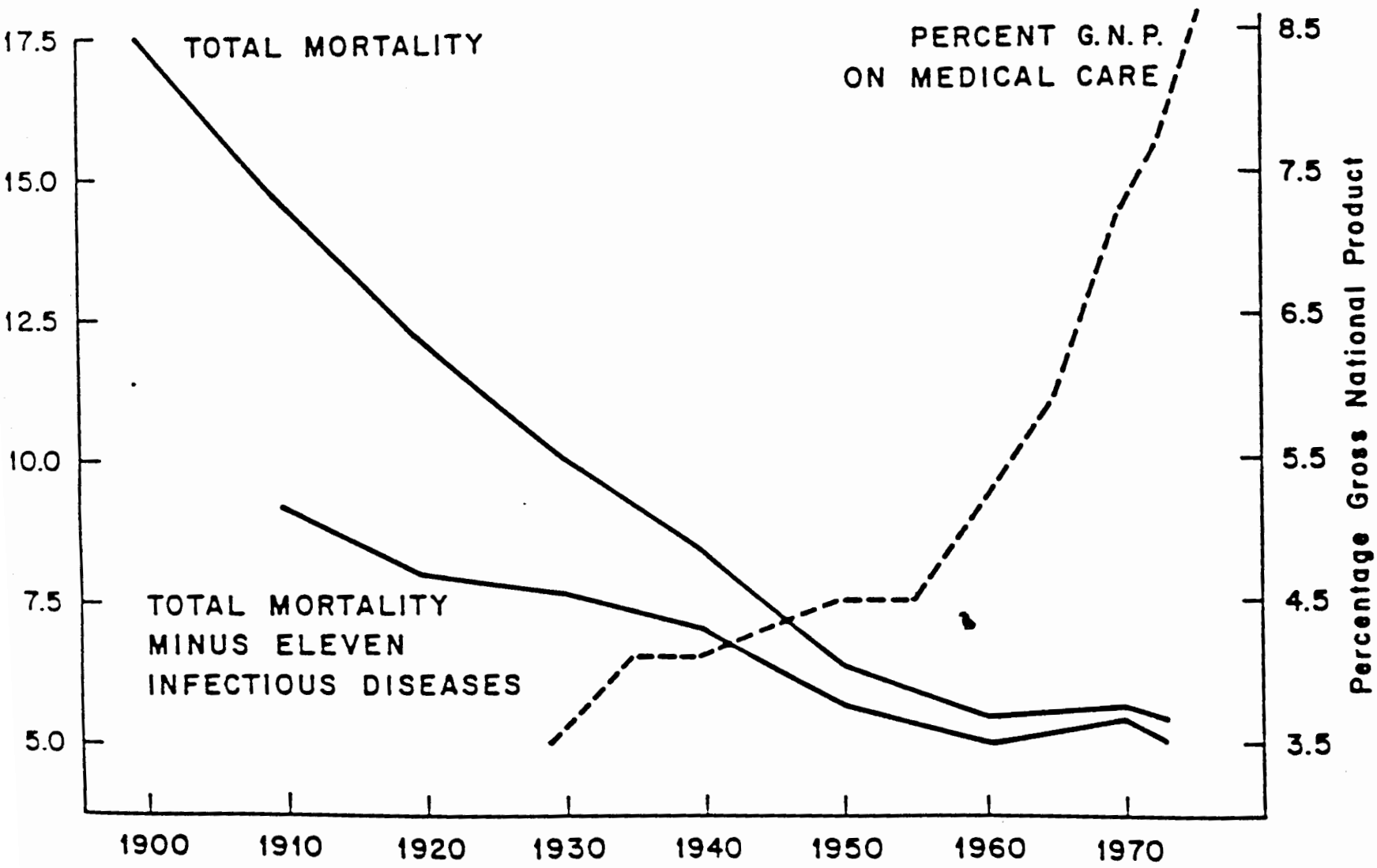
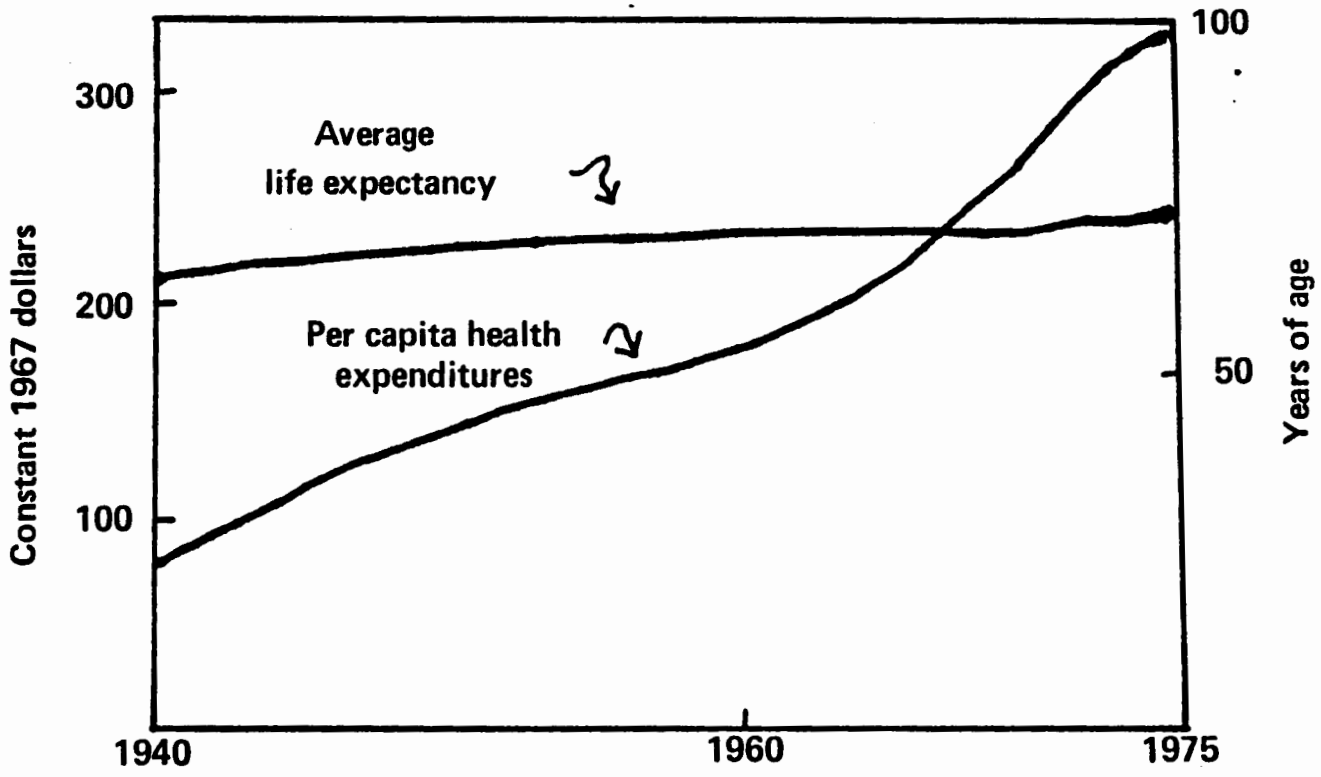


FIG. 2. Age-and Sex-Adjusted Mortality Rates for the United States 1900–1973, Including and Excluding Eleven Major Infectious Diseases, Contrasted with the Proportion of the Gross National Product Expended on Medical Care.


Constant 1967 dollars
300
200
100
Average
life expectancy
Per capita health
expenditures
100
50
Years of age
1940
1960
1975

Waldrop - Are you against the third party, as you call the senior citizens, being financed?

Terrell - If you mean by third party the senior citizen, certainly not.

Waldrop - Well what did you just say?

Terrell - I am against third party involvement in the delivery of individual health care. I'm not so foolish as to think it could be stopped overnight. It would take a generation to factor it out. It's killing us quite literally. If you had time, I have data to back that up.

Waldrop - Well what's killing us? Us helping people is killing everything. Right?

Terrell - You call it help because it's within total health service. It doesn't have that effect.

Waldrop - You are a professional. You're a doctor. Am I correct?

Terrell - Yes sir.

Waldrop - I would have thought you a minister.

Terrell - Yes sir, some people make that confusion.

Marilyn Koerber
SC Gerontological Society
c/o Lowman Home
P. O. Box 444
White Rock, SC 29177

Joint Legislative Study Committee on Aging

Public Hearing

September 14,1988

Testimony presented by Marilynn Koerber on behalf of the South Carolina Gerontological Society.

I am Marilynn Koerber, appearing on behalf of the Board of Directors and members of the South Carolina Gerontological Society. The Society will be celebrating its Tenth Anniversary at its annual meeting in Greenville, November 2, 3, & 4, 1988. The purpose of the Society is to promote advancements in gerontology in the state through education, training, advocacy, networking, and coordination. We have chapters in Columbia, Greenville, Florence, Charleston, and Rock Hill.

One of the main goals of the Society is to increase knowledge and research in the area of Gerontology. With increased life expectancy and diversification of the elderly population, there is a demand for professionals, paraprofessionals, and informal service providers trained in the care of the elderly. Training programs for formal and informal providers must be expanded to address current and future needs. Service providers must keep abreast of recent research in aging and the latest technologies. Educational institutions must expand their offerings in gerontology and geriatrics to ensure a supply of professionals and paraprofessionals trained in the care of the elderly. This is especially important with the passage of the Nursing Home Reform Act, Subtitle C, of the Omnibus Budget

Reconciliation Act of 1987. The requirement for nurse aide training specifies the establishment of programs for training nurse aides, competency evaluation of nurse aides already working in nursing home settings and the establishment of a registry system for these individuals. With the enactment of PL 100-203 The Federal Government has mandated the states to implement the provisions of that statute through state legislation. The Joint Legislative Study Committee should promote the training of employees whose primary responsibility is to deal with older persons. The Gerontological Society supports measures which would encourage official consideration in employment practices to persons who have training in gerontology.

In other legislative matters, the South Carolina Gerontological Society adds its endorsement to the following measures:

1) The state needs to seek measures to alleviate spousal impoverishment in cases where a married person applies for Medicaid coverage. Medicaid often forces many older persons into poverty due to complex eligibility rules.

2) Passage of a Long Term Care [3]insurance bill is needed to promote public interest and availability of policies to protect applicants, to establish standards, and to facilitate the development of private Long Term Care insurance coverage. The Reagan Administration expects all who can to purchase private insurance against long-term medical or nursing home costs. Consumer Reports, after analyzing 53 0f 70 insurance company programs for long-term care, found most of them overpriced and offering many benefits inadequate to the costs generally incured. Many of them were encumbered with waivers and

limitations that confuse even their own agents.

3) A state provision of financial incentives for employers to develop and support adult day and respite care for their employees.

The South Carolina Gerontological Society would appreciate your careful consideration of the matters that I have brought before you. In closing I would like you to remember the words of Ethel Percy Andrus, founder of the AARP/NRTA.

Upon leaving here today may you demonstrate that old age is not a defeat, but a victory. Not a punishment but a privilege. Let us hold ourselves responsive to their needs. Let us be successful social innovators, and prove that life, for the long-lived, can be a many splendored thing.

Blackwell - I noted with interest your spousal impoverishment suggestion in connection with Medicaid. Does that same bill provide specifically that we cannot impoverish the spouse? What limit would you set?

Koerber - I'm not certain how much farther up.

Blackwell - But just upward.

Koerber - Upward, yes.

McLeod - Doesn't the Long Term Care Insurance protect people who purchase it.

Blackwell - Just the state employees. We allow it otherwise but the only parts we mandated were state employees.

McLeod - Yes, but did the legislation protect persons from being "ripped off?"

Barron - We've regulated the medigap supplemental policies and we recently passed the Long Term Care Insurance Act. The Department of Insurance will be developing regulations.

Michael Horton
Comptroller General
Wade Hampton Building
3rd Floor
Columbia, SC 29211

STATEMENT PRESENTED TO
JOINT LEGISLATIVE STUDY COMMITTEE ON AGING
9/14/88
Michael L. Horton
Comptroller General's Office

RE: Recommended Legislation to Amend
Section 12-37-250 - Homestead Tax Exemption Law.

Each year across the state many of those who would otherwise be eligible for the Homestead Tax Exemption fail to receive it because they don't make application during the prescribed dates. Section 12-37-250 of the South Carolina Code of Laws provides that application for the Homestead Tax Exemption must be made between the dates of January 1 and July 15. The law offers no exception nor does it give discretion to any office or official to vary from those dates. The problem arises because many of these folks don't think about their property taxes until they get a tax bill. By then it's too late. Tax books open on September 31. These disappointed taxpayers are told to come in the following January. Many don't remember again until the next tax bill is mailed - by then they have lost two years of the exemption that they would have been eligible for. I have talked to a number of County Auditors across the state and all have experienced the problem. There is, as usual, no perfect solution - especially for the first time that the July 15 deadline is exceeded. However, there is something quite simple that can be done to keep the person from having to come back over and over, or from missing it the second time.

We propose that the Committee recommend legislation that would enable the County Auditor to receive applications all year long. Those received on or before July 15 would apply to the current tax year. Those received after July 15 would apply to the next tax year. It would be as simple as that. We still need the administrative cutoff date (July 15) in order that the tax books can be prepared. We would recommend that the committee enlist the aid of the South Carolina Association of Auditors, Treasurers and Tax Collectors (SCAAT) to propose the text for an actual Bill for your consideration at an early date in this next General Assembly that would carry out the proposal as I have described. Most of all, this proposal allows the State and Local Governments to be better servants of the people. It prevents many from making a second trip to the courthouse, which is an ordeal for many of these who are disabled, blind or infirm. Secondly it allows those who are eligible to receive the Homestead Tax Exemption without loss for a second year. There are no hard fiscal impact figures, but we estimate the cost of the few who miss the second application period to be well under $10,000 statewide. We have made a survey of a few of the County Auditors and each of those surveyed said that they would support such a change.

Harris - **Are the County Auditors receptive to this?**

Horton - **I did talk to Annie Frances Clark, the Auditor of Anderson county. She is in favor of it and sends her regards. She would even be in favor of going a little further. That's why I recommended perhaps letting the Auditors and Treasurers associations get involved because they may even be able to do a little more than that.**

Harris - **I think this is a good idea that we involve them and let them propose the legislation. Then they'll find it hard to disagree with the bill. We appreciate your coming.**

Dr. Richard Cowling,
SC Nursing Association
USC
School of Nursing
Columbia, SC 29208

W. Richard Cowling, III, Ph.D., R.N.
Associate Professor and Chair
Department of Developmental Nursing
College of Nursing
University of South Carolina
Member, Council on Gerontological Nursing
South Carolina Nurses' Association

The interest of the South Carolina Nurses' Association Council on Gerontological Nursing is in the health and well-being of the elderly citizenry of South Carolina. With the well-documented health care plight of older persons, the need for legislative attention to health care related issues is evident. At least 23% of older people living in the community have health-related difficulties requiring attention to personal care and home management, according to studies by the AARP. Many older persons have at least one chronic condition and many have multiple chronic conditions. Older people accounted for 31% of all hospital stays and 42% of all days of care in hospitals in 1986. Hospital expenses are projected to account for the largest share of health expenditures of older persons. (data from A Profile of Older Americans: 1987 prepared by the Program Resources Department, American Association of Retired Persons and the Administration on Aging, U.S. Department of Health and Human Services)

The essential priorities for legislative initiatives that facilitate the health and well-being of older persons should center on the spectrum of health care needs of this group. This spectrum encompasses: 1) the promotion and maintenance of health in persons in basically good health; 2) the provision of services for health-related difficulties that do not require institutional care; and 3) the improvement of conditions and forms of care in institutional environments.

The weaknesses of the health care continuum have been documented and presented in previous years. The weaknesses have been attributed to:

1) lack of access due to cost and inadequate financing models;
2) fragentation of services within the state and localities;
3) nonexistence of services in certain geographical areas;
4) difficulty in navigating the health care system to obtain and utilize what already exists; and
5) a lack of innovation in creating programs of care that facilitate client independence, autonomy, dignity, and self-sufficiency.

Strides have been made in the state to facilitate options for long term care insurance, and attempts have been in process to legislatively support in-home services and continuing care communities. These achievements have been accomplished through documentation of the problems and issues by organized groups. The opportunity to share these in such hearings as this have facilitated change.

Rather than suggest specific pieces of legislation which are consistent and obvious for the health care needs of older persons, I would like to address the qualities of legislative programs that could facilitate creative approaches to the problems rather than promote only further documentation of them. Also, I would like to share a perspective on these problems from one discipline and community of health care providers, that is nurses, with the aim of adding to the potential for legislative problem-solving. The relevance of this perspective is based upon their close experiential proximity to the consumer.

Legislative initiatives should give attention to new programs of intervention that go beyond the traditional approaches. It has been suggested that incentives for families to care for their older members could be provided in such forms as cash assistance, tax credits or deductions, and home delivered services. Likewise, incentives for private sector, or public and private

sector collaboration to provide adult day care and respite care could expand current options. The program, "a nursing home without walls," coordinated by registered nurses in Fulton and Montgomery counties of upstate New York is an example of the type of program needed. This program allows elderly with health care needs to stay at home with a nurse and nurse supervisor on call for assistance to families 24 hours a day seven days a week. Patients who are alone wear a telephone-monitoring device. Legislation needs to be constructed to facilitate such creative interventions.

Further, programs of health care services should be rewarded for capitalizing on the resources that exist within the community of older persons itself. For instance, the development of programs of visitations for frail elderly by well elderly would reinforce self-sufficiency within the community. The utilization of nurses to train families and friends to provide in-home services would foster independence and autonomy. The point I am making here is for the monitoring and evaluation of legislative development to avoid legitimizing programs of health care that decrease appropriate choice, independence and self-responsibility.

The facilitation of health promotion and disease prevention in the elderly also needs to be given legislative priority. While the needs of the elderly requiring extensive services seems the most pressing, the value of incentives for wellness has a great potential for positive outcomes. The development of health plans common for the employed have relevance for supporting older people to stay healthy as well. An example of health promotion activities is the Shepherd Center concept which exists in some localities. Older persons form a community of self-support and ~~illicit~~ Solicit assistance from health care providers to learn good self-care practices. The focus on consumer education for continuing health care needs is also an aspect of health promotion and disease prevention.

Assistance in the production of materials and use of peer education is essential.

Another pressing problem that is beginning to face us is the shortage of nurses. Hospitals are providing increasingly high incentives for recruitment of nurses into acute care. Some local hospitals for instance give a $2,000 entry bonus to new nurses, and also pay high differentials for weekend coverage. Long term care facilities are already unable to compete with hospitals in terms of wages and benefits. Assistance may be needed to prevent a dramatic drain of well-qualified nursing staff from nursing homes.

Finally, legislative approaches to financing research and educational opportunities in the area of health care for the elderly is crucial. Research focused on the study of physical aging and diseases associated with age is on the rise. Support for research on clinical intervention and therapeutic programs is lacking. Programs of research support, such as the one for research on the economic development of the state could be applied to this area. The recruitment and education for gerontology health-care careers is extremely difficult since it appears unattractive and unrewarding to those in a position to be making career choices, that is college-age individuals. Support is needed here to avoid future problems in availability of health-care professionals. Graduate education in gerontology is needed to provide for advanced practice.

The emphasis on this presentation has been on qualities or features of legislative program initiatives to address the health care needs and problems of the older citizenry of South Carolina. I appreciate the opportunity to share nursing's perspective, and also to offer our support in legislative development.

McLeod - I see in the ads where people can subscribe to a service that allows someone to use an electronic device that will contact help if assistance is needed. Do we have that system available in S.C.?

Cowling - Not that I'm aware of but other people may know.

McLeod - As far as you know have these programs in other states been truly a private enterprise initiative or some cooperative programs where a state has participated in helping it.

Cowling - Some of the efforts that I know about reported in the nursing literature are reported as parts of larger programs that are funded by the state that might be part of the State Health Department program.

Judith P. Baskins
Elder Care Plus
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Columbia, SC 29203

JOINT LEGISLATIVE
COMMITTEE ON AGING
PUBLIC HEARING
September 14, 1988

SPEAKER: Judith Pinner Baskins, R.N.
Director of Palmetto SeniorCare
Richland Memorial Hospital
5110 Fairfield Road
Columbia, South Carolina 29203
765-7850

On behalf of Richland Memorial Hospital, I would like to join the South Carolina Hospital Association and the Council on Elder Affairs in their support of the priority categories of the South Carolina Commission on Aging.

The Hospital Association's Task Force on Aging and Long Term Care is actively encouraging hospitals to begin to address the needs of the elderly in areas such as long term care.

Richland Memorial Hospital, in conjunction with the South Carolina Department of Health and Environmental Control, is currently involved in the development of a Risk-Based Long Term Care replication, based on the On Lok model in San Francisco. As one of six sites chosen nationally, we represent the only area in the Southeast.

The purpose of the program is to provide a community based outpatient "continiuum of care" with all medical, health and supportive services needed for the elderly to remain in the community.

The philosophy of the program is two fold:

1) To maximize the independence of the frail elderly.

2) To maintain the frail elderly in their homes and/or community for as long as it is medically, socially, and economically feasible.

The first phase in the program development has been to establish a Day Health Center in the Eau Claire area. Unlike our traditional Adult Day Cares and Medical Day Cares, the focus of our target population are those persons who are frail with multiple health care problems. Criteria for admission are based on the intermediate and skilled levels of care as defined by Community Long Term Care.

By providing the elderly and their families an alternative to institutionalization, we may allow them to remain in the place that they know the best - their home. Hopefully, this will reduce unnecessary institutionalization, allowing more beds to be available for persons who truly need a more intensive level of care.

Our program allows family members to continue to work, or provides the opportunity for respite from the day to day burden of providing for the care of these types of patients.

Within the center, services are provided such as nursing care, personal care, physical therapy, occupational therapy, speech therapy, medical social work, nutritionist and recreational therapy. Each discipline evaluates participants routinely at admissions, quarterly or more frequently if their condition warrants. Plans of care are developed not just with a rehabilitative focus but with an emphasis on helping the participants maintain their existing functional level.

Transportation in a specially equipped van is also provided to bring participants to and from the center.

By combining the services in the Day Health Center with those of Home Care and Personal Care Aide services, we have been able to provide continuity of care between all levels.

A special Multidisciplinary team, composed of center staff, representatives from DHEC Home Health Services and Personal Care Aide Program, Community Long Term Care and the Council on Aging, develop and/or recommend plans of care involving all components of services.

As noted in the priority categories developed by the Commission on Aging, we must all continue to look for creative and innovative approaches to dealing with the long term care needs of the elderly. Programs and services that are designed to allow the elderly to remain in the community, to remain relatively financially independent and provide support to the care giver are needed. While our program is one approach that we hope will prove to provide a quality service in an economically feasible manner, there are also other areas needed such as Adult Foster Care, Social and Medical Day Care and easily accessible transportation to the service delivery systems.

Robin Fantl
Irmo Chapin Recreation Commissio
Aging Program
200 Leisure Lane
Columbia, SC 29210

LEGISLATIVE PUBLIC HEARING

SEPTEMBER 14, 1988

ROBIN FANTL, SPEAKER

GOOD AFTERNOON, LADIES AND GENTLEMAN,

I APPRECIATE THE OPPORTUNITY TO VOICE MY SUPPORT FOR THE RECOMMENDATIONS AND APPROACHES TO CONCERNS WHICH FACE OUR OLDER CITIZENS, AND CAREGIVERS OF OLDER ADULTS, ENUMERATED BEFORE YOU TODAY.

AS OUR ELDERLY POPULATION ESCALATES, STATEWIDE EFFORTS MUST BE OF PRIMARY CONCERN. THE NEEDS OF OUR OLDER CITIZENS DIRECTLY AND INDIRECTLY IMPACT THE TOTAL POPULACE OF OUR STATE. CHILDREN ARE IMPACTED UPON WHEN THEIR PRIMARY CARETAKERS MUST BECOME CARETAKERS OF OLDER LOVED ONES, THE WORK FORCE IS IMPACTED UPON WHEN THE SANDWICH GENERATION MUST PROVIDE FOR THE NEEDS OF OLDER LOVED ONES, AND OUR OLDER CITIZENS THEMSELVES ARE IMPACTED UPON WHEN WE PROVIDE ALTERNATIVES AND CHOICES WHICH ALLOW THEM TO MAINTAIN THE RIGHT TO SELF DETERMINATION. OUR COMMITTMENT TO OLDER ADULTS MUST BE MULTIFACETED, AS THE EFFECTS OF THEIR NEEDS ARE SOCIAL, EMOTIONAL, PHYSICAL, AND FINANCIAL IN SCOPE. AS A SOCIETY WE CAN ENHANCE THE POSITIVE ASPECTS OF GROWING OLDER AND THE RESPONSIBILITIES OF CAREGIVING THROUGH LEGISLATIVE SUPPORT FOR PROGRAMS AND SERVICES WHICH ENABLE OLDER CITIZENS TO REMAIN IN THE COMMUNITY.

WITH THE RAPID GROWTH OF THE OVER SIXTY AGE GROUP IN SOUTH CAROLINA WE HAVE A UNIQUE OPPORTUNITY TO SET A PRECEDENT, AND MAKE A STATEMENT ABOUT THE QUALITY OF LIFE FOR ALL PERSONS, AND INSURE THAT OUR OWN OLD AGE IS PROVIDED FOR IN AN ACCEPTABLE MANNER.

OUR SOCIETY IS THE VIVID REFLECTION OF CHANGING POLITICAL AND ECONOMIC CLIMATES. SOUTH CAROLINA IS A PRIME EXAMPLE OF ALTERNATIVE CARE COMING FULL CIRCLE. UNTIL THE EARLY 1960's LOVED ONES WERE PRIMARILY CARED FOR IN THE HOME ENVIRONMENT. THEY WERE NOT ISOLATED OUTSIDE OF THE MAINSTREAM. WITH THE ADVENT OF TITLES XVIII AND XIX, MEDICAID AND MEDICARE, THE NURSING HOME INDUSTRY SNOWBALLED. FINANCIAL ASSISTANCE, BOTH STATE AND FEDERAL, BECAME, AND REMAINS, AVAILABLE FOR NURSING HOME PLACEMENT. TODAY, IN SOUTH CAROLINA THERE ARE SOME 333 LONG TERM CARE FACILITIES REPRESENTING PUBLIC SUPPORT OF SOME 29,975 BEDS. THIS REPRESENTS AN ENORMOUS PERCENTAGE OF THE TOTAL TAX DOLLARS ALLOCATED FOR CARE FOR OLDER ADULTS. NURSING HOMES ARE LIMITED IN THE SCOPE OF PERSONS THEY CAN SERVE. WITH SHRINKING DOLLARS AT ALL LEVELS WE HAVE BEGUN TO FOCUS ON OTHER AVENUES OF SUPPLYING CARE IN LESS COSTLY, MORE EFFICIENT FORMS, TO A WIDER SEGMENT OF THE OLDER POPULATION. FAMILIES HAVE AGAIN BECOME THE PRIMARY FOCAL POINT FOR THE COMMODITY OF CAREGIVING.

DURING THE 87 - 88 LEGISLATIVE YEAR SEVERAL BILLS WERE ENACTED WHICH SIGNIFICANTLY DECREASED THE FINANCIAL BURDENS ASSOCIATED WITH CAREGIVING. AMONG THESE WAS A TAX CREDIT FOR CAREGIVERS WHO EMPLOY IN-HOME HELP BECAUSE THEY HAVE TO WORK. HOWEVER, MANY CAREGIVERS ARE UNABLE TO LOCATE SUITABLE IN-HOME HELP, AND MANY OLDER ADULTS WHO NEED FULL-TIME CARE ARE NOT NECESSARILY HOMEBOUND. THESE OLDER ADULTS WOULD BENEFIT FROM THE SOCIALIZATION, INTERACTION AND OTHER ASPECTS OF ADULT DAY CARE.

THE AVAILABILITY OF BOTH MEDICAL AND SOCIAL DAY CARE IS VERY LIMITED, AT THE PRESENT TIME, IN SOUTH CAROLINA. THERE ARE

ONLY 24 ADULT DAY CARE CENTERS WITH A TOTAL CAPACITY OF 700 CLIENTS. DAY CARE IS EXPENSIVE FOR FAMILIES WHO ARE NOT CARING FOR A MEDICAID ELIGIBLE LOVED ONE. THEY ARE CHARGED AT THE RATE PER DAY WHICH MEDICAID ALLOWS. THAT RATE IS OVER $34.00 PER DAY. THIS CREATES A FINANCIAL BURDEN WHEN THE FAMILY MUST PRIVATELY BEAR THIS EXPENSE. MANY CAREGIVERS ARE THEMSELVES OLDER SPOUSES LIVING ON LIMITED INCOMES. THEY SAVE UNTOLD TAX DOLLARS THROUGH PROVIDING AT HOME CARE FOR IMPAIRED, INCAPACITATED LOVED ONES. THEY PERFORM A JOB 24 HOURS A DAY, 365 DAYS A YEAR WHICH TAKES THREE SHIFTS OF EMPLOYEES TO DO IN ANY GIVEN FACILITY. THESE CAREGIVERS NEED OUR SUPPORT.

IT IS A LOGICAL LEGISLATIVE PROGRESSION TO SUPPORT THESE CAREGIVERS THROUGH ENACTING A BILL PROVIDING TAX CREDIT FOR ADULT DAY CARE FOR PERSONS PRIVATELY FOOTING THE BILL FOR SUCH CARE. ADULT DAY CARE IS A VITAL PROGRAM WITHIN THE CONTINUUM OF CARE FOR OLDER ADULTS. IT IS ONE ASPECT OF THE CONTINUUM WHICH ENHANCES THE QUALITY OF LIFE FOR BOTH THE OLDER IMPAIRED ADULT AND THE CAREGIVER. DAY CARE HAS THE POTENTIAL TO SERVE A LARGER PROPORTION OF THE OLDER POPULATION IN A SIGNIFICANT MANNER AS IT ALLOWS THE OLDER PERSON TO REMAIN IN THE HOME AND THE COMMUNITY, AROUND FAMILY, FRIENDS, AND FAMILIAR SURROUNDINGS WHILE PARTICIPATING IN SERVICES WHICH STRIVE TO DELAY OR NEGATE THE NEED FOR INSTITUTIONAL CARE.

TAX CREDITS ARE A KEY COMPONENT WHICH WILL FINANCIALLY ALLOW FAMILIES TO CONTINUE SHARING THE RESPONSIBILITY OF CARE FOR OUR OLDER CITIZENS. THESE TAX CREDITS MUST BE EXPANDED TO INCLUDE THE COST OF DAY CARE IF WE ARE TO MAINTAIN THE OLDER INDIVIDUAL'S SENSE OF INTEGRITY WITHIN THE LARGER FAMILY UNIT.

The South Carolina State Library

Department for the Blind and Physically Handicapped

301 GERVAIS STREET
P.O. BOX 821
COLUMBIA, SOUTH CAROLINA 29201

PHONE 737-9970
TOLL FREE 1-800-922-7818

Frances K. Case
SC State Library Dept. for Blind
and Physically Handicapped
301 Gervais St., P. O. Box 8[illegible]
Columbia, SC 29202

BETTY E. CALLAHAM
DIRECTOR
SOUTH CAROLINA STATE LIBRARY

FRANCES K. CASE
LIBRARY SERVICES FOR
THE HANDICAPPED

Testimony Presented
at
Public Hearing
September 14, 1988
to
Joint Legislative Committee on Aging
by
Frances K. Case

The best things in life are free! This is not about what could be done with additional money but what is available now with current funding. The S.C. State Library for the Blind and Physically Handicapped in cooperation with Library of Congress National Library Service serves readers of all ages. Older adults are a big part of that group. Of the 28 million Americans over 65, many have trouble reading conventional print. Some cannot hold a book or turn the pages because of a physical impairment. Since there is no reason to lose touch with the joy of reading even for a short while, participation is encouraged when the condition is a temporary one such as eye surgery, broken hands or arms, or being placed in traction. Use of this service brings excitement, adventure, and pleasure in addition to improving the quality of life in general. Books and magazines are available in large print, and recorded on disc and tape as well as in braille. Record players and cassette playback machines to play books recorded at special speeds are available on loan. A cassette machine designed primarily for elderly persons is the newest equipment available. This equipment is easy to operate and is replaced quickly if any problems develop or repair is needed. Special accessories such as light weight headphones; pillow speakers for readers confined to bed; and remote control units that can be operated by touch or with an optional breath attachment are also available.

Families and other care givers need to be aware that the talking book program is available to help people keep active, stimulated and interested in the world around them. Since users can choose to hear what they want to read, this library service gives older people a sense of control over their lives and helps them stay active mentally. No postage and no wrapping are required for mailing. More than 43,000 biographies, bestsellers, classics, mysteries, romances, westerns, poetry books, histories, children's and how to books are available in addition to more than 70 popular magazines. Instructional music materials, book reviews, and some foreign language titles are also available. Borrowers may choose their owm books or have the library choose titles based on their reading interests.

Books are chosen for the library collection on the basis of their appeal to a wide range of interests. Titles expected to be extremely popular are produced in large number so that they may be circulated to borrowers within several months of their publication. Magazines such as U.S. News and World Report, National Geographic, Reader's Digest, Sports Illustrated and Guideposts are available and recorded versions are received at about the same time as the print copies.

Catalogs are produced annually in addition to Talking Book Topics which is a bi-monthly publication listing new titles available. Currently, the library is serving about 7,000 persons, about half of whom are age 65 or over or in nursing homes. Service can be started for new readers as soon as completed applications are received. All public libraries and some other state agencies have applications available. Applications are mailed upon request. We have a twenty four hour toll-free number 1-800-922-7818. I have applications with me today and invite everyone to visit our library at 301 Gervais Street. The Tax Commission and the State Museum are our neighbors.

We appreciate the continued support from this committee. It is our pleasure to serve our print-handicapped citizens of all ages.

Harris - You did say that these application are available at all local libraries.

Case - Yes sir. I have some extra ones if anybody wants one. I would like to invite this Committee to meet in the library at any time or come for a tour at your personal convenience.

Harris - Thank you! We'll try to have a meeting and tour at the same time.

RECOMMENDATIONS TO THE JOINT LEGISLATIVE COMMITTEE ON AG[illegible]

FROM THE SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

SEPTEMBER 14, 1988

Dr. Joseph Bevilacqua
Nancy Carter
Department of Mental Heal[illegible]
2414 Bull Street
P. O. Box 485
Columbia, SC 29202

From January 1, 1988 to June 30, 1988, the Department of Mental Health admitted approximately 271 individuals 65 years of age and older, under emergency psychiatric commitment papers. Of these, 223 or 80% had no mental illness. Of these individuals 19 had to be sent directly to a medical facility to treat their physical ailments; 61 have died; and there are currently 179 who require Intermediate or Skilled levels of nursing care services and are awaiting placement; 109 of these who are at Crafts-Farrow State Hospital, Byrnes Medical Center and Harris Hospital are Medicaid eligible and are waiting for Medicaid funded nursing home beds that do not exist.

These people require a level of care that the Department is not staffed or funded to provide. They are retained at the Department "pending suitable placement." In facilities that are not certified to provide nursing care services in violation, we believe, of their civil rights and their rights to receive appropriate treatment in the least restrictive environment.

RECOMMENDATIONS:

1. Under the leadership of the Joint Legislative Committee on Aging, the Governor's Legislative Committee on Mental Health and Mental Retardation and with the active involvement of other appropriate legislative committees, the Long Term Care Council and other State agencies and interested individuals, study and define the following policy issues:

A. The role of the State in providing nursing care services to the people of South Carolina needs to be examined. The scope of those services in relation to the private sector, the availability of resources and the need to insure that facilities and services meet acceptable standards are all critical issues.

B. Through incremental decisions designed to respond to specific needs and issues over many years, the Department of Mental Health has become the caretaker of over 1500 people who need nursing care services. The State has assumed a role in providing nursing care services almost by default. Before committing even more resources to this expensive level off service delivery, a conscious decision needs to be made as to whether the State wishes to continue to meet this need as recommended above and if so, to determine which agency is the appropriate one to provide it.

2. There are a number of legislative issues that also need to be examined:

A. The use of the psychiatric emergency and judicial commitment processes to provide medical and nursing care services to individuals who are unable to secure these privately for economic or other reasons raises some fundamental questions about patients constitutional rights to the least restrictive and most appropriate level of care. If the State is to provide nursing care services, legislation needs to be developed to allow the State to provide these services to people on a basis other than a psychiatric commitment.

The Department's burden in caring for people who have no mental illness and no other place to go continues to grow and compromises its capacity to carry but its primary mission to treat seriously mentally ill children, adults and elderly. With the implementation of the Federal Nursing Home Reform Act, the State and the Department may be faced with some difficult decisions about converting existing nursing home beds to ones certified to treat severely mentally ill elderly who need concomitant nursing care services. It is for all of us an expanding crisis.

McLeod - You say 80% of these clients have no mental illness. What was wrong with them?

Bevilacqua - This deals with the folks that are indigent, have run out of insurance and need some type of protective care. They may be in a hospital, they may be at home. There are situations where families can no longer deal with these folks. So the only way is to move them into a setting that can provide them some care. Unfortunately too often Crafts Farrow becomes the only available service that can pick these folks up. These are the ones we are talking about.

McLeod - The court is saying they need to be committed, to find an outlet.

Bevilacqua - They're sending them to us under commitment statute. The fact is that these people are not mentally ill. The court recognizes that but the court has no other place to send these folks. So we are in essence the only game in town.

McLeod - Has the legislation about people sending you the alcoholics been of any help? Don't you look at them to see whether or not you are going to take them.

Bevilacqua - We do deal with alcoholics through a statute that was passed several years ago and that's an appropriate statute that the court is using more community services. When they come to us, they come because they indeed do have an alcohol problem as designated by the court. These folks that we are talking about are elderly, usually poor and have a physical condition that can no longer be taken care of wherever they are. We are the only facility that has some capacity to deal with it. We feel that often it is not adequate placement because Crafts Farrow is a psychiatric hospital not an acute care medical facility but because there is no other place to go that's how we get them. It's very difficult for the Department to simply turn these people back and send them from where they came because they are often in very fragile condition.

McLeod - Is Ms. Rowe still here? or maybe I'll ask anybody? It seems to me because all the studies say that we are going to have more and more elderly and get more and more expensive, we are going to have to deal with it. Is anybody aware of this need under the volunteer program? You've got an awful lot of folks that are 60 to 70 even 80. Some folks that I know who are 60 and 65 are about to go bananas really trying to find something to do. Are these volunteer programs? Do you know if anyone has had any success. Now I know that some of the churches are doing it but has there been any movement through the churches to try to get something coordinated to help in this regard? The churches for example have really backed off because the state is doing more. However there is alot of manpower that could help and wants to volunteer to help if we could figure how to funnel it. Has anybody ever addressed that?

Harris - I don't think we have even addressed that at the Committee level. I'm aware of what you are talking about and it's out there. I don't know what you are addressing to Dr. Bevilacqua as to whether they might fit in to any program that he has but they have a number of volunteers. We have the Mental Health Association and the Alliance for Mentally Ill. Do you have any specific areas?

McLeod - Not for him. It would seem to me.

Bevilacqua - There's no question that this population would represent needs that a good volunteer program in a community or in a church that could provide assistance. I think the patients that we are talking about though Senator, are usually seriously disabled. They are going through acute medical problems.

McLeod - They need to be in a skilled nursing home facility. Is that what you are talking about?

Bevilacqua - Exactly. Often they do have compounded medical problems. The number of deaths we have with some of these suggest that they are quite frail.

Blackwell - How many total patients have you now in care in the department?

Bevilacqua - Department wide about 3200.

Blackwell - Of that over 1500 of them need nursing care services that are not appropriate to the care you are giving?

Bevilacqua - That's correct.

Blackwell - Of 3200, 1500 shouldn't be there?

Bevilacqua - That's our question. (Nancy Carter, DMH staff asked to respond).

Carter - The 1500 include Tucker Center and Harris Hospital.

Bevilacqua - I think the question Mr. Blackwell is asking is, "How many do we have who are currently in Crafts Farrow and Harris?"

Carter - We have about 1200 certified nursing home-nursing care level beds but between the people that come in Crafts Farrow and Harris Hospital we have a larger number of those who need that level of care.

Bevilacqua - How many are there?

Blackwell - Do you follow what I'm trying to say -- your testimony is that you have over 1500 people who need nursing care services that the state has assumed a role almost by default by implication. Your testimony is that they don't belong there. You really have them just because decisions have been made in the past that you've taken these people in.

Bevilacqua - With the exception that we do have a nursing facility at Tucker Center that can take some of those clients, this is insufficient to cover the traffic that we have.

Blackwell - So what I'm trying to drive at is what percentage of your total patient load is that 1500?

Bevilacqua - I would say almost 60-40 is the split between what I would consider psychiatric patients.

Blackwell - In other words 40% of the patients that you are treating don't belong there.

Bevilacqua - Well I can't quite say that because we do have nursing facilities.

Harris - How many nursing home beds do you have?

Bevilacqua - At Tucker Center, we have roughly 650 beds at Dowdy-Gardner in Rock Hill there are 220 beds and Dowdy-Gardner, Columbia campus has 320 beds. Roughly around 1190 that are nursing home beds.

Blackwell - Alright you got 1500 patients in those 1100 beds. So you have 400 too many, is that what we are saying?

Bevilacqua - We overflow at Crafts Farrow, Harris, and other places when traffic gets heavy.

Blackwell - Is that correct? When we talk about 1500 we are only talking about 400 too many.

Carter - We are talking about 400 who can not go into nursing care beds because it's not available.

Blackwell - So we've got them in mental beds.

Carter - Yes.

Blackwell - The problem is really those 400.

Carter - Yes and the ones that continue to come in.

Harris - I had an occasion to look at a national publication that showed the standing of various state institutions of Mental Health. Our SC facility was rated as having made significant improvements. There were a number of states that had remained still. Some had gone backward and done nothing at all within the last year. This report showed that the SC Department of Mental Health had made significant improvement and I thank you for that.

ORAL TESTIMONY BEFORE THE JOINT LEGISLATIVE COMMITTEE ON AGING

RICHLAND COUNTY MULTIDISCIPLINARY ADVISORY COMMITTEE

SEPTEMBER 1988

Pat Harmon
Council on Aging
1800 Main St.,
Columbia, SC 29201

Distinguished officials and interested persons: Our group, the Richland County Multidisciplinary Advisory Committee, represents 14 organizations, county, state, federal and private, who serve older adults on a daily basis. Our clients are from a diverse socioeconomic background but face common problems they cannot handle.

Two major problems are a lack of resources to assist older persons not covered by medicaid or drug insurance with purchase of prescription medications and lack of transportation for health impaired frail elderly requiring escort services.

Many aging persons experience health problems which require prescription medications to stabilize multiple chronic conditions. It is not uncommon for monthly medications to average $200, or up to 30 percent of a person's fixed monthly income. For persons on limited incomes who do not qualify for medicaid or drug insurance the impact of this expense can be disasterous. Negative areas of ecological impact include: medication purchase in lieu of maintenance of regular expenses such as rent, utilities and life and health insurance; or medication purchase in lieu of maintenance of good nutrition; or partial purchase of medications.

These inadequate coping mechanisms combine and result in preventable health crises, emergency general and psychiatric hospitalizations and jeopardization of independent living because very often no financial or resource cushion exists to meet the medical expenses incurred from chronic health impairment.

Many older adults who cannot afford monthly medications have no reliable transportation and escort services. However, older persons with adequate financial resources are just as likely to have transportation difficulties.

Imagine, if you will, the quandry of a 78 year old, widowed female who lives alone, has glaucoma, is legally blind in one eye, experiences dizziness and shortness of breath, has arthritis, uses a walker and has very limited access to her adult children. Whether her monthly income is $580.00 or $1580.00 she needs someone to be with her while she is away from home. Persons living in rural areas have even greater difficulty obtaining transportation than do urban dwellers. The transportation services now available to the elderly are needed but are inadequate.

General utopia pictures retirement as a time to enjoy life and meet our own needs through our own resources and resourcefulness. Some of us may find utopia; many of us will not. Our hope is to help older people come closer to the dream of utopia through your legislative efforts.

Assistance in obtaining prescription medication could be through use of a "drug card," incentives to pharmacies to discount particular medications, or incentives to pharmaceutical companies to donate medications to local distribution points. Transportation and escort services could be generated through incentives to private indiciduals volunteering through an established volunteer or transportation program.

Thank you for hearing us. Thank you for remembering that an older person in need could be our father or mother or it could be us.

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STATEMENT OF THE STATEWIDE COMMITTEE TO STUDY THE NUMBER AND PLACEMENT OF AREA AGENCIES ON AGING IN SOUTH CAROLINA

TO THE
JOINT LEGISLATIVE STUDY
COMMITTEE ON AGING

September 14, 1988

Federal law requires that the S.C. Commission on Aging divide the State into substate Planning and Service Areas (PSAs) and that an Area Agency on Aging (AAA) be designated for each of those areas. The original designation of PSAs in the early 1970's followed the same lines as the ten Economic Development Districts, within which the Councils of Governments (COGs) operate, and in all except one of the PSAs the COG was designated as the Area Agency on Aging.

There have been several changes in regions and organizations designated as Area Agencies on Aging, which have occurred piecemeal during the 1980's. There have also been changes in Federal requirements which have increased the responsibilities of AAAs, without corresponding increases in funding.

As a result of all these factors, three different studies related to this issue have been conducted over the past several years; however, no final resolution of the issue was achieved. The configuration issue continues to be a complex one and is the source of a significant amount of tension in the Aging Network. Now that the Commission on Aging has completed a transition in leadership and a reorganization of its staff, the timing was appropriate to initiate a process to bring that issue to final resolution.

The Statewide Committee to Study the Number and Placement of Area Agencies on Aging in South Carolina was established by the Commission to review all of the existing data that was collected in previous studies, to receive input and additional data from interested parties, to analyze all of the information collected and to develop a recommendation to the Commission on the best configuration for the Aging Network in South Carolina. The Committee has met four times and based on its progress thus far, expects to complete its work in early spring, 1989. If a change in configuration is recommended, it would be effective July 1, 1990.

The Committee is a broad-based group, with representatives of all levels of the Aging Network, the Governor's Office, the General Assembly, and other public and private groups and organizations. A membership list is attached. The Committee welcomes the input and involvement of the Joint Legislative Study Committee on Aging as well as other members of the General Assembly in this important task.

Note: Dr. Joyce Tolbert, Chairman, was unable to attend the hearing due to a conflict. This statement was submitted by William Wells, Director of Planning and Research, S.C. Commission on Aging, staff member assigned to the Committee.

Statewide Committee to Study the Number and Placement of Area Agencies on Aging in South Carolina

Name	Representing
Dr. Joyce Tolbert, Chairman Columbia	Governor Campbell
Honorable Patrick B. Harris Anderson	Joint Legislative Committee on Aging
Ms. Keller Barron Columbia	Joint Legislative Committee on Aging
Ms. Mary Gail Douglas Winnsboro	Council on Aging Directors
Ms. Leila McMillan McCormick	Single County AAA Directors
Ms. Connie Shade Aiken	AAA Directors
Mr. James Darby Sumter	AAA Host Agency Directors
Ms. Nancy Patrick Columbia	S.C. Gerontological Society
Mr. Albert M. Baldwin Hilton Head Island	American Association of Retired Persons
Mr. Julian W. Culler, Jr. Columbia	American Association of Retired Persons
Mr. Don Caughman Columbia	S.C. Federation of Older Americans
Ms. Josie Claiborne Columbia	Private Sector
Dr. Robert Carswell Columbia	Private Sector
Ms. Lillian McCreight Columbia	State Agencies
Dr. Donald Blackman Columbia	State Agencies

Membership list cont.

Name	Representing
Mr. Phillip Grose Columbia	State Agencies
Ms. Miriam Patterson McCormick	S.C. Council on Elder Affairs
Mr. Joseph Strickland Columbia	Commission on Aging

TESTIMONY

SUBJECT: Support for the South Carolina Registry for Dementing Illnesses--presented before the Joint Legislative Committee on Aging

DATE: September 14, 1988

PRESENTER: Quincy S. Neal, Executive Director
American Heart Association
South Carolina Chapter

South Carolina has been among the top ranking states in the United States for coronary heart disease and stroke among all age groups. The Pee Dee region of South Carolina may lead the nation in having the highest cardiovascular disease mortality. Although mortality statistics represent the end result of the disease state, they do not address the cost of cardiovascular disease in general, or cerebrovascular disease in particular, to the State of South Carolina. Multi-infarct dementia, an effect of the cerebrovascular disease process when one or more strokes have occurred, is estimated to be the second most common cause of dementia nationwide. However, there are few good studies to predict how many patients with cardiovascular disease and stroke will develop multi-infarct dementia, and whether there are differences in the rate of dementia in white versus black populations. I am appearing before you today to give testimony that addresses these issues. I want to support strongly the continuation funding of the South Carolina Registry for Dementing Illnesses.

The South Carolina Chapter of the American Heart Association has been active in supporting research on cardiovascular disease, especially studies to identify factors that can reduce

cardiovascular mortality. Although there has been a significant decline in mortality from cerebrovascular disease (stroke) in South Carolina since the 1960s (5% to 50%, depending on race and sex), South Carolina continues to have significantly higher rates than the nation as a whole. In 1982, according to statistics from the National Center for Health Statistics, for all age groups from 45 years of age on, the South Carolina rate per 100,000 for death due to cerebrovascular disease was and continues to be significantly higher than the U.S. rate. It is almost double the U.S. rate for those persons between 45 and 74 years of age.

South Carolina, like other southern states, has a large nonwhite population, representing about 33% of the total. In our state, the rate of cerebrovascular mortality for nonwhites is 156% of the average rate for the nonwhite population of the entire United States. Comparison of the nonwhite to white stroke rates within South Carolina indicates that nonwhite males and nonwhite females have had and continue to have markedly higher mortality than their white counterparts over the past 20 years--two to three times greater.

By 1990, more than 1.3 million residents of the state, about 43% of the total population of South Carolina--will be over age forty and at increased risk of cerebrovascular disease. Multi-infarct dementia (MID) is thought to be very common in this state because high blood pressure is a major suspected risk factor, and among all the states, South Carolina has the top ranking for both hypertension-related strokes and coronary heart disease among white

males ages 35-54. Although we have begun to effect a decline in mortality in cardiovascular diseases in South Carolina, we can make no good estimates of changes in the rates of MID. In part this is because no other registry has such a large segment of blacks in its catchment area. Other registries from which rates for multi-infarct dementia can eventually be derived cover primarily caucasian populations.

With the cost of medical care escalating, it is urgent that the limited resources of the state be channeled to the most effective uses. To this effort, the South Carolina Chapter of the American Heart Association strongly advocates for the continuation funding of the South Carolina Registry for Dementing Illnesses either through the Commission on Aging's budget or by separate legislation, whichever route will ensure support of this effort. The impact of this chronic disease registry cannot be underestimated in providing clear statistics on the incidence of multi-infarct dementia and cerebrovascular disease in South Carolina. This is particularly critical because of the large nonwhite population in South Carolina, which makes extrapolation from the data of other registries to our state inappropriate.

The South Carolina Registry for Dementing Illnesses will permit clear identification of the rate of multi-infarct dementia in white and nonwhite populations in South Carolina, provide information on its natural history, provide data for descriptive and analytic epidemiological studies (including risk factors and protective factors), monitor medical and social services provided to multi-

infarct dementia victims, and assess unmet service needs. Importantly, the dementia registry will also become able to differentiate between the rates of multi-infarct dementia and Alzheimer's disease. This will enhance attention to the different research, medical, and social service needs of multi-infarct dementia. These data are critical for marshaling resources of the state health agencies for both the chronic care of MID victims and also for preventive services. These data are also needed for intelligent policy planning in the future with limited resources. Even though there has been a decrease in mortality in cardiovascular disease, this fact may be misleading in the case of multi-infarct dementia. Indeed, with prolongation of life, the already high rate of this disease may even be increasing.

In summary, I strongly urge you to provide for the continuation funding of the South Carolina Registry for Dementing Illnesses, either within the Commission on Aging appropriation or by separate legislation. With the increasing age of the population in general, and the growing popularity of South Carolina as a retirement state in particular, the importance of this effort cannot be stressed enough.

July 28/1988

JUL 29 1988

DEAR MS. KELLER H. BARRON:

Enclosed is A Copy of the "South Carolina Recoupment Surcharge" document, which I Received with my Auto Insurance policy Renewal papers this month, and for which I was assessed $73.00!!

This surcharge, if I understand it right, is <u>TO ASSURE Automobile coverage to Qualified South Carolina drivers who cannot get coverage in the Voluntary market.</u>'b

My Questions are as follows:

1- IF these people are <u>Qualified</u> South Carolina drivers, <u>why do we</u> have to pay for their insurance?

2- IF they are <u>Not</u> Qualified drivers, why are they being allowed to drive?

3- I assume that we've been paying for these people all along without knowing it so the question is how was it done, & why weren't we

II

told about it.'
+ Is it legal to assess someone under the guise of Auto Insurance, & not notify them that they are being assessed by the Government? (If it is legal, then I'd say that our Laws needs changing.!)

I called the State Dept. of Insurance to-day, & found out that this surcharge is assessed on <u>each car</u> in the State of S.C., & that we've got 1,375,000 cars (to the best of their knowledge) operating in the state.
A simple computation of 1,375,000 X $73^{00} = $100,375,000^{00}$!! This is using the 73^{00} assessment which is used for "Good drivers" only — I understand that depending on your driving record it could be much higher.!
Now, I am a 65 year old Retiree & forced to live on a Fixed income, so

when I recieved my insurance bill for our single car & noted that it had increased $103 again this year (from $552.05 to $655.05), then to discover that $73 of that is to benefit other S.C. drivers needless to say I was dismayed & decided to follow up on it & passing this info on to you, since you are the DIRECTOR OF RESEARCH FOR the joint LEGISLATIVE Committee on AGING, & possibly in a position to initiate some Relief FOR The Retired driver in South Carolina.

I want to thank you very much FOR the 19th Annual Report of the joint Legislative Committee on AGING which you sent me. Regarding my testifying at your next Public hearing on Sept. 14 of 1988, I'm AFRAID that the fact that I can not hear very well, having Lost just about ALL OF my hearing in the

IV

Right ear & at least half of it in the Left ear I must decline but I Really hope that this Letter could be used instead.

Thank You Kindly,
James G Jardin

JAMES G JARDIN
132 VILLAGE-FARM RD
COLUMBIA SC 29223

☒

GOVERNMENT EMPLOYEES INSURANCE COMPANY
HOME OFFICE, WASHINGTON, D. C. 20076

POLICY NUMBER 952-59-98 DATE ISSUED 07-21-88 PAGE 1

FAMILY AUTOMOBILE POLICY RENEWAL DECLARATIONS

POLICY PERIOD FROM 07-01-88 TO 07-01-89 12:01 A.M. LOCAL TIME AT THE ADDRESS OF THE NAMED INSURED.

CONTRACT TYPE: A-50

ITEM 1
NAMED INSURED AND ADDRESS
JAMES G JARDIN
132 VILLAGE FARM RD
COLUMBIA SC
29223-4401

THE INSURED VEHICLE(S) WILL BE REGULARLY GARAGED IN THE TOWN AND STATE SHOWN IN ITEM 1, EXCEPT AS NOTED HERE:

CURRENT ANNUAL PREMIUM	$622.35
CURRENT BALANCE CREDIT	$32.65

NO AMOUNT DUE

YOUR PREMIUM INCLUDES A $73.00 RECOUPMENT SURCHARGE AS REQUIRED BY LAW.

COUNTERSIGNED BY AUTHORIZED REPRESENTATIVE

* * * * OFFICE USE ONLY * * * *
* REG III FILE LOCATION 4 *
* 8-39 *
* * * * * * * * * * * * * * * *

U-31-DP

GEICO

Regional Office:
4295 Ocmulgee East Blvd. ■ Macon,, GA 31295-0001

■ Government Employees Insurance Company
■ GEICO General Insurance Company

SOUTH CAROLINA RECOUPMENT SURCHARGE

The South Carolina Reinsurance Facility is a state mandated program established to assure automobile coverage to qualified South Carolina drivers who cannot get coverage in the voluntary market.

All companies writing automobile insurance in the State must belong to the Reinsurance Facility. The South Carolina Reinsurance Facility has recently introduced a new procedure for recovering the Facility's private passenger automobile operating losses. The losses will be recovered by use of a recoupment surcharge on your policy. This change applies to policies effective on or after July 1, 1988.

YOUR POLICY HAS NOW BEEN ADJUSTED TO INCLUDE THIS SOUTH CAROLINA RECOUPMENT SURCHARGE IN YOUR TOTAL PREMIUM.

1988- pd. $73.00 combined with my Auto Ins.
Tax deductable?

M-307-SC (7-88) NB

142

5803 Canterbury Lane
Myrtle Beach, S.C. 29577

June 3, 1988

Representative Patrick B. Harris
Joint Legislative Study
Commission on Aging
212 Blatt Building
Post Office Box 11867
Columbia, S.C. 29211

Dear Mr. Harris,

The present Homestead Tax Exemption Program pays the corresponding taxes to the first $20,000 of the total real property value.

The Homestead Exemption Program was first created in 1972.

Since this time real estate property values have increased, and further increases appear inevitable.

In my opinion, in all fairness to the Senior residents, who live on a fixed income, its about time this Homestead Tax Exemption Program have an increase and be bought in line with the current property value changes.

Your consideration in this matter would be very much appreciated.

Very truly yours,

John J. Stokes

JS/s
cc: Congressman Robin Tallon
County Council Chairman Laurie McLeod

122 Summerall Court
Aiken, South Carolina 29801
August 10, 1988

Rep. Patrick B. Harris
Joint Legislative Study Commission on Aging
212 Blatt Building
P. O. Box 11867
Columbia, South Carolina 29211

Dear Sir:

I am a bit perturbed today.

In August of 1987, I went to the Aiken County Auditors Office to inquire about my eligibility for Homestead Exemption. I am retired and turned 65 years of age in August 1987. I have been a resident of Aiken County since February 1953.

I was told that I would be eligible after January 1988 and that I had to apply for this any time after January 1988 and not before. The clerk went to the trouble of finding out how much tax money I would save. She, however, did not tell me there was a July 15 deadline for applying. My intentions were diverted because I was involved in an automobile accident and was injured. For the record, I was not at fault. I had to undergo surgery and physical therapy, etc. from then until May 1988. I am still waiting for a final judgement in this matter as my attorney is currently involved in a Federal Court case.

I realized last evening that I had better check into my Homestead Exemption. I went to the Aiken County Auditors office today only to find out that I was too late to file for this exemption, July 15 had passed and I would have to wait until January 1989 to file. I did not see any notice in the local newspaper about this approaching deadline; although, there are always notices that taxes are due.

I don't understand all this. If I forget to apply in January 1989 since I can apply at this time then I would have to wait until January 1990, and so on. My tax dollars are paying for all these "goodies" that I am entitled to, IF, I know what they are and when to apply. As a matter of fact, I learned about homestead exemption from a friend of ours in Florida some years ago. Why is it that we who reside in South Carolina are not aware of these advantages? Seems like something is lacking in communication with the public.

Sincerely yours,

Peter A. Makohon

cc: Mr. Earle E. Morris, Jr. South Carolina Comptroller General

Ms. Ruth Q. Seigler, Exec. Dir. South Carolina Commission for Aging.

AUG

[illegible]
St Matthews S.C
Aug. 29, 1988

Walter H. Barron
Director of Research
212 Blatt Bldg.
P.O. Box. 11867
Columbia S.C 11867

The subjects coming up on Sept 14 - are includ-ing important issues but there is one more, "Living with Dignity". I have recently learned there is no place to turn when your'e lost and need some type of help for survival - I'm not talking about free hand outs, but some way to continue on with dignity in society - Due to cancer surgery - [illegible] about a year from working - When I talk to all the agencys that are to help I find no one really puts teeth into the problem -

I wanted to [illegible] a small [illegible] business - offering my home as collateral - [illegible] [illegible] business woman [illegible] [illegible] to [illegible] the need of my [illegible] [illegible] [illegible] [illegible] [illegible] survival. My thinking ability is

[illegible]

in 12 + 14 hours daily - Now would like to work from the home -

I also wanted to get my house Winterized Needed $20,000 against a 30,000 piece of property

Farmers Home - told me I was too old one bank - because I was single and no charge cards -

Some would not even listen.

I also find if I sell my house it will almost be impossible for me to get a loan to buy another home.

Ex: The State Housing Autho - no Good for singles -

Another: you have to make at least 20,000 per year -

There should be some type of loans at low interest and long term so we could handle payments and live in society like other people - You can't die with dignity if you can't live with dignity

I visit anyone [illegible] just [illegible] they find themselves in a financial proble.

One agency told me quote - "why with your income 551[51] [00] S.S. mo you should be entitled to a Farm Home grant" she sends me a booklet but no one tells me how to break thru the red tape - When Seabrook Carter here in St Matthews - swings around in his chair and tells me "At your age I don't want to get involved?"

Please see some of these issues are addressed at the Sept 14 - Meeting

Sincerely

Margaret Lowell
426 W. Bridge St
St Matthews S.C 29135

1-800-655-5837

I would like to see action on -

"Living with Dignity"
Don't push us in the gutter -

"Loans with payments we can afford"
- Not for Housing -

"The Hutch Babies"
Get us our dismissal S S -.

We pay the same taxes as any one else -
We pay the same for gasoline -
We pay the same for Groceries -

TESTIMONY PRESENTED TO
THE STATE OF SOUTH CAROLINA
STUDY COMMITTEE ON AGING
SEPTEMBER 14, 1988

The Memory Disorders Association of the Midlands (MDAM) is a private, non-profit voluntary health organization, chartered by the State of South Carolina and granted tax-exempt status by the Internal Revenue Service. MDAM is dedicated to improving the quality of life of persons who suffer from memory disorders, including the various types of dementia, and the families of these victims.

The Memory Disorders Association applauds the progress made by the State of South Carolina in addressing the devastating problems caused by Alzheimer's disease and similar disorders. The state income tax credit for institutional care, increased funding for inhome and community-based services, and long term care insurance legislation are major steps in recognizing what needs to be done. We ask for your support in expanding these efforts:

1.) <u>More funding for inhome services and caregiver support</u>
The funds allocated by the State legislature for community services and alternative care for the elderly---approximately $750,000 statewide this year---are desperately inadequate. There are waiting lists across the state for inhome services, such as home delivered meals, homemaker services, and respite care. Day care programs are non-existent in most communities, despite the growing numbers of working caregivers. These are services needed not only by persons suffering from memory disorders but by many others with chronic disabilities. We urge you to increase the funds available for such services.

2.) <u>Continued support for the Statewide Dementia Registry</u>
The establishment of a dementia registry operated by the University of South Carolina School of Public Health represents a critical advance in filling the data void that currently exists about dementia victims. Good, sound planning is the best way to conserve and effectively utilize our scarce state dollars. The registry will provide us the kinds of information needed to accomplish that goal. We therefore ask you to ensure adequate funding to provide for the registry's continuation.

Again, we thank you for the support and leadership of this Committee.

Respectfully submitted,
Billy F. Scally
Billy F. Scally
Executive Director
Memory Disorders Association
of the Midlands

August 29, 1988

Representative Patrick B. Harris, Chairman
Joint Legislative Study Committee on Aging
State House of Representatives
Columbia, SC 29211

Dear Rep. Harris:

I am writing this letter to express our strong support of 1988-'89 legislative priority number one of the Advisory Council on Elder Affairs. Priority number one is a strong commitment and support for the budget request of the Commission on Aging for 1989-'90. This commitment is especially needed since the Commission's budget over the last two years has been reduced in the face of rising needs.

The aging of America is a fact of life. Various studies and reports by organizations like the Urban Institute for the Federal Administration on Aging, as well as statistics and projections by the U.S. Census Bureau indicate that between 1975 and 2010, the population over 65 years of age will increase from 22 to 39 million. This represents a growth rate of 77 percent compared to 32 percent for the population as a whole. The population over 75 years of age will more than double (from 8.5 to 19 million). Beyond the 2010 this aging will accelerate as the baby boom generation retires. Higher proportions of elderly will inevitably mean higher proportions of people with activity limitations, higher proportions living alone, and a host of other changes. These changes will increase the amount and types of services needed by the elderly, as well as what they can afford. A similar situation will exist for South Carolina but even more so than for most states. This is so because South Carolina is experiencing and is likely to continue to experience a high influx of retirees from other areas of the country.

On behalf of the Advisory Council for the Area Agency on Aging (AAA) serving Chester, Lancaster, Union & York Counties (under the Volunteers of America - VOA) I thank you for the opportunity to provide the Joint Legislative Study Committee on Aging with our concerns and recommendations.

Sincerely,

Nellie-Claire Brown

Nellie-Claire Brown, Chairperson
Advisory Council - VOA-AAA

cc: Ms. Keller H. Barron

Roland Richter

608 N. Almond Dr.
Simpsonville, SC 29681

September 7, 1988

South Carolina Commission on Aging
915 Main Street
Columbia, SC 29201

Dea Mr. Harris:

I am writing to you because I feel the South Carolina tax law which pertains to my pension is discriminatory. I am a retired teacher from the public school system in the State of Michigan. I did not have to pay any tax on my pension while I lived in that state.

Two years ago when I began looking for a retirement place I asked the realtor I was working with to call the state tax commission to find out if I would have to pay tax on my pension here in South Carolina. She was told no. At that time I picked up a copy of South Carolina Mature Lifestyles. The information under Income Taxes indicated that no retired public school teachers would have to pay a tax on their pension. I am enclosing a copy of a page from the latest issue of that same publication. The underlined paragraph contains the same sort of information. Before I moved here in June of 1987 I also called the state tax office and was told that I would not have to pay any tax on my pension. You can imagine my surprise when the person who did my 1987 taxes told me I would have to pay. He said the reciprocal agreement with Michigan allows the first $7,500.00 to be tax exempt. I realize you have no control over the tax people who gave us the wrong information. Maybe I would have moved here even if I had received the correct information. But it did influence the comparisons I was making with many other retirement areas.

I am sending letters to the Governor, the editor of the magazine, South Carolina Mature Lifestyles, and to the Michigan Public Schools Employees Retirement Board. I would appreciate any information on what else I might do to get a change in the tax law. It shouldn't matter whether you were a public school teacher in South Carolina or any other state. I pay real estate and personal taxes. I don't feel my pension should be treated differently from the pension of a South Carolina public school teacher.

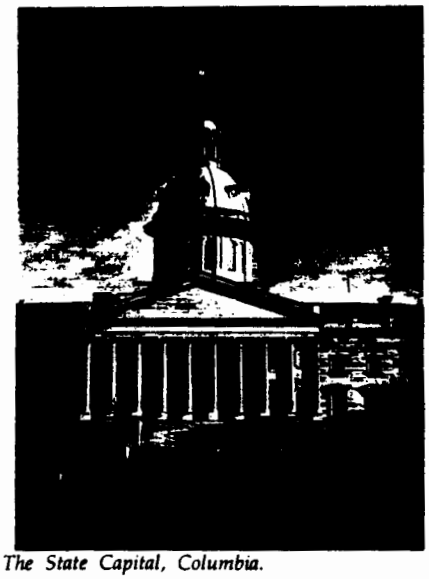
Sincerely,

Roland Richter

Roland Richter

Legislated Privileges For Retirees

by Keller H. Barron



Bill Barley

The State Capital, Columbia.

State legislators have listened to their senior generation constituents and considered their interests through laws and tax relief proposals.

Income Tax

Projected increases in the elderly population have South Carolina lawmakers looking carefully at the special needs of older citizens.

Unlike many states, South Carolina does not tax Social Security income.

The full amount of your South Carolina state retirement income is exempt from state taxation, and the state also excludes up to $3,000 of retirement income from other qualifying retirement plans. This exclusion is for each plan, not each person. For instance, if you retired from both military and civil service and are covered by two distinct retirement plans, you would be entitled to exclude up to $6,000. Similarly, if you and your spouse share one retirement plan (if you bought one together) you could exclude $3,000.

South Carolina has adopted the federal provisions regarding Individual Retirement Accounts.

In 1986, legislation was passed to allow a 20 percent nonrefundable state income tax credit, not to exceed $300, of expenses paid by the taxpayer for institutional, intermediate, or skilled care for the taxpayer or another person.

South Carolina allows reciprocal agreements with most other states to refrain from taxing retirement income of public school teachers or state employees who have relocated to South Carolina.

In addition, the gain on the sale of a personal residence by an individual fifty-five or older is excluded from gross income for the purposes of state income tax, up to $125,000, as a one-time residential exclusion.

Property Tax Laws

Another example of laws showing sensitivity to the financial needs of our senior generations is the South Carolina homestead exemption law. Homeowners who are sixty-five or older and have resided in the state for at least one year receive the benefits of a homestead tax exemption providing that the first $20,000 of the fair market value of the dwelling place, including mobile homes on leased land, shall be exempt from municipal, county, school, and special assessment real property taxes. Bills were introduced in 1987 to increase this exemption to $30,000.

Exemption from these taxes is also provided to a surviving spouse who is fifty or older. The surviving spouse may transfer the exemption to a newly acquired dwelling place. For information on obtaining the homestead exemption, contact your county auditor's office.

Health Regulations

Nursing homes at all levels of care are strictly regulated and inspected by the state. As a member of the governor's staff, an ombudsman receives and reports complaints concerning nursing home patient care.

Also, persons who fit and sell hearing aids are licensed and regulated by the state. Hearing aids and their attachments are exempted from sales tax. No sales tax is charged on any prescription drug in South Carolina.

The South Carolina General Assembly has also appropriated money to establish clinics throughout the state to screen for high blood pressure and diabetes.

Other Privileges and Benefits

In South Carolina those age 65 and older are granted free admission to state park facilities and half-price admission to campsites. And, after one year of residency, that same age group is eligible for free hunting and fishing licenses. Subject to space restrictions and usual entrance requirements, those age 60 or older are granted free tuition at state educational institutions. And, finally, if called to jury duty, persons 65 or older may be excused from service on request.

Legislation such as these are physical evidence that South Carolina legislators have a consistent track record of listening to their retired constituents and taking action on their behalf.

Keller Barron is director of research for the South Carolina Joint Legislative Study Committee on Aging chaired by Representative Patrick B. Harris.

JOINT LEGISLATIVE COMMITTEE ON AGING

Public Hearing Schedule

September 14, 1988
10:30 am
Room 101 Blatt Building

10:30 - 10:40	Opening Remarks - Rep. Patrick B. Harris
10:40 - 10:50	C.M. Johnson, Chairman Ruth Q. Seigler, Executive Director S.C. Commission on Aging
10:50 - 11:00	Betty H. Park, Legislative Committee Chair Advisory Council on Elder Affairs
11:00 - 11:10	David Sojourner, Attorney Advisory Committee on Legal Advocacy for the Elderly
11:10 - 11:20	Michael J. Stogner, Aging Unit Director Appalachian Council of Governments
11:20 - 11:30	Mary Gail Douglas, President S.C. Association of Council on Aging Directors
11:30 - 11:40	Al Reynolds, Richland County Citizen Harold Pasch, Orangeburg County Citizen
11:40 - 11:50	Dolores Masey, Chairman Statewide Advisory Committee on Alzheimer's Disease Jean Hutson, President Alzheimer's Disease and Related Disorders Assn., Inc.
11:50 - 12:00	Ken White, State Legislative Committee American Association of Retired Persons
12:00 - 12:10	Rona B. Sayetta, Director S.C. Registry for Dementing Illnesses
12:10 - 12:20	Carl May, Legislative Committee S.C. Federation of Older Americans
12:20 - 12:30	Diana B. Jones, Executive Director S.C. Episcopal Home at Still Hopes, Inc.
12:30 - 12:40	William P. Simpson, Chairman S.C. Health & Human Services Finance Commission
12:40 - 12:50	Patricia C. Rowe, RSVP Director Retired Senior Volunteer Program

12:50 - 1:00	Frances K. Case, Director S.C. State Library, Department for Blind and Physically Handicapped
1:00 - 2:00	LUNCH
2:00 - 2:10	Joyce Tolbert, Chair Study of Number and Placement of Area Agencies
2:10 - 2:20	Maggie Hope, Volunteer Foster Grandparent Program
2:20 - 2:30	Purvis Collins, Director S.C. Retirement System
2:30 - 2:40	Col. Angelo Perri S.C. Council of Chapters, Retired Officers' Association
2:40 - 2:50	James R. Rider, Horry County Citizen
2:50 - 3:00	T.B. Willis, Sr.; Legislative Chairman S.C. Retired Educators Association
3:00 - 3:10	Girish Yajnik, Associate Director Center for Developmental Disabilities - Elderly Assistance Line
3:10 - 3:20	Margaret Wickenberg, Elderly Liaison S.C. Hospital Association
3:20 - 3:30	Judith P. Baskins, Director Elder Care Plus - Eau Claire Senior Center
3:30 - 3:40	Patrick Mason, Executive Director S.C. Retirement Communities Association
3:40 - 3:50	Hilton P. Terrell, Editor Journal of Biblical Ethics in Medicine
3:50 - 4:00	Michael L. Horton, Sen.Asst. Comptroller General Local Government Division
4:00 - 4:10	Pat Harmon, Richland County Multidisciplinary Advisory Committee Robin Fantl, Chapin Recreation Commission on Aging Program
4:10 - 4:20	Joseph J. Bevilacqua, State Commissioner Nancy Carter, Director of Elderly and Long Term Care S.C. Department of Mental Health
4:20 - 4:30	Quincy S. Neal, Executive Director American Heart Association, S.C. Chapter

4:30 - 4:40	Ernest Furchtgott, Director S.C. Gerontology Center
4:40 - 4:50	Richard Cowling, Chair of Developmental Nursing, USC S.C. Nurses' Association
4:50 - 5:00	Marilyn Koerber S.C. Gerontological Society

Written Testimony Submitted:

James G. Jardin, Richland County Citizen

John J. Stokes, Horry County Citizen

Peter A. Makohon, Aiken County Citizen

Margaret Lovell, Orangeburg County Citizen

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