State Plan on Aging
2005 - 2008

STATE OF SOUTH CAROLINA

OFFICE OF THE LIEUTENANT GOVERNOR

Bureau of Senior Services

SOUTH CAROLINA
STATE PLAN ON AGING

2005 – 2008

THE HONORABLE MARK SANFORD
Governor of the State of South Carolina

The Honorable Andre Bauer
Lieutenant Governor

Director, State Unit on Aging

Table of Contents

CHAPTER 1: INTRODUCTION

A. Purpose

The Older Americans Act (OAA) of 1965 and as amended in 2000 requires that each state submit a State Plan on Aging (hereinafter referred to as the "Plan"} in order to be eligible for federal funding under the OAA. The Bureau of Senior Services, Office of the Lieutenant Governor is the designated State Unit on Aging (SUA) for South Carolina, and as such is responsible for administering and carrying out requirements of the OAA.

This Plan provides a blueprint for how the SUA will manage OAA programs, services, and other activities from October 1, 2004 through September 30, 2008. It provides guidance on how the SUA will carry out its mission of enhancing the quality of life of all older citizens, regardless of whether they participate in OAA programs. This four-year Plan incorporates major goals and objectives adopted by the state's ten (10) AAAs in their three-year Area Plans submitted in 2002 and in updates for 2003 and 2004. Additionally, it draws on input from the FY 2004-2006 Area Plan, as well as input from various needs assessments carried out throughout the state and from the State AARP, the Silver-Haired Legislature and various senior forums.

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

South Carolina's aging programs have undergone significant change since the submission of the 2001-2004 State Plan. The Family Caregiver Support Program has been in place, and other key initiatives are in the process of being implemented over the next two years. The SUA is also overseeing a new award process whereby AAAs will contract with local services providers in a competitive process. The SUA moved from the South Carolina Department of Health and Human Services to the Office of the Lieutenant Governor effective July 1, 2004.

B. Verification of Intent

The Plan is hereby submitted for the State of South Carolina for the period October 1, 2004 through September 30, 2008. It includes all assurances and activities to be conducted by the under provisions of the Act (as amended) during the period identified. The SUA has been given the authority to develop and administer the Plan in accordance with all requirements of the Act, and is primarily responsible for the coordination of all State activities related to the purposes of the OAA, i.e., development of comprehensive and coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for the elderly in South Carolina.

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

_____ _____

Date **Director, State Unit on Aging**

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

_____ _____

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

_____ _____

Date **Mark Sanford, Governor**
State of South Carolina

CHAPTER 2: EXECUTIVE SUMMARY

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

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

South Carolina faces the growth of in-migrating seniors who wish to enjoy the climate, lower cost of living and various cultural and natural resources. The successful incorporation of these newcomers into our communities will have an important impact on them and the demand for resources as they age. South Carolina also has many less fortunate seniors who have not shared in the wealth of a growing economy and may face difficult years as they age. "The mixing of those with different backgrounds and perspectives can benefit us, as long as we work toward a common goal of bettering all age groups throughout South Carolina's communities. The way communities, churches, governments and private interests rise to meet the challenges of this population will determine the quality of life as we face the next millennium" ("Sunny Faces, Many Places", Mature Adults Count: A Profile of South Carolina's Older Population 2003, SC Department of Health and Human Services).

South Carolina's aging programs have undergone significant change since the submission of its 2001-2004 State Plan. The Family Caregiver Support Program and other key initiatives have been implemented, or are in the process of being implemented. The State Unit on Aging (SUA) is also in the midst of transitioning AAAs to a fully competitive procurement process at the AAA level.

Programs and services designed to meet the needs of this population must continue to evolve within ever-changing political and economic environments. South Carolina's approach to preparing for the aging of its population is focused on helping its senior citizens maintain their independence and allowing choice in the services that they receive. South Carolina has recognized that with the significant growth in its senior population, there will not be adequate public resources to pay for significantly increased levels of long-term care.

Seniors wish to remain independent and in their homes. South Carolina has sought to build public/private initiatives that help all of our seniors, while still meeting the needs of the most frail and economically needy. It is clear that public policy on aging issues must emphasize personal and family responsibility. Furthermore, public policy must promote those behaviors and attitudes that prevent many of the negative outcomes often associated with the aging process. This plan focuses on services provided with public funding but also addresses strategies to involve the private sector in expanding the options available for older South Carolinians and their families.

CHAPTER 3: OVERVIEW OF THE 2005 – 2008 STATE PLAN

This Chapter presents issues to be addressed through the Plan for the period October 1, 2004 through September 30, 2008. These issues were identified through a series of public forums in May 2003, two-year plans developed in 2004 by the area agencies on aging, POMP IV survey data, recommendations made by the Silver Haired Legislature, the State AARP, and data gathered from a variety of other sources, including the 2000 Census and its annual community updates, and *Mature Adults Count* reports.

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

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

The Plan outlines the major challenges that face us individually and collectively as an aging society. Implementation of the strategies will require partnerships among all state agencies and between public and private sectors. Individuals and families face the need to take on greater personal responsibility and accountability for their lives and life decisions to ensure that their later years are productive and healthy. Many seniors face the prospect of being caught between caring for their children and parents. Individuals and families must take greater responsibility for planning their financial future and take preventive steps to enhance their personal health in preparation for their later years. Government must carefully use its scarce resources together with all available resources to empower, enable and assist our seniors and their families to meet the challenges and opportunities that the dramatic aging of our society will present. The quality and vision of our public policy will have a significant impact on the changes caused by the aging of our population. It is for this purpose that the State Unit on Aging offers this plan.

Key Outcomes And Strategies

A. South Carolina Initiatives

1. *SC Access* and *SC Choice*

In October 2001, the SUA received a $2.3 million grant from the Center for Medicare and Medicaid Services (CMS) for a three-year Real Choice Systems Change grant. Through this grant, the SUA has developed two major initiatives:

- *SC Access* – a web-based, comprehensive statewide system that provides information, assistance, and referral to enable seniors and persons with disabilities in South Carolina to find the services they need.
- *SC Choice* – the infrastructure to support more consumer directed services, including the development of care advising, financial management services, and the use of cash equivalencies. This program enables the consumer, in

consultation with a care advisor, to perform many of the duties currently performed by a case manager. These choices include: defining needs for the development of a care plan; developing a financial plan for addressing priority personal assistance needs, goods, and services, arranging and utilizing cash equivalencies for consumers to select and pay for services. This project is being pilot tested in a selected area of the state, and will be implemented statewide.

2. SC Access Plus

In September 2003 the SUA received an $800,000 grant from AoA and CMS to fund a third initiative known as *SC Access Plus*. This project will move South Carolina beyond information and assistance to coordinate resources at the local level into centralized resource centers, one-stop entry points into the long term care support system that are based in local communities accessible to people who may require long term support. With this project, the State will bridge the gap between *information about services* and *access to those services.*

B. Family Caregiver Support Program and Regional System of Information, Referral, and Assistance

Under the legislative authority of Title III, Part E of the OAA, as amended in 2000 (P.L.106-501), effective 11/13/00, the National Family Caregiver Support Program (FCSP) was established to help families sustain their efforts to care for a chronically ill or disabled an older relative. South Carolina developed a statewide support system to respond to the needs of family caregivers. The SUA received new federal funding to begin this effort that required a 25% match, from state and local resources.

A planning committee developed considerations for statewide program design, principals, goals, and outcomes to guide implementation of the South Carolina FCSP. The committee included representatives of the area agencies on aging, local service providers, Department of Disabilities and Special Needs, consumers, and the SUA. The committee's considerations were as follows:

- The initial focus should be on development of an infrastructure to provide services to family caregivers.
- It is important to create multiple services that are flexible to meet the full range of needs of the caregivers being served.
- Limited resources must be used wisely to develop a system that offers both flexibility and consistency statewide.
- Funding should be viewed as seed money to leverage other systems and resources to expand the program. The funds should be used to enhance existing services and develop new service options.
- Evaluation needs to be built into the program design so that outcomes can be documented.
- The program design needs to balance the need for flexibility at the local level to allow innovation and the need for accountability at the state level.
- The program design should ensure the availability and consistent quality of services to caregivers throughout the state.

South Carolina has built an infrastructure of Information, Assistance, and Referral throughout the state with Title III funding in conjunction with the implementation of the

Family Caregiver Support Program (FCSP) and *SC Access*. An Information, Assistance, and Referral specialist in each of the state's planning and service areas assist persons who need access to information, resources and services, and thus prevent higher –cost long term care expenses to the state's assistance programs.

C. Information Technology, Information Systems, and Infrastructure

Prior to January 1999, the Aging Network in South Carolina had been using a DOS-based client tracking information system that was developed in the late 1980's to collect and transmit AoA required data. In 2000, the SUA implemented statewide the Windows-based Advanced Information Manager (*AIM*) system to collect not only AoA data, but also to collect additional and more specific assessment and demographic information to assess more completely the population of South Carolina seniors served through the Aging Network. With the addition of the Family Caregiver program in 2002, the SUA considered ways to consolidate client data through a Web-based system. Caregivers across the state currently enter their client data into a cutting-edge web-based program.

The completion of the implementation of these efforts will allow the use of information technology to document more effectively unduplicated client counts, demographics, functional limitations, and unmet needs for services. The *SC Access*, *SC Choice*, and *SC Access Plus* grants provide platforms for merging these different information technology programs into a seamless structure for accessing information and services for seniors in South Carolina that will help seniors and caregivers navigate the complex application process for available services.

D. Elder Rights and Related Issues

America's expanding elderly population affects every segment of the social, political, and economic landscape. As individuals age, there are often changes in their living patterns and conditions which sometimes contribute to the deterioration of their rights. Issues surrounding the changing needs of the approximately 44 million persons in this country age 60 years and over have heightened national awareness and concern. It is no surprise that elderly people with physical and mental frailties are more vulnerable to abusive behavior from those whom they depend upon to provide care and support.

Nationally, nursing homes provide care to over 1.7 million people every year. Generally, a nursing home or residential care facility offers daily assistance to individuals physically or mentally unable to live independently. The long-term care system is complex and often difficult to understand. Many individuals and family members find it a real challenge to select a facility and to ensure that appropriate care will be provided. There are many different agencies responsible for helping to ensure good care for long-term care residents. The Long Term Care Ombudsman Program is one of the agencies responsible for assisting individuals in understanding long-term care issues.

South Carolina is embracing The Eden Alternative™, which recognizes that being institutionalized often breaks the spirit and ultimately the health of many formerly vibrant people. The South Carolina Eden Alternative Coalition was established for the purpose of enhancing the quality of life for nursing home residents primarily through the promotion and support of the concepts of The Eden Alternative™ as developed by Dr. Bill Thomas. The Coalition, acting in conjunction with the South Carolina Department of Health and Human Services developed the South Carolina Eden Alternative Grant Program to provide seed money to nursing facilities that are committed to implementation of The Eden Alternative™ process.

For many older persons, whether they are working or retired, receiving public benefits makes the difference between independence and dependence. Ensuring fair and equitable access to public benefits is an important elder rights issue. Barriers to receiving public benefits may be created by geographic or social isolation, or by language, educational and cultural barriers. Likewise, inappropriate denial of benefits for such key entitlement programs as Medicare, Medicaid, Food Stamps, and Supplemental Security Income can jeopardize the independence of economically disadvantaged older people.

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

E. Changes in the Award Process

As the SUA for South Carolina and in accordance with federal requirements, the SUA designates Area Agencies on Aging (AAAs) to serve as planning, coordinating, and administrative entities for their specified planning and service area (PSA). The SUA has designated ten (10) multi-county planning and service areas in South Carolina and has designated an area agency for each PSA. AAAs are responsible for assessing the needs of seniors in their PSA and, when appropriate, for contracting with provider organizations to provide those services. The AAAs contract for a variety of services that currently include transportation, home care, senior center activities, health and wellness, group dining, and home delivered meals.

Beginning in the late 1970s, AAAs in South Carolina contracted for services through solicitation of competitive proposals. After several years of experience, there were few, if any, proposals submitted to AAAs in competition with local councils on aging. As a result of this, the practice of open procurement was discontinued in the 1980s.

In January 2003 the SUA was notified by the AoA that the Area Agency award process for OAA funds was not in compliance with federal laws and regulations. The SUA, in partnership with the AAAs, prepared a draft plan for submission to the Administration in July 2003. The plan was presented at ten public hearings throughout the state in July. After thorough review of public input, the final draft was submitted to the AoA by September 1, 2003. It is the goal of the SUA that the aging services procurement process will be in full compliance with AoA policies and provide the most cost effective quality services to seniors in South Carolina.

F. Volunteer and Employment Opportunities

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

The trend toward earlier and longer retirement creates some new challenges for South Carolina's seniors. While the majority of senior "transplants" tend to be of middle income

or above, many of South Carolina's lifelong residents have lived in rural communities with below-the-national-average income levels. Many native South Carolina seniors are ineligible for federal financial assistance, and with skyrocketing health care costs, must continue to work in order to afford the basics.

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

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

Programs currently utilizing a sizeable number of volunteers are I-CARE (Insurance Counseling Assistance and Referral for Elders) and the Living Will Witness Program. In addition, some volunteers are involved with Advance Directives (see "Elder Rights & Related Issues" section), as well as Alzheimer's support and caregiving groups (see "Services for Caregivers" section).

G. Education and Training

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

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

H. Resource Allocation:

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

I. Promotion of Independence and Choice for Senior Adults

With increased longevity, more of today's 65 year-olds can plan on living to their eighties and beyond. However, it is likely that not all of these years will be active and independent. One in four older adults has some type of physical impairment and most suffer from one of more chronic conditions. The challenge that accompanies the increase longevity is how to ensure the quality of life that older adults want and expect.

Increased longevity brings with it a concern about the rising health care needs and long term care costs for the older population. There is growing recognition that our nation cannot afford continuing escalation of costs for a greatly increasing senior population. This is contributing to a greater interest in health promotion and disease prevention for older adults, as well as the recognition of each person's responsibility to adequately plan for an independent and healthy retirement. Very little of the health care dollar is spent on prevention and early detection, yet many deaths are due to identifiable and preventable behavior. Such awareness is leading to exploration of how to re-direct more public and private funding to support health promotion activities, as well as how to create an environment that encourages greater personal responsibility and choice.

Additionally, efforts are being made in South Carolina to increase transportation, and other services that are prevention-oriented and often limit the need for more costly institutional services. Greater efforts are being made to address these concerns through improvement and expansion of senior centers where education and other prevention activities take place.

CHAPTER 4: OVERVIEW OF THE STATE UNIT ON AGING

A. State Unit on Aging

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

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

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

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

The mission of the SUA is to enhance the quality of life for older South Carolinians. The SUA is the leader for advocating, planning, and developing resources in partnership with individuals and communities to meet present and future needs of the elderly and their caregivers; and to promote education and training in the field of gerontology.

The vision of the SUA is to create a dynamic, energized environment with a prevention focus that results in a safe, independent, and productive life, and respects the dignity and personhood of all older South Carolinians.

The SUA is responsible for oversight of home and community-based services funded through federal and state sources that are not specifically under the jurisdiction of another state agency. These include primarily programs funded through the federal OAA and various state-funded programs. The SUA consists of four (4) divisions.

B. Lieutenant Governor

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

C. Director

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

D. SUA Divisions

1. Planning and Education

This division is responsible for the development and implementation of state planning activities, including the integration of area plans and the State Plan on Aging, and for collection, analysis, and publishing of statistical data on older citizens of South Carolina through the Advanced Information Management (*AIM*) system and the Mature Adults Count. Staff oversee the Bureau budget, prepare contract documents, and approve invoices for payments to the AAAs. Another duty assigned to this division is the Quality Assurance process for review of Area Agencies on Aging. It is also responsible the development and implementation of a statewide program of education and information for the public, program administrators, and regional sub-grantees/contractors. Training activities are provided primarily through the annual Summer School of Gerontology and the statewide Conference on Aging.

2. Aging Network Services

This Division is responsible for a broad array of program services directed toward enhancing the quality of life for older persons and assisting area agencies on aging in carrying out their responsibilities. These services include consultative services in nutrition, in-home and community-based care, wellness, employment, housing and transportation services, and development of volunteer opportunities. Staff provide technical assistance and guidance to AAAs and other organizations on a wide array of administrative issues. The division also provides assistance to organizations serving primarily minority populations. The division is responsible for the statewide Medicare Fraud Patrol project and insurance counseling services.

3. Consumer Information and Caregiver Support Services

This division is responsible for the national Family Caregiver Support program and the South Carolina Alzheimer's Resource Coordination Center (ARCC). The Family Caregiver Support program provides information, assistance, counseling, respite, and supplemental services to caregivers of older adults and older relatives caring for children under nineteen (19). The ARCC is a state-funded program to provide grants for innovative approaches to assist caregivers of persons with Alzheimer's disease. The statewide development of certified information, referral, and assistance specialists is another responsibility of this division.

4. State Long Term Care Ombudsman Program

The State Long Term Care Ombudsman directs this division. Staff are responsible for the implementation, training and evaluation of the statewide long term care ombudsman program at the AAAs and the development of legal assistance services throughout the state. Promotion of Advanced Directives, Living Wills, Health Care Power of Attorney, and abuse prevention are other division responsibilities. Staff also provide support for the state's Adult Protection Coordinating Council.

5. Other Activities

When the SUA receives grants for special purposes, such as the Real Choice Grant Initiative, responsibility for the grant may be assigned to a temporary division, or incorporated into an existing division.

E. Designation of Planning and Service Areas (PSAs)

Area agencies on aging, mandated by the federal OAA, are organizations designated by the SUA to provide planning and administrative oversight for a multi-county planning

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

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

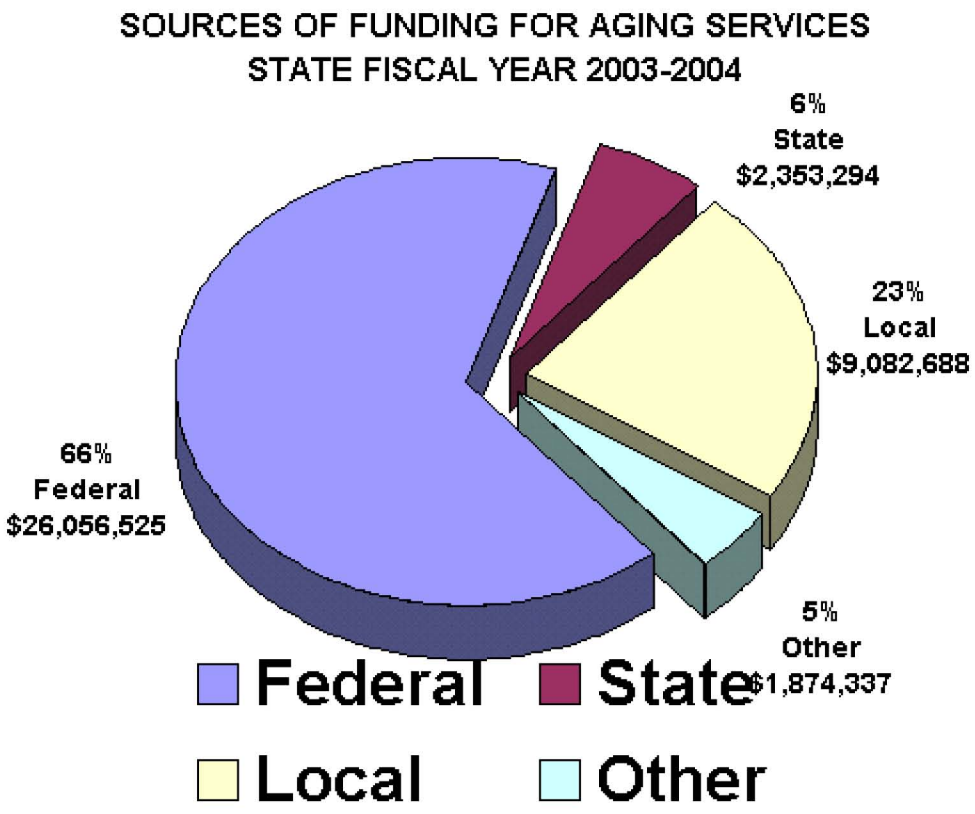
F. Funding Sources

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

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

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

The chart below shows funding amounts in place for the State Fiscal Year 2003 – 2004.



Federal Programs:

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

Older Americans Act - Title V: funds employment and training services to people age 55 and older who meet income guidelines. Title V is administered by the SUA and five national contractors: Green Thumb, National Council on the Aging, AARP, National Council of Senior Citizens, and the National Forestry Service. In addition to receiving employment and training experience, Title V workers also supplement the work force for Aging Network providers and many other non-profit organizations.

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

Health Insurance Counseling Program - (I-CARE): Beneficiaries face a myriad of choices and rules when choosing supplemental health insurance and understanding the Medicare program. For these reasons, the Omnibus Budget Reconciliation Act of 1990 established federally funded, state-managed, Insurance Counseling and Assistance programs for Medicare beneficiaries. In 1992, HCFA (now CMS) awarded the first grants for this program.

The I-CARE/State Health Insurance Program is a volunteer-based program designed to provide Medicare information and assistance to beneficiaries and caregivers, using a peer approach that involves recruiting and training Medicare

beneficiaries and retired seniors to provide the counseling. To avoid any potential conflict of interest, the grant prohibits insurance and medical sales agents from being volunteer counselors.

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

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

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

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

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

State Sources:

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

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

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

Senior Citizens Center Permanent Improvement Fund - This program, funded by earmarked taxes and licensing fees from bingo games, provides capital improvement funds for the construction and renovation of multi-purpose senior centers throughout the state. Projects are subject to all state regulations for capital improvement projects. Enabling legislation established the fund for $948,000 annually.

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

Other Sources:

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

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

G. Programs and Services

For the 2005 - 2008 Plan period, the SUA supports through federal and state funds the following services. The SUA may identify other sources of funds to support services where state and federal funds are not available.

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

Group Dining - provides a nutritionally balanced meal five days per week to older adults at a senior center or other designated place. The program includes nutrition education and other activities designed to promote health and wellness.

Disease Prevention and Health Promotion - These activities are designed to maintain and/or improve health status; reduce risk factors associated with illness, disability or disease; delay onset of disease; preserve functional status and manage chronic disease. Such activities include routine health screenings; nutritional assessment, counseling and follow-up; health promotion programs; physical fitness programs; and accident prevention activities. These activities occur in a variety of community settings, including senior centers.

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

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

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

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

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

Information, Assistance, and Referral - Information and Referral is a system to link people in need of services to appropriate resources. An Area Plan must provide for a regional information and referral specialist to ensure that all older persons within the PSA have reasonably convenient access to the service. In areas in which a significant number of older persons do not speak English as their principal language, the AAA must provide access to information and referral services in the language spoken by the older persons.

Insurance Counseling (I-CARE) and Senior Medicare Patrol - The Insurance Counseling Assistance, Referral and Education Program trains volunteers to provide free counseling related to health insurance and long term care insurance. The Senior Medicare Patrol program operates in tandem with the I-CARE program.

Legal Assistance Services - These services provided by an attorney give the older adult access to the judicial system through advocacy, advice and representation, thereby protecting the older person's dignity, rights, autonomy and financial security.

Living Will Witness Program - State statute requires that living wills executed in hospitals or skilled long term care facilities be witnessed by a representative of the State Long Term Care Ombudsman. The SUA oversees this program and trains volunteers who are then designated by the State Long Term Care Ombudsman.

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

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

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

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

Additional Related Activities:

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

Alzheimer's Resource Coordination Center - Act 195 of 1993 directed the Joint Legislative Committee on Aging to form a Blue Ribbon Task Force to study the planning, coordination and delivery of services for individuals with Alzheimer's disease and related disorders, their families and caregivers. Following a recommendation of this Task Force and subsequent legislation, a statewide Alzheimer's Resource Coordination Center (ARCC) was established in the SUA under the direction of an Advisory Committee appointed by the Governor. The mission of the ARCC is to improve the quality of life for persons with Alzheimer's disease and related dementias through planning, education, coordination, advocacy, service system development and communication. Alzheimer's 101 classes are taught around the state for formal and informal caregivers. Competitive grants are awarded annually to promote the delivery of services.

Summer School of Gerontology - 2004 marks the 28th year of this annual event. Each year a broad array of classes are offered for persons working in programs and services for older adults. The Summer School is held on the campus of one of the state's institutions of higher education or another appropriate location. Classes are offered on both a college credit and continuing education unit basis.

Annual State Conference on Aging - This is an annual event that brings together seniors and professionals to address major aging issues. Training and continuing education opportunities are provided for all state and regional staff.

Senior Celebration - During the awards luncheon at the Annual State Conference on Aging, special recognitions are presented. These include the Outstanding Older South Carolinian, the S.C. Business and Aging Award, Aging Impact Award, Network Volunteer Service, Intergenerational Program Award, Health Promotion Award, and the Print and Electronic Media Award.

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

The most recent report is for the period October 1, 2002, through September 30, 2003. The following tables show data from the NAPIS report for Fiscal Year 2002 – 2003.

SUMMARY OF PERSONS, UNITS OF FUNDING FOR FISCAL YEAR 2002-2003

	TOTAL CLIENTS	TOTAL UNITS	TOTAL $$	TITLE III $$	% of III TOTAL $$
CLUSTER 1 SERVICES					
PERSONAL CARE	1,355	111,537	$433,880	$1,721,996	25.20%
HOMEMAKER	2,093	82,427	$587,530	$1,183,220	49.66%
HOME-DELIVERED MEALS	14,423	2,246,821	$2,576,321	$10,185,279	25.29%
ADULT DAY CARE	208	83,086	$33,346	$860,107	3.88%
CASE MGMT	5,500	20,490		$341,224	0%
CLUSTER 2 SERVICES					
CONGREGATE MEALS	12,947	1,106,421	$4,029,463	$6,098,961	66.07%
NUTRITION COUNSELING	333	1,542	4,455	12,974	34.34%
ASSISTED TRANSPORTATION	59	12,072		$210,374	
CLUSTER 3 SERVICES					
TRANSPORTATION	8,959	1,602,100	$2,529,468	$5,755,239	43.96%
LEGAL ASSISTANCE	780	1,773	$66,100	$67,402	98.07%
HEALTH PROMOTION	1,232	23,022	$30,308	$51,859	58.44%
I, A&R OUTREACH	1,666	13,802	157	$1,673	9.38%
TOTAL UNDUPLICATED	**33,849**				

UNDUPLICATED COUNT BY CHARACTERISTICS OF CLIENTS SERVED

Clients by Minority Status:	
African-American	15,380
Hispanic	34
American Indian/Native Alaskan	27
Asian American/Pacific Islander	10
Non-Minority/Other	18,398
TOTAL	**33,849**
Rural Clients	19,178
Clients in Poverty	16,002
Clients in Poverty/Minority	8,166
New Clients Served	14,135

13,287 (30%) of all clients are below poverty level. 58% live in rural areas.

SOURCE: NAPIS 2003

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

NUMBER OF PERSONS WAITING FOR SERVICES AT THE END OF 2003

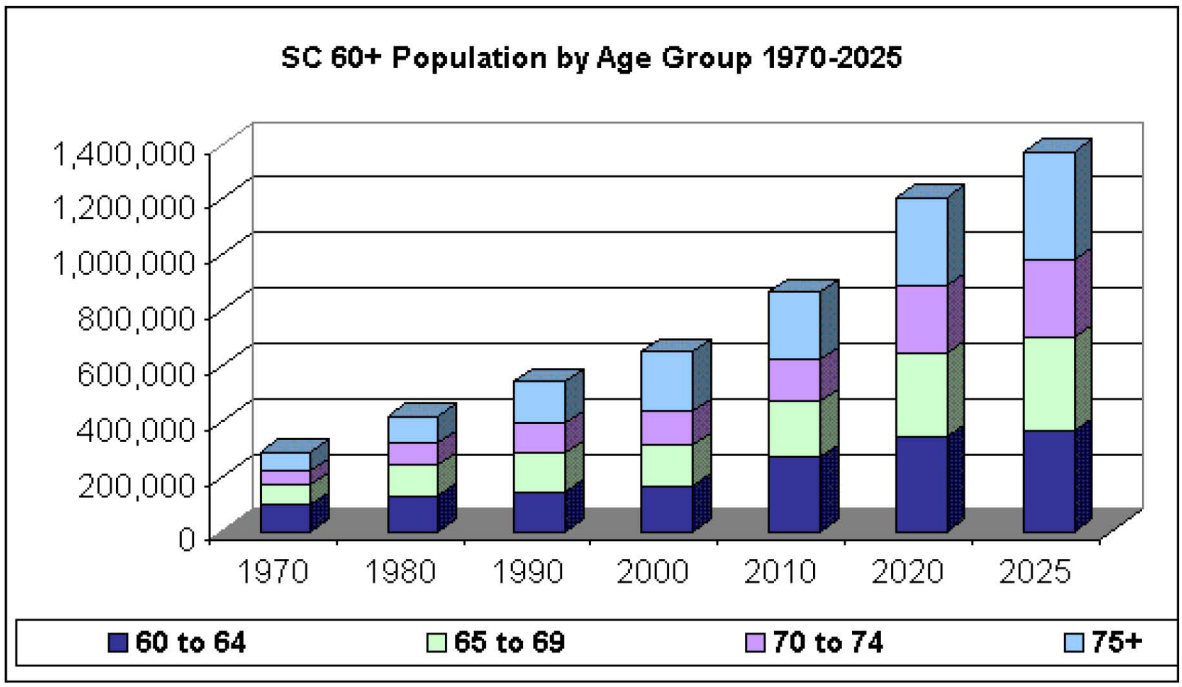
Home-Delivered Meals	2,083
Congregate Meals	97
Home Care (Levels 1, 2, and 3)	1,045
Transportation	266
Escorted Transportation	52
Adult Day Care	46
Group Respite Services	68
Home Respite Services	100
Care Management	33
Home Repair	100
Legal Services	25

SOURCE: NAPIS 2003

CHAPTER 5: CHARACTERISTICS OF THE OLDER POPULATION

A. Introduction

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



The population 60 years and over is projected to increase to 1,359,120 by the year 2025.

South Carolina Population by Age 1970-2025

	1970	1980	1990	2000	2010	2020	2025
50 TO 54	131,916	149,126	159,507	262,543	327,880	326,490	332,030
55 to 59	115,021	149,937	148,762	206,762	304,020	353,980	342,290
60 to 64	95,312	128,816	144,020	166,149	267,330	342,310	363,370
65 to 69	74,257	110,235	140,455	145,599	202,230	299,260	337,580
70 to 74	50,967	79,292	105,850	124,449	149,450	243,500	279,360
75 to 84	53,117	77,797	119,881	165,016	180,560	247,510	326,570
Total 60+	286,272	416,144	540,955	651,482	864,890	1,207,480	1,359,120
Total 65+	190,171	287,328	396,935	485,333	597,560	865,170	1,007,640
Total 75+	65,736	97,801	150,630	215,285	245,880	322,410	390,709
Total 85+	11,830	20,004	30,749	50,269	65,320	74,900	64,130

Source: U.S. Census Bureau Decennial Census 1970, 1980, 1990, and 2000.

2010-2025 Population Projections calculated by SC Budget & Control Board, Office of Research & Statistics (most recent calculations based on 2000 census).

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

Nationally, South Carolina ranks 31st with 12.25% of its population 65 and over. This population has increased from 40,000 (3% of the population) in 1900, to 485,333 in 2000 (12.25% of the total population) and is projected to reach 1,007,640 (20% of the population) in 2025.

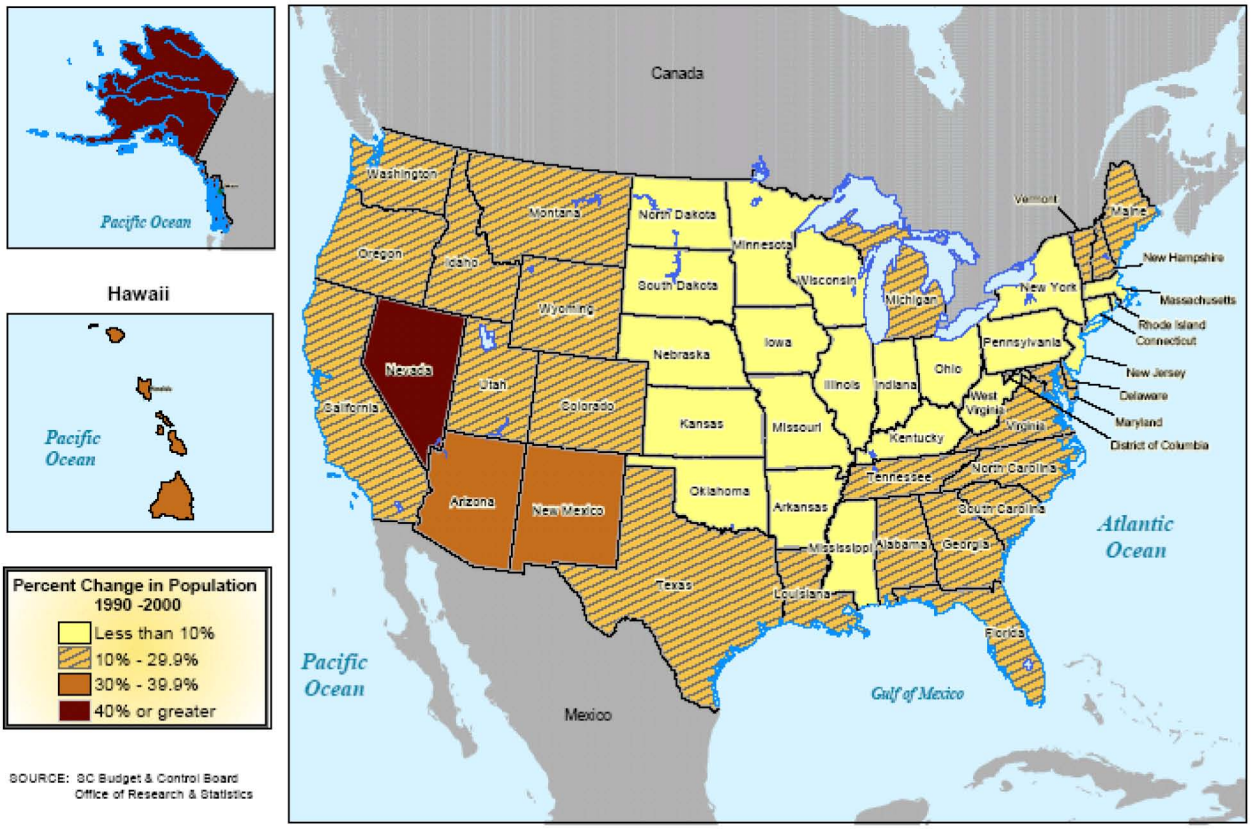
65+ Population as a Percent of Total State Population 2002

Rank	State	%	Rank	State	%
1	Florida	17.08	27	Kentucky	12.45
2	Pennsylvania	15.48	28	Tennessee	12.41
3	West Virginia	15.32	29	Indiana	12.30
4	North Dakota	14.84	30	Michigan	12.26
5	Iowa	14.74	**31**	**South Carolina**	**12.25**
6	Maine	14.40	32	Mississippi	12.06
7	Rhode Island	14.24	33	North Carolina	12.00
8	South Dakota	14.23	34	District of Columbia	12.00
9	Arkansas	13.89	35	Minnesota	11.99
10	Connecticut	13.65	36	New Hampshire	11.97
11	Montana	13.50	37	New Mexico	11.94
12	Massachusetts	13.44	38	Illinois	11.90
13	Nebraska	13.42	39	Wyoming	11.88
14	Hawaii	13.41	40	Louisiana	11.61
15	Missouri	13.35	41	Maryland	11.30
16	Ohio	13.25	42	Idaho	11.27
17	Oklahoma	13.18	43	Virginia	11.21
18	Alabama	13.12	44	Washington	11.16
19	Delaware	13.07	45	Nevada	11.05
20	Kansas	13.07	46	California	10.58
21	New Jersey	13.05	47	Texas	9.88
22	Wisconsin	12.98	48	Colorado	9.64
23	New York	12.91	49	Georgia	9.50
24	Arizona	12.85	50	Utah	8.59
25	Vermont	12.85	51	Alaska	6.09
26	Oregon	12.61			

Source: Population Division, U.S. Census Bureau.

The map and table below show that from 1990 to 2000, South Carolina's growth rate ranked ninth in the nation with a 22.3% rate of growth of its 65+ population. Clearly, South Carolina has seen a significant growth in its senior population.

UNITED STATES PERCENT POPULATION CHANGE: AGE 65+

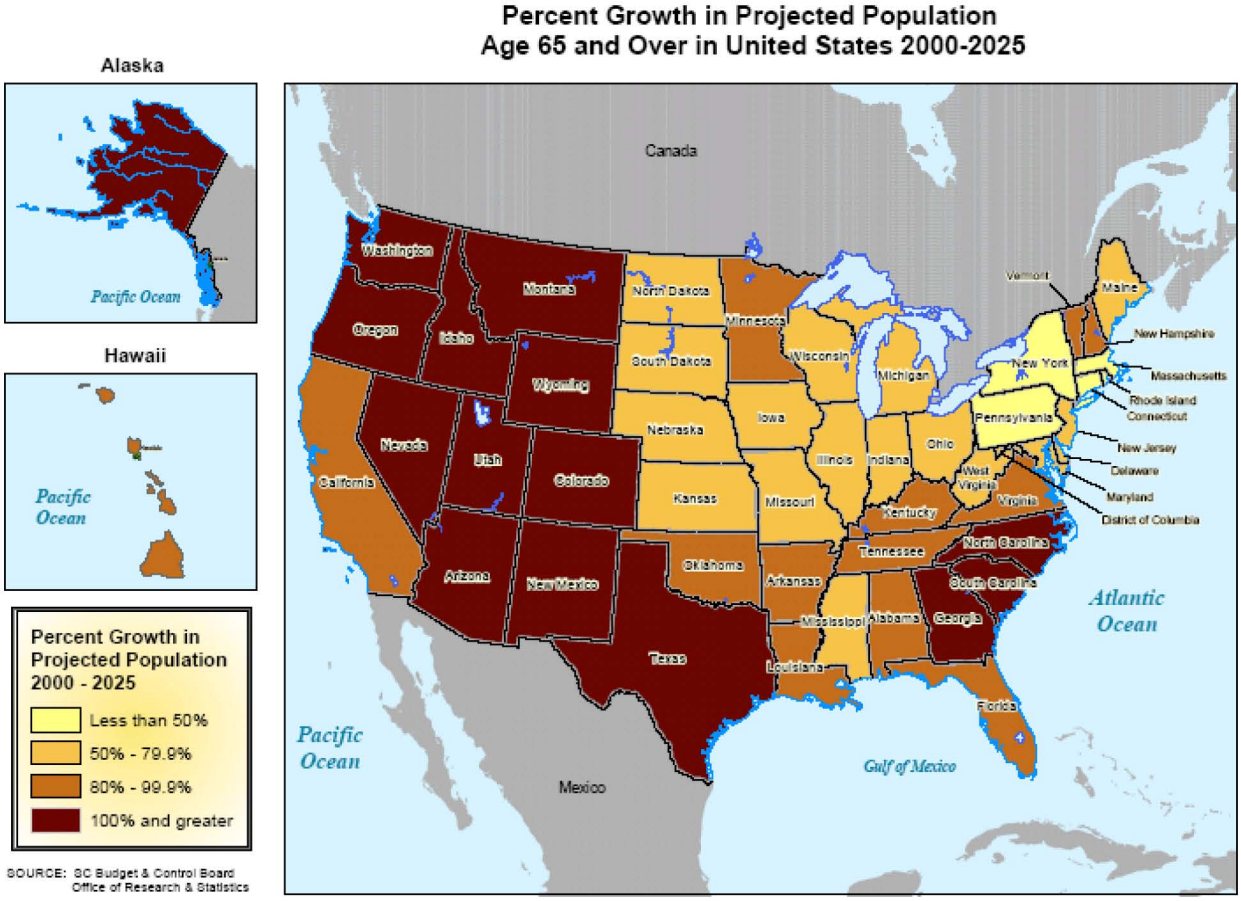


GROWTH OF U.S. POPULATION 1990 - 2002

Rank	State	%	Rank	State	%	Rank	State	%
1	Nevada	88.24	18	Vermont	19.77	35	Mississippi	7.77
2	Alaska	75.24	19	Maryland	19.17	36	Ohio	7.56
3	Arizona	46.47	20	California	18.54	37	Arkansas	7.52
4	New Mexico	35.81	21	Washington	17.77	38	Connecticut	5.92
5	Hawaii	33.52	22	Tennessee	16.22	39	South Dakota	5.85
6	Utah	32.73	23	Montana	15.31	40	Missouri	5.51
7	Colorado	31.88	24	Maine	14.08	41	Massachusetts	5.42
8	Delaware	30.66	25	Oregon	13.45	42	New York	4.64
9	**South Carolina**	**26.79**	26	Alabama	12.53	43	Pennsylvania	4.37
10	Wyoming	25.48	27	Michigan	11.14	44	Illinois	4.36
11	Texas	25.42	28	Louisiana	10.97	45	Nebraska	4.06
12	Idaho	24.64	29	Minnesota	10.02	46	Kansas	3.66
13	Georgia	24.36	30	Kentucky	9.13	47	North Dakota	3.32
14	North Carolina	24.13	31	Indiana	8.80	48	West Virginia	2.63
15	Virginia	23.02	32	New Jersey	8.64	49	Iowa	1.57
16	New Hampshire	22.03	33	Oklahoma	8.54	50	Rhode Island	1.16
17	Florida	20.49	34	Wisconsin	8.48	51	Dist. of Columbia	-11.96

The map and table below show the projected growth of the 65+ population nationally. South Carolina is projected to rank 18th by 2025 based on the 1990 census. Based on the 2000 census, South Carolina will have an increase of 107.6% growth in the 65+ population by 2025.

PERCENT PROJECTED GROWTH UNITED STATES: AGE 65+



% PROJECTED GROWTH OF U.S. POPULATION 2000 - 2025

Rank	State	%	Rank	State	%	Rank	State	%
1	Utah	160.22	**18**	**South Carolina**	**92.86**	**35**	Kansas	69.83
2	Alaska	157.71	19	Tennessee	92.66	36	Indiana	67.37
3	Idaho	156.31	20	Virginia	91.21	37	Missouri	66.54
4	Wyoming	151.33	21	Minnesota	84.93	38	West Virginia	66.13
5	Colorado	150.92	22	New Hampshire	84.50	39	Maine	65.76
6	Oregon	140.54	23	Alabama	84.37	40	Delaware	62.20
7	Washington	138.62	24	Louisiana	82.81	41	Iowa	57.26
8	Montana	126.54	25	Kentucky	81.66	42	Ohio	52.88
9	Nevada	121.99	26	Hawaii	79.95	43	Michigan	49.38
10	Georgia	112.41	27	Mississippi	79.03	44	Illinois	48.93
11	Texas	110.56	28	California	78.66	45	New Jersey	48.59
12	New Mexico	107.80	29	Vermont	78.04	46	Massachusetts	45.55
13	North Carolina	106.80	30	North Dakota	75.70	47	Connecticut	42.71
14	Arizona	104.84	31	Nebraska	74.42	48	Rhode Island	40.42
15	Arkansas	95.44	32	South Dakota	73.86	49	Pennsylvania	38.55
16	Oklahoma	94.76	33	Maryland	71.70	50	New York	33.27
17	Florida	94.22	34	Wisconsin	70.81	51	Dist. of Columbia	31.62

Note: This national table was based on 1990 census data.

B. Population Trends

The growth of South Carolina's 60 and over population will continue to increase significantly over the next twenty years. Overall, persons 60 and above are anticipated to increase from 651,482 in 2000 to 1,359,120 in 2025 for a 108.6% increase. The fastest growing segments of our senior population will be in the 65 to 69 and 75+ age categories.

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

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

Maps and tables at the end of this chapter show the projected growth by county of the 60 plus, 75 plus, and 85 plus populations in South Carolina by region from 2000 to 2025.

C. Growth of 85+ Population

When looking at the 85 and over population from 1980 to 2000, we can see the significant rate of growth in this sector. All ages have increased by 28.6 percent. However, South Carolinians aged 75 to 84 have increased by 112.1 percent, and those 85 and over have increased by 151.3 percent, as illustrated below:

SC POPULATION GROWTH BY AGE GROUP

	Percent Change		
	1970 – 1980	**1990 – 2000**	**1980 - 2000**
All Ages	11.7	15.1	28.6
50 – 54	7.0	64.6	76.1
55 – 59	-0.8	39.0	37.9
60 – 64	11.8	15.4	29.0
65 – 69	27.4	3.7	32.1
70 – 74	33.5	17.6	57.0
75 – 84	54.1	37.6	112.1
85+	53.7	63.5	151.3

Source: 1980, 1990, 2000 Census Bureau General Population Survey

D. In-migration

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

From 1990 -2000 314,917 persons migrated to South Carolina. Of those individuals, 38,740 are aged 65 and above accounting for 12.2% of the total in-migration for the state for that period.

The increase in population 65 years and over is from the aging of the population and from in-migration. Counties that have out migration of their youth tend to have a high percent of persons 65 years and over from ageing in place (examples: Bamberg, Calhoun, Clarendon, McCormick, Newberry, Union). Counties that have in-migration of older population have a

higher percent of persons 65 and over from retirees (examples: Beaufort, Georgetown, Horry). When retirees lose a spouse or their health or mobility (generally when they reach their upper seventies), they usually return to the state they migrated from for care from relatives. (Source: *South Carolina Data Center Newsletter*, December 2003)

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

County or County Group Destination of SC In-migrants age 65 and Older
Total Net Migration 1990-2000

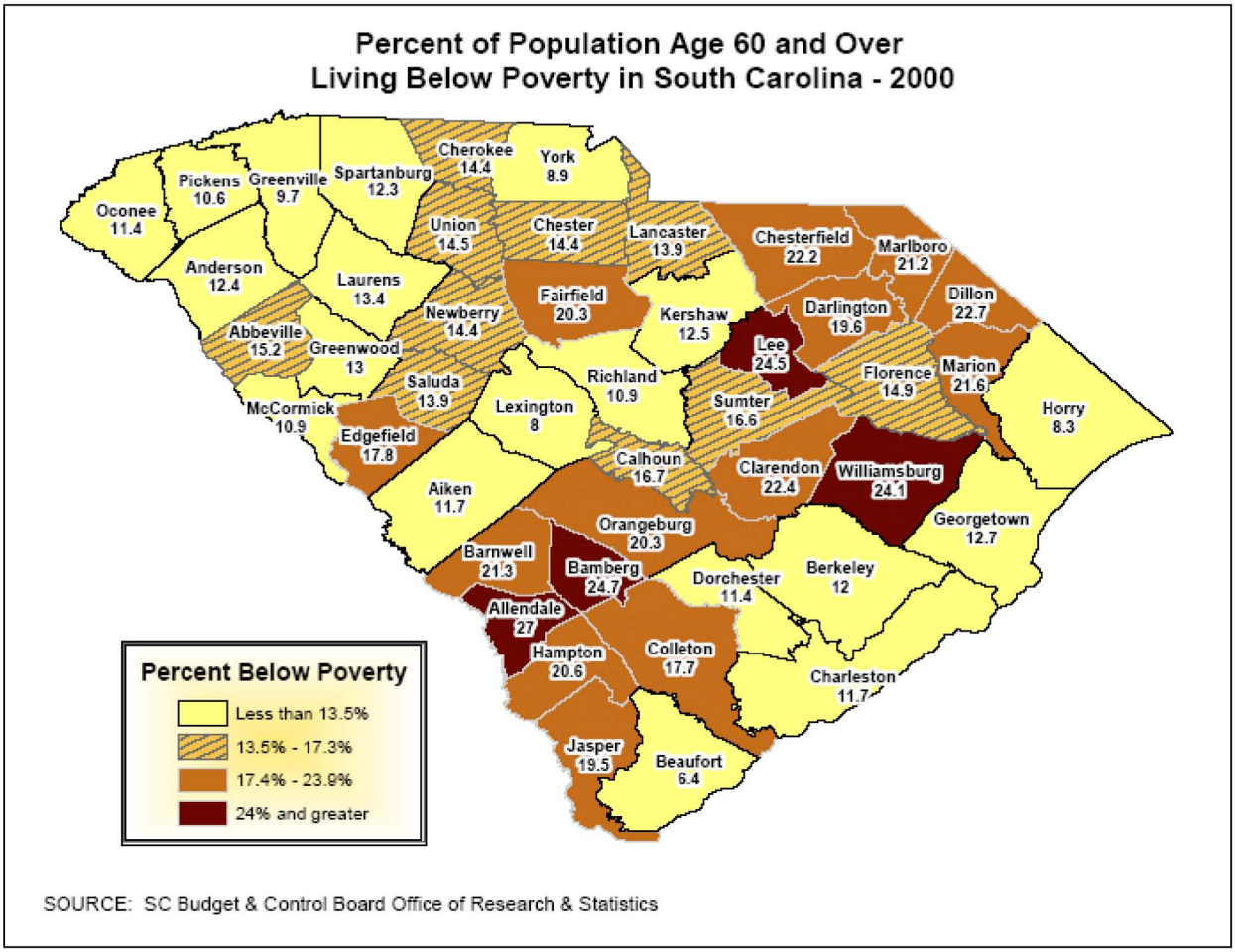
Rank	County/County Group	Number
1	Horry	7,350
2	Beaufort, Colleton, and Jasper	6,600
3	Lexington	3,770
4	Berkeley and Dorchester	2,870
5	Charleston	2,600
6	Aiken	2,360
7	Clarendon, Georgetown, and Williamsburg	2,270
8	Allendale, Bamberg, Barnwell, Calhoun, Hampton, and Orangeburg	1,920
9	Pickens and Oconee	1,630
10	Florence	1,450
11	Abbeville, Edgefield, Greenwood, McCormick, and Saluda	1,270
12	Fairfield, Laurens, and Newberry	1,260
13	Anderson	800
14	Sumter	750
15	York	750
16	Greenville	680
17	Spartanburg	440
18	Richland	410
19	Kershaw, Lancaster, and Lee	390
20	Chesterfield, Darlington, Dillon, Marion, and Marlboro	-390
21	Cherokee, Chester, and Union	-440
	SC Total	**38,740**

Source: US Bureau of the Census; Data compiled by the SC Office of Research & Statistics; SC DHEC

E. Socio-Economic Profile

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

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



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

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

The following table gives the number of persons age 65 or older in South Carolina who are below poverty levels.

2000 POVERTY STATUS FOR PERSONS OVER AGE 65

	Age 65+	Cumulative Percent	% of Persons 65+
Less than 50% of poverty	17,900	3.8	3.8
50% to less than 74% of poverty	15,430	7.2	3.3
75% to less than 100% of poverty	31,358	13.9	6.7
100% to less than 125% of poverty	30,630	20.5	6.6
125% to less than 150% of poverty	28,641	26.6	6.1
150% to less than 174% of poverty	25,617	32.1	5.5
175% to less than 200% of poverty	24,929	37.5	5.4
200% or more of poverty	291,342	100.0	62.5

Source: U. S. Census Bureau, Census 2000 Summary File 3, Table PCT50.
Note: Detail may not sum to total due to rounding.

Based upon 2000 Census statistics, 13.5 percent of all South Carolinians live below the poverty level (currently $9,310.00 for one person and $12,490.00 or a two person household). This income equates to $775.83 per month for one person and $1,040.83 per month for two persons. Approximately 37.5 percent of all persons 65 and older earn less than 200 percent of poverty (currently $18,620 for one person and $24,980 for two persons). This equates to $1,551.66 per month for one person and $2,081.66 per month for two persons.

2004 INCOME LEVELS FOR PERSONS AGE 65+ IN SC

	Annual Income for One Person Household	Monthly Income for One Person Household	Annual Income for Two Person Household	Monthly Income for Two Person Household
Living at 50% of Poverty	$4,655.00	$387.92	$6,245.00	$520.42
Living at 75% of Poverty	$6,982.50	$581.88	$9,367.50	$780.63
Living at 100% of Poverty	$9,310.00	$775.83	$12,490.00	$1,040.83
Living at 125% of Poverty	$11,637.50	$969.79	$15,612.50	$1,301.04
Living at 150% of Poverty	$13,965.00	$1,163.00	$18,735.00	$1,561.25
Living at 175% of Poverty	$16,292.50	$1,357.71	$21,857.50	$1,821.46
Living at 200% of Poverty	$18,620.00	$1,551.66	$24,980.00	$2,081.66

Source: Federal Register: February 13, 2004 (Volume 59, Number 30)

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

Race. Minorities make up approximately 22.8% of the 60 and older population statewide, ranging from only 6.6% in Pickens County to 56.8% in Williamsburg County. The disparity in life expectancy between whites and blacks has remained at over 5 years, reflecting differences resulting from low income and inadequate health and preventive care. As the total population becomes more heterogeneous, the composition of the older population will likewise begin to reflect this diversity. As with gender, racial and minority status continues to pose additional vulnerability beyond that of old age.

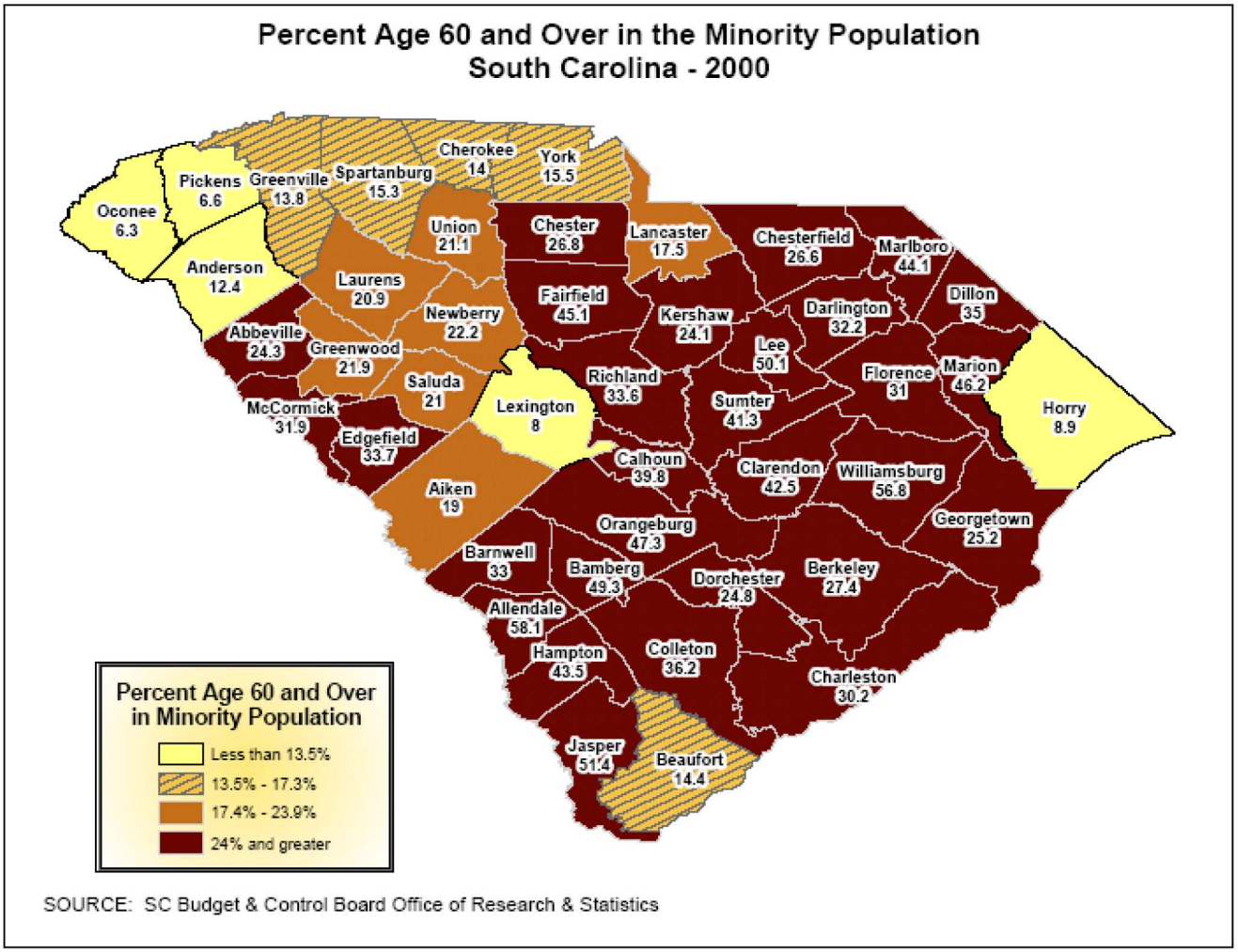
The following table shows various groups by age, race and sex for South Carolina based upon 2000 Census statistics. The disparity in life expectancy between males and females, and whites and minorities is evident as they age.

Age Group, Race and Sex 2000					
	Age 50+	**50-64**	**65-74**	**75-84**	**85+**
All Races					
Male	501,442	304,708	120,813	62,785	13,136
Female	619,345	330,746	149,235	102,231	37,133
White					
Male	387,266	231,102	96,245	50,073	9,846
Female	462,846	242,619	113,322	79,026	27,879
Nonwhite					
Male	114,176	73,606	24,568	12,712	3,290
Female	156,499	88,127	35,913	23,205	9,254

Source: U. S. Census Bureau, Census 2000 Summary File 1, Tables P12 and P12A-G.

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

PERCENT OF 60+ MINORITY POPULATION TO TOTAL 60+ POPULATION

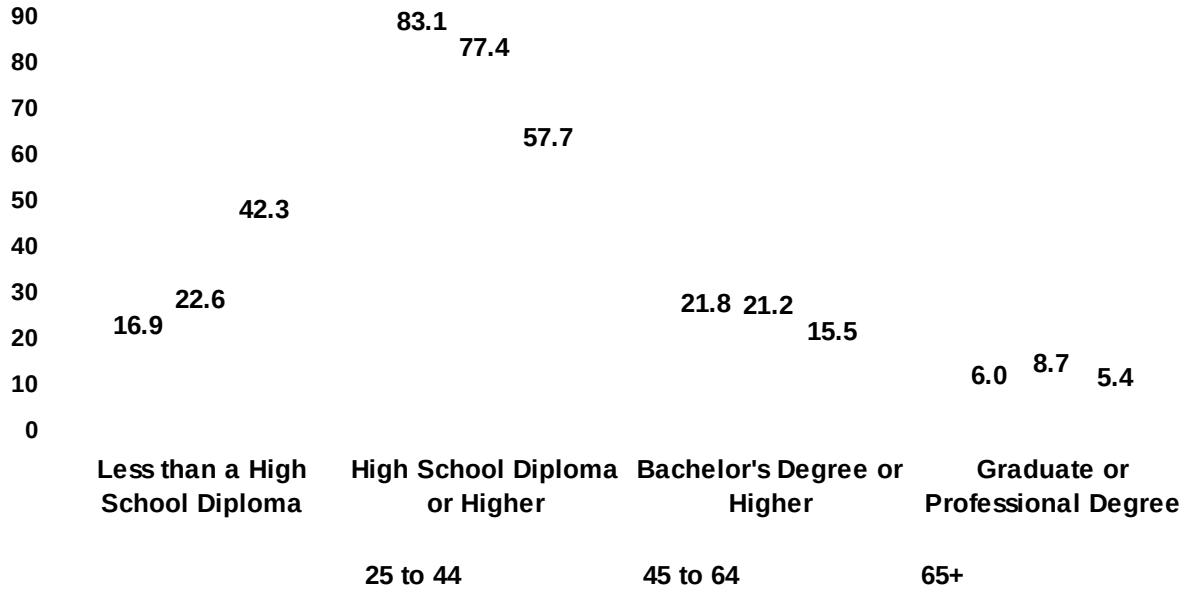


PSA	POP	#	%	PSA	POP	#	%	PSA	POP	#	%
APPALACHIA				**UPPER SAVANNAAH**				**CATAWBA**			
Anderson	30,240	3,739	12.4	Abbeville	5,005	1,218	24.3	Chester	5,751	1,541	26.8
Cherokee	8,672	1,216	14.0	Edgefield	3,568	1,201	33.7	Lancaster	10,107	1,773	17.5
Greenville	59,563	8,242	13.8	Greenwood	11,781	2,584	21.9	Union	6,139	1,293	21.1
Oconee	14,116	884	6.3	Laurens	12,222	2,559	20.2	York	23,395	3,637	15.5
Pickens	17,034	1,130	6.6	McCormick	2,286	730	31.9	**SANTEE-LYNCHES**			
Spartanburg	42,408	6,509	15.3	Saluda	3,671	770	21.0	Clarendon	6,197	2,631	42.5
CENTRAL MIDLANDS				**LOWER SAVANNAH**				Kershaw	9,095	2,189	24.1
Fairfield	4,047	1,824	45.1	Aiken	24,112	4,571	19.0	Lee	3,244	1,626	50.1
Lexington	30,215	2,405	8.0	Allendale	1,844	1,072	58.1	Sumter	15,809	6,531	41.3
Newberry	6,892	1,528	22.2	Bamberg	3,014	1,485	49.3	**TRIDENT**			
Richland	41,607	13,987	33.6	Barnwell	3,840	1,267	33.0	Berkeley	16,280	4,463	27.4
PEE DEE				Calhoun	2,804	1,115	39.8	Charleston	48,734	14,742	30.2
Chesterfield	6,933	1,843	26.6	Orangeburg	16,065	7,600	47.3	Dorchester	12,353	3,063	24.8
Darlington	11,101	3,571	32.2	**WACCAMAW**				**LOW COUNTRY**			
Dillon	4,773	1,670	35.0	Georgetown	11,434	2,884	25.2	Beaufort	25,040	3,594	14.4
Florence	19,986	6,186	31.0	Horry	40,104	3,560	8.9	Colleton	6,711	2,431	36.2
Marion	5,753	2,658	46.2	Williamsburg	6,405	3,638	56.8	Hampton	3,392	1,476	43.5
Marlboro	4,656	2,053	44.1					Jasper	3,084	1,586	51.4

SC Totals: Total Over 60 Population = 651,482; Total Minority Over 60 = 148,275; Percent of Over 60 Minority = 22.8
Source: Office of Research and Statistics based on Census 2000 data.

Education. Educational attainment varies greatly among older South Carolinians. As shown below, 42.3 percent of our 65 and older population have less than a high school education compared to 22.6% or our 45 to 64 year olds, while 22% of the 65+ population have less than a 9th grade level of education and may be functionally illiterate. The table below also indicates that future generations of older adults are more likely to have at least a high school education or higher. Education is a powerful predictor of health status and income. Educational attainment offers the hope of improved health status and quality of life.

Educational Attainment in South Carolina by Age Group 2000



Source: Source: Office of Research and Statistics based on Census 2000 data

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

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

DISTRIBUTION OF SOURCES OF INCOME FOR THE POPULATION AGE 65 AND OLDER
1962 - 2001

	TOTAL %	SOCIAL SECURITY %	ASSET INCOME %	PENSIONS %	EARNINGS %	OTHER %
1962	100	31	16	9	28	16
1967	100	34	15	12	29	10
1976	100	39	18	16	23	4
1978	100	38	19	16	23	4
1980	100	39	22	16	19	4
1982	100	39	25	15	18	3
1984	100	38	28	15	16	3
1986	100	38	26	16	17	3
1988	100	38	25	17	17	3
1990	100	36	24	18	18	4
1992	100	40	21	20	17	2
1994	100	42	18	19	18	4
1996	100	40	18	19	20	3
1998	100	38	20	19	21	2
2000	100	38	18	18	23	3
2001	100	39	16	18	24	3

Census Bureau. These data refer to the civilian *noninstitutional* population.

Employment. Employment continues to be an important, although not primary, source of income for older adults. National data for 2001 indicate that Social Security was a major source of income for 39% of older couples and individuals, followed by asset income (16%), public and private pensions (18%), earnings (24%) and all other sources (3%).

Participation in the Labor Force by Age: South Carolina 2000

	% in Labor Force	# Employed	% Employed	% Unemployed	% Not in Labor Force
45-54	76.9	405,465	74.1	2.6	23.1
55-59	63.2	125,835	61.1	2.0	36.8
60-64	43.5	70,025	42.2	1.3	56.5
65-69	22.7	32,429	22.0	0.7	77.3
Total 25+	63.3	1,558,369	60.0	2.6	36.7
Total 55+	31.2	256,430	29.9	1.3	68.8
Total 65+	13.5	60,570	12.5	1.0	86.5
Total 75+	6.8	11,493	5.4	1.4	93.2

* Includes civilian and military **Source:** 2000 Census, SF3 Table PCT35

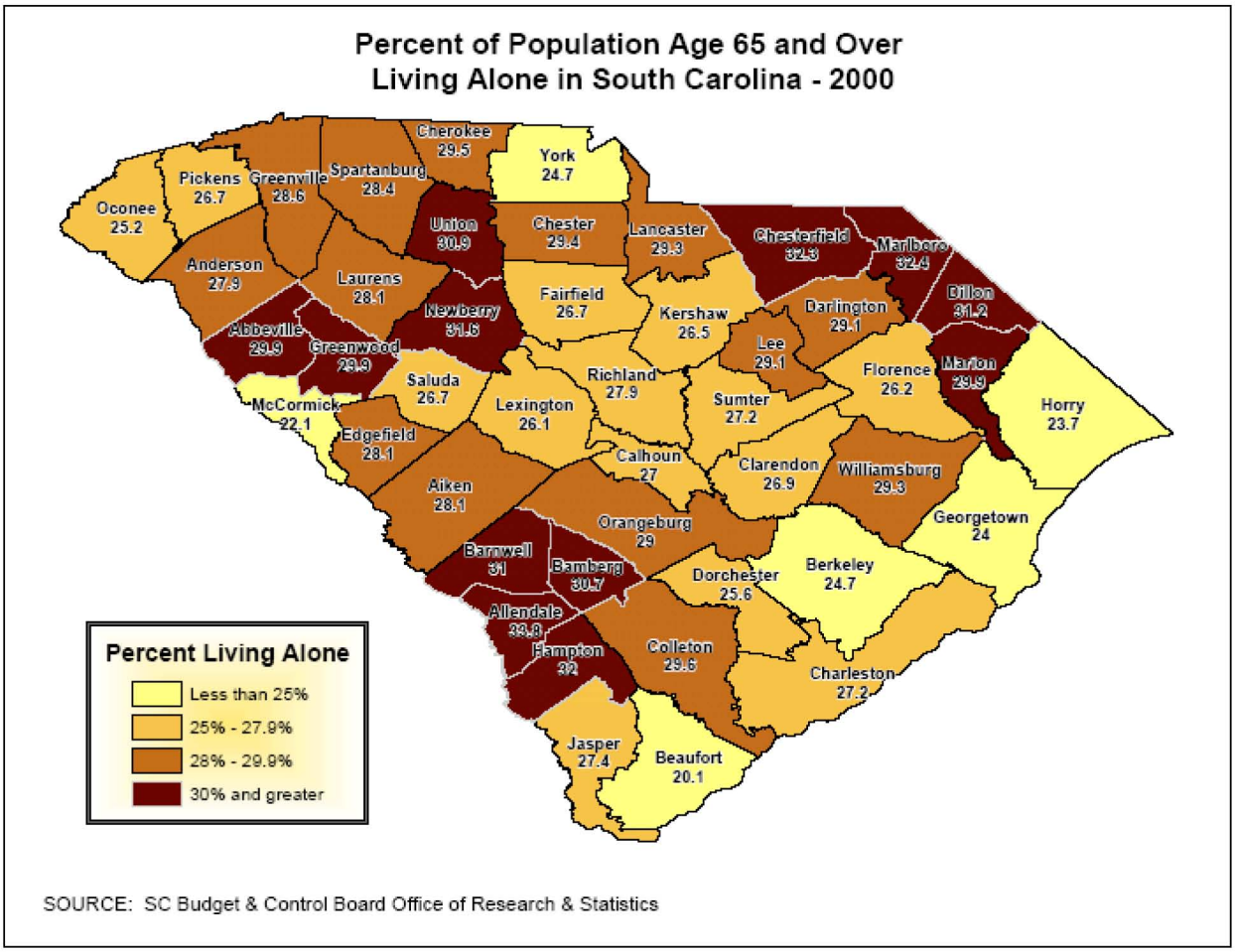
Despite the trend toward earlier retirement among those who can look forward to adequate income replacement, many older workers are strongly induced and/or are essentially forced out of their jobs. They subsequently have difficulty finding work with comparable wages and salaries. Pressures on older workers to leave the workplace have been growing during the past 15 to 20 years as employers have tried to reduce the costs of wages and employee benefits and to create labor force structures that can be readily altered at management discretion. These trends are likely to be increasingly significant for coming generations, seriously impacting job security and economic well-being and thus retirement planning.

Insurance. Health insurance is a very important component of economic security. As the population ages, it is especially important for security as acute, chronic and disabling conditions become more prevalent. Most older Americans and South Carolinians are covered by health insurance, primarily by Medicare. Based on 2003 Census data 99.4% of all older South Carolinians are covered by government or private health insurance. Of all persons 65 and older, 96.2% have Medicare, 57.1% have private insurance, 7.2% are covered by military health care, and 9.9% have Medicaid coverage; .6% have no insurance. Most elderly, however, lack insurance coverage for long term care, leaving them especially vulnerable to the high cost of nursing home care.

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

As people age, they are increasingly likely to live alone: 31.3% of 65+ year olds live alone. We may expect that the numbers of older adults living alone may increase as the baby boomers age; this cohort has been more likely to remain single and childless. The following map and table show the numbers and percents of 65+ population living alone by PSA, by county.

PERCENT OF 65+ POPULATION LIVING ALONE IN 2000



	POP	#	%	PSA	POP	#	%	PSA	POP	#	%
APPALACHIA				**UPPER SAVANNAAH**				**CATAWBA**			
Anderson	22,627	6,314	27.9	Abbeville	3,842	1,149	29.9	Chester	4,317	1,271	29.4
Cherokee	6,517	1,923	29.5	Edgefield	2,669	750	28.1	Lancaster	7,413	2,172	29.3
Greenville	44,573	12,768	28.6	Greenwood	9,075	2,717	29.9	Union	4,670	1,443	30.9
Oconee	10,311	2,598	25.2	Laurens	9,168	2,576	28.1	York	17,072	4,217	24.7
Pickens	12,616	3,373	26.7	McCormick	1,645	363	22.1	**SANTEE-LYNCHES**			
Spartanburg	31,740	9,027	28.4	Saluda	2,778	743	26.7	Clarendon	4,538	1,221	26.9
CENTRAL MIDLANDS				**LOWER SAVANNAH**				Kershaw	6,796	1,804	26.5
Fairfield	3,094	827	26.7	Aiken	18,287	5,139	28.1	Lee	2,504	729	29.1
Lexington	21,989	5,734	26.1	Allendale	1,421	480	33.8	Sumter	11,760	3,201	27.2
Newberry	5,323	1,683	31.6	Bamberg	2,314	710	30.7	**TRIDENT**			
Richland	31,475	8,772	27.9	Barnwell	2,962	917	31.0	Berkeley	11,261	2,787	24.7
PEE DEE				Calhoun	2,102	567	27.0	Charleston	36,858	10,016	27.2
Chesterfield	5,120	1,656	32.3	Orangeburg	12,091	3,508	29.0	Dorchester	8,791	2,254	25.6
Darlington	8,158	2,376	29.1	**WACCAMAW**				**LOW COUNTRY**			
Dillon	3,545	1,107	31.2	Georgetowm	8,354	2,001	24.0	Beaufort	18,754	3,774	20.1
Florence	14,837	3,881	26.2	Horry	29,470	6,984	23.7	Colleton	4,928	1,460	29.6
Marion	4,298	1,287	29.9	Williamsburg	4,856	1,423	29.3	Hampton	2,595	831	32.0
Marlboro	3,550	1,149	32.4					Jasper	2,269	622	27.4

SC Totals: Total Population Over 65 = 485,333; Total Over 65 Living Alone = 132,302; Percent of Over 65 Living Alone = 27.3
Source: Office of Research and Statistics based on Census 2000 data.

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

Household Type for Population 65+ in South Carolina

	Number	Percent
Total Population	**485,333**	**100.0**
In Family Households	**317,398**	**65.4**
In Non-Family Households:	**140,485**	**28.9**
Male, Living Alone	31,635	6.5
Male, Not Living Alone	2,195	0.5
Female, Living Alone	100,667	20.7
Female, Not Living Alone	2,197	0.5
Nonrelatives	3,791	0.8
In Group Quarters	**27,450**	**5.7**

Source: U.S. Census Bureau, Census 2000.

2002 Elderly Households by Type and Income

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

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

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

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

In South Carolina there are currently 195 nursing homes with 18,947 beds providing 24-hour skilled or intermediate nursing care and related services for persons with a wide range of physical and mental disabilities. Persons over 65 comprise. 91.5% of the nursing home population. The percent of older adults residing in nursing homes in South Carolina is 3 percent. The risk of persons age 65+ spending more than one year in a nursing facility is 22%.

South Carolina Nursing Homes as of September 30, 2003

Number of Nursing Homes	195
Number of Beds	18,947
Patients:	
Under age 65	1,409
65 – 74	2,442
75+	12,706
Total Patients	16,557
Difference Between # Patients and # of Beds	2,390
Percent of Nursing Home Patients Over Age 65	91.5%

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

There are 14,431 persons in the Medicaid elderly/disabled waiver program. These persons are at a nursing home level of care, but are able to remain at home. There are 3,417 persons waiting placement or eligibility determination. (Source: SC Department of Health and Human Services and Mature Adults Count)

F. Health and Functional Status Profile

Mortality. The five major causes of mortality for older adults 65-74 in South Carolina are malignant neoplasms, diseases of the heart, chronic lower respiratory disease, cerebrovascular disease and diabetes mellitus. For those persons 75 and older the five major causes of mortality are diseases of the heart, malignant neoplasms, cerebrovascular diseases, chronic lower respiratory disease, and Alzheimer's disease.

For persons 65-74, some significant differences between whites and minorities are apparent. Minorities have a 8.1 percent mortality rate for cerebrovascular disease compared to 5.6 percent for whites. Whites are more likely to die from chronic lower respiratory disease than minorities (8.1 percent for whites compared to 2.9 percent for minorities). 6.7 percent of minorities die from diabetes melitus as compared to 3.2 percent for whites.

When comparing whites and minorities aged 75 and over, the differences become less striking. Chronic obstructive pulmonary disease and allied conditions still affect more whites than minorities (5.9 percent for whites compared to 3.0 percent for minorities).

South Carolina Mortality from Five Leading Causes of Death 2000

	Total		White		Minority	
Ages 65-74: Causes	**#**	**%**	**#**	**%**	**#**	**%**
Malignant Neoplasms	2,336	31.8	1,757	33.0	579	28.5
Diseases of the Heart	1,977	26.9	1,437	27.0	540	26.6
Chronic Lower Respiratory Disease	490	6.7	432	8.1	58	2.9
Cerebrovascular Disease	464	6.3	299	5.6	165	8.1
Diabetes Mellitus	305	4.1	168	3.2	137	6.7
All Other Causes	1,782	24.4	1,225	23.0	552	27.2
Total	**7,354**	**100.0**	**5,318**	**100.0**	**2,031**	**100.0**

	Total		White		Minority	
Ages 75+: Causes	**#**	**%**	**#**	**%**	**#**	**%**
Diseases of the Heart	5,591	30.7	4,357	31.3	1,234	28.9
Malignant Neoplasms	3,168	17.4	2,358	16.9	810	19.0
Cerebrovascular Disease	2,022	11.1	1,495	10.7	527	12.3
Chronic Lower Respiratory Disease	949	5.2	822	5.9	127	3.0
Alzheimer's Disease	796	4.4	673	4.8	123	2.9
All Other Causes	5,684	31.2	4,227	30.3	1,452	34.0
Total	**18,210**	**100.0**	**13,932**	**100.0**	**4,273**	**100.0**

Source: SC Department of Health & Environmental Control, 2000 Vital and Morbidity Statistics.

The leading causes of hospitalization for older South Carolinians are similar for all age groups. Chest pain is the leading cause for hospitalizations for all three age groups above 45 years of age. For individuals 65-74 and 75 and above, heart failure and shock are the leading causes of hospitalization.

South Carolina, Fiscal Year 2002: Leading Causes of Hospitalization by Age Group

	Total		White	Minority
Ages 45-64: Causes	#	%	%	%
Total Hospital Discharges	126,079	100.0	100.0	100.0
Chest Pain	5,338	4.2	4.1	4.4
Heart Failure & Shock	3,712	2.9	2.0	4.8
Chronic Obstructive Pulmonary Disease	3,268	2.6	3.1	1.6
Uterine & Adnexa Proc For Non-Malignancy W/O Cc	3,130	2.5	2.6	2.2
Circulatory Disorders Except Ami, W Card Cath W/O Complex Diag	3,041	2.4	2.6	2.0

South Carolina, Fiscal Year 2002: Leading Causes of Hospitalization by Age Group

	Total		White	Minority
Ages 65-74: Causes	#	%	%	%
Total Hospital Discharges	73,142	100.0	100.0	100.0
Heart Failure & Shock	3,361	4.6	3.9	6.8
Major Joint & Limb Reattachment Procedures of Lower Extremity	2,909	4.0	4.4	2.8
Chronic Obstructive Pulmonary Disease	2,615	3.6	4.0	2.3
Simple Pneumonia & Pleurisy Age >17 W Cc	2,308	3.2	3.3	2.8
Specific Cerebrovascular Disorders Except Tia	1,854	2.5	2.2	3.4

South Carolina, Fiscal Year 2002: Leading Causes of Hospitalization by Age Group

	Total		White	Minority
Ages 75+: Causes	#	%	%	%
Total Hospital Discharges	97,693	100.0	100.0	100.0
Heart Failure & Shock	6,476	6.6	6.3	7.7
Simple Pneumonia & Pleurisy Age >17 W Cc	4,799	4.9	5.0	4.7
Nutritional & Misc Metabolic Disorders Age >17 W Cc	3,648	3.7	3.3	5.1
Specific Cerebrovascular Disorders Except Tia	3,313	3.4	3.3	3.8
Major Joint & Limb Reattachment Procedures Of Lower Extremity	3,121	3.2	3.6	1.7

Source: SC Budget & Control Board, Office Of Research & Statistics. Inpatient Hospital Discharge Reports.

Differences in hospitalizations between whites and minorities are not as apparent as for causes of mortality.

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

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

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

PERSONS ASSESSED WITH AT LEAST ONE ACTIVITY OF DAILY LIVING OR INSTRUMENTAL ACTIVITY OF DAILY LIVING DIFFICULTY BY SELECTED CHARACTERISTICS BETWEEN 7/1/2002 AND 6/30/2003

CHARACTERISTICS	NUMBER OF PERSONS	% ASSESSED WITH AT LEAST ONE DIFFICULTY
AGE (16,656 Assessed)		
55 – 64	1,838	7%
65 – 74	4,355	19%
75 – 84	7,162	34%
85 and Older	5,078	23%
HOUSEHOLD INCOME (15,943 Assessed)		
Poverty	13,372	64%
101 – 200% of Poverty	3,713	20%
201 – 300% of Poverty	462	3%
301+% of Poverty	185	1%
RACE (16,658 Assessed)		
White	10,428	48%
Non-White	9,002	38%
GENDER (16,658 Assessed)		
Male	5,335	19%
Female	14,088	55%
EDUCATIONAL LEVEL (11,272 Assessed)		
Less Than Third Grade	677	6%
3rd through 8th Grade	4,310	37%
High School/GED	1,737	15%
Some College	861	7%
Advanced Degree		
LIVING ARRANGEMENT (14,082 Assessed)		
Live Alone	7,834	51%
Live with Others	6,299	41%

Source: AIM data Cluster 1of NAPIS Services: Personal Care, Homemaker, Home-Delivered Meals, Adult Day Care, and Care Management.

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

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

PERSONS 60+ WITH ACTIVITIES OF DAILY LIVING (ADL)

PROBLEM	% WITH PROBLEM	NUMBER OF PERSONS
Feeding	3%	487
Dressing	15%	2,530
Bathing	21%	3,496
Toileting	7%	1,197
Bladder/Bowel	8%	1,361
I/O of Bed	14%	2,384
Unduplicated Count with at lease one ADL		7,101
Persons Indicating 3 or More ADLs		2,281

Source: AIM data Cluster 1of NAPIS Services (Above)

PERSONS WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING (ADL)
AGE 60 AND OVER

PROBLEM	% WITH PROBLEM	NUMBER OF PERSONS
Normal Housework	61%	10,240
Cooking	60%	9,964
Checkbook	39%	6,450
Heavy Cleaning	75%	12,447
Shopping	63%	10,523
Medication	35%	5,883
Phone	14%	2,360
Unduplicated Count of Persons with at lease one IADL		14,190
Persons Indicating 3 or More ADLs		10,676

Source: Source: AIM data Cluster 1of NAPIS Services (Above)

Looking at the numbers of persons with impairments raises the questions of who cares for these persons and where they receive their care. Approximately 80% of the care received is provided by informal caregivers, such as family and neighbors. According to the Family Caregiver Alliance:

- Caregivers have been providing care to the dependent person for an average of almost seven years.
- An estimated 12.1 million Americans need assistance from others to carryout everyday activities.
- Most, but not all persons in need of long term care are elderly. Approximately 3% are persons aged 65 and older (6.4 million)
- Of the older population with long term care needs in the community, about 30% (1.5 million) have substantial long term care needs (3 or more ADL limitations). Of these, about 25% are 85 and older, and 70% report that they are in fair to poor health.
- 52 million informal and family caregivers in the U.S. provide care to someone who is ill or disabled.
- 25.8 million family caregivers provide personal assistance to adults with a disability or chronic illness.
- Nearly **one out of every four households** (23% of 22.4 million households) is involved in caregiving to a person aged 50 or over.

SOUTH CAROLINA POPULATION BY AGE 2000 – 2025: AGE 60+ By PSA

	2000	2005	2010	2015	2020	2025
Appalachia PSA	**172,033**	**186,440**	**212,860**	**241,230**	**278,140**	**307,320**
Anderson County	30,240	32,420	36,850	40,930	47,540	51,610
Cherokee County	8,672	9,150	10,300	11,540	13,220	14,530
Greenville County	59,563	63,770	72,600	82,280	95,630	107,090
Oconee County	14,116	16,770	19,930	23,260	26,910	29,630
Pickens County	17,034	18,810	21,460	24,570	28,130	31,370
Spartanburg County	42,408	45,520	51,720	58,650	66,710	73,090
Upper Savannah PSA	**38,533**	41,940	**48,530**	**56,020**	**64,880**	**73,210**
Abbeville County	5,005	5,150	5,870	6,540	7,490	8,250
Edgefield County	3,568	3,970	4,870	6,110	7,590	9,110
Greenwood County	11,781	12,300	13,560	14,840	16,470	17,750
Laurens County	12,222	13,450	15,470	17,870	20,570	23,200
McCormick County	2,286	3,110	4,290	5,610	7,050	8,510
Saluda County	3,671	3,960	4,470	5,050	5,710	6,390
Catawba PSA	**45,392**	**49,080**	**56,810**	**65,170**	**76,780**	**87,110**
Chester County	5,751	6,080	6,940	7,790	8,960	9,860
Lancaster County	10,107	10,360	11,780	13,220	15,290	16,410
Union County	6,139	6,370	6,900	7,310	8,050	8,340
York County	23,395	26,270	31,190	36,850	44,480	52,500
Central Midlands PSA	**82,761**	**91,810**	**109,480**	**129,110**	**152,480**	**172,400**
Fairfield County	4,047	4,260	5,040	6,130	7,200	8,300
Lexington County	330,215	35,680	43,450	51,510	61,070	70,340
Newberry County	6,892	7,270	8,240	9,380	10,740	11,930
Richland County	41,607	44,600	52,750	62,090	73,380	81,830
Lower Savannan PSA	**51,679**	**67,970**	**67,710**	**79,520**	**94,280**	**108,090**
Aiken County	24,112	27,960	32,880	38,880	46,590	54,450
Allendale County	1,844	2,110	2,530	2,880	3,410	3,600
Bamberg County	3,014	3,020	3,480	3,880	4,520	4,530
Barnwell County	3,840	4,290	5,040	6,000	7,250	8,550
Calhoun County	2,804	3,020	3,720	4,540	5,620	6,570
Orangeburg County	16,065	17,570	20,060	23,340	26,890	30,390
Santee-Lynches PSA	**34,345**	**38,390**	**45,430**	**53,160**	**64,090**	**72,220**
Clarendon County	6,197	7,140	8,900	10,790	13,080	14,730
Kershaw County	9,095	9,810	11,590	13,380	16,120	18,430
Lee County	3,244	3,490	4,180	4,920	6,040	6,450
Sumter County	15,809	17,950	20,760	24,070	28,840	32,610
Pee Dee PSA	**63,202**	**55,710**	**64,390**	**73,630**	**85,920**	**92,210**
Chesterfield County	6,933	7,200	8,380	9,510	10,930	12,130
Darlington County	11,101	11,680	13,480	15,510	18,000	19,420
Dillon County	4,773	4,730	5,280	5,980	6,840	7,660
Florence County	19,986	21,680	25,210	29,370	33,900	37,470
Marion County	5,753	5,880	7,010	7,940	10,080	9,380
Marlboro County	4,656	4,540	5,030	5,320	6,170	6,150
Waccamaw PSA	**57,943**	**69,030**	**85,870**	**105,770**	**129,770**	**153,420**
Georgetown County	11,434	13,800	17,640	22,100	17,940	32,490
Horry County	40,104	48,470	60,420	74,460	91,060	109,060
Williamsburg County	6,406	6,760	7,810	9,210	10,770	11,870
Trident PSA	**77,367**	**92,870**	**114,490**	**139,130**	**167,866**	**180,640**
Berkeley County	16,280	22,110	29,430	37,340	46,370	42,300
Charleston County	48,734	54,520	63,770	74,880	88,090	98,260
Dorchester County	12,353	16,240	21,290	26,910	33,400	40,080
Low Country PSA	**38,227**	**46,460**	**59,320**	**74,710**	**93,280**	**112,500**
Beaufort County	25,040	32,230	42,320	54,650	69,260	85,220
Colleton County	6,711	7,200	8,470	9,950	11,600	12,870
Hampton County	3,392	3,570	4,360	5,120	6,350	7,040
Jasper County	3,084	3,410	4,170	4,990	6,070	7,370
South Carolina Totals	**651,482**	**729,700**	**864,890**	**1,017,450**	**1,207,480**	**1,359,120**

SOUTH CAROLINA POPULATION BY AGE 2000 – 2025: AGE 75+ By PSA

	2000	2005	2010	2015	2020	2025
Appalachia PSA	**58,533**	**59,070**	**60,990**	**62,100**	**76,650**	**88,520**
Anderson County	10,289	10,280	10,750	10,600	13,580	14,830
Cherokee County	2,947	2,940	2,940	2,800	3,520	4,020
Greenville County	20,747	20,930	20,970	20,840	25,550	30,430
Oconee County	4,074	4,570	5,640	6,580	8,040	8,940
Pickens County	5,857	5,990	6,230	6,630	7,840	9,120
Spartanburg County	14,619	14,360	14,460	14,650	18,120	21,180
Upper Savannah PSA	**13,403**	**13,780**	**14,350**	**14,810**	**17,650**	**21,676**
Abbeville County	1,784	1,780	1,900	1,810	2,050	2,460
Edgefield County	1,195	1,220	1,280	1,350	1,700	2,260
Greenwood County	4,245	4,250	4,150	4,080	4,680	5,670
Laurens County	4,194	4,280	4,490	4,630	5,590	6,610
McCormick County	681	860	1,070	1,380	1,840	2,460
Saluda County	1,304	1,390	1,460	1,560	1,790	2,110
Catawba PSA	**14,920**	**15,120**	**15,900**	**16,140**	**19,820**	**23,469**
Chester County	1,954	1,880	2,030	1,850	2,450	2,919
Lancaster County	3,279	2,930	2,990	3,050	3,930	4,170
Union County	2,180	2,260	2,360	2,300	2,550	2,870
York County	7,507	8,050	8,520	8,940	10,890	13,510
Central Midlands PSA	**28,365**	**29,770**	**31,060**	**31,700**	**38,980**	**49,380**
Fairfield County	1,405	1,340	1,350	1,340	1,610	2,230
Lexington County	9,764	11,290	12,550	13,610	16,450	20,220
Newberry County	2,661	2,490	2,480	2,550	3,120	3,720
Richland County	14,536	14,650	14,680	14,200	17,800	23,210
Sub Total						
Lower Savannah PSA	**17,557**	**19,130**	**20,400**	**20,670**	**24,980**	**30,590**
Aiken County	7,943	9,350	10,220	10,320	12,210	15,360
Allendale County	707	770	770	760	1,080	1,210
Bamberg County	1,092	920	970	810	1,240	1,090
Barnwell County	1,336	1,480	1,580	1,570	1,860	2,410
Calhoun County	949	880	950	950	1,290	1,570
Orangeburg County	5,530	5,730	5,910	6,260	7,300	8,950
Santee-Lynches PSA	**11,335**	**11,950**	**13,560**	**13,840**	**7,960**	**19,850**
Clarendon County	1,869	1,940	2,300	2,580	3,450	4,230
Kershaw County	2,946	3,000	3,350	3,240	4,020	4,800
Lee County	1,169	1,220	1,440	1,290	1,750	1,730
Sumter County	5,351	5,790	6,470	6,730	7,960	9,090
Pee Dee Psa	**17,950**	**17,220**	**17,270**	**16,890**	**22,290**	**24,790**
Chesterfield County	2,203	2,030	2,180	2,160	2,690	3,220
Darlington County	3,704	3,530	3,470	3,520	4,580	5,200
Dillon County	1,603	1,520	1,380	1,410	1,610	2,080
Florence County	6,897	7,020	7,110	7,320	8,970	11,260
Marion County	1,944	1,750	1,830	1,440	2,780	1,490
Marlboro County	1,599	1,370	1,300	1,040	1,660	1,540
Waccamaw County PSA	**16,614**	**19,550**	**23,450**	**26,850**	**33,330**	**40,940**
Georgetown County	3,476	3,910	4,770	5,350	7,480	8,730
Horry County	11,011	13,560	16,540	19,330	23,290	28,970
Williamsburg County	2,127	2,080	2,140	2,170	2,560	3,240
Trident County PSA	**24,905**	**28,610**	**31,780**	**35,570**	**45,800**	**59,510**
Berkeley County	4,288	5,800	7,440	9,360	12,500	16,690
Charleston County	16,828	18,010	18,420	18,930	23,760	30,340
Dorchester County	3,789	4,800	5,920	7,280	9,520	12,480
Low County PSA	**11,703**	**13,760**	**17,120**	**20,410**	**26,730**	**32,090**
Beaufort County	7,425	9,640	12,460	15,600	19,580	14,970
Colleton County	2,134	2,020	2,210	2,260	2,910	3,380
Hampton County	1,148	1,040	1,260	1,250	1,670	1,700
Jasper County	996	1,060	1,190	1,300	1,570	2,040
South Carolina Totals	**215,285**	**227,960**	**245,880**	**258,980**	**322,410**	**390,709**

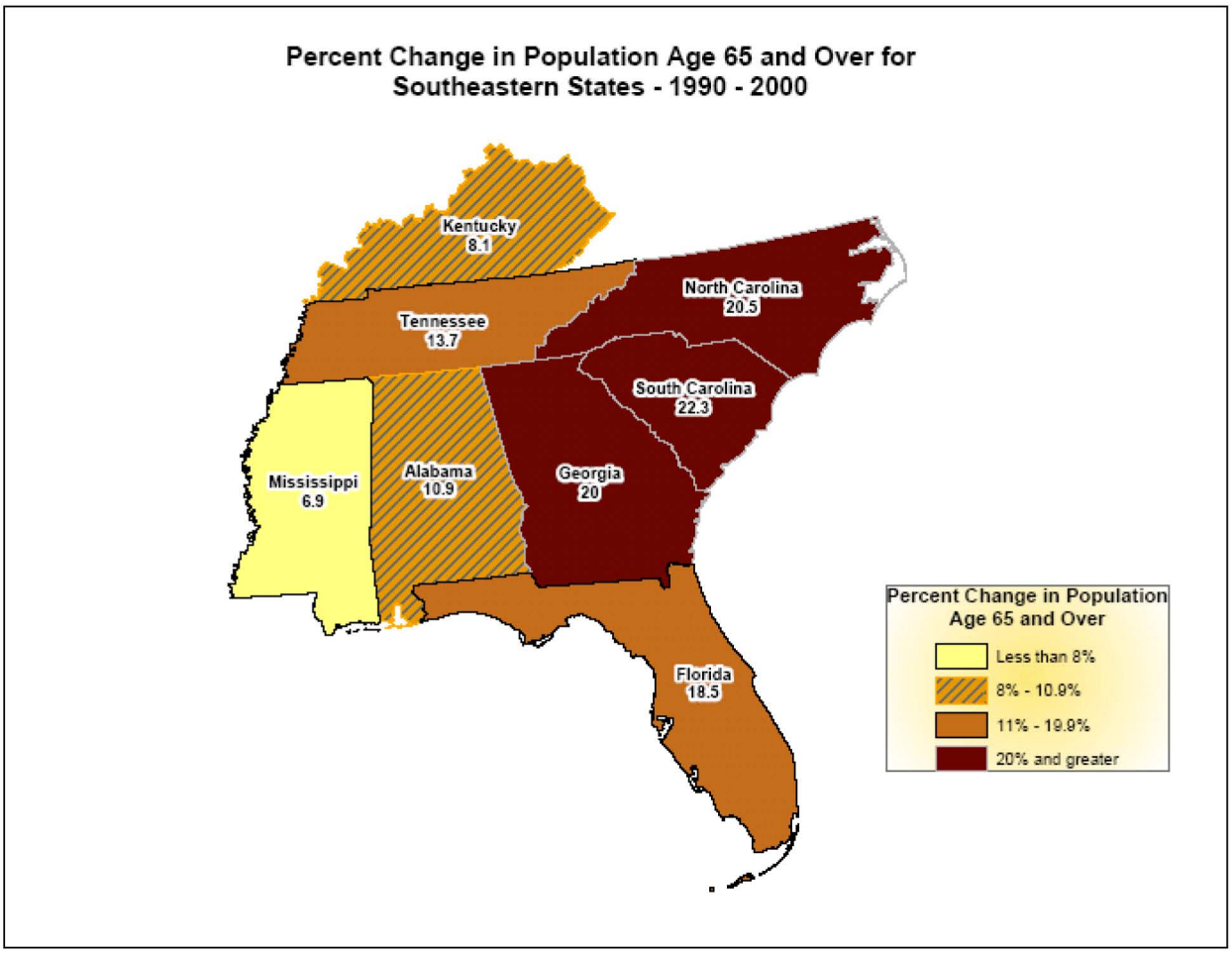
SOUTH CAROLINA POPULATION BY AGE 2000 – 2025: AGE 85+ By PSA

	2000	2005	2010	2015	2020	2025
Appalachia PSA	**14,010**	**13,520**	**16,310**	**11,860**	**17,550**	**14,090**
Anderson County	2,344	2,110	2,890	1,640	3,300	1,820
Cherokee County	721	650	820	560	780	670
Greenville County	5,009	4,870	6,010	4,320	5,630	5,450
Oconee County	848	880	1,080	1,000	1,750	1,050
Pickens County	1,504	1,640	1,720	1,490	1,970	1,780
Spartanburg County	3,583	3,370	3,790	2,850	4,120	3,320
Sub Total						
Upper Savannah PSA	**3,462**	**3,580**	**3,980**	**3,620**	**4,020**	**4,380**
Abbeville County	488	380	610	380	580	470
Edgefield County	293	350	360	330	400	390
Greenwood County	1,041	1,060	1,100	1,000	950	1,160
Laurens County	1,121	1,130	1,230	1,080	1,360	1,210
McCormick County	178	240	300	320	380	520
Saluda County	341	420	380	510	350	630
Csataawba PSA	**3,476**	**3,440**	**4,250**	**3,110**	**4,680**	**3,850**
Chester County	446	310	550	280	490	490
Lancaster County	752	650	450	440	1,000	400
Union County	505	510	640	460	680	540
York County	1,772	1,970	2,310	1,930	2,480	2,420
Central Midlands PSA	**6,840**	**7,520**	**9,100**	**7,620**	**9,690**	**8,830**
Fairfield County	344	640	320	340	340	280
Lexington County	2,412	3,170	3,950	3,930	4,500	4,620
Newberry County	706	660	680	520	780	610
Richland County	3,376	3,350	4,150	2,830	4,070	3,320
Lower Savannah PSA	**4,089**	**4,430**	**6,440**	**4,680**	**5,790**	**5,020**
Aiken County	1,782	2,070	2,650	2,520	2,660	2,820
Allendale County	189	190	240	140	300	110
Bamberg County	240	150	260	40	400	-220
Barnwell County	301	350	440	390	450	450
Calhoun County	242	180	260	160	280	180
Orangeburg County	1,335	1,490	1,590	1,430	1,700	1,680
Santee-Lynches PSA	**2,704**	**2,610**	**3,660**	**2,510**	**4,460**	**2,700**
Clarendon County	433	380	550	390	740	590
Kershaw County	703	590	890	580	960	610
Lee County	287	230	420	220	540	10
Sumter County	1,281	1,410	1,800	1,320	2,210	1,490
Pee Dee PSA	**4,378**	**4,010**	**5,000**	**2,940**	**5,750**	**2,510**
Chesterfield County	516	410	470	350	580	340
Darlington County	843	810	1,000	550	1,110	590
Dillon County	353	330	360	290	240	560
Florence County	1,797	1,880	2,150	1,660	2,260	2,110
Marion County	470	290	590	0	1,050	-1,040
Marlboro County	399	290	430	90	510	-50
Waccamaw PSA	**3,170**	**3,650**	**5,070**	**4,620**	**6,870**	**5,910**
Georgetown County	657	650	1,140	660	1,630	750
Horry County	2,041	2,540	3,410	3,570	4,610	4,790
Williamsburg County	472	470	520	390	630	370
Trident PSA	**5,604**	**6,730**	**8,640**	**7,960**	**10,600**	**11,120**
Berkeley County	879	1,240	1,770	2,030	2,720	3,040
Charleston County	3,855	4,170	5,060	3,990	5,160	5,110
Dorchester County	870	1,320	1,810	1,940	2,620	2,970
Low Country PSA	**2,537**	**2,840**	**3,870**	**4,220**	**5,630**	**5,720**
Beaufort County	1,512	2,060	2,830	3,410	4,260	5,090
Colleton County	493	380	500	350	610	350
Hampton County	274	180	280	150	490	-70
Jasper County	258	220	260	310	270	350
South Carolina Totals	**50,269**	**52,340**	**65,320**	**53,140**	**74,900**	**64,130**

Poverty Status: Age 65+

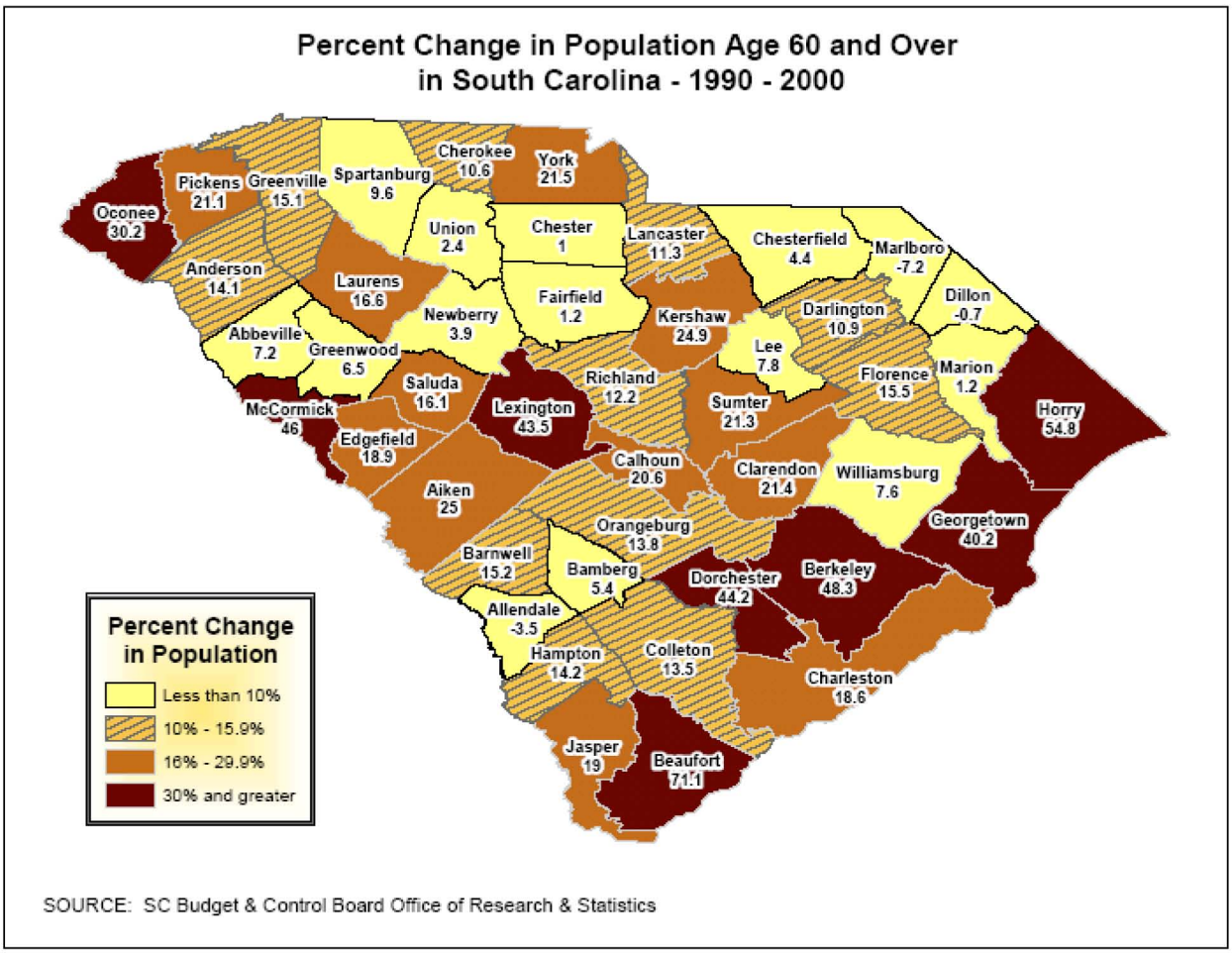
Planning & Service Area	Over 65	Under 100%	% Under	Under 150%	% Under	Under 200%	% Under
Appalachia	**123,859**	**15,311**	**12.4**	**32,419**	**26.1**	**46,955**	**37.9**
Anderson County	21,705	2,995	13.8	6,369	29.2	8,867	40.9
Cherokee County	6,254	952	15.2	1,949	31.2	2,890	46.2
Greenville County	42,872	4,524	10.6	10,323	24.1	14,876	34.7
Oconee County	10,126	1,307	12.9	2,550	25.2	3,524	34.8
Pickens County	12,104	1,422	11.7	3,106	25.7	4,643	38.4
Spartanburg County	30,798	4,111	13.3	8,122	26.4	12,155	39.5
Upper Savannah	**27,747**	**4,104**	**14.8**	**8,694**	**31.2**	**12,189**	**43.9**
Abbeville County	3,725	629	16.9	1,324	35.5	1,825	49
Edgefield County	2,655	489	18.4	815	30.7	1,160	43.7
Greenwood County	8,826	1,243	14.1	2,757	31.2	3,737	42.3
Laurens County	8,497	1,147	13.5	2,576	30.4	3,808	44.8
McCormick County	1,424	169	11.9	413	29	587	41.2
Saluda County	2,620	427	16.3	809	30.9	1,072	40.9
Catawba	**32,021**	**4,033**	**12.1**	**8,537**	**30.8**	**12,504**	**45.1**
Chester County	4,123	614	14.9	1,210	29.3	1,813	44
Lancaster County	7,326	1,155	15.8	2,461	33.6	3,490	47.6
Union County	4,551	724	15.9	1,445	31.8	2,001	44
York County	16,021	1,540	9.6	3,421	21.4	5,200	32.5
Central Midlands	**58,246**	**6,969**	**11. 9**	**13,449**	**31.9**	**19,367**	**33.3**
Fairfield County	2,835	682	24.1	1,176	41.5	1,492	52.6
Lexington County	20,670	1,912	9.3	4,240	20.5	6,663	32.2
Newberry County	5,134	821	16	1,567	30.5	2,163	42.1
Richland County	29,607	3,554	12	6,466	21.8	9,049	30.6
Lower Savannah	**37,764**	**6,789**	**17.9**	**12,053**		**16,167**	**42.8**
Aiken County	17,856	2,237	12.5	4,327	24.2	6,268	35.1
Allendale County	1,366	355	26	617	45.2	799	58.5
Bamberg County	2,290	591	25.8	943	41.2	1,192	52.1
Barnwell County	2.806	684	24.4	1,176	41.2	1,520	54.2
Calhoun County	1,987	364	18.3	681	34.3	932	46.9
Orangeburg County	11,459	2,558	22.3	4,309	37.6	5,456	47.6
Santee-Lynches	**24,721**	**4,654**	**18.8**	**8,156**	**32.9**	**11,320**	**45.8**
Clarendon County	4,472	1,099	24.6	1,819	40.7	2,467	55.2
Kershaw County	6,461	914	14.1	1,673	25.9	2,431	37.6
Lee County	2,340	653	27.9	1,005	42.9	1,232	52.6
Sumter County	11,448	1,988	17.4	3,659	32	5,190	45.3
Pee Dee	**37,272**	**7,799**	**20.9**	**13,468**	**36.1**	**17,812**	**47.7**
Chesterfield County	4,982	1,208	24.2	2,008	40.3	2,636	52.9
Darlington County	7,627	1,683	22.1	2,725	35.7	3,577	46.9
Dillon County	3,361	893	26.6	1,468	43.7	1,857	55.2
Florence County	13,736	2,262	16.5	4,166	30.3	5,827	42.4
Marion County	4,193	987	23.5	1,592	38	2,052	48.9
Marlboro County	3,373	766	22.7	1,509	44.7	1,863	55.2
Low Country	**41,732**	**3,166**	**11.3**	**8,700**	**20.8**	**12,562**	**30.1**
Georgetown County	8,282	1,159	14	1,921	23.2	2,723	32.9
Horry County	28,709	2,497	8.7	4,757	16.6	7,293	25.4
Williamsburg County	4,741	1,230	25.9	2,022	42.7	2,546	53.7
Trident	**54,519**	**6,977**	**12.9**	**12,457**	**22.8**	**17,749**	**32.6**
Berkeley County	10,980	1,415	12.9	2,620	23.9	3,884	35.4
Charleston County	35,242	4,461	12.7	7,868	22.3	11,055	31.4
Dorchester County	8,297	1,101	13.3	1,969	23.7	2,810	33.9
Low Country	**27,966**	**3,166**		**6,022**	**21.5**	**7,882**	**28.2**
Beaufort County	18,492	1,240	6.7	2,413	13	3,190	17.3
Colleton County	4,834	924	19.1	1,793	37.1	2,348	48.6
Hampton County	2,472	537	21.7	1,007	40.7	1,270	51.4
Jasper County	2,168	465	21.4	809	37.2	1,074	49.5
State Totals	**465,966**	**62,968**	**13.5**	**123,955**	**26.6**	**179,507**	**38.5**

SOUTHEASTERN STATES PERCENT POPULATION CHANGE: AGE 65+



State	1990 Population 65+	2000 Population 65+	# Change 1990-2000	% Change 1990-2000
Alabama	522,989	579,798	56,809	10.9
Florida	2,369,431	2,807,597	438,166	18.5
Georgia	654,270	785,275	131,005	20.0
Kentucky	466,845	504,793	37,948	8.1
Mississippi	321,284	343,523	22,239	6.9
North Carolina	804,341	969,048	164,707	20.5
South Carolina	**396,935**	**485,333**	**88,398**	**22.3**
Tennessee	618,818	703,311	84,493	13.7

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



	1990	2000	%
APPALACHIA			
Anderson	1,911	30,240	-3.5
Cherokee	7,843	8,672	10.6
Greenville	51,733	59,563	15.1
Oconee	10,842	14,116	30.2
Pickens	14,067	17,034	21.1
Spartanburg	38,690	42,408	9.6
CENTRAL MIDLANDS			
Fairfield	4,000	4,047	1.2
Lexington	21,056	30,215	43.5
Newberry	6,636	6,892	3.9
Richland	37,097	41,607	12.2
PEE DEE			
Chesterfield	6,643	6,933	4.4
Darlington	10,012	11,101	10.9
Dillon	4,807	4,773	-0.7
Florence	17,311	19,986	15.5
Marion	5,687	5,753	1.2
Marlboro	5,019	4,656	-7.2

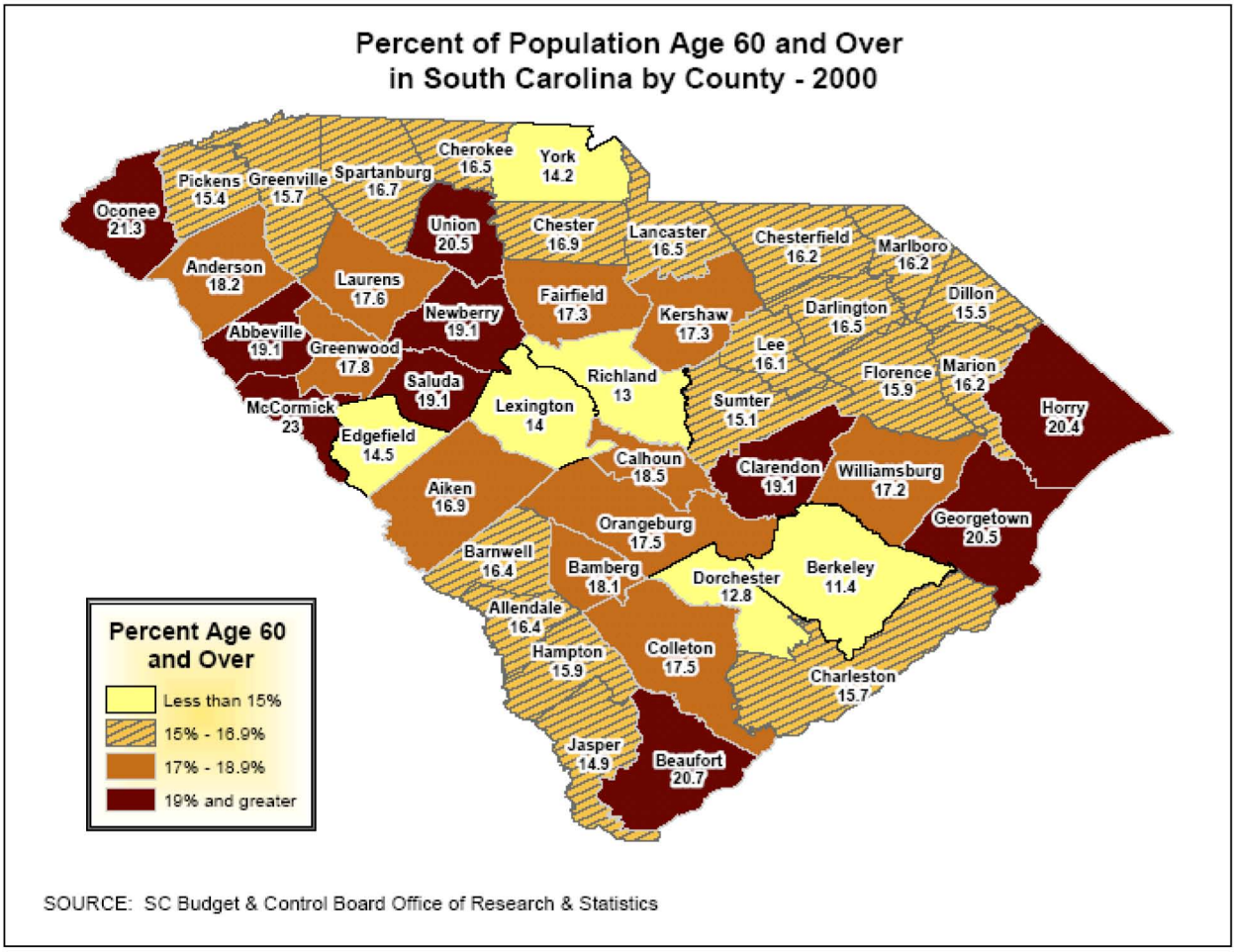
PSA	1990	2000	%
UPPER SAVANNAAH			
Abbeville	4,669	5,005	7.2
Edgefield	3,001	3,568	18.9
Greenwood	11,059	11,781	6.5
Laurens	10,485	12,222	16.6
McCormick	1,566	2,286	46.0
Saluda	3,162	3,671	16.1
LOWER SAVANNAH			
Aiken	19,296	24,112	25.0
Allendale	1,911	1,844	-3.5
Bamberg	2,860	3,014	5.4
Barnwell	3,334	3,840	15.2
Calhoun	2,326	2,804	20.6
Orangeburg	14,115	16,065	13.8
WACCAMAW			
Georgetown	8,153	11,434	40.2
Horry	25,911	40,104	54.8
Williamsburg	5,955	6,405	7.6

	1990	2000	%
CATAWBA			
Chester	5,693	5,751	1.0
Lancaster	9,080	10,107	11.3
Union	5,996	6,139	2.4
York	19,250	23,395	21.5
SANTEE-LYNCHES			
Clarendon	5,103	6,197	21.4
Kershaw	7,279	9,095	24.9
Lee	3,008	3,244	7.8
Sumter	13,030	15,809	21.3
TRIDENT			
Berkeley	10,977	16,280	48.3
Charleston	41,107	48,734	18.6
Dorchester	8,567	12,786	44.2
LOW COUNTRY			
Beaufort	14,638	25,402	71.1
Colleton	5,915	6,711	13.5
Hampton	2,971	3,392	14.2
Jasper	2,592	3,084	19.0

SC Totals: 1990 0ver 60 Population = 540,955; 2000 0ver 60 Population = 651,482; Percent Change = 20.4

Source: Office of Research and Statistics based on Census 2000 data.

POPULATION OVER AGE 60 IN 2000



PSA	TOTAL	60+	%	PSA	POP	#	%	PSA	POP	#	%
APPALACHIA				**UPPER SAVANNAAH**				**CATAWBA**			
Anderson	165,240	30,240	18.1	Abbeville	26,167	5,005	19.1	Chester	34,068	5,751	16.9
Cherokee	52,537	8,672	16.5	Edgefield	24,595	3,568	14.5	Lancaster	61,351	10,107	16.5
Greenville	379,616	59,563	15.7	Greenwood	66,271	11,781	17.8	Union	29,881	6,139	20.5
Oconee	66,215	14,116	21.3	Laurens	69,567	12,222	17.6	York	164,614	23,395	14.2
Pickens	110,757	17,034	15.4	McCormick	9,958	2,286	23.0	**SANTEE-LYNCHES**			
Spartanburg	253,791	42,408	16.7	Saluda	19,181	3,671	19.1	Clarendon	32,502	6,197	19.1
CENTRAL MIDLANDS				**LOWER SAVANNAH**				Kershaw	52,647	9,095	17.3
Fairfield	23,454	4,047	17.3	Aiken	142,552	24,112	16.9	Lee	20,119	3,244	16.1
Lexington	216,014	30,215	14.0	Allendale	11,211	1,844	16.4	Sumter	104,606	15,809	15.1
Newberry	36,108	6,892	19.1	Bamberg	16,658	3,014	18.1	**TRIDENT**			
Richland	320,677	41,607	13.0	Barnwell	23,478	3,840	16.4	Berkeley	142,651	16,280	11.4
PEE DEE				Calhoun	15,185	2,804	18.5	Charleston	309,969	48,734	15.7
Chesterfield	42,768	6,933	16.2	Orangeburg	66,215	16,065	21.3	orchester	96,413	12,353	12.8
Darlington	67,394	11,101	16.5	**WACCAMAW**				**LOW COUNTRY**			
Dillon	30,722	4,773	15.5	Georgetown	55,797	11,434	20.5	Beaufort	120,937	25,040	20.7
Florence	125,761	19,986	15.9	Horry	196,629	40,104	20.4	Colleton	38,264	6,711	17.5
Marion	35,466	5,753	16.2	Williamsburg	37,217	6,405	17.2	Hampton	21,386	3,392	15.9
Marlboro	28,818	4,656	16.2					Jasper	20,678	3,084	14.9

SC Totals: Total Population = 4,012,012; Total Over 60 Population = 651,482; Total % = 16.2

Source: Office of Research and Statistics based on Census 2000 data.

CHAPTER 6: IDENTIFICATION OF ISSUES AND NEEDS

The SUA uses a variety of mechanisms and resources to identify the needs of senior citizens of South Carolina. Information gathered will aid state, regional and local agencies to plan for services to meet the needs of seniors.

A. South Carolina College of Social Work and System Wide Solutions, Inc.

During the summer of 2003, the University of South Carolina College of Social Work and System Wide Solutions, Inc. entered into an agreement with the SUA to identify issues that determine when and if elderly persons move to a higher level of care.

The primary sources for these issues came from focus groups and interviews of caregivers and clients served through the Medicaid Elderly and Disabled waiver (Community Long Term Care agencies) and seniors served by agencies funded by the Older Americans Act. Professionals from these agencies also participated in individual interviews to provide their objective perspective of seniors' issues. The information gathered from the knowledgeable professionals matched the feedback from the caregivers and seniors.

Seven major issues important to prevent the seniors from moving to a higher level of care, derived from the seniors' focus groups, are:

- Social stimulation and companionship
- Maintaining an independent role
- Maintaining intellectual functioning
- Keeping active
- Receiving appropriate and timely support
- Receiving appropriate, timely and complete information
- Transportation and mobility

Three major issues were apparent from the caregiver's focus groups. They include:

- Preventive measures that might have been taken
- Taking care of the caregivers
- Provision of more services

The issues identified above came from information gathered from within eight geographic areas throughout the state. Area Agencies on Aging in South Carolina can refer to findings from focus groups and interviews held within specific geographic areas to highlight issues pertinent to their service delivery area.

B. Sage Institute's Area Market Analysis Of The 10 Regions

The Sage Institute, located within the Spartanburg Regional Healthcare System, conducted a *Senior Service Needs Assessment* within each of the 10 service areas in South Carolina, as part of the Geriatric Best Practice Initiative. The "Geriatric Best Practice Initiative" is funded by The Duke Endowment and an initiative within the South Carolina Hospital Association. From June 2002 though December 2003, the Initiative explored, evaluated and cataloged over 200 Geriatric Best Practices (senior healthcare and non-healthcare) across South Carolina and the region in order to move one step closer toward meeting the care needs of our seniors.

Nine questions were asked of senior citizens ranging from asking about their level of satisfaction with senior services to strengths and weaknesses of services to identifying service gaps and barriers within a county. Three questions are highlighted below with the most responses indicated.

NOTE: Responses are listed from highest number to lowest number of answers.

1. **Where do you believe the senior service gaps are within your county?**

   Responses: Transportation, behavioral health, home care, lack of community-based education, lack of services in rural areas, single point of entry, and funding.

2. **What services would you like to see developed within your county and/or service area?"**

   Responses: Transportation (not Medicaid kind), Alzheimer's services, outpatient behavioral health, affordable respite, mental health, mobile health assessments, more geriatricians, and medical assistance.

3. **What do you believe the barriers might be to keep the senior service gaps from being filled?"**

   Responses: Funding, communication, politics, lack of education, mental health, lack of trained staff, and competition/turfism among service agencies.

C. POMP IV Survey Results

The SUA received a grant from the Administration on Aging in 2002 to conduct a telephone survey to assist in developing satisfaction and performance measures. The surveys were conducted statewide by the University of South Carolina Institute for Public Service and Policy Research in the summer of 2003, with the cooperation of the state's Aging Network.

The major program and services areas surveyed were as follows:

- Home Delivered Meals
- Congregate Meals
- Information and Assistance
- Transportation
- Caregiver Support Services

The POMP IV surveys in the five services showed the consumers were satisfied overall with the services they received. Gaps, barriers, and additional needs within the services were explored through the questions.

People would participate more in the home delivered meals program if the meals were offered more, particularly on week-ends. For 60% of survey participants in the home delivered meals program, the daily meal they received represented half or more of all the food they ate that day. As a result of participating in the home delivered meals program, 96% eat more balanced meals and 74% find it easier to keep to a special diet. Nutrition counseling, transportation, and help with grocery shopping received high percentages as additional services clients would use if offered.

Clients of congregate meals first heard of the program through friends, family or community organizations. Only 13% had heard of the congregate meals program from the local office on aging. As in the home delivered meals program, more clients would like week-end meals. Both home delivered and congregate meals program surveyed clients indicated they had only one serving of meat and one serving of milk products per

day. They received these servings from the aging meals program. Additional services clients would use if offered included nutrition counseling, transportation, assistance in getting other services such as legal, and accessing other benefits like food stamps.

Physical fitness and health screening activities had the highest percentage of needed additional service (81% each). Clients indicated they would use these services if they were offered.

The Information and Assistance survey found callers were promptly answered. For those that had to leave a message though, it could take a few days to receive a call back. It was split 50/50 for people who answered they received the information or help they needed. (50%-yes, 50%-no). A third were referred to another agency. Overall, 80% said they expected the information they received would be helpful in resolving the issue they called about.

During the Family Caregiver Support survey, it was quite evident that financial support, tax break, stipend, or government subsidy was the overwhelming need for caregivers (84%). Housekeeping and respite were the next highest needs indicated. Survey participants said they needed help in dealing with other agencies (bureaucracy) to get services. They needed help in understanding changes in laws and how to pay for nursing homes. Counseling or support groups were indicated as a need 66% of the time. Caregiving strained relationships, affected the caregiver's health, and made for a less effective employee, causing many to quit work.

Transportation survey participants were overwhelmingly female (89%) and black (80%) and much older (age 80 plus) with small incomes (85% under $15,000 a year). Clients relied on transportation service for over 40% of all trips they took. Clients said drivers were polite and on time. Vehicles were comfortable and easy to get in and out. However, trip length and getting to places wanted/needed were sometimes a problem.

For all five POMP surveys, the evaluation of the service was positive. POMP stands for Performance Outcomes Measures Project and was sponsored by the Administration on Aging. It is apparent South Carolina's aging network is performing well in many areas and could use some improvement in other areas. For the most part, clients are having a positive outcome through the use of Older American Act services.

D. Public Forums

The Real Choice Advisory Committee, South Carolina's Silver Haired Legislature, the SUA, and the University of South Carolina School of Public Health worked with the National Council on Aging and the National Association on State Units on Aging Consumer Direction Project. This was a national project, funded through the Robert Wood Johnson Foundation, to identify issues related to consumer direction in the service delivery system for seniors and people with disabilities.

In fall of 2002, nearly 6,000 surveys were mailed to seniors and people with disabilities in South Carolina to receive their feedback regarding the current service delivery system. Over 500 surveys were returned and analyzed by the University of South Carolina School of Public Health. The results of the survey helped the Real Choice Advisory Committee to identify six key areas of concern. These key areas of concern were discussed more fully with six focus groups representing people with dementia, developmental disabilities, mental illness, spinal cord injuries, brain injuries, and seniors. The results of the survey and focus groups were used to identify six priorities that were presented at four regional public forums in May 2003 for public input.

The public comments received at the public forums regarding the priority policy recommendations, as well as the input received from the focus groups and survey results, were used by the Real Choice Advisory Committee to formulate implementation strategies.

These implementation strategies were presented to key aging and disability state leaders and advocacy organizations in November 2003. The result of this meeting was development of a common action plan to promote greater consumer direction and control of home and community based long term care services in South Carolina for seniors and people with disabilities.

The following is a summary of comments received at Public Forums held May 2003 as part of a NASUA Project:

Information About Programs & Services

- "No wrong door" should be our goal. People are often shifted from place to place. The Legislature needs to be educated to fund programs that improve access to information about services and programs.
- Information about services is often hidden or not accessible. Agencies need to make information available about the services they offer and be prepared for increased service demand. The Internet is a useful tool for accessing information.
- It is difficult for families (particularly caregivers) to get information and to access services. Improved networking and availability of information is needed among agencies.

Application for Services

- There needs to be a simplification of the application process. A single portal of entry is needed. Often people give up and don't get services they need.
- Make eligibility requirements simple and easy to understand. Offer different choices for services. Many families of individuals with disabilities are not aware of choices when applying for services.

Choice and Control

- People with long term care needs, regardless of age, should have choices. Individuals with disabilities and seniors need more choice and control. The services provided in a long-term care facility can be provided at home. The question is how much do we want to spend and where.
- Give people the tools they need to live at home and be fully integrated into the community.
- The Family Caregiver program is successful because flexibility has been given to AAAs, providers, and families. Families have been asked to identify what is important to them; thus there has been high client satisfaction with the program.
- Choice of respite care providers is needed. It will be important that there are viable options available in the community in terms of service providers. In many communities, especially rural areas, there are not multiple choices in terms of providers of service.

Inadequate Funding of Service Delivery System

- Sometimes information is provided about various services only to be told it is not available due to funding cuts.
- Agencies are hiding because they lack adequate funding to provide services.
- There are long waiting lists for services. The current service delivery system is not able to serve those already in the system.
- There are no funds available to provide safe emergency shelter for elderly abused victim's care. State funds are needed for food, shelter, clothing, supplies and services for the victims of elder abuse, neglect, and exploitation
- There is a lack of resources to support seniors and their families.
- Approximately 80% of the 24,000 individuals served by DDSN live at home. More than 1200 of these individuals live at home with a caregiver over 65 years of age. Aged caregivers are concerned about what will happen after they die.
- The main obstacle to choice for consumers, their families and service providers is the lack of available and adequate funding, not the community resources to meet the variety of needs
- Funding should be increased so that direct care providers are paid at a higher level.

Respite Care

- There is a desperate need for respite across the life span. There are an increasing number of grandparents raising grandchildren who need respite.
- It is often difficult to find someone to provide respite care. Consideration needs to be given to faith-based solutions as an option for providing respite care.
- Need for respite care for those caring for someone 24 hours a day. As little as 4 hours a week can result in improved physical health and emotional health of the caregiver, as well as reduction of the risk of institutionalization of the care recipient. At $10.00 per hour, respite cost about $2,080 a year compared to $35,000 - $40,000 for nursing home care
- Respite should be offered in group and home settings, as well as on short and long term basis. Families should be able to select their respite care providers, with the option of exercising training exceptions for family members who already know the person needing care.

Abuse and Neglect

- Serious incidents of abuse and neglect are not being reported to the families.

Mental Health

- Need for respite care for those caring for someone with mental health issues. These families have no respite at present and must come to a crisis before the state intervenes.

Transportation

- Lack of transportation is a major issue and barrier to people receiving the services they need.

Accessibility Issues

- There is a need for legislation for universal accessibility design for buildings.
- Talk to legislators before passing laws. The SLED-check requirement has resulted in good, long-term employees being terminated for writing bad checks many years ago.

Impact on Working

- Concern that working will impact Medicaid and other benefits.

E. AARP South Carolina Legislative Priorities for 2004

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

Medicaid Funding:

AARP supports establishing a stable, recurring funding source for Medicaid. This can be accomplished by increasing the cigarette tax to at least the national average and earmarking the increase solely for Medicaid. We urge full funding for the SUA's existing programs for seniors, especially the Community Long Term Care program. We support legislation to expand and improve statewide in-home and community-based services for all South Carolinians. AARP continues to advocate consumer-directed long term care choices.

Telemarketing Fraud - "Do Not Call" Registry:

AARP supports enacting state "do-not-call" legislation. Although the Federal Trade Commission and the Federal Communications Commission have issued final regulations establishing a national "Do Not Call" registry, offenders can be prosecuted in state courts only if there is a state statute. Because consumer complaints will be numerous, federal prosecution may lag behind. While telemarketing fraud victimizes people of all ages, ethnic groups, educational backgrounds, and income levels, the repeated victimization of the elderly is the cornerstone of illegal telemarketing.

Ombudsmen Program for Nursing Homes:

AARP supports a volunteer ombudsmen program that would send trained volunteers into nursing homes on a regular, weekly basis. This would make life safer for our most vulnerable seniors. South Carolina is one of only five states that have no such program.

Financial Fraud:

Identity theft is a growing problem as sophisticated criminals find new ways to obtain personal information and then use this information to obtain credit. The result can ruin an individual's credit record and requires the victim to expend time and money to correct the problem.

Credit repair scams prey on people in financial trouble by offering to consolidate their debts into "one low monthly payment." These firms often imply that they provide consumer credit counseling when, in fact, their motive is profit. Consumers may find

themselves in worse financial position when the so-called counseling proves inadequate.

F. Silver-Haired Legislature

The following resolutions were submitted to the 2004 Second Session of the General Assembly of South Carolina:

First Priority: *Establishment of Volunteer Ombudsman Program*, to include both paid and volunteer ombudsman to ensure that the laws and regulations are carried out and that the senior citizens of this state receive adequate and proper care and a quality of life they richly deserve.

Second Priority: *Criminal Background checks for In-Home and Adult Day Care Providers,* requiring criminal background checks for all paid professional in-home and adult day care providers.

Third Priority: *Statewide In-Home Respite Program*, to provide adequate funding for a statewide in-home respite program that will provide respite services for all 46 counties.

Fourth Priority: *Support of Certain Unfunded Services for Abused Elders*, providing food, shelter, supplies, and services for abuse victims who have been removed from their homes.

Fifth Priority: Equitable Approach to Motor Vehicle Sales Tax, to eliminate the $300 limit and place a 2% sales tax on all motor vehicles.

Sixth Priority: *Tax Credits for Payment of Long Term Care Insurance Premiums*, to provide an income tax credit to any person who pays a premium for long term care.

Seventh Priority: *In-Home and Community–Based Services*, increasing funding for all in-home and community-based services which are coordinated through the Department of Mental Health and the Department of Social Services.

Eighth Priority: *Standardized Long Term Care Policies*, the development of regulations for companies selling long term care policies in the state and that these regulations include comparison of features similar to those found in federal regulations/procedures for Medicare policies, and the statewide education and awareness efforts promote these regulations utilizing I-CARE volunteers, as well as local aging service providers.

Ninth Priority: *Transportation for an Affordable Fee*, requiring that transportation for an affordable fee be provided the elderly of South Carolina.

Tenth Priority: *Recurring Funding for Medicaid*, establishing a special dedicated fund in the state treasury that would be recurring, sustainable, and reliable for the sole purpose of supporting Medicaid. This fund should be separate and distinct from the state General Fund and be used solely to provide monies for the state match fund for the federal Medicaid program. It should be exempt from budgetary cuts or reductions resulting from lack of general fund revenues.

Eleventh Priority: *Debt Forgiveness for Doctors in Geriatric Medicine*, providing up to $25,000 per year, up to a maximum of five years, to graduates of South Carolina medical schools who practice geriatric medicine and accept Medicare patients and payments in South Carolina.

Twelfth Priority: *Access to Long Term Care Services for Seniors*, to fund and implement a system that will provide/expand an information single point of entry for mature/older persons seeking long term care services.

Thirteenth Priority: *SC Silver Haired Legislature Funding*, allowing state taxpayers to donate a portion and/or all of their state tax refund to support the South Carolina Silver Haired Legislature using a check-off box on their respective SC income filing tax form.

G. Comparison of Major Needs

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

Issues	Sage	Senior Forums	LTC Survey	POMP IV	Waiting List	Silver-Haired Legislature
Transportation	1	7	5	2	3	9
Mental Health	2	6				
Respite		4				3
Access to Information and services	4	1	4			
Home Care	3				2	
Staying active-physical fitness			3	4		

The 2005 Area Plans indicated a variety of major needs, as listed above, as well as the need for employment and funding adequate to deliver services or give assistance to seniors.

CHAPTER 7: ISSUES, OUTCOMES, AND STRATEGIES

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

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

Over the past twenty years, we have seen a shift from the provision of institutional-based long term care services to a continuum of care with the provision of residential care or assisted living to home and community-based models of service. With the increasing need for support for seniors and caregivers, we are moving toward the development of a seamless long term support services system that is flexible and meets the needs of consumers. Prior to discussing various initiatives and programs that South Carolina will utilize to address these problems/issues over the next four years, we will elaborate on some of the key factors that move us toward a long-term support system.

Growth of the Senior Population

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

The growth of South Carolina's 60+ population will continue to increase significantly over the next twenty years. Overall, persons 60 and above are anticipated to increase from 651,482 in 2000 to 1,359,120 in 2025 for a 108.6% increase. The fastest growing segments of our senior population will be in the 65 to 69 and 85+ age categories.

In Chapter 5, a table on page 1 shows the growth of the 75-84 population and 85+ from 1980-2000, and the projection for 2025. These groups are particularly important because of their higher incidence of Alzheimer's disease. South Carolinians aged 75-84 have increased by 112.1 percent, and those 85 and over have increased by 151.3 percent. The 85+ population growth will increase from 50,269 to 74,900 by 2020 for a 49% increase.

In the 2000 census, there were an estimated 4 million people age 85+ in the United States. Nationally, this figure is expected to increase to 18 million in the next 50 years.

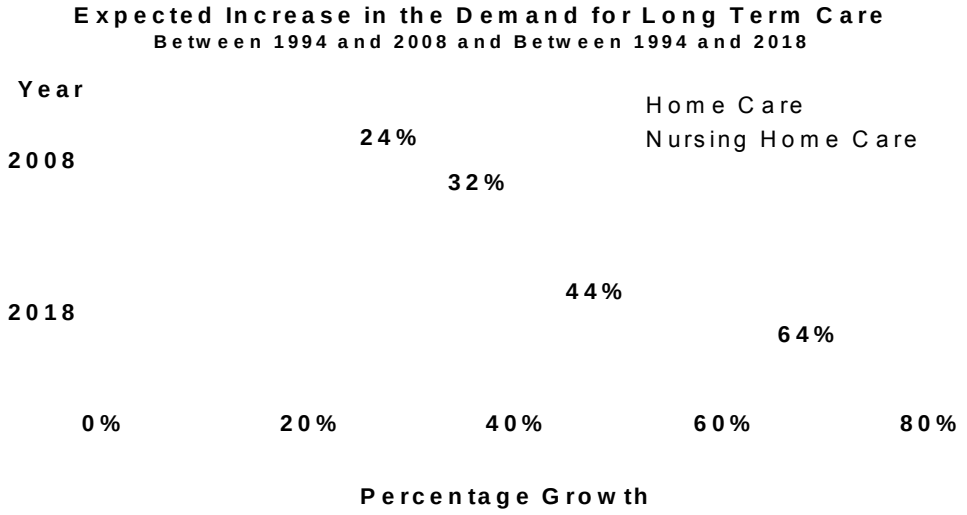
Long Term Care and An Aging Society

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

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

Growth in the Demand for Long Term Care Services

Most but not all persons in need of long- term care are elderly. Of the older population with long term care needs in the community, about 30% (1.5 million persons) have substantial needs. Approximately 53% are aged 65 and older. Of these, about 25% are 85 and older. As South Carolina and the nation ages, we can expect significant increases in the demand for long term care services. The chart below shows the anticipated increases in the need for long term care services by the year 2018.

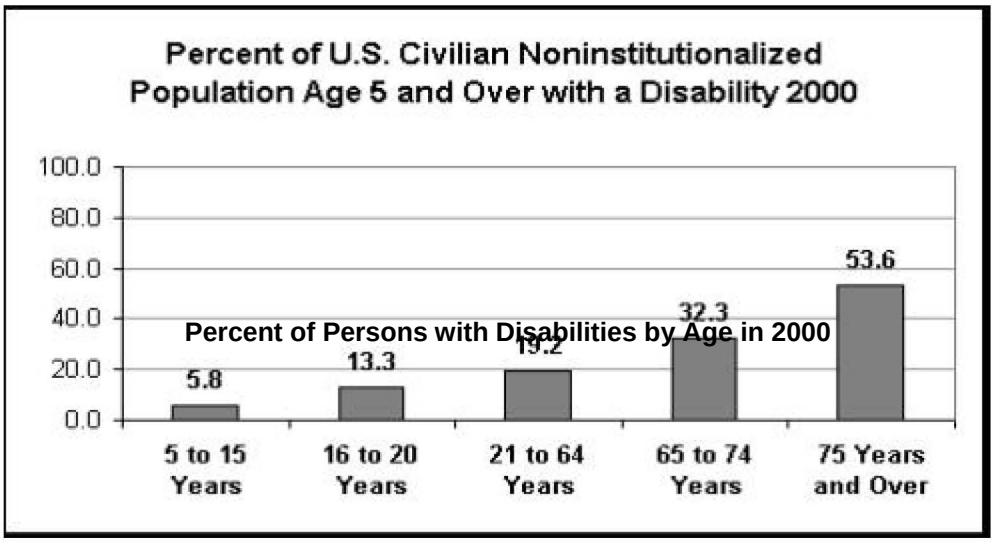


Age Group	Total Population	Any Disability		One Disability		2 or More Disabilities	
		#	%	#	%	#	%
5 to 15	633,667	40,209	6.3	32,174	5.1	8,035	1.3
16 to 64	2,553,295	557,200	21.8	296,808	11.6	260,392	10.2
65+	465,847	213,448	45.8	95,969	20.6	117,479	25.2

Source: Tabulations from the Pepper Commission, updated by Brookings/Lewin-IFC Long Term Care Financing Model

Growth in the Number of Persons with Disabilities

According to the US Census, as people age a higher percentage of individuals experience moderate to severe disabilities. In 2000, 32.3% of persons 65 to 74, and 53.6 % persons over the age of 75 experienced some disability.

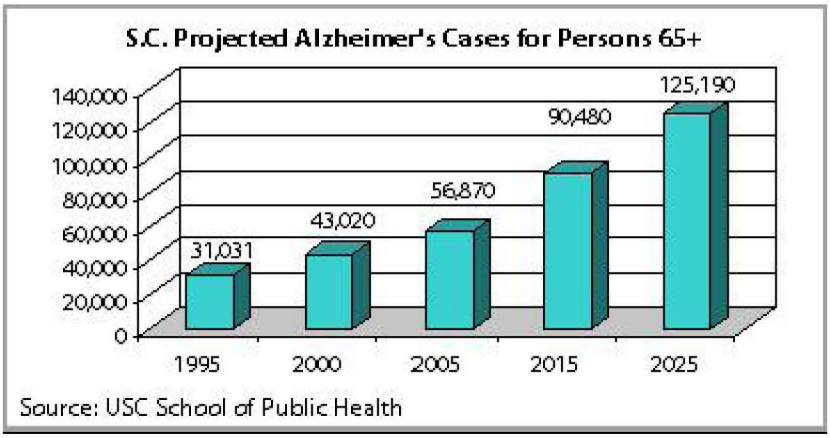


Source: U.S. Census Bureau, Census 2000. SF3, Table PCT 26

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

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

An estimated 4.5 million Americans have Alzheimer's disease, based on the number of cases detected in an ethically diverse population sample and the 2000 census. This number is expected to continue to grow to 11.3 million to 16 million by the year 2050. South Carolina is also facing the same trends. The chart below shows the projected growth in the number of Alzheimer's cases in South Carolina.



In the year 2000, there were 43,020 persons in South Carolina 65 and older with Alzheimer's disease. By the year 2025, it is estimated that there will be 125,190 persons with Alzheimer's disease. This growth will have a dramatic impact upon South Carolina's governmental programs, families, caregivers and businesses as society addresses how to handle the many problems and costs associated with this disease.

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

Alzheimer's Disease, Population Prevalence in South Carolina, Ages 55 and Over

	Ages 55 – 64	Ages 65 – 74	Ages 75 – 84	Ages 85+
Women	0.3%	1.4%	7.1%	33.8%
Men	0.3%	1.4%	6.0%	29.9%
White, All	0.2%	1.1%	5.7%	29.3%
White Women	0.2%	1.2%	6.1%	30.4%
White Men	0.2%	1.0%	4.9%	26.3%
Blacks, All	0.6%	2.7%	10.8%	43.6%
Black Women	0.5%	2.5%	10.8%	44.4%
Black Men	0.7%	3.1%	10.7%	41.2%
All	0.3%	1.4%	6.7%	32.8%

Source: 2001 South Carolina Alzheimer's Disease Registry and 2000 U.S. Census.
Table is for diagnosed Alzheimer's disease only, and does not include other types of dementia.

Rising Cost of Health Care and Long Term Care

Growth in the population needing long-term care, home and community based care and prescription drugs, diminishing capacity of family members to provide long-term care to families on a full time basis, and medical technology have increased the cost of public and private expenses for long-term care and other health care expenses. Medicaid is the largest government payer for long term care services.

Medicaid also pays for a large portion of prescription drugs and home care. The fact that our older citizens are the highest users of health care services poses some serious issues for policymakers. Based upon national data provided by the Centers for Medicare and Medicaid (CMS), the cost of health care has risen dramatically since 1980. CMS indicates that three major areas of health care spending have risen and will continue to rise dramatically throughout the year 2012. Nursing home costs will increase from $17.7 billion in 1980 to $178.8 billion in 2012. Home health care spending will increase from $2.4 billion in 1980 to $68.9 billion in 2012. Prescription drugs will increase from $12 billion in 1980 to $445.9 billion in 2012. The following chart shows the growth in all three areas of spending nationally.

National Health Care Expenditures (In Billions of Dollars)

Year	Nursing Homes	Home Health Care	Prescription Drugs
1980	17.7	2.4	12.0
1990	52.7	12.6	40.3
1998	89.1	33.6	87.3
1999	89.6	32.3	104.4
2000	93.8	31.7	121.5
2001	98.9	33.2	140.6
2002	103.7	36.2	160.7
2003	108.2	38.3	182.1
2004	113.3	40.9	204.7
2005	119.8	43.7	228.6
2006	126.8	46.9	254.0
2007	134.3	50.1	280.9
2008	142.1	53.3	309.7
2009	150.3	56.7	340.5
2010	159.1	60.4	373.3
2011	168.7	64.5	408.3
2012	178.8	68.9	445.9

Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

South Carolina has experienced the same cost trends as have occurred nationally. When reviewing Medicaid expenditures for the senior population (Persons 65+), the CMS – 2082 Report shows the dramatic growth in expenditures for seniors from 1981 to 2002. We have considered the following service areas in relation to total Medicaid expenditures: home health/Community-Based Care, Nursing Facility Services, and prescribed drugs. The following table shows the dramatic cost increases for these services from 1981 to 2002 in South Carolina:

- Home Health/Community –Based Care has increased from $ 494,768 in 1981 to $93,602,218 in 2002 for an increase of 18,818%.
- Nursing Facility Services (long term care services) have increased from $78,251,339 in 1981 to $318,779,194 in 2002 for an increase of 307%.
- Prescribed drugs have increased from $11,487,235 in 1981 to $111,857,254 in 2002 for an increase of 874%.
- Overall, Medicaid expenditures for persons 65 and older have increased from $115,352,442 in 1981 to $622,903,757 in 2002 for an increase of 440%

TYPE OF SERVICE	AGE	1981	1990	1995	2000	2002
Home Health/ Community-Based Care	65 – 74		5,810,732	9,738,699	24,646,134	28,281,049
	75 – 84		8,712,252	11,421,820	34,828,720	37,940,826
	85+		6,878,032	9,417,927	27,568,743	27,380,343
	Total 65+	**494,768**	**21,401,016**	**30,578,446**	**87,043,596**	**93,602,218**
Nursing Facility Services	65 – 74		20,715,717	36,438,437	44,495,700	49,405,587
	75 – 84		50,514,503	81,390,681	109,703,201	116,775,550
	85+		49,252,795	97,137,864	145,663,209	152,598,057
	Total 65+	**78,251,339**	**120,483,015**	**214,966,982**	**299,862,110**	**318,779,194**
Prescribed Drugs	65 – 74		11,610,032	22,898,673	45,744,937	51,607,088
	75 – 84		8,992,745	16,807,773	37,500,116	42,161,767
	85+		3,005,494	6,605,401	16,088,699	18,088,399
	Total 65+	**11,487,235**	**23,608,271**	**46,311,847**	**99,333,752**	**111,857,254**
Total Medicaid Payments	65 - 74		68,416,361	123,593,081	178,202,298	185,957,443
	75 - 84		93,173,728	148,874,557	224,699,561	225,908,809
	85+		69,979,862	130,815,984	208,059,651	211,037,505
	Total 65+	**115,352,442**	**231,569,951**	**403,283,622**	**610,961,510**	**622,903,757**

An additional factor that must concern South Carolina government and businesses employing persons who are caregivers over the next twenty years is the growth of Alzheimer's disease and related dementias. The number of persons that are 65+ and older with Alzheimer's disease in South Carolina is expected to increase from 43,020 in 2000 to 125,190 in 2025. Considering that the current lifetime cost to treat a person with this disease is $174,000, the state will need to find ways to address the growing cost of health care and long term care, as well as develop a long term support services system that will help families, businesses and caregivers address the needs of our growing senior population. Based upon estimates prepared in conjunction with USC's School of Public Health, the total cost to families, government, businesses, etc., was $794,000,000 in the year 2000, with a projected increase to $7.7 billion by 2025.

Services provided through funding from the Older Americans Act will assist the State of South Carolina in providing cost/effective services which will work in conjunction with Medicaid, Medicare, private insurance and families to provide a continuum of care as well as helping to develop a long term support system through the SUA and the state's ten Area Agencies on Aging working with local service providers to meet the need of our

consumers. The following parts of this chapter will address those initiatives and program services that will be major areas of emphasis over the next four years.

A. SOUTH CAROLINA'S REAL CHOICE SYSTEMS CHANGE INITIATIVES

SC Access: South Carolina's Aging and Disability Information System

Difficulty in finding information about services continues to be one of the major barriers to accessing services that older adults and their caregivers face. In a recent survey by the University of South Carolina (2003) only 27 percent found information about services to be simple and clear. Only 22 percent stated that applying for services was simple. For older adults to continue to live in the community, they may require multiple supports from a variety of sources. Many times, obtaining essential information requires going to multiple agencies and enduring multiple assessments and applications for services. Agencies too often have inadequate information about other providers to make appropriate referrals. In addition, agencies often lack staff specifically trained to assess needs and assist individuals and families in understanding the options and resources available to them. Providing service and resource information that is easily accessed and provided at the appropriate time is critical to making informed choices that yield successful outcomes.

SC Access is being developed by the SUA as part of South Carolina's Real Choice Grant. It is funded in part by the Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services. It grew out of the Olmstead planning process and although many needs were identified and pages of recommendations were made, two major themes emerged. Consumers want:

- More and better access to information about services available to older adults and persons with disabilities; and
- More consumer choice and control of services including who, when and how those services are provided.

SC Access addresses the need for increased access to information about services that are available. People with disabilities and older adults want choice in the services and supports they receive. *SC Access* will help South Carolinian's find the information they need to make informed choices and connect to the services they need. *SC Access* is a system that combines the technology of a web-based, comprehensive database of information and assistance services, and the support of a statewide network of professional Information, Referral and Assistance (I,R&A) Specialists who are trained and certified by the Alliance of Information and Referral Systems (AIRS). The *SC Access* database will provide an essential tool for consumers, their families, caregivers and the network of service providers.

SC Access includes local, state and national providers who offer services in South Carolina. Examples of services include: personal care, home health, financial assistance, respite care, housing options, advocacy, employment, legal, adult day care, child care, education, recreation, assistive technology and other long-term care services. Individuals will be able to find services locally or anywhere in the state.

On the *SC Access* website, older adults and other users will be able to directly access a Learn About section for more information on many related topics. This educational portion of the website will include related links to other organizations, fact sheets and how-to booklets on issues of interest, as well as help with acronyms and terminology.

Additionally, for those who would rather talk with an IR&A specialist in the Aging Network to find services, and Assistance by phone option is available.

Issues for *SC Access*:

Designing the system:

A large portion of 2002 and 2003 was devoted to design and development of: (1) the web-based application that will enable older adults and others to search directly for information about services available to them and (2) the network of Information, Referral and Assistance Specialists. Focus groups were held with the project Advisory Committee, consumers and providers to assess the information needs and to identify what features potential users wanted in the system. A statewide workgroup of aging providers, IR&A personnel, Family Caregiver Advocates and state staff examined technology issues and developed IR&A protocols and marketing strategies.

- A fundamental design consideration was to ensure that the system was accessible to the widest audience possible. To achieve this objective, the website has been developed to follow the Web Content Accessibility Guidelines 1.0 (WCAG) established by the Web Accessibility initiative (WAI) of the World Wide Web Consortium (W3C). By following these guidelines, we also will be compliant with the Americans with Disabilities Act and Section 508 of the Rehabilitation Act. Additionally, we have followed the recommendations of the SPRY Foundation related to designing websites for older adults. The capacity of the computers of many users in South Carolina is also a concern, so minimal graphics and pictures have been used in SC Access.
- Beyond the technical aspects of accessibility, it is imperative to enable multiple methods of access to information. The internet adds value to the I&R system by enabling more people to directly access the information about services in South Carolina. For example, many adult children of senior parents live out of state. The internet gives them a mechanism to search for information. The baby boomer generation is used to finding their own information on the internet and that method of access is becoming even more important. Older adults are the fastest growing segment of our population who are using the internet. This initiative is dedicated to increasing choice and control for consumers and empowering them to make informed decisions by giving them access to needed information. The network of IR&A Specialists is an important part of the overall information system because we know many people in South Carolina do not have access to computers or don't know how to use them. Often they don't understand the service system and need help to understand what to look for and how the access the services they find. A map of the IR&A Specialists is accessible via a button on the website so that at anytime during their search, people can choose to call an IR&A Specialist in their area.

Maintenance of the database:

For information to be useful, it must be relevant and up-to-date. Several mechanisms have been put in place to ensure the quality and accuracy of the data. Every provider on the database will be updated, at a minimum of once a year. They can be updated as often as needed or as often as the provider chooses, but the minimum will be annually. Three staff persons are dedicated to collecting and updating the information. Updating information is an on-going process that happens daily. A feature in the system will

automatically pull providers monthly based on the date they were last updated. Each provider's information will be either mailed or emailed to the provider, or printed for the Access Coordinator to call by phone.

Providers will also be able to register and/or update information about their organization as often as necessary on-line through the Provider Registration process. Everything entered will be sent to the Data Coordinator for review before posting to the database. That controls what is added and ensures consistency of information and the way it is presented in the database.

The project is guided by a Real Choice Statewide Advisory Committee wiht a Subcommittee specifically focused on *SC Access*. This committee is overseeing the development of the Inclusion/Exclusion criteria which will define what types of providers are included in the database and which providers will not be included and why. Standards are being established based on the Alliance of Information and Referral Systems criteria to guide the development and operation of all aspects of *SC Access*.

A significant difficulty in keeping a centralized database up-to-date is not having eyes and ears in the local communities to know when providers go out of business, move, or new providers open their doors. The network of professional IR&A Specialists and Family Caregiver Advocates will be the eyes and ears of *SC Access*. These groups meet monthly with the staff to discuss types of IR&A calls received, protocols and reporting needs. This group has already identified some of the initial providers for the database. They will use the database daily and will be a feeder network to notify us when information is inaccurate or when they identify new providers not on the database.

Training of the I, R & A Specialists:

The Regional IR&A Specialists are required to be certified by the Alliance of Information and Referral Services (AIRS). All of our Access Coordinators who maintain the database are required to be certified. Other I&R workers in the Aging and Disability Networks will be encouraged to be certified but not required.

There are several forms of training. *The Basics of I&R* and the *ABCs of I&R*, a two day training session that is based on AIRS Certification Training, is provided twice a year. SUA staff have been approved by AIRS to administer the certification exam. Additional continuing education is provided through monthly meeting/trainings sponsored by the SUA. These monthly meetings provide training in the morning, and coordination and planning meetings in the afternoon. Through these meetings, processes are developed and strategies for responding to challenging requests are discussed.

Goal for *SC Access*:

The goal of *SC Access* is to improve the ease with which older adults and caregivers are able to identify and receive the supportive services they need to maintain the greatest independence possible. *SC Access* will provide a system of information, referral and assistance that does not "bounce" consumers from agency to agency. The driving philosophy is NO WRONG DOOR.

Desired Outcomes for *SC Access*:

- Establish an easily accessible web-based information system with comprehensive up-to-date information on services for older adults and persons with disabilities.

- Improved access to information and improved understanding of services available to older adults and caregivers.
- To partner with community organizations and other agencies to build a broader network of trained Information and Referral Specialists to assist consumers.
- To ensure effective use of resources.
- To provide a universally accessible system to all consumers and families.

Strategies for *SC Access*:

- Establish an Advisory Committee with broad representation of older adults, persons with disabilities and providers to assist with planning, implementation and marketing of *SC Access*.
- Develop a web-based, comprehensive database of providers, services and areas of interest.
- Assess the information needs of older adults and persons with disabilities to identify and prioritize the service and other information needs of consumers and caregivers.
- Create a statewide network of professional Information, Referral and Assistance Specialists who are trained and certified through the Alliance of Information and Referral Systems (AIRS).
- Pilot test the system in at least one area of the state, then implement statewide.
- Market the system through a variety of media to consumers, caregivers and providers.
- Evaluate *SC Access* focusing on the implementation process and impact on consumers.

SC Choice

The lack of an infrastructure to support a full range of consumer-directed care options was identified as a significant problem in our state through the Olmstead planning process. Through funding obtained through the Real Choice Systems Change grant, South Carolina addressed this need though the development of a new consumer-directed long-term care waiver. *SC Choice*, the first Elderly/Disabled Medicaid Waiver of this kind to be approved under the SUA's new Independence Plus initiative, was approved by the Centers for Medicare and Medicaid Services on March 11, 2003. The purpose of *SC Choice* is to create the infrastructure to support consumer directed services, including the development of staff to provide care advice, financial management services, and the use of a budget. *SC Choice* gives consumers greater say in selecting what services they receive, who provides the services and when the services are provided.

Implementation of *SC Choice* began in the Spartanburg Area Community Long Term Care (CLTC) Area, consisting of Spartanburg, Cherokee, and Union counties, on September 3, 2003. There has been overwhelming response in support of this new waiver. Initially it was projected that approximately 10% of the nearly 720 CLTC clients in this first pilot area would be interested in *SC Choice* based on the experience in the three states with Cash and Counseling projects. Our initial projections were surpassed.

There have been numerous phone inquiries, not only from the pilot area, but also from other areas of the state regarding the availability of this new CLTC waiver option. Expansion to a second pilot area will begin in June 2004 after preliminary evaluation of the first pilot and incorporation of necessary revisions. The greater Charleston area, encompassing Charleston, Dorchester and Berkeley Counties, has been selected for the second pilot. *SC Choice* will then be expanded statewide by July 2005.

Issues for *SC Choice*:

Older adults continually and clearly state their strong preference for maintaining control of their lives. According to AARP, "Persons 50 and older with disabilities, particularly those age 50 to 64, strongly prefer independent living in their own homes to other alternatives. They also want more direct control over what long term supportive services they receive and when they receive them." We need to encourage 'consumer-directed' long-term supportive services in publicly funded programs.

"Family support remains strong, but the impact of such trends as greater longevity, more women in the labor force, and greater geographic dispersion is now hitting home. Either in person or 'at a distance,' families are finding themselves with new roles as caregivers to aging parents, spouses, or siblings, aging children with developmental disabilities, and other relatives and friends. Caregivers age 50 and older often experience considerable stress as a result of their care giving roles."

Families continue to be the primary source of assistance to older adults needing help with their daily activities. National estimates show that family and friends are the sole source of assistance for nearly three-quarters of impaired older adults in the community. Furthermore, only a small proportion (5-9%) of elders receive all their care from formal, community-based providers. Thus, there is a need to strengthen supports for families and other informal caregivers.

Some policymakers, providers and even aging advocacy organizations, have expressed reservations about the applicability of consumer-directed service options for older adults. The concerns generally focus on issues such as who should be "allowed" to self-direct, who can be hired as a service provider, and how can service quality be assured?

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

According to a report to Congress, issued by the United States Department of Health and Human Services, America will need more than three times the current number of long term care workers by 2050 to meet the needs of the aging baby boom generation.

The report further predicts that the number of people using institutional or home and community-based services will increase from 15 million in 2000, to 27 million by 2050. As a result, the number of long term care nurses, nurse aides, home health and personal care workers will need to increase from about 1.9 million in 2000, to 5.7 - 6.5 million during this same time period. An additional challenge to finding an adequate supply of workers concerns the number of women (25 to 54 years of age) who

traditionally fill the roles of both paid and unpaid workers. The number of women willing and able to perform these jobs will increase only slightly (about 9 percent) from 2000 to 2050.

A number of states are finding that implementing consumer-directed services can significantly expand the potential pool of workers by adding workers who, though willing to work for a relative or friend, would not join the staff of a provider agency. This has been particularly true for consumers living in rural areas who find it difficult to access traditional agency based workers. Experience thus far in our first pilot area indicates that when given the option to direct their own services, many consumers choose to hire family members and/or friends. Those consumers who hire family and friends are highly satisfied and are less likely to be subjected to fraud or abuse. Allowing greater flexibility has also resulted in greater access to care, particularly in rural areas.

The need to address quality issues, potential fraud and even worker exploitation are quality issues for all home care programs, including consumer-directed programs. Research is beginning to dispel the myths about poor quality in consumer-directed services.

South Carolina implemented an electronic monitoring system, Care Call, in January 2003. The system is a toll free telephone check-in and check-out system for in-home services. The system provides automatic electronic billing weekly when services are provided as authorized. Claims are generated by phone calls to the Care Call phone number from the consumer's home. Care-Call verifies that the worker is present in the consumer's home. This web-based system provides real time information to the care advisor regarding whether a worker is present, as well as information about the consumer's budget.

Consumers in *SC Choice* are required to develop a back-up plan to outline how the consumer's needs will be met should a provider not be able to provide services. During monthly monitoring visits, the care advisor ask whether the back-up plan has been implemented, the number of times it was implemented, and how the plan is working. The back-up plan is amended as necessary to assure that a feasible plan is in place at all times.

Goals for *SC Choice*:

The overall goals of *SC Choice* are as follows:

- to increase consumer control, empowerment, and independence;
- to increase consumer satisfaction and quality of life;
- to provide greater flexibility in service delivery by making available a broader range of service options and services tailored to the individual's needs and preferences; and
- to decrease administrative expense and bureaucracy.

Outcomes for *SC Choice*:

The desired outcomes for SC Choice are to:

- allow seniors and adults with disabilities the opportunity to exercise greater control in their services;

- provide a cost effective option promoting independence by enabling consumers to be responsible for:
    - defining their own personal care needs
    - managing a set individual budget
    - hiring, supervising and firing the people who provide the services
    - deciding when and how the services are provided using a wider provider network to get the best price for products and services
- ensuring that funds are spent properly and consumers receive the care they need through the assistance of a care advisor and a financial management service to handle all payroll and tax reporting.
- increase access to paid care and reduce unmet needs for assistance through greater service flexibility.
- increase consumer satisfaction and quality of life.

Strategies for *SC Choice:*

These strategies will be utilized to work toward the desired outcomes:

- Establish a local advisory committee to assist with the planning, implementation, and marketing of *SC Choice*.
- Develop policy, procedures, training materials and public information strategies for the development and implementation of *SC Choice*.
- Expand Care Call to include the more than 40 *SC Choice* services.
- Amend an existing contract with the company that developed Care Call to include the subcontracting of the financial management services for *SC Choice* participants.
- Develop a Provider Agreement, which provides an opportunity for consumers to use local, neighborhood businesses, resulting in greater choices for the consumer.
- Pilot *SC Choice* in two areas of the state, with implementation statewide by July 2005.
- Evaluate *SC Choice*, focusing on consumer satisfaction and the implementation process.

SC Access Plus

Beginning in 2000, South Carolina has undergone an extensive needs assessment and planning process to identify areas where consumers experience barriers to increased consumer direction. Through consumer involvement with the development of the State's Olmstead Plan, and consumer surveys and forums as part of a grant funded by the National Association of State Units on Aging (NASUA), the State has identified several overwhelming issues for older adults and persons with disabilities. These include: 1) the difficulty in making informed choices due to lack of adequate information about available options; 2) the lack of flexibility and personal control over the kinds of services received and how they are provided; and 3) the difficulty in successfully maneuvering through complicated eligibility and application processes. *SC Access* and *SC Choice* address the first two concerns. *SC Access Plus* (the Aging and Disability

Resource Center) goes one step further to address the third concern. The Center will serve as an entry point to publicly administered long-term supports, as well as a trusted source of information on long-term support services for individuals who may be eligible for those programs.

South Carolina has made significant strides in shifting from an institution-based system of long-term care services to an expanded system of community-based care. Using Medicaid waivers, dedicated resources from the Older Americans Act (OAA), and the 2001 Real Choice grant, South Carolina has begun to respond to identified needs related to consumer information and access to services. As discussed above, *SC Access* will provide comprehensive information to consumers about the services available to them. While these activities have laid a good foundation, the State still needs to bridge the gap between *information about services* and *access to those services*. Therefore, South Carolina will pilot the development of an Aging and Disability Resource Center. The Center will provide services in three functional areas: 1) awareness and information, 2) assistance and 3) access. The pilot will be developed in the Lower Savannah region.

Discussion for *SC Access Plus*:

In March 2003 South Carolina received approval of a new *Independence Plus* waiver under the President's New Freedom Initiative to offer expanded choices for persons in the Elderly/Disabled Waiver. Parallel to the development of Medicaid services, the OAA has supported a statewide network of home and community-based services, reaching out to persons of all incomes, frequently assisting persons who are not Medicaid eligible because of their income or level of care. Because of the legal and regulatory flexibility of the OAA, these programs also serve as stop-gap measures for persons who do qualify for Medicaid, but who are awaiting services through Medicaid waivered programs. Thus, OAA services provide a safety net for those whose condition otherwise would likely deteriorate, thereby protecting options for future care.

The Aging and Disability Resource Center will serve consumers regardless of income who are seeking information about public and private-pay services. The Center will be a resource for health and social service professionals who provide services to the elderly and to people with physical disabilities, as well as to individuals planning for future long-term support needs. People need information and counseling about low cost community-based options and long-term care insurance before they have a need for higher cost or publicly funded long-term care. Access to such information can help people make well-informed choices about the use of their own resources, and help delay or prevent the need to spend down resources to qualify for Medicaid.

In the first year, the Center will focus primarily on the elderly and their caregivers. By the first quarter of the second year the major target group will expand to include individuals with physical disabilities.

The Lower Savannah Region where the Center will be piloted has a mix of urban and rural areas. It includes the counties of Aiken, Allendale, Bamberg, Barnwell, Calhoun, and Orangeburg. There are 51,679 persons age 60+ in this area: 22% are below poverty and 33% are minority. According to US Census 2000 data for this same area, there are 51, 259 persons of all ages with physical disabilities, which include persons with sensory, physical, and self-care disabilities.

Goals for *SC Access Plus*:

The primary goals for *SC Access Plus* include the following:

- to pilot an Aging and Disability Resource Center (hereinafter referred to as the Center) to serve as a visible single point of entry for older adults and persons with physical disabilities; and
- streamline and simplify the eligibility determination and service application process for long-term care services.

Additionally, the Center will seek to provide visibility, trust, ease of access, responsiveness, efficiency and effectiveness for consumers seeking information or access to long term support services.

Desired Outcomes for *SC Access Plus:*

Through the Resource Center consumers will:

- Find information, referral and assistance regarding their specific needs;
- Receive information/counseling about long-term support options, public and private;
- Receive assessment and short-term case management;
- Be linked to eligibility information, screening, determination for public services;
- Complete initial applications for public services; and
- Make well-informed choices about the use of their own resources.

Evaluation of outcomes will include looking at indicators for visibility, trust, ease of access, responsiveness, and efficiency/effectiveness.

Strategies for *SC Access Plus:*

A pilot for the Aging and Disability Resource Center will be developed through the Lower Savannah Council of Governments in partnership with the state office on aging.

- The Center will bring together specialists in information and referral, family caregiver support, State Health Insurance Program (SHIP), Medicaid eligibility, level of care determination, nursing home pre-admission screening, and one-stop employment centers.
- *SC Access Plus* will incorporate a short term case management system to enable Center staff to follow-up with consumers, track progress, assess needs, identify barriers, and provide assistance to ensure access to services.

The Resource Center will streamline, simplify, and track eligibility determination and the application for service process by:

- Involving key stakeholders in the planning, implementation and evaluation of the program
- Developing a process for sharing data between organizations in the pilot area;
- Using software developed by AssistGuide to allow users to provide data only once that can be converted into, various service applications, and that can be updated as needed;
- Providing an automated link between the process of seeking information and assistance, and the process of applying for services selected. In partnership with *AssistGuide*, this project will add a web-based process enabling consumers to apply directly for Medicaid and Aging long-term support services.

B. FAMILY CAREGIVER SUPPORT PROGRAM AND REGIONAL SYSTEM OF INFORMATION, REFERRAL, AND ASSISTANCE

Family Caregiver Support Program

Families - not institutions, not formal service providers - are the major providers of long term care, providing 80% of care at home. (ASA, 1997) Families provide care willingly, but at great personal cost to their health, to other family and job responsibilities, and to their own financial security. A report by Peter Arno, Ph.D. and Margaret Memmott (March 1999) estimates that there are 364,804 family caregivers of adults in South Carolina who provide 339.6 million hours of caregiving per year at an estimated value of $2.77 billion.

Policymakers are beginning to recognize the critical role of families in the provision of long-term care. Family caregiving, often referred to as “informal” care, may precede, substitute for, and/or supplement “formal”, or paid, care. It is often the informal caregiving that enables the older person to remain at home despite frailties and chronic illnesses, and thus delay or avoid care in an institutional setting. The unpaid care provided by family and friends translates into tremendous savings in public monies. However, caregivers may need supportive services in order to maintain their role. The concept of caregiver support for an aging population is a growing concern.

Issues for the Family Caregiver Support Program:

Changing Demographics and Social Trends:

As more persons live to “old, old” age, more face chronic illnesses and disabilities. The fastest growing segment of the population in America is those 85 and over. With increased life expectancy and aging of the “baby boomers”, long term care costs may more than double in the next 25 years. At the same time, families are changing.

Working Caregivers:

With a high percentage of caregivers in the work force, the impact of caregiving on workers as well as on the workplace is a consideration. The recent report on “Caregiving in the U.S.” from AARP and the National Alliance for Caregiving (April 2004) states that nearly six in ten caregivers are currently employed, some full-time, some part-time. Caregivers with the heaviest caregiving responsibility are less likely to be employed. Adding work and caregiving responsibilities produces additional stress. In their article on caregiving and work, Wagner and Neal (1994) point out that the effects of caregiving on employed caregivers are substantial, including:

- missed work hours
- lost job or career opportunities
- decreased time for social life, vacation, or relaxation

Some caregivers cut back on work hours or quit work to provide needed care.

Results of the Performance Outcomes Measures Program (POMP IV) Survey on Cargiving in South Carolina show that caregivers report their caregiving responsibilities have had negative effects on their regular employment. Caregivers who worked at the time they began providing care have had to use vacation time to provide care, have experienced conflicts between work and caregiving, have had to reduce their working hours or their work responsibilities and, in some cases, have had to quit working in order to provide full time care for their family member.

The Demands and Stress of Caregiving Affect Health:

While there are many personal rewards in providing needed care for a loved one, caregivers contend with myriad demands - physical, emotional, and financial - that can take their toll. Often, the demands of caregiving evolve and expand as the needs of the care recipient change. The prolonged stress of long-term caregiving can result in depression, burnout, and declining physical health. Older caregivers are particularly vulnerable to becoming sick and in need of care themselves. The demands of caring for a person with dementia can be particularly intense. Research is producing growing evidence that caregiving is a risk factor for health problems. Men and women who provide care to a spouse with a stroke or dementia have been shown to report more episodes of infectious illness, poorer immune responses to influenza virus and pneumococcal pneumonia vaccines, their wounds heal more slowly, they are at greater risk for developing hypertension, and they may be at greater risk for coronary heart disease. Researchers found that caregivers had a 23% higher level of stress hormones and lower antibody production, increasing the risk for diabetes, hypertension, and flu. (Vitaliano, 2003) The relative risk for all causes of mortality among strained caregivers has been shown to be 63% higher than non-caregiving controls in a recent longitudinal study of caregiving. (Kiecolt-Glaser, 2003). As the population continues to age, caregivers will play an increasingly greater role in the provision of long term care. Interventions that help caregivers maintain their health will benefit the caregivers, the care recipients, and society.

Dementia Caregiving:

Nationally, over one in five caregivers say they take care of someone with Alzheimer's disease, mental confusion, dementia or forgetfulness. Alzheimer's caregivers are twice as likely as non-Alzheimer's caregivers to have a highly intense care experience, and a higher level of stress, based upon the tasks they perform and the time they spend giving care. The average lifetime cost of Alzheimer's disease, per person, is $174,000. One in eight Alzheimer caregivers becomes ill or injured as a direct result of caregiving. One in three uses medication for difficulties related to caregiving, such as sleeplessness and anxiety. Older caregivers are three times more likely to become clinically depressed than others in their age group. (Alzheimer's Association 1999 Public Policy Report)

Alzheimer's Resource Coordination Center Needs Assessment*:*

The Alzheimer's Resource Coordination Center (ARCC), within the SUA, conducted a needs assessment with the South Carolina Alzheimer's Advisory Council. The needs assessment obtained information from two main sources. Ten focus groups were held across the state with caregivers. A total of 87 caregivers participated. Focus group responses showed that:

- 1 out of 2 caregivers stated that they need education and information;
- 1 out of 3 caregivers stated that respite care is a great need when caring for a person with dementia; and
- 1 out of 4 caregivers stated that support groups, family support, and financial assistance are greatly needed by caregivers.

Demographic Projections and Impact*:*

Demographic projections show that over the next two decades, if a cure or treatments to slow progression of Alzheimer's disease are not found, aging "Boomers" could swell the

numbers of persons afflicted with dementia. It is difficult to estimate the number of persons currently affected, since the disease may go undiagnosed or the diagnosis may go unreported. The Alzheimer's Association estimates that there are 62,345 persons with Alzheimer's disease or a related dementia in South Carolina. The Association predicts a 92% increase in the incidence of Alzheimer's in the state by 2025, estimating there will be 119,092 cases in the state within 25 years. The South Carolina Alzheimer's Disease Registry estimates that currently there are 43,020 persons with dementia in South Carolina. They project an almost three-fold increase in the next 25 years, projecting an incidence of 125,190 by 2025. The projected increases in numbers and costs is staggering when considering the impact on our long term care system.

Such an increase will have profound effects on Medicaid costs.State Medicaid programs share with the federal government the cost of care for 73% of persons in nursing homes in South Carolina (Source: SC DHEC Division of Planning and Certification of Need). Over half of all nursing home residents have Alzheimer's or a related dementia. Typically these residents have the longest and most costly stays. Approximately 36% of Medicaid waiver clients suffer the symptoms of dementia (SC Alzheimer's Registry). Based upon national data, the Alzheimer's Association estimates that 75% of persons with Alzheimer's are at home and 25% are in a long term care facility. Using South Carolina Alzheimer's Registry projections, we can anticipate a three-fold increase in the number of nursing home beds needed for persons with dementia. Assuming a 5% cost of inflation in the cost of care, the projected annual cost for Medicaid nursing home care for persons in South Carolina with dementia in 2025 would be $1,595,385,233. (The Medicaid cost figure is based upon total payments. Patients' recurring income pays for 18.57% of the cost.)

Researchers are working to develop bio-medical interventions that can delay or prevent the onset of symptoms of the disease. In the meantime, there is research evidence that suggests early support for caregivers - such as respite, training and other supportive services - can postpone institutionalization and save money for the family and the state (Mittlemann, et al, "A Family Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease," *Journal of the American Medical Association* 276, December 4, 1996: 1725-31.) The development of caregiver support services, including appropriate respite care services, can lead to significant cost savings. Using the projected figures for 2025, delaying nursing home placement for persons with dementia through appropriate community services could result in savings to Medicaid of $21,292,549 for a one-month delay in placement. The Mittlemann study referenced above showed caregiver support services delayed the average nursing home placement by over 300 days.

Respite: A Caregiver Support Program:

The state has an interest in supporting family caregivers, the backbone of the long-term care system. The annual value of the work of family caregivers far exceeds the amount of funding spent on nursing homes and home health care. However, these caregivers need some supplemental support to sustain their caregiving roles over the extended period required for many chronic conditions and diseases. The majority of caregivers provide unpaid assistance for one to four years; 20% provide care for five years or longer. (Family Caregiver Alliance, 1998) More than one in 10 caregivers become physically ill or injured as a direct result of caregiving and approximately 43-46 percent suffer from depression.

Studies have shown that respite and caregiver support programs can relieve some of the stress on caregivers and thereby delay or prevent early placement in an institutional setting caused by caregiver burnout or stress related illness. A growing body of evidence from research shows that providing help at home to supplement and support families can delay or prevent the need for costly nursing home care, but that it must be provided soon enough to make a difference. When home and community based services are concentrated on those who already are eligible for nursing home placement, they may provide little more than a transition to the institution. When respite is provided to caregivers early in their long-term caregiving experience and in significant amounts, it can significantly lower stress, improve caregiver well-being and extend the time they can provide care at home.

Community Based Services as Cost Containment:

Policymakers have a strong interest in maintaining the strength, health, and durability of family and informal caregiver networks as the primary providers of long term care. Most families prefer to provide care at home as long as possible. Providing caregiver support has two primary incentives: first, as a matter of humane public policy; secondly, as a matter of economics. Therefore, it is essential that home and community-based services include support services for family caregivers.

The Division of Consumer Information and Caregiver Support is working to increase supportive services for family caregivers. Federal and state funding for Alzheimer's service development has made possible the expansion of available services and the enhancement of existing services.

The Family Caregiver Support Program:

Thanks to a change in the Older Americans Act, new funding became available in 2000 to establish the National Family Caregiver Support Program (FCSP), a program of information, assistance and support services for family members who help disabled or frail seniors manage their daily activities. The creation of the National Family Caregiver Support Program has enabled South Carolina to develop a new statewide program focused on the needs of family caregivers. Five services are available statewide 1) information 2) assistance in gaining access to services 3) counseling, training and support in solving problems related to caregiving 4) respite care and 5) supplemental services to complement the care provided by caregivers. Consumers in SC don't want "agency focused" services but rather "consumer directed" services. Consumer direction ensures that the person using the service has the choice about who provides the service, what services are needed and when and how they are given. The FCSP builds on that idea and was designed to help caregivers gain access to a full range of options, including education, counseling, emotional support, occasional relief from caregiving duties and limited services to supplement the care they provide.

Today, caregivers in SC who contact the FCSP receive one-on-one assistance and support from the Family Caregiver Advocate located in their region of the state. Caregivers tell their story and determine what they need most to continue in their caregiving role. The Advocate provides information, assistance, counseling and support targeted to the caregiver. Armed with current, local information about the full range of options available in the community, the caregiver can then select the service that best meets their needs. A one-time mini-grant may be available to help the caregiver purchase respite or other caregiver services.

During fiscal year 2003 14,396 people received one-on-one assistance, support, information, caregiver training, respite and other services through the FCSP. 2,155 people received 139,751 hours of respite at an average cost of $6.50/hour. 77% of caregiver's surveyed in 2002 report that FCSP services they received help them continue their caregiving role longer than would have been possible without those services. FCSP services were well received by caregivers. 93% of caregivers rated the quality of the service as excellent, very good or good.

Caregiver Quotes On FCSP Services:

- *"One of the main points that we have learned* (at the caregiver training) *is there needs to be some quality of life for everyone in our family including my mom."*
- *"It (FCSP) has helped with the tremendous financial burden of my mother's "around the clock" care, and the materials I received were understandable and comforting . . ."*
- *"It feels good to see that someone recognizes the difficult position we are in and that we are totally exhausted."*

The Alzheimer's Resource Coordination Center:

In addition to the federally funded caregiver support program, the state has provided some funding for Alzheimer's service development and coordination. The Alzheimer's Resource Coordination Center (ARCC) was created through state legislation in April of 1994. The center is housed in the SUA. The center was created to provide statewide coordination, service system development, information and referral, and caregiver support services to individuals with Alzheimer's disease and related disorders, their families, and caregivers. The center is supported by an advisory council appointed by the Governor. Legislation directs the center to do the following:

- Initiate the development of systems which coordinate the delivery of programs and services;
- Facilitate the coordination and integration of research, program development, planning and quality assurance;
- Identify potential users of services and gaps in the service delivery system and expand methods and resources to enhance statewide services;
- Serve as a resource for education, research, and training and provide information and referral services;
- Provide technical assistance for the development of support groups and other local initiatives to serve individuals, families, and caregivers;
- Recommend public policy concerning Alzheimer's disease and related disorders to state policymakers; and
- Submit an annual report to the Joint Legislative Committee on Aging and to the General Assembly.

To assist local communities in developing or strengthening programs or services to serve people with dementia and their caregivers, the ARCC awards seed grants to community organizations. In awarding grants, consideration is given to recommendations made by the advisory council to the center on priority needs and criteria for selecting grant recipients. As a condition to receiving a grant, the community

or other entity must provide matching funds or in-kind contributions equal to the amount of funds awarded in the grant.

The center maintains resource materials, such as training videos and resource books on Alzheimer's disease and related dementias that are available for use by entities serving persons with Alzheimer's disease and/or their caregivers. Technical assistance and training is provided through the center. An Alzheimer's disease Resource Directory provides information on services available in the state.

Desired Outcomes for the Family Caregiver Support Program:

Caregivers are a critical component of the long term care "team" and must be recognized and supported in their role. As we develop caregiver support services, we seek these outcomes:

- Family caregivers throughout South Carolina will have access to supportive services such as:
  - information about available resources
  - information about management of chronic diseases
  - individual and family counseling
  - support groups
  - respite services
  - families are able to continue their role as caregiver
- People throughout South Carolina, regardless of economic status, will have access to supplemental long term care services, on a limited basis, to complement the care provided by family caregivers and other informal caregivers
- Families will have access to a full continuum of long term care options including home care, adult day services, assisted living, and nursing home care.
- The statewide delivery system of long term care services will have the capacity, the flexibility, and the sensitivity to meet the unique needs of caregivers of persons with Alzheimer's disease and related disorders.

Strategies for the Family Caregiver Support Program:

The following strategies will be utilized as a means to working toward the desired outcomes:

- Support the development of community-based projects by providing seed grants to local communities to develop or expand respite programs or to provide Alzheimer's education and training programs for family caregivers and service providers.
- Facilitate the statewide development and coordination of services through the Alzheimer's Resource Coordination Center to meet the unique needs of families coping with Alzheimer's disease and related disorders using models developed through Project COPE (Care Options and Public Education) Alzheimer's Demonstration project.
- Support the respite coalition to promote the development of and access to respite services across the life span.
- Encourage the development or expansion of caregiver support services provided through the state through the statewide Family Caregiver Support Program.

- Improve the responsiveness of local programs to caregivers and other informal care providers.
- Seek additional funding for caregiver support services.
- Provide a resource center of reference materials, educational materials for caregivers, videos and training materials within the Bureau of Senior Services for use by service providers, other professionals, and family caregivers.
- Provide technical assistance to local or regional organizations/service providers who provide supportive services for caregivers of older adults.

Regional System of Information, Referral, and Assistance:

Information, referral and assistance (I/R&A) services are the gateway to accessing other services and resources for older adults and persons with disabilities. Persons looking for help need a single place where they can receive information about resources and services that might address their identified need(s), be linked to the agencies and organizations that provide those services, and receive one-on-one attention through appropriate follow up. The State Unit on Aging felt that establishing a Regional Information Referral and Assistance Specialist at each of the state's ten regions would help meet that goal.

Many I/R&A activities are occurring within the Aging Network. Examples include some basic general I&A provided by the State Office, AAAs and CoAs; insurance counseling (I-CARE) information and counseling; some long term care ombudsman activities; the new Family Caregiver Support Program; periodic disaster assistance services and others. Adding a Regional I/R&A Specialist to provide I/R&A services would enhance these other programs and in effect provide some relieve to the other programs.

In October 2001 the Real Choice Options for Community Living (OCL) grant was received and used to create a web-based resource directory that will greatly improve the capacity of Aging network personnel to provide complete and up-to-date information about programs and services. An existing web-based system (SCSIS), and staff were transferred to THE SUA effective July 1, 2002. This will provide a bridge or transition to the OCL resource database.

During this period, DHHS developed and provided intensive I&A training to staff of all agencies within the aging network. Focus was placed on developing Regional I/R&A fashioned after the Alliance for Information and Referral Services (AIRS) standards. A training protocol was developed that included interviewing and screening techniques, referral skills, and how to use the web-based SCSIS system pending completion of the OCL database. Training emphasized cross-training between the discrete I&A activities that are ongoing. The intent of the training was to lay the foundation for the uniformity, consistency and comprehensiveness necessary for a system. Training was successful in that over 250 Aging Network staff have been trained in the following courses: the *Basics of I&R*, the *ABCs of I&R* and *Effective Communication* since the spring of 2002.

Job descriptions were developed for these specialists and, along with the Regional I&R Specialist Standards, submitted to the 10 regions for use in hiring. Beginning in July 2002, eight of the 10 regions hired one full-time I/R&A Specialist and two the regions hired 2 specialists for a total of 12 I/R&A Specialist for South Carolina. Each of the I/R&A Specialists must become certified as Aging I&A Specialists through the Alliance for Information and Referral Systems. Of the 11 I/R&A Specialist currently hired 9 are

certified and 2 will be eligible for certification testing in August of 2004. One region is currently in the process of hiring a new specialist. It is expected that these Specialists will respond to specialized or complex I&A requests that may come from other network agencies within the region and out of state.

In addition to the I&R Specialists being trained over 50 aging network staff, AAA staff and DHHS staff have taken the ABCs of I&R training and the certification exam and have become either Certified Information and Referral Specialists (CIRS or Certified Information and Referral Specialist in Aging.

South Carolina anticipates continued success with the I/R&A program and has even been able to offer training to general and aging network staff out of state, specifically North Carolina and Georgia. Staff from the 2-1-1 I&R network in South Carolina have also participated in the training and certification process.

C. INFORMATION TECHNOLOGY, INFORMATION SYSTEMS, AND INFRASTRUCTURE

Prior to January 1999, the Aging Network in South Carolina had been using a DOS-based client tracking information system that was developed in the late 1980's to collect and transmit Administration on Aging (AoA) required data. In 2000, THE SUA implemented statewide the Windows-based Advanced Information Manager (*AIM*) system to collect not only AoA data, but also to collect additional and more specific assessment and demographic information to better assess the needs of the South Carolina seniors served through the Aging Network. With the addition of the Family Caregiver program in 2002, and the federal government's move toward community based services, THE SUA started looking at ways to consolidate client data, Caregiver data, and Information and Referral/Assistance data through a Web-based system.

Issues for Information Technology, Information Systems, and Infrastructure:

Web-based Software:

Caregivers across the state currently enter their client data into a cutting-edge secure, web-based system called Portal. This system is the standardized tool for collecting data. Information and Referral/Assistance (I&R/A) data is also being collected statewide and THE SUA is working on integrating its data collection into the Portal through *SC Access*. The federal Options for Community Living Grant for South Carolina, *SC Access*, funded the creation of a statewide web-based I&R/A database of services and service providers. The I&R/A data collection will become part of the SC Access web-based system, which is also part of the Portal. The AIM system provides for data collection by local service providers and then a secure, Internet-based replication process transfers that local information to the regional Area Agencies on Aging (AAAs) and then to the state. THE SUA is considering several options to integrate the AIM data with the Caregiver and I&R/A data: 1) An SQL Server platform to integrate data at the state level; 2) Translation of the AIM program into a web-based program, accessed through the Portal; 3) Analysis of other software available that could be made compatible with Portal.

Data Analysis:

THE SUA will continue to make extensive use of the ad-hoc reporting capability of the AIM system to draw conclusions about the frailty and needs of the seniors served in the Aging Network. The Caregiver, *SC Access*, and I&R/A data will map out a course for identifying unmet needs and clients with the greatest economic and social needs.

Applications for Services:

The *SC Access* and Aging Resource Center grants organize a platform for merging these different IT programs into a seamless structure for accessing information and services for seniors in South Carolina and to help seniors and their caregivers navigate the complex applications process for all of the services available. AssistGuide software is a part of this plan, through the Aging Resource Center cooperative agreement. AssistGuide is a web-based tool that allows for data collection of client information through a secure Internet site and then automates the Intake Form/Application process for as many programs as needed.

Outcomes for Information Technology, Information Systems, and Infrastructure:

Portal and the Caregiver and *SC Access* Web-based programs are leading the way for THE SUA to integrate its client information and to assess service needs. The detailed client information provided by the AIM system allows for much more accurate information about the demographics and frailty of the clients served throughout the Aging Network. With AIM's replication process, the state office continually has up-to-date, detailed, unduplicated information on the approximately 35,000 clients being served in South Carolina.

- The *AIM* database will enable Aging Network providers, AAAs and THE SUA to perform quality assurance measures on client files, and to create ad hoc reports using valid, up-to-date, comprehensive data.
- The I&R/A data being collected statewide will be a powerful tool for assessing the needs of South Carolina seniors and identifying the gaps in services.
- Data collected through all of these forms of Information Technology are invaluable in planning for the future.

Strategies for Information Technology, Information Systems, and Infrastructure:

A primary strategy is to continue to use information technology to more effectively document unduplicated client counts, demographics, functional limitations, and unmet needs for services, to advocate for more resources, and to ensure the allocation of services to the most needy clients.

The SUA is using, and will in future use the *SC Access* and Aging Resource Center grants to provide a platform and to provide a catalyst for merging these different IT programs into a seamless structure for accessing information and services for seniors in South Carolina and to help seniors and their caregivers navigate the complex applications process for all of the services available.

D. ELDER RIGHTS AND RELATED ISSUES

America's expanding elderly population affects every segment of the social, political, and economic landscape. As individuals age, there are often changes in their living patterns and conditions which sometimes contribute to the deterioration of their rights. Issues surrounding the changing needs of the approximately 44 million persons in this country age 60 years and over have heightened national awareness and concern. It is no surprise that elderly people with physical and mental frailties are more likely to be vulnerable to abusive behavior from those whom they depend upon to provide care and support. Elderly persons who are unable to care for themselves are especially vulnerable to abuse, neglect, and exploitation. State and local organizations need to mobilize to recognize such potential problems and provide support. Given the large

number of incidents of abuse and neglect that are reported, service providers, caregivers, and all citizens who relate to seniors need to be alerted to the problem of abuse and neglect, taught to recognize it, and encouraged to report it. As a result, public policies relating to issues such as health care, health care insurance, retirement, affordable long term care, and quality of life are changing to meet the unique needs of the aging population.

Issues for Elder Rights and Related Issues:

Prevention of Abuse, Neglect and Exploitation:

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

During FY 2003, 4,082 people received services through the Department of Social Services' Adult Protective Services (APS). Sixty-three (63) percent of the APS cases were due to self-neglect, twenty-three (23) percent due to neglect by another, eight (8) percent due to exploitation, five (5) percent due to abuse and one (1) percent due to psychological abuse. The following types of abuse are reported:

Abuse. Mistreatment or abuse can either be physical, psychological or both. It occurs in both the community and in long-term care settings. Nationally, studies indicate elder abuse is grossly underreported in the community. Statistics show as few as one in four cases of abuse are ever reported to the proper authorities. Although long- term care facilities are heavily regulated and monitored by both federal and state statutes, abuse can also occur in this setting. Residents of long-term care facilities may be extremely frail, cognitively impaired and totally dependent on caregivers for their needs. Because of these conditions they may be at risk for abuse. The highest risk factor may be the presence of dementia (which may be present in 50 -75% of nursing home residents). Residents with dementia, especially if they have disruptive or violent behaviors, are at increased risk for being abused.

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

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

Neglect. The failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult is likely to increase with the growing numbers of the age 80+ population. *Self-neglect* includes the inability of a vulnerable adult without a caregiver to provide for his or her own

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

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

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

Nursing homes provide care to over 1.7 million people every year. However, many individuals and family members find it a real challenge to select a facility and to ensure appropriate care will be provided. Generally, a nursing home or residential care facility offers daily assistance to individuals who are physically or mentally unable to live independently. Residents are provided rooms, meals, assistance with daily living, nursing services and some medical treatment. Individuals who require custodial care such as help with eating, bathing, taking medicine and toileting, as well as those who require skilled care may have their nursing home stay paid for by Medicaid if they meet specific financial criteria.

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

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

The State Long Term Care Ombudsman Program, located in the SUA, has responsibility for directing the program and oversees the investigation of complaints by its ten (10) Regional Programs. While the Ombudsmen do not have direct authority to

require action by a facility, they have the responsibility to negotiate on the resident's behalf and to work with other state agencies for effective enforcement. The ten Regional Ombudsman Programs are located throughout the state. With the exception of one region, the administration of these regional programs is through the local Area Agencies on Aging. These agencies employ 14 full time ombudsmen to investigate complaints and provide assistance to all nursing home and residential care facility residents.

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

In FY 2003, the Ombudsman Program completed 5,239 complaint investigations. Often a single complaint affects more than one resident. For example, complaints regarding lack of staff to assist with meals could reasonably affect a single resident or the entire facility depending on the circumstances. This information is tracked over the reporting year to yield the number of people the ombudsman affects by conducting complaint investigations. The majority of the complaints received are called in by facility staff or by families and friends of the resident.

When a complaint is received, it is represented using one of 133 federally required codes, which are classified into five (5) major categories. Of the complaints received by the Ombudsman Program in this report period, 3,028 were lodged against nursing homes, 1,340 were lodged against residential care facilities, and 642 were lodged against other facility types. The total number of abuse, neglect, and exploitation cases (ANE) was 1,517.

The following is a breakdown of the categories of complaints that occurred in long term care facilities:

- 32% were Resident's Rights;
- 32% were Resident Care;
- 19% were Quality of Life;
- 11% were Administration;
- 6% were not against the facility; and
- 42% ANE cases (verified)

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

South Carolina is embracing The Eden Alternative™, which recognizes that being institutionalized often breaks the spirit and ultimately the health of many formerly vibrant

people. The Eden Alternative™ counters boredom, loneliness, and helplessness with animals, plants, and children, and requires an entire shift in management philosophy that brings decision making authority closer to the residents and staff.

The South Carolina Eden Alternative Coalition was established for the purpose of enhancing the quality of life for nursing home residents primarily through the promotion and support of the concepts of The Eden Alternative™ as developed by Dr. Bill Thomas. The Coalition, acting in conjunction with the South Carolina Department of Health and Human Services developed the South Carolina Eden Alternative Grant Program to provide seed money to nursing facilities that are committed to implementation of The Eden Alternative™ process.

Funding for the Grant Program was provided by the South Carolina Department of Health and Human Services, acting through its Division of Community Facility Services. Civil monetary penalties collected through enforcement activities of the federal Health Care Financing Administration (HCFA, now CMS), were used to fund the Grant Program.

Article Three of the Omnibus Adult Protection Act created the Adult Protection Coordinating Council under the auspices of the SUA. The Council was created because of the depth of concern about the need for frequent, continued coordination and cooperation among the entities involved in the adult protection system.

Key community service agencies have begun to work together to effectively identify and report crimes against the elderly, especially abuse, neglect and exploitation. The Medicaid Fraud Control And Patient Abuse Unit of the South Carolina Attorney General's Office is charged with investigating and prosecuting Medicaid fraud and patient abuse, neglect and exploitation in nursing homes, residential care facilities or any health care facility. The Unit has convicted over seventy individuals and businesses of fraud and patient abuse and over four million dollars in restitution, penalties fines and court costs have been ordered. Many complaints are investigated jointly by the Long Term Care Ombudsmen and Local Law enforcement. Cases involving deaths, sexual battery, aggravated assault, time sensitive evidence and possible abuse/neglect are referred immediately to Law Enforcement and the Attorney General's Office.

Decisions Regarding Health Care and End-of-Life:

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

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

communication between the patient, family and physician prior to the health care incident that would invoke the use of an advance directive type document.

Legal Assistance:

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

Program Goals for Elder Rights and Related Issues:

- To reduce the prevalence of elder abuse, neglect and exploitation in home and institutional settings
- To improve the safety and well-being of residents of long term care facilities through a stronger statewide long term care ombudsman program with increased funding and positions
- To empower residents to know and exercise their rights, voice their concerns and, to the extent possible, act on their own behalf or to seek outside assistance
- To identify and resolve resident problems relating to poor facility practices
- To identify and represent the interests of residents and seek appropriate remedies
- To improve the economic security of older persons through access to and appropriate use of public benefits and insurance and empowerment of older adults thorough education about money management
- To improve access to legal assistance services for older adults who have no other legal resources.
- To increase awareness and promote the use of advance directives for health care planning in the community and long term care facilities through training and education
- To increase partnering and collaborative opportunities to increase knowledge of advance directives for health care providers

Strategies for Elder Rights and Related Issues:

- To increase public awareness about issues of elder abuse, neglect and exploitation including causes, profiles of victims and perpetrators, warning signs, reporting, and strategies for prevention through work with member agencies of the Adult Protection Coordinating Council
- To increase professional understanding of physicians and other health care and social service professionals and educate them about the Omnibus Adult Protection Act through work with member agencies of the Adult Protection Coordinating Council

- To develop methods for standardized collection, reporting, and coordination of data related to adult abuse, neglect and exploitation through work with member agencies of the Adult Protection Coordinating Council
- To improve the coordination with law enforcement, solicitors and the judicial system to increase prosecution of adult abuse, neglect and exploitation through the work of the Adult Protection Coordinating Council
- To ensure timely and responsive access to the services of the long term care ombudsman program for all residents in long term care facilities
- To support the statewide Long Term Care Ombudsman program through training and technical assistance
- To increase the access to regular, ongoing ombudsman services by recruiting, training and placing volunteer ombudsmen in long term care facilities in accordance with the completion of a strategic plan developed in conjunction with stakeholders
- To expand the advocacy capacity of the ombudsman program by increasing the number of community outreach connections, increasing the profile and visibility of the ombudsman program, and by improving effective networking
- To develop and nurture effective self-advocacy of nursing home residents by supporting the development of family councils through collaboration with the long term care ombudsman program
- To ensure the health, safety, welfare and rights of residents by working more vigorously with long term care providers and related health and human services agencies toward a level of care that is responsive, individualized, and of high quality
- To provide collective and analytical data concerning complaints, trends, patterns and condition of residents in long term care facilities and identifying and presenting essential information to appropriate public policymakers
- To provide unbiased insurance counseling information to caregivers and the senior population through a statewide network of trained volunteers.
- To Support the trained insurance counseling volunteers through update training and technical assistance.
- To provide ongoing training and public information for the public and professionals who serve older adults about advance directives
- To support the network of trained volunteers to provide ombudsman witness services to persons who are in hospitals and long term care facilities

Desired Outcomes for Elder Rights and Related Issues:

- Reports will be produced on a regular basis identifying unduplicated crimes of abuse, neglect and exploitation of vulnerable adults through the Adult Protection Coordinating Council.
- Reporting of abuse and neglect by hospitals and physicians will increase.
- Public awareness of factors related to abuse, neglect and exploitation will result in increased reporting.
- Residents, families and agencies contact the ombudsman program for

information and assistance to resolve problems with long term care facilities.

- Residents and families initiate and participate in resident and family councils.
- Initiate a Volunteer ombudsman program after completion of a pilot project developed in conjunction with stakeholders (e.g., Bureau of Senior Services, Regional Ombudsmen, AAA Directors, nursing home administrators).
- Complaints are analyzed to identify major issues impacting residents and strategies are developed based on identified issues.
- Needed regulatory and law enforcement actions are initiated.
- Citizen groups and other advocates push the long term care ombudsman's advocacy agenda.
- Consumers' quality of care and quality of life are improved.
- Residents, families and the public understand the need for systems change, make comments and provide testimony on legislative and regulatory proposals.
- Knowledge and public understanding of advance directives will increase.
- Older adults will have more pro bono or sliding fee scale legal assistance services available.

E. CHANGES IN THE AWARD PROCESS

The State Unit on Aging is designated by South Carolina's Governor to receive and administer federal OAA funds. In accordance with federal requirements, the SUA designates Area Agencies on Aging (AAAs) to serve as planning, coordinating, and administrative entities for their specified planning and service area (PSA). The SUA has designated ten (10) multi-county planning and service areas in South Carolina and has designated an area agency for each PSA. AAAs are responsible for assessing the needs of seniors in their PSA and, when appropriate, for contracting with provider organizations to provide those services. The AAAs contract for a variety of services that currently include transportation, home care, senior center activities, health and wellness, group meals, and home delivered meals.

Beginning in the late 1970s, AAAs in South Carolina contracted for services through solicitation of competitive proposals. After several years of experience, there were few, if any, proposals submitted to AAAs in competition with local councils on aging. As a result of this, the practice of open procurement was discontinued in the 1980s.

In January 2003 the SUA was notified by the Administration on Aging (AoA) that the Area Agency award process for OAA funds was not in compliance with federal law and regulations. The SUA, in partnership with the AAAs prepared a draft plan for submission to the Administration in July 2003. The plan was also presented at ten public hearings throughout the state in July. After thorough review of public input, the final draft was submitted to the AoA by September 1, 2003. It is the goal of the SUA that the aging services procurement process will be fully in compliance with AoA policies. The intent of the procurement compliance process is to provide the most cost effective quality services to seniors in South Carolina.

Issues for the New Award Process:

Transition to New Award Process

The SUA is committed to ensuring the change is a smooth and seamless process that maintains services to South Carolina's seniors without disruption. The SUA is concerned about the importance of equity and access to services. This means that the Area Agencies on Aging and local service providers will be treated in an equitable manner under the competitive procurement process. The department will coordinate an open and fair process where Requests for Proposals (RFP's) and contract awards are used for all interested parties. The department is committed that all organizations and consumers may have access to participate in the delivery and receipt of services whenever possible.

Provision of Cost Effective Quality Services

The provision of services for seniors throughout South Carolina and the nation is in a process of change. With the dramatic growth of the number of seniors and caregivers needing services, government is facing a serious problem of limited resources. As a result of this, States' Units on Aging and Area Agencies on Aging must provide quality services in the most cost effective manner possible. All government and private non-profit and for-profit organizations are being forced to innovate and change service provision models to meet the changing needs of seniors and society. Consumers want choice and quality services that meet their needs. Providers in some cases are too small and will need to adapt and work with other entities to meet consumer's needs in order to grow and survive. In other cases new providers may need to enter the market place to meet these needs. A change in the current award process from grant award to competition is expected to enhance the provision of cost effective services.

Goal for the New Award Process:

The goal of the SUA is to be in full compliance with federal laws and regulations for the award process used by the state's Area Agencies on Aging by July 1, 2005.

Desired Outcomes for the New Award Process:

- Complete a successful competitive procurement process to provide quality services to South Carolina's seniors.
- Ensure a smooth and seamless transition to a competitive procurement process without disruption of services to South Carolina's seniors.
- Provide the maximum amount of quality service units to eligible persons with available resources.
- Coordinate the process in a fair and equitable manner.
- Provide access to services for the maximum number of seniors and meet consumer's needs.

Strategies for the New Award Process:

- Extend contracts for one year to allow all parties involved to adjust to the new award process.
- Contract with national consultant to provide training and necessary RFP and Contract development to assure a smooth process.
- Update the state's Quality Assurance Standards for services.

- Empower AAAs to make decisions at the regional level regarding funding allocations and service delivery decisions such as bundling/unbundling of services based upon the regional needs assessment and resource inventory.
- Minimize workload burden for all parties; minimize potential service disruptions by awarding service contracts on a multi-year basis contingent upon acceptable performance by service providers.
- Evaluate outcomes of the process and make necessary changes as required

F. VOLUNTEER AND EMPLOYMENT OPPORTUNITIES

As South Carolina's population ages dramatically in the future, available resources will continue to be a major concern for policymakers, providers of service and to families and individuals needing care and assistance. Funding will be stretched, and the federal, state and local governments will not be able to provide for all needs of the aging population. Seniors currently living in South Carolina and seniors moving to South Carolina offer a wealth of knowledge, skills and abilities. Through volunteerism and employment, these older adults contribute to quality of life for other seniors and to their communities in general. Many of our seniors are living longer, and are healthier, better educated and more financially secure than seniors of several decades earlier. They want the opportunity to remain involved in their communities through participation in the workforce through both paid and volunteer activities.

The trend toward earlier and longer retirement creates some new challenges for South Carolina's seniors. While the majority of senior "transplants" tend to be of middle income or above, many of South Carolina's lifelong residents have lived in rural communities with below-the-national-average income levels. With skyrocketing health care costs, these seniors -- many of whom are ineligible for federal financial assistance -- must continue to work in order to afford the basics. Often their jobs are unskilled jobs at minimum wage or slightly above. Some who live in rural areas are unable to gain employment because transportation to work is unavailable.

The needs and goals of our state's senior population are reflected in both a greater need for additional income for many seniors, as well as interest by others in community volunteer services for a type of enrichment and satisfaction that previous employment constraints may not have permitted.

Existing Programs

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

Programs currently utilizing a sizeable number of volunteers are I-CARE (Insurance Counseling Assistance and Referral for Elders), Living Will Witness Program**,** RSVP (Retired Senior Volunteer Program), Senior Companion and Foster Grandparents Programs. In addition, some volunteers are involved with Advance Directives (see "Elder Rights & Related Issues" section), as well as Alzheimer's support and caregiver groups (see "Services for Caregivers" section).

Issues for Volunteer and Employment Opportunities:

Volunteer Issues:

A major issue is how to best mobilize and utilize our state's seniors so that available community and state resources may be maximized while offering seniors the opportunity to make a positive contribution. This involves identifying the skills and abilities needed for each volunteer activity, developing recruitment strategies based on this "volunteer profile", and utilizing the media and other community resources to the best advantage. In addition, effective use of volunteers requires ongoing efforts, including adequate training, supervision and support, as well as recognition and appreciation of their service. Full utilization of senior volunteers also requires addressing barriers such as liability insurance and transportation difficulties (especially in rural South Carolina).

Employment Issues:

Issues related to job discrimination and stereotypes about older workers continue to be of concern while other issues are being created with changes in the economy and workforce dynamics. Rapid technological change poses increasing challenges for workers who lack the necessary skills, and often leads to unemployment and under-employment.

As discussed earlier in this section, we are witnessing two seemingly contradictory trends emerging: earlier retirement on the one hand and workers re-entering the workforce on the other. How to accommodate these divergent developments will continue to be a challenge for individual seniors, as well as our state. The primary response of the State Unit on Aging to these challenges has been two-fold: 1) public information and awareness and 2) worker training and subsidized employment opportunities. Transportation issues for rural seniors wishing to work will continue to impact employability.

Outcomes for Volunteer and Employment Programs:

- I-CARE program has a roster of 516 certified volunteer insurance counselors.
- Medicare is growing and offering more options. The program is widely used because it is a peer counseling idea. I-CARE volunteers provide information to more than 10,689 Medicare beneficiaries, offering a savings of more than $259,000 per year. This corps of volunteers helps beneficiaries understand the complexities of these health programs and obtain the appropriate assistance with the recent changes in Medicare regulation. This corps must be greatly expanded to meet the needs of seniors seeking information.
- Currently there are over 200 volunteers in the Living Will Witness Volunteer program, accounting for 84% of the staffing needed to enact a Living Will, offering a substantial savings to the state, as well as timely execution of the document. Recruitment and training of additional volunteers will continue to be a focus for state-level staff.
- Over 800 mature adults are employed through Title V. There are 4 national contractors who operate in South Carolina. SUA staff will continue to aggressively search for eligible Title V individuals who wish to gain new skills and seek employment.
- Competitive procurement of Title V begins July 1, 2004 with the issuance of RFPs, for awards to be given in January 2005

Strategies for Volunteer and Employment Programs:

The following strategies will be used work toward desired outcomes:

Volunteer Strategies:

- Continue to promote volunteerism
- Provide support to existing volunteers in the aging network through provision of training and technical assistance and connections to the South Carolina Association for Volunteer Administrators.
- Identify barriers in state law or policies that hinder recruitment and maintenance of volunteers
- Develop a coalition of Aging volunteer advocates at the state level
- Study approaches for using volunteers in the Long Term Care Ombudsman program. This will involve the development of a strategic plan with interested stakeholders in order that a program may be implemented that is supported by and assists all parties in the Continuum of Care and recruits, trains, and retains volunteers over time.
- Seek opportunities for working with other agencies and organizations for promoting intergenerational programs
- Continue to identify additional areas of unmet need in our state (transportation, legal guardians, etc.) that could utilize volunteers and seek ways of developing these volunteer resources
- Help recruit and train additional volunteers for other programs such as Advanced Directives and Caregiving/Respite

Employment Strategies:

- Volunteer opportunities will be presented in new ways through the next four years. Internet access and access through improvement in statewide technology with area agencies on aging will also allow for expedient information exchange as volunteer possibilities are expanded.
- Through the Title V Senior Community Service Employment Program, provide more training and subsidized employment opportunities for 287 older adults.
- Initiate an experimental private sector employment program in each region.
- Implement new policies as required through any re-authorization of the Older Americans Act.
- Develop a coordinated approach to employment and training services for older adults through partnership with the Workforce Investment Act one-stop shops.
- Promote the value of older workers and address negative stereotyping through Job Fairs held in each region
- Provide scholarships to older workers in the Title V program to encourage their attendance at the Summer School of Gerontology

G. EDUCATION AND TRAINING

Authority for the state education and training program is the Older Americans Act of 1965 as amended (Public Law 89-73) 42 U.S.A. 3001. The purpose is to improve the quality of service and to help meet critical shortages of adequately trained personnel for programs in the field of aging. This is accomplished by identifying both short- and long-

range manpower needs and providing a broad range of education and training opportunities. Training is provided to the personnel of State offices, area agencies on aging, senior centers, nutrition and counseling programs and personnel of other agencies in the field of aging or who are preparing to enter the field. Training is intended to strengthen their capacity to remain responsive to the needs of older individuals with special emphasis on using culturally sensitive practices.

Issues for Education and Training:

The rapid growth in the aging population in South Carolina portends the expansion of need for home and community based services. Older adults in-migrating to South Carolina in retirement often means the absence of family support in declining years. Such older adults rely more heavily on service systems for needed assistance. In recent years liability concerns have deterred many agencies and businesses from pursuing or expanding the opportunities to deliver home based care and community based services.

The preparation of personnel to work with older adults and caregivers is essential to ensuring an adequate supply of services now and in the future. Such preparation must include gerontological education and skills training specific to the services offered. Such training will address concerns regarding quality of care and accountability. Very few educational institutions offer courses specifically geared to careers in aging. Many current staff "grew" into the responsibilities they encounter on a daily basis. This method of on-the-job training may have met the needs of the time but can no longer answer the current and projected staffing needs.

Provision of training and education in state-of-the-art professional practice will improve the quality of care, will foster cost effective and efficient business practices, and may result in more business and service opportunities.

The gap between numbers of workers needed and numbers available is evident in the area of homemaker/home health aide services. The Bureau of Labor Statistics (2004) projects that between 2002-2012 the need for home health aides will increase by 48%, from 580,000 to 859,000, making it the second fastest-growing occupation; personal and home care aides by 40%, from 608,000 to 854,000; and nurses aides by 25%, from 1,375,000 to 1,718,000. Contributing to the need is the aging of baby boomers, with a reduction in the number of family members traditionally providing support.

According to a report done for the Robert Wood Johnson Foundation and USDHHS, the shortage of nursing assistants and home care aides is severe, with unprecedented vacancies and turnover rates (Stone & Wienet, 2001). Estimates of turnover for nursing homes range from 45-100% and about 10% for home care. The approximate turnover rate in South Carolina is estimated at 40 percent (based on compilation of information from several provider agencies). Elements of the retention problem include low wages, lack of benefits, and limited training opportunities (Stone & Wienet).

For the past 12 years, the SUA has provided training for certified home health aides and certified nursing assistants. All agencies providing home health and nursing assistant services needed professionally trained staff. The SUA, because of its experience in developing training curricula and organizing training events, took on the task of training such professionals. Despite the low cost of such training opportunities, there is a waiting list of individuals desiring the training but without the means to pay for it without a subsidy. Due to lack of funds, the SUA has discontinued the training.

Federal requirements mandate that all employees used as nurse aides in Medicaid certified nursing facilities be certified and listed on the South Carolina Nurse Aide Registry. These requirements were designed to improve the quality of care in long term care facilities and to define training and evaluation standards for nurse aides who work in nursing facilities.

Nurse aide candidates must attend a state approved nurse aide training before they can take the Nurse Aide Assessment Program Examination. State approved programs include at least 80 hours of training, 40 hours classroom and 40 hours clinical. Upon successful completion of training, aides may apply to take the exam. This exam consists of both a written and a manual skills evaluation. The nurse aide is not placed on the registry until the aide has successfully passed both the written and skills portion of the exam. Nurse aide certifications are valid for 24 months. Certification renewals are granted to any CNA whose employer verifies that the CNA performed nurse aide duties for at least 8 hours during the previous 24-month period. There are approximately 22,683 certified nurse aides currently on the SC Nurse Aide Registry.

Any certified nurse aide who is convicted of resident abuse, neglect, or misappropriation of resident property is no longer eligible for employment in a Medicaid certified nursing facility and the conviction is documented on the Nurse Aide Abuse Registry.

Outcomes for Education and Training:

- To maintain/enhance quality of care by providing opportunities for the education and training of direct service staff, professionals, and policy makers in gerontology and skills development.
- To increase the number of persons with geriatric/gerontological training

Strategies for Education and Training:

- To provide through the annual S.C. Conference on Aging professional and paraprofessional opportunities for interdisciplinary education and exchange.
- To provide skills training to direct service staff through courses offered in the Summer School of Gerontology, through regional training with the Area Agencies and coordination of effort with training offered by other entities.
- To continue training to professionals, paraprofessionals and caregivers in Alzheimer's Disease and Related Disorders.

References

U.S. Bureau of Labor Statistics. (2004). Occupational employment projections to 2012. *February 2004 Monthly Labor Review.* Washington, D.C.: Author.

Stone, R. & Wienet, J. (2001). *Who will care for us? Addressing the long-term care workforce crisis.* The Urban Institute and the American Association of Homes and Services for the Aging.

H. PROMOTION OF INDEPENDENCE AND CHOICE FOR SENIOR ADULTS

The expanding older population in South Carolina is a diverse group with diverse needs. Though one in four will have some problem with activities of daily living that may require long-term care interventions in a residential care facility or in community based care systems, the majority of seniors will not.

Transportation

Issue for Transportation:

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

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

Outcome for Transportation:

Seniors able to have accessible and affordable transportation

Strategies for Transportation:

- Participate in coordination efforts and meetings with the South Carolina Department of Transportation (SCDOT)
- Obtain and consolidate accurate statewide aging network transportation data as requested by SCDOT
- Provide accessible Defensive Driving training to transportation contractors
- Ensure the continued availability of leased vehicles by acting as the single-point-of-contact between the SUA and State Fleet management

Senior Centers

Issues for Senior Centers:

Senior Centers offer a broad range of services that enhance seniors' health, nutritional and social well-being and help them remain independent and involved in their community for as long as possible. A 1989 survey conducted by the Commission on Aging identified a need for more senior centers and found that improvements were sorely needed to upgrade the physical condition of many of the existing centers.

In response to this need, the South Carolina State Legislature established the Senior Center Permanent Improvement Program (PIP) in 1991 and appropriated $948,000 per year from State Bingo tax and licensing fee revenues to fund 74 specifically identified capital improvement projects. After the total amount of funding required to complete these projects was reached, the original legislation was amended to continue the program, with the SUA assuming responsibility for developing an on-going process to select and fund applications for senior center capital improvement projects.

The impact of having funds available for permanent improvements has been significant. When all of the projects approved through the 2004 grant cycle are completed:

- over $13,000,000 in PIP funds will have been spent on 91 different projects;
- PIP funds will represent about 30% of the total cost of these projects, the remainder coming primarily from CDBG, local government and private contributions;

- almost half (44) of the 91 projects will be either new senior centers or projects that included major expansion of at least 1500 sq. ft.; and
- over 300,000 additional sq. ft. for senior services will have been completed.

An additional $1,800,000 (not included above) was approved for funding in March 2004. Of the seven projects authorized, five will be construction of new senior centers.

Outcome for Senior Centers:

To develop a network of comprehensive, multipurpose senior centers that provide quality programs and services that enhance the health and wellness of seniors

Strategies for Senior Centers:

- Coordinate the development of programs and services in senior centers with the development of wellness, prevention and health promotion programs;
- Provide technical assistance to providers seeking to make permanent improvements to senior centers, whether utilizing PIP funds or not; and
- Encourage senior center management to collaborate with community and local government collaboration to improve financial stability.

Nutrition and Wellness

Issue for Nutrition and Wellness:

Many of the health problems related to aging, especially those most prevalent in South Carolina – cardiovascular disease, osteoporosis, obesity, and diabetes, benefit from improved nutrition, instructional interventions, and regular physical activity. Seniors need to have opportunities to remain active and involved in the community, they need to learn to deal with health concerns in a way that will help them manage their condition and delay the onset of debilitating effects.

Over the past several years, nutrition staff have received instruction on the use of high quality and age appropriate teaching materials to enhance the older adult's understanding of the principles of good nutrition and the impact it has on their ability to manage diseases. The meal plan adopted for use in the nutrition program statewide focuses on improved dietary choices and has significantly reduced the amount of sodium and fat in the meal served to older adults. More recent guidelines will further improve the nutritional value of the meals provided.

State staff has identified several health issues that need increased awareness. Senior Immunization, Medication Management, Obesity Prevention and Fall Prevention are priorities for a healthy aging campaign. Instructional materials are being distributed throughout the aging network to use in health promotion activities and programs such as local health fairs and outreach services.

With the development of senior centers, opportunities for organized regular physical fitness activities have increased and will continue to increase. The SUA continues to work throughout the field to identify award winning exercise programs to be replicated and used throughout the State. Partnership projects continue to be researched through both the University of South Carolina and Clemson University.

Outcome for Nutrition and Wellness:

- to promote the renaissance of the congregate nutrition program with focus on the expansion of quality wellness programs

Strategies for Nutrition and Wellness:

- to reestablish the nutrition and wellness task force as an instrument for promoting quality programs and services;
- to collectively review and revise, as appropriate, the minimum meal specifications to allow for greater flexibility in the type of meals offered at congregate sites;
- to assist the aging network in developing outcome measures appropriate for use by individuals participating in fitness activities at sites and senior centers; and
- to assist area agencies in determining causes of and responses to the declining participation in the congregate nutrition program.

Medication Management

Nationally, each state office on Aging received Title III-D funds from the Administration on Aging designated for medication management activities as part of a new initiative in the OAA, reauthorized, October 2000 (Public Law 106-554). Medication management activities include health screenings and education activities to prevent incorrect use of medication and adverse drug reactions.

The SUA has the responsibility of developing a medication management program for South Carolina. A task force was established in March 2001 charged with developing medication management programs that will have the greatest impact on South Carolina Seniors. Partners included the South Carolina Pharmacy Association, The South Carolina Primary Health Care Association, AARP, and the state Aging Network.

Issue for Medication Management:

There is a growing problem in America that does not make the headlines in our newspapers or the evening news. Americans are taking prescription and over-the counter drugs in record numbers for a variety of ailments. If medications are not used properly, the risk of adverse side affects is predictable. The risk has a greater impact among the elderly. The list below offers a partial explanation for this greater risk:

- Medications are probably the single most important health care technology in preventing illness, disability, and death in the geriatric population
- Seniors account for 34% of the annual prescription sales and 35% of over-the-counter sales in the United States.
- More than 9 million adverse drug reactions occur in older Americans
- Over two-thirds of all doctors' visits end with a prescription being written
- As much as 50% of medications prescribed for chronic use are never taken
- Improper medication usage among older adults is frequently attributed to poor communication between older patients and health professionals
- Nearly 25 % of all hospital admissions result from older adults who don't take medications properly
- Seniors take four times as many prescriptions per capita as non-seniors
- Drugs taken by older people act differently from the way they do in middle age people, i.e. the liver and kidneys, that breakdown and eliminate drugs, may not work as well in order people. (National Institute on Aging)

Our challenge is to ensure that those seniors have access to services that will maintain their quality of life and offer appropriate assistance to maximize independence.

Outcomes for Medication Management:

- To increase the awareness of the importance of using medications appropriately among seniors in South Carolina
- To maximize resources
- To expand the number of medication management programs in South Carolina
- To learn more about seniors in South Carolina who take prescription and over-the-counter drugs

Strategies for Medication Management:

- Continue the activities of the task force.
- Continue to develop programs and activities that educate seniors about the importance of taking medications properly.
- Continue to identify and target those individuals most in need of help with their medications.
- Continue to develop partnerships.
- RFP to fund promising practices

CHAPTER 8: RESOURCE ALLOCATION PLAN

A. Background:

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

B. Philosophy of the Intrastate Funding Formula

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

C. Goals of the Intrastate Funding Formula

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

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

D. Assumptions of the Intrastate Funding Formula

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

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

- Since the definition is broad and non-specific, it is assumed that many individuals age 60 and over who do not fit into a specific category are in greatest social need. Therefore, the number of people age 60 and over is included as a factor.
- The definition refers to racial or ethnic status as a cause of isolation that causes need. Therefore, the number of minority individuals age 60 and over is included as a factor.
- The definition refers to geographic isolation as cause of need. It is assumed that persons who reside in rural areas are more geographically isolated, relative to those who reside in urban areas. Therefore, the number of people with a rural residence is included as a factor.

- The definition refers to physical and mental disabilities and restricted ability to perform normal daily tasks. Therefore, an estimate of the number of people age 85 and over with moderately or severe impairment is included. The FY 2001 – 2004 State Plan included 60+ with 2 ADLs, based upon the 1990 Panel Study of Older South Carolinians. In view of the age, the SUA, in conjunction with the AAAs, agreed to use the 85+ population as a proxy for the frail elderly.

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

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

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

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

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

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

Numerical Statement of the Formula

A = Planning and Service Area (PSA) Allocation

T = Total Federal Funds Available for Allocation

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

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

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

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

I = PSA Proportion of State 85 plus Moderately or Severely Impaired Population; **Weight: 5%**

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

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

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

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

SOUTH CAROLINA INTERSTATE FUNDING FORMULA
NUMBERS OF PEOPLE IN EACH REGION FOR EACH FROMULA CRITERIA

PLANNING AND SERVICE AREA	AGE 60+	AGE 60+ POVERTY	AGE 60+ MINORITY	AGE 85+ 2+ ADLs	TOTAL POPULATION RURAL SCALE
Appalachia	172,033	19,434	21,720	14,010	348,000
Upper Savannah	38,533	5,321	9,062	3,462	139,173
Catawba	45,392	5,204	8,244	3,475	139,032
Central Midlands	82,761	8,783	19,744	6,840	155,547
Lower Savannah	51,679	8,621	17,110	4,089	165,209
Santee-Lynches	34,345	5,937	12,977	2,704	117,435
Pee Dee	53,202	10,002	17,981	4,378	176,000
Waccamaw	57,943	6,332	10,082	3,170	134,806
Trident	77,367	9,047	22,268	5,604	116,500
Lowcountry	38,227	4,079	9,087	2,537	93,186
TOTAL	**651,482**	**82,760**	**148,275**	**50,269**	**1,584,888**

Source: 2000 Census

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

PLANNING AND SERVICE AREA	AGE 60+	AGE 60+ POVERTY	AGE 60+ MINORITY	AGE 85+ 2+ ADLs	TOTAL POPULATION RURAL SCALE
Appalachia	26.74%	23.48%	14.65%	27.87%	21.96%
Upper Savannah	6.11%	6.43%	6.11%	6.89%	8.78%
Catawba	6.88%	6.29%	5.56%	6.91%	8.77%
Central Midlands	12.89%	10.61%	13.3%	13.61%	9.81%
Lower Savannah	8.16%	10.42%	11.54%	8.13%	10.42%
Santee-Lynches	5.23%	7.17%	8.75%	5.38%	7.41%
Pee Dee	8.24%	12.09%	12.13%	8.71%	11.11%
Waccamaw	8.39%	7.65%	6.80%	6.31%	8.51%
Trident	11.65%	10.93%	15.02%	11.15%	7.35%
Lowcountry	5.71%	4.93%	6.13%	5.05%	5.88%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Source: 2000 Census

AMERICAN INDIAN AND ALASKAN NATIVE 60+ POPULATION IN SC

APPALACHIA: 163		**UPPER SAVANNAH: 31**		**CATAWBA: 129**	
Anderson	19	Abbeville	3	Chester	6
Cherokee	7	Edgefield	7	Lancaster	9
Greenville	64	Greenwood	7	Union	6
Oconee	14	Laurens	10	York	108
Pickens	12	McCormick	0	**SANTEE-LYNCHES: 36**	
Spartanburg	47	Saluda	4	Clarendon	8
CENTRAL MIDLANDS: 128		**LOWER SAVANNAH: 139**		Kershaw	12
Fairfield	3	Aiken	57	Lee	2
Lexington	54	Allendale	2	Sumter	14
Newberry	10	Bamberg	3	**TRIDENT: 171**	
Richland	61	Barnwell	10	Berkeley	44
PEE DEE: 197		Calhoun	4	Charleston	59
Chesterfield	12	Orangeburg	63	Dorchester	68
Darlington	13	**WACCAMAW: 58**		**LOW COUNTRY: 40**	
Dillon	53	Georgetown	9	Beaufort	11
Florence	22	Horry	40	Colleton	24
Marion	8	Williamsburg	9	Hampton	4
Marlboro	89			Jasper	1

TOTAL AMERICAN INDIAN AND ALASKAN NATIVE 60+ POPULATION IN SC: 1,092

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

STATE UNIT ON AGING
PARTICIPATION OF TARGET GROUPS BETWEEN 7/1/2002 AND 6/30/2003

Target Group	Title III-B	Title III-C-1	Title III C-2	Title III-D	Title III-E	All Titles
# Low Income	5,399	7,011	5,288	3,367	See note	13,810
% Low Income	61%	58%	66%	58%	below	58%
# Minorities	4,683	5,993	3,907	2,679		10,973
% Minorities	52%	50%	49%	46%		47%
# Low Income Minorities	2,816	3,696	2,373	1,623		6,507
% Low Income Minorities	32%	31%	30%	28%		28%
# Rural	5,089	7,362	5,057	3,511		13,945
% Rural	57%	61%	63%	61%		60%
# Social Need	3,954	5,187	3,530	2,349		9,600
% Social Need	44%	43%	44%	41%		41%
# Frailty/Disabled	3,037	2,821	4,558	1,491		8,336
% Frailty/Disabled	34%	23%	57%	26%		36%
All Clients Served	8,919	12,072	8,041	5,782		23,364
% Served	38%	52%	34%	25%		100%

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

STATE UNIT ON AGING
STATE FISCAL YEAR: 2004-2005
ALLOCATION FOR AREA AGENCY ON AGING OMBUDSMAN SERVICES AS OF MARCH 3, 2004

PLANNING AND SERVICE AREA	TITLE III-B OMBUDSMAN	STATE 5% Match	LOCAL 10% MATCH	TITLE VII OMBUDSMAN	TITLE VII ELDER ABUSE	SUBTOTAL OAA OMBUDSMAN	MEDICAID FEDERAL	MEDICAID STATE	SUBTOTAL MEDICAID	TOTAL OMBUDSMAN
APPALACHIA FY03	$32,291	$1,899	$3,799			$37,989				$37,989
APPALACHIA FY04	53,528	$3,149	$6,297	$72,361	$28,202	$163,537	$37,471	$37,471	$74,942	$238,479
UPPER SAVANNAH	14,497	$853	$1,706	$12,194	$4,586	$33,836	$16,706	$16,706	$33,412	$67,248
CATAWBA	13,440	$791	$1,581	$11,276	$4,081	$31,169	$9,347	$9,347	$18,694	$49,863
CENTRAL MIDLANDS	48,358	$2,845	$5,689	$30,707	$9,471	$97,070	$66,415	$66,415	$132,830	$229,900
LOWER SAVANNAH	13,706	$806	$1,612	$11,490	$4,105	$31,719	$15,049	$15,049	$30,098	$61,817
SANTEE-LYNCHES	9,418	$554	$1,108	$7,764	$2,882	$21,726	$10,768	$10,768	$21,536	$43,262
PEE DEE	17,863	$1,051	$2,102	$14,959	$5,253	$41,228	$5,850	$5,850	$11,700	$52,928
WACCAMAW	15,232	$896	$1,792	$8,994	$3,128	$30,042	$5,951	$5,951	$11,902	$41,944
TRIDENT	33,907	$1,994	$3,989	$20,019	$6,963	$66,869	$13,246	$13,246	$26,492	$93,361
LOWCOUNTRY	7,604	$447	$895	$6,383	$2,325	$17,654	$11,962	$11,962	$23,924	$41,578
TOTALS	259,841	$15,285	$30,570	$196,147	$70,996	$572,838	$192,765	$192,765	$385,530	$958,368
STATE OMBUDSMAN	105,000	$18,529				$123,529				$123,529
TOTAL	364,841	$33,814	$30,570	$196,147	$70,996	$696,368	$192,765	$192,765	$385,530	$1,081,898

STATE UNIT ON AGING
STATE FISCAL YEAR: 2004-2005
ALLOCATION FOR AREA AGENCY ON AGING **PLANNING, ADMINISTRATION AND PROGRAM DEVELOPMENT** AS OF MARCH 3, 2004

PLANNING AND SERVICE AREA	TITLE III-B,C, and E PLANNING AND ADMINISTRATION	TITLE III-B PROGRAM DEVELOPMENT	STATE 5% MATCH	LOCAL MATCH	SUBTOTAL TITLE III-B,C,and E	STATE GRANT	BASE STATE COLA		P&A (100%) TITLE III-B and C Only	P&A (100%) TITLE III-E Only	TOTAL P&A and PD ALLOCATION
APPALACHIA	224,657	$0	$0	$74,886	$299,543	$4,398	$10,654		$258,300	$41,243	$314,595
UPPER SAVANNAH	111,342	$25,633	$1,508	$40,130	$178,613	$4,398	$3,851		$127,999	$20,457	$186,862
CATAWBA	113,181	$23,729	$1,396	$40,519	$178,825	$4,398	$6,718		$130,239	$20,669	$189,941
CENTRAL MIDLANDS	150,373	$0	$0	$50,124	$200,497	$4,398	$14,601		$172,904	$27,593	$219,496
LOWER SAVANNAH	131,528	$5,906	$347	$44,537	$182,318	$4,398	$5,937		$151,208	$24,163	$192,653
SANTEE-LYNCHES	112,147	$24,758	$1,456	$40,295	$178,656	$4,398	$5,751		$129,028	$20,501	$188,805
PEE DEE	136,033	$1,442	$85	$45,514	$183,074	$4,398	$2,517		$156,460	$24,917	$189,989
WACCAMAW	121,160	$15,779	$928	$42,243	$180,110	$4,398	$4,311		$139,592	$21,955	$188,819
TRIDENT	147,416	$0	$0	$49,139	$196,555	$4,398	$10,496		$169,681	$26,873	$211,449
LOWCOUNTRY	105,888	$30,835	$1,814	$38,924	$177,461	$4,398	$5,759		$121,879	$19,305	$187,618
TOTAL	1,353,725	$128,082	$7,534	$466,311	$1,955,652	$43,980	$70,595		$1,557,290	$247,676	$2,070,227

ESTIMATED FLOW -THROUGH ALLOCATIONS FOR SERVICE PROVISION
STATE FISCAL YEAR 2004 – 2005

PLANNING AND SERVICE AREA	TITLE III-B SUPPORTIVE SERVICES	TITLE III-C1 CONGREGATE NUTRITION	TITLE III-C2 HOME DEL. NUTRITION	TITLE III-D HEALTH PROMOTION	TITLE III-E CAREGIVER SUPPORT SERVICES	TITLE III FEDERAL SUBTOTAL
Appalachia	$598,247	$671,196	$350,507	$34,588	$278,401	$1,932,939
Upper Savannah	$296,458	$332,607	$173,692	$17,140	$138,084	$957,981
Catawba	$301,645	$338,426	$176,731	$17,440	$139,514	$973,756
Central Midlands	$400,461	$449,292	$234,626	$23,153	$186,258	$1,293,790
Lower Savannah	$350,213	$392,916	$205,186	$20,247	$163,093	$1,131,657
Santee-Lynches	$298,842	$335,282	$175,089	$17,277	$138,385	$964,875
Pee Dee	$362,377	$406,564	$212,313	$20,951	$168,194	$1,170,398
Waccamaw	$323,309	$362,733	$189,424	$18,692	$148,191	$1,042,349
Trident	$392,997	$440,918	$230,253	$22,721	$181,393	$1,268,282
Lowcountry	$282,283	$316,704	$165,387	$16,320	$911,006	$45,923
TOTAL FOR PSAs	**$3,606,832**	**$1,046.638**	**$2,113,208**	**$208,529**	**$1,671,826**	**$11,647,033**

PLANNING AND SERVICE AREA	STATE 5% MATCH	LOCAL MATCH	EST. BINGO REVENUE ACE	STATE COMMUNITY SERVICES	STATE GRANT	BASE STATE COLA
Appalachia	$97,326	$231,755	$108,472	$37,391	$14,572	$131,194
Upper Savannah	$48,229	$114,861	$52.156	$16,339	$14,572	$60,689
Catawba	$49,073	$116,739	$43,053	$178,427	$14,572	$63,076
Central Midlands	$65,149	$155,121	$58,866	$23.312	$14,573	$94,270
Lower Savannah	$56,974	$135,685	$57,687	$18,413	$14,572	$50,265
Santee-Lynches	$48,617	$115,677	$38,442	$15,682	$14,572	$51,112
Pee Dee	$58,953	$140,322	$58,281	$18,660	$14,572	$60,216
Waccamaw	$52,597	$124,945	$42,410	$19,399	$14,572	$56,541
Trident	$63,935	$152,044	$50,605	$22,470	$14,572	$52,396
Low Country	$45,923	$109,213	$40,028	$16,298	$14,572	$39,057
TOTAL FOR PSAs	**$586,776**	**$1,396,362**	**$550,000**	**$205,391**	**$145,720**	**$658,816**

STATE UNIT ON AGING

Projected State Unit on Aging Operating Budget Fiscal Year 2005

South Carolina State Plan on Aging 2005 - 2008

Budget Category	Title III - OAA	Title V - OAA	Other Federal	State Revenue	Other Funds	Total
Salaries	$310,843	$53,374	$436,126	$668,918		$1,469,261
Fringe Benefits	$87,036	$14,944	$122,116	$87,087		$311,183
Direct Operating Costs	$225,417	$32,499	$155,806	$167,188	$35,000	$615,910
Allocated Costs (1)	$189,272	$11,665	$393,856	$294,175		$888,967
Total	$812,568	$112,482	$1,107,903	$1,217,368	$35,000	$3,285,321
	(2)	(3)	(4)	(5)		

(1) Allocated Costs are uniform throughout the agency and the rate is approved by the Centers for Medicare and Medicaid Services (CMS)

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

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

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

(5) Includes required match for all federal grants administered by the SUA ($592,047) plus additional state general revenue to support state mandated responsibilities of the State Unit on Aging ($516,107)

STATE UNIT ON AGING
State Fiscal Year 2004 - 2005
Allocation to Area Agency on Aging for BINGO FUNDED SERVICES as of March 3, 2004
Estimated Bingo Tax Allocation: $550,000

APPALACHIA: $108,472		**UPPER SAVANNAAH: $52,156**		**CATAWBA: $18,739**	
Anderson	$18,739	Abbeville	$8,090	Chester	$8,893
Cherokee	$9,636	Edgefield	$7,504	Lancaster	$10,241
Greenville	$31,114	Greenwood	$10,955	Union	$8,563
Oconee	$11,946	Laurens	$11,148	York	$15,851
Pickens	$13,156	McCormick	$6,941	**SANTEE-LYNCHES**	
Spartanburg	$23,881	Saluda	$7,518	Clarendon	$8,591
CENTRAL MIDLANDS		**LOWER SAVANNAH**		Kershaw	$9,828
Fairfield	$7,683	Aiken	$16,156	Lee	$7,362
Lexington	$18,739	Allendale	$6,756	Sumter	$12,661
Newberry	$8,893	Bamberg	$7,243	**TRIDENT**	
Richland	$23,551	Barnwell	$7,601	Berkeley	$12,853
PEE DEE		Calhoun	$7,160	Charleston	$26,549
Chesterfield	$8,893	Orangeburg	$12,771	Dorchester	$11,203
Darlington	$10,653	**WACCAMAW**		**LOW COUNTRY**	
Dillon	$7,986	Georgetown	$10,818	Beaufort	$16,538
Florence	$14,420	Horry	$22,919	Colleton	$8,811
Marion	$8,398	Williamsburg	$8,673	Hampton	$7,408
Marlboro	$7,931			Jasper	$7,271

Services to Low Income and Minority Older Individuals

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

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

Services to Older Individuals in Rural Areas

According to the 2000 Census approximately 40% of South Carolina's population resides in rural areas. With respect to the fiscal year preceding the fiscal year for which the plan is prepared, the methods used to satisfy the service needs of older individuals who reside in rural areas included efforts to make services accessible in rural areas. Efforts have been made by the Area Agencies on Aging in rural areas of the state to decentralize the location of congregate nutrition sites to the extent that it is feasible to do so. Many congregate nutrition sites and other service delivery sites are located in rural areas. In addition, statewide, 69% of the Title III-B funds have been allocated to transportation services in order to provide access to services for those older individuals residing in rural areas.

Additional Costs of Services in Rural Areas

As required, an effort was made to identify the additional costs (if any) of services in rural areas. For purposes of this analysis, total unit cost data by provider for Fiscal Year 2003 was examined for the core services of transportation, congregate meals, and home-delivered meals.

Much of South Carolina is rural, and all of the Planning and Service Areas include some rural areas. None of the Planning and Service Areas are totally urban. For the purposes of this analysis a county was considered rural if more than 50 percent of its population was rural, and a county was considered urban if more than 50 percent of its population was urban, as determined by the 2000 Census.

There is wide variation in unit costs across the state, making it difficult to identify a consistent pattern for comparison of costs between rural and urban areas. The SUA has carefully reviewed the unit costs of services, and the analysis of this data does not show a consistent pattern that would indicate a significant difference in cost between rural and urban areas.

Title III-B Minimum Percentage Requirement

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

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

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

TOTAL III-B EXPENDITURES FOR FISCAL YEAR 2002 – 2003

CATEGORY	EXPENDITURES	PERCENTAGE
Access Services	$2,944,625	73%
In-Home Services	$1,021,410	25%
Legal Services	$66,100	2%
TOTAL	**$4,032,135**	**100.0%**

Preference for Greatest Economic or Social Need

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

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

The SUA allows the Area Agencies on Aging flexibility in determining the specific process that will be used to assess needs in each Planning and Service Area; however all Area Agencies are required to use a uniform Client Intake and Client Assessment information. Effectiveness is monitored through the Program Performance Report, and by periodic on-site monitoring and assessment of the Area Agencies on Aging. Current statistics indicate that 39% of participants are below the poverty threshold, 46 percent are minorities (Fiscal year 2003, NAPIS). According to the 2000 Census, 13% percent of the population over age sixty are below the poverty threshold, 60% live in rural areas, and 23% percent are minorities. These figures demonstrate that the target population is receiving preference because they are being served in greater proportions than their percentages of the total population over age sixty in South Carolina. Therefore, it has not been deemed necessary to add additional procedures to target these groups.

APPENDIX A: ASSURANCES

Listing of State Plan Assurances
Older Americans Act, As Amended in 2000

ASSURANCES:

Sec. 305, ORGANIZATION

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

After consideration of the views offered by the unit or units of general purpose local governments, the State Agency agrees to designate a public or private nonprofit agency or organization as the area agency on aging for each planning and service area.

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

In connection with matters of general policy arising in the development and administration of the State Plan, the State Agency agrees to take into account the views of recipients of supportive services, nutrition services, wellness services or individuals using multi-purpose senior centers.

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

The State Agency agrees to give preference to providing services to older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals and older individuals residing in rural areas and include proposed methods of carrying out the preference.

(4) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(1 6). **((a)(2)(F))**

The State agency agrees to require area agencies on aging to use outreach efforts that will identify individuals eligible for assistance, with special emphasis on older individuals residing in rural areas; older individuals with greatest economic need; low-income minority individuals residing in rural areas; older individuals with greatest social need; older individuals with severe disabilities; older individuals with limited English-speaking abilities; and older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction and the caretakers of such individuals.

The State Agency also agrees to inform the older individuals stipulated above of the availability of such assistance.

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

The State Agency agrees to undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and to provide a description of these efforts in Chapter 8, page 9.

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

The State Agency shall ensure that the area agency on aging will have the ability to develop an area plan and to carry out a program in accordance with the plan, directly or through contractual or other arrangements.

Sec. 306, AREA PLANS

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

(A) services associated with access to services (transportation, outreach, information and assistance, and case management services);

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

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded. **((a)(2))**

The State Agency agrees to set an adequate proportion of the amount allotted to the State for Part B to be expended for the delivery of each category of the specified services: services related to access to services; in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and legal services. The State Agency agrees to require each area agency on aging to report annually to the State Agency the amount of Part B funds expended for each such category during the fiscal year most recently concluded, Chapter 8, page 10.

(2) Each area agency on aging shall provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan. **((a)(4)(A)(i))**

The State Agency shall require area agencies on aging to set specific objectives for providing services to older individuals with greatest economic need; older individuals with greatest social need; low-income minority older individuals and older individuals residing in rural areas, and to specify in the area plan those objectives and the proposed methods of carrying them out.

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

(A) specify how the provider intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas in the area served by the provider;

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

(C) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals and older individuals residing in rural areas within the planning and service area. **((a)(4)(A)(ii))**

The State Agency shall require that area agencies will include in each request for proposals to provide services under this title that each applicant will specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas in accordance with their need for such services, and how the applicant plans to meet specific objectives established by the area agency on aging for providing services to such individuals. The area agency on aging shall include these commitments in any agreement with chosen providers of service.

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

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

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

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

For the fiscal year preceding the fiscal year for which the plan or plan update is prepared, the State agency shall require AAAs to identify the number of low-income minority older individuals served in the planning and service area; describe the method used to address the service needs of such minority older individuals; and provide Information on the extent to which the area agency on aging met the objectives set for service to these targeted older individuals, Chapter 8, pages 4 and 11.

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

(A) older individuals residing in rural areas;

(B) older individuals with greatest economic need (with particular attention to low-

income minority individuals and older individuals residing in rural areas);

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

(D) older individuals with severe disabilities;

(E) older individuals with limited English-speaking ability; and

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

and inform the older individuals referred to in (A) through (F), and the caretakers of such individuals, of the availability of such assistance. **((a)(4)(B))**

The State Agency agrees to require area agencies on aging will use outreach efforts to identify individuals eligible for assistance, with special emphasis on older individuals residing in rural areas; older individuals with greatest economic need; low income minority older individuals; older individuals residing in rural areas; older individuals with greatest social need; older individuals with severe disabilities; older individuals with limited English-speaking ability; and older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caregivers of such individuals).

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

The State Agency shall require each area agency to ensure that each activity undertaken by the area agencies, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

The State Agency shall require each area agency to coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, with agencies that develop or provide services for individuals with disabilities.

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

In carrying our the State Long Term Care Ombudsman program under section 307(a)(9), the State agency shall require each area agency to expend for ombudsman services all funds allocated for that service for that period.

(9) Each area agency on aging shall provide information and assurances concerning

services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including -

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

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

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans. **((a)(11))**

In area plans and program reporting, the State agency shall require each area agency on aging to provide information related to services to older Native Americans, including the population of older Native Americans in the planning and service area, and the number receiving services under the Act. If feasible, the area agency on aging will pursue activities, including outreach, to increase access of older Native Americans to programs and benefits provided under this title. In any planning and service area in which a native American tribe receives funding under Title VI of the Act, the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI. In planning and service areas where there are no Title VI grantees, the area agency on aging will assure that services under the area plan are available to older Native Americans, to the same extent as such services are available to older individuals within the planning and service area (Chapter 8, page 4).

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

The State agency shall require each area agency to maintain the integrity and public purpose of services provided, and service providers, in all contractual and commercial relationships entered into under this title.

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

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

(B) the nature of such contract or such relationship. **((a)(13)(B))**

In the area plan, the State agency shall require each area agency to disclose the identity of each entity with which the agency has a contract or commercial relationship for providing any service to older individuals and provide information on the nature of each contract or relationship.

(12) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result

from such non-governmental contracts or such commercial relationships. **((a)(13)(C))**

In area plans and annual updates the State agency requires each area agency to document any changes in units of service and service costs and to justify any reductions in service quantity or quality.

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

In area plans and annual updates the State agency requires each area agency to document any changes in units of service and service costs and to justify any reductions in service quantity or quality.

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

For the purpose of monitoring compliance with this Act, or conducting an audit, the State agency shall require each area agency to disclose to the Assistant Secretary or the State all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

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

The State Agency agrees that AAAs will ensure that preference in receiving services under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(16) Each area agency on aging shall provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title. **((a)(15))**

The State Agency agrees that area agencies will ensure that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title.

Sec. 307, STATE PLANS

(1) The plan describes the methods used to meet the need for services to older persons residing in rural areas in the fiscal year preceding the first year to which this plan applies. The description is found in Chapter 7 of this plan. **((a)(3)(B)(iii))**

The State Agency agrees to maintain expenditures for services in rural areas at no less than the amount spent in those areas in fiscal year 2000.

(2) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper

disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract. **((a)(7)(A))**

The State Agency ensures that the financial control and fund accounting procedures required by the State of South Carolina to ensure proper disbursement of, and accounting for, Federal funds paid under this Title to the State, including any such funds paid to the recipient of a grant or contract.

(3) The plan shall provide assurances that --

(A) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(B) no offcer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and (C) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act. **((a)(7)(B))**

The State agency ensures that there are currently no conflicts of interest at the State and area level and that mechanisms are in place to identify and remove any conflict should one occur.

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

The State Agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will ensure maintenance of effort at no less than fiscal year 2000 levels in expending both Title III part B and Title VII funds.

(5) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs. **((a)(1O))**

The State agency shall describe the efforts undertaken to address the needs of older individuals residing in rural areas and describe how funds have been allocated to address those needs (Chapter 8, page 3).

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

(A) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(B) include in any such contract provisions to ensure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(C) attempt to involve the private bar in legal assistance activities authorized under

this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis. **((a)(11)(A))**

The State agency shall require each area agency on aging to enter into contracts or other relationships only with providers of legal assistance that can demonstrate the experience or capacity to deliver legal assistance and commit to comply with the requirements and restrictions stated in 307(a)(11)(A). Each area agency shall be required to attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

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

The State agency ensures that area agencies on aging select only contractors that are best able to provide the legal assistance services described in the Act, and that no legal assistance will be furnished with funds under this title unless the contractor, if not a Legal Services Corporation project grantee, agrees to coordinate its services with Legal Services Corporation projects in order to concentrate the use of funds provided under this title on individuals with the greatest need.

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

The State agency shall require that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals.

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

The State agency shall require each area agency on aging to require legal assistance contractors to give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(10) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program

consistent with relevant State law and coordinated with existing State adult protective service activities for --

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

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

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

(D) referral of complaints to law enforcement or public protective service agencies where appropriate. **((a)(12))**

The State agency ensures that all activities funded under the Act to prevent abuse, neglect or exploitation of older individuals in the community will be consistent with relevant State law, coordinated with State adult protective service, and include: activities for public education to identify and prevent abuse of older individuals; receipt of reports of abuse of older individuals; referral of such individuals to other sources of assistance only with the informed consent of the parties to be referred; and referral of complaints to law enforcement or public protective service agencies when required by law.

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

The State agency assigns the duty of providing state leadership in developing legal assistance programs for older individuals throughout the State to a designated staff person.

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

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include-

(I) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences. **((a)(14))**

The State agency agrees that, when a substantial number of the older individuals

residing in any planning and service area are of limited English-speaking ability, the area agency on aging for each such planning and service area will be required to comply with the provisions of this section.

(13) The plan shall provide assurances that the State agency will require outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on --

(A) older individuals residing in rural areas;

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

(D) older individuals with severe disabilities;

(E) older individuals with limited English-speaking ability; and

(F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in clauses (A) through (F) and the caretakers of such individuals, of the availability of such assistance. **((a)(16))**

The State agency agrees to require area agencies on aging to use outreach efforts that will identify individuals eligible for assistance, with special emphasis on older individuals residing in rural areas; older individuals with greatest economic need; low-income minority older individuals; older individuals with greatest social need; older individuals with severe disabilities; older individuals with limited English-speaking abilities; and older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction and the caretakers of such individuals.

The State agency also agrees to require area agencies on aging to inform the older individuals stipulated above of the availability of such assistance.

(14) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities. **((a)(17))**

The State Agency will coordinate planning, identification, assessment of needs, and services for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies having primary responsibility for these individuals to enhance services and develop collaborative programs, where appropriate.

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

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

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

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them. **((a)(18))**

The State agency shall require each area agency on aging to conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who are at risk of institutionalization; who are patients in hospitals; or who are patients in long-term care facilities, but who want to return to their homes and could do so if community-based services are provided to them.

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

This assurance was addressed in detail under Section 307(a)(19).

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

The State Agency agrees that special efforts will be made to provide technical assistance to minority providers of services.

(18) The plan shall

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

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities. **((a)(21))**

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

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

The State agency will ensure that case management services provided under this title through the area agency on aging will not duplicate case management services provided through other Federal and State programs; be coordinated with such services and be provided by a public agency or a nonprofit private agency that (i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging; (ii) gives each such individual a statement specifying that the individual has a right to make an independent choice of service providers; documents receipt by such individuals of such statement; (iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or (iv) when the case management service is

required in a rural area the provider shall obtain a waiver of the requirements described in clauses (i) through (iii).

(20) The plan shall provide assurances that demonstrable efforts will be made –

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

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs. **((a)(23))**

The State Agency agrees that demonstrable efforts will be made to coordinate services provided under this Act with other State services that benefit older individuals; and to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

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

The State Agency will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

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

The State agency requires each area agency contracting for in-home services to require provider compliance with statewide quality assurance standards established for in-home services.

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

The State agency does not use funds received under this title and does not permit area agencies on aging to use such funds to pay any part of a cost, including an administrative cost, incurred by the State or area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

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

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

supported through use of amounts received under this paragraph. **((b)(3)(E))**

This provision is no longer applicable because the Older Americans Act appropriation now exceeds $800,000,000.

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

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

This assurance was addressed in detail under Section 307)a)(19).

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

The State Agency will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

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

The State Agency shall, in consultation with area agencies on aging, identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

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

The State agency shall use funds made available under title VII for vulnerable elder rights protection activities that are in addition to those activities supported by any funds expended under any Federal or State law in existence prior to November 1, 2000.

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

The State Agency will place no restrictions on the eligibility of entities for designation as local Ombudsman entities other than those required by Section 712(a)(5)(C).

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

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for -

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except -

(i) if all parties to such complaint consent in writing to the release of such information; (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(ii) upon court order.

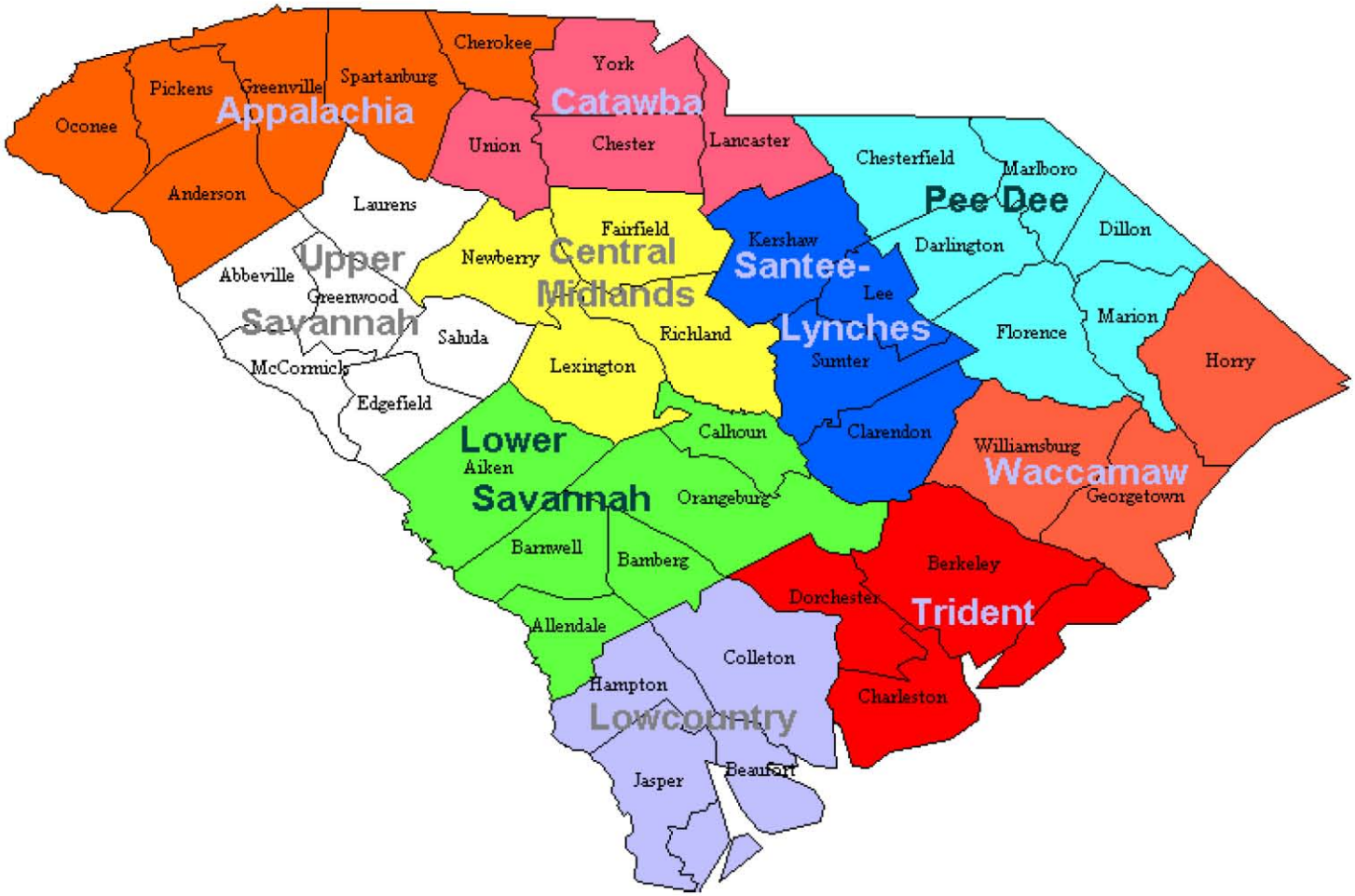
The State agency, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3, ensures that all activities to prevent abuse, neglect or exploitation of older individuals in the community will be consistent with relevant State law, coordinated with State adult protective service, and include: activities for public education to identify and prevent abuse of older individuals; receipt of reports of abuse of older individuals; referral of such individuals to other sources of assistance only with the informed consent of the parties to be referred; and referral of complaints to law enforcement or public protective service agencies when required by law.

The State agency shall not permit involuntary or coerced participation in the program or services by alleged victims, abusers, or their households.

The State agency shall require that all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to such complaint consent, in writing, to the release of such information.

Such information, when required by law, may be released to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection and advocacy system; or upon court order.

APPENDIX B: SOUTH CAROLINA PLANNING AND SERVICE AREAS



AREA AGENCIES ON AGING AND SERVICE PROVIDERS

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DR. MICHAEL STOGNER, Aging Unit Director
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Ms. Joyce Beason
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Mr. Fred Graham
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Greenville, SC 29603
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Ms. Nancy Ogle
Senior Centers of Spartanburg County, Inc
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Spartanburg, SC 29302
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Mr. J.W. Sanders, Jr
Bethel Senior Day Care Center.
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Gaffney, SC 29342
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FAX: (864) 489-0604

REGION II - UPPER SAVANNAH

MS. PATRICIA C. HARTUNG, Executive Director
MS.VANESSA WIDEMAN, Aging Unit Director
Upper Savannah Council of Governments
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E-MAIL: vwideman@uppersavannah.com

COUNTIES SERVED: Abbeville, Edgefield, Greenwood, Laurens, McCormick, and Saluda

REGIONAL OMBUDSMAN: Ericca Livingston
Phone: 864-941-8070

REGIONAL I/R&A SPECIALIST: Kathy Dickerson
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REGIONAL FAMILY CAREGIVER ADVOCATE: **Barbara Wright**
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Jgriffith@ecscc.org

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Ms. Becky McDade
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McCormick, SC 29835
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Phone: (864) 445-2175

Ms. Kathy Hendricks-Dublin
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Post Office Box 997
Greenwood, SC 29648-0997
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FAX: (864) 223-6530
E-Mail: kdublin@piedmontaoa.com
COUNTIES SERVED: Abbeville & Greenwood

Correspondence Directly Related to the Abbeville office may be sent to:
Piedmont Agency on Aging
Abbeville Senior Center
Center Street
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Abbeville, SC 29620
Phone: (864) 459-9666
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Mr. John Snyder
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REGION III - CATAWBA

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Sherron Marshall=Sherron.Marshall@Catawba-Aging.com

COUNTIES SERVED: Chester, Lancaster, York, & Union

REGIONAL OMBUDSMAN: Melissa Morrison
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REGIONAL I/R&A SPECIALIST: Krystle Stephens, York County CoA
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REGIONAL FAMILY CAREGIVER ADVOCATE: Deb Lewis
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REGION IV - CENTRAL MIDLANDS

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E-Mail: aging@centralmidlands.org
bmauldin@centralmidlands.org
For Sharon Seago = sseago@centralmidlands.org

COUNTIES SERVED: Fairfield, Lexington, Newberry, and Richland

REGIONAL OMBUDSMAN: Anna Harmon, Shirley Smith, LaToya Buggs
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REGIONAL I,R&A SPECIALIST: Jackie Thompson
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REGIONAL FAMILY CAREGIVER ADVOCATE: **Joe Ritchey**
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Lexington County Recreation and Aging Commission
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Ms. Susan Wrigley, R.N.
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REGION V - LOWER SAVANNAH

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MS. LYNNDA BASSHAM, Human Resource Director
MS. LINDA HOLMES, Aging Unit Director
Lower Savannah Council of Governments
2748 Wagener Road
Post Office Box 850
Aiken, South Carolina 29802
Phone: 649-7981 **FAX:** 649-2248 **E-Mail:** lholmes@lscog.org
lbassham@lscog.org

COUNTIES SERVED: Aiken, Allendale, Bamberg, Barnwell, Calhoun, and Orangeburg

REGIONAL OMBUDSMAN: Susan H. Garen
Phone: (803) 649-7981

REGIONAL I/R&A SPECIALIST: Mary Beth Fields
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REGIONAL FAMILY CAREGIVER ADVOCATE: Cathy Lindler
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REGION VI - SANTEE LYNCHES

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MS. VICKIE WILLIAMS, Aging Unit Director
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COUNTIES SERVED: Clarendon, Kershaw, Lee, and Sumter

REGIONAL OMBUDSMAN: Vickie Williams, Janice Reed Coney

REGIONAL I/R&A SPECIALIST: Jonathan Perry
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REGIONAL FAMILY CAREGIVER ADVOCATE: Toni Brew **Phone:** (803) 775-7381
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REGION VII - PEE DEE

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COUNTIES SERVED: Chesterfield, Darlington, Dillon, Florence, Marion, and Marlboro

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REGION VIII - WACCAMAW

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MS. KIMBERLY HARMON, Aging Unit Director
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Kim Harmon – harmonkd@yahoo.com
Fanny Johnson — funooch@yahoo.com
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COUNTIES SERVED: Georgetown, Horry, and Williamsburg

REGIONAL OMBUDSMAN: Alice Streetman and Patti Lobik
Phone: 1-800-864-6446 or 843-745-1706

REGIONAL I,R,&A SPECIALISTS: Tina Pressley (*Georgetown*)
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Mitzi Tisdale (*Kingstree*)
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REGION IX - TRIDENT

MS. STEPHANIE BLUNT, Executive Director
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Charleston, South Carolina 29405
Phone: (843) 745-1710 **FAX:** (843) 745-1718 (24-hour)
E-Mail: sblunt@bellsouth.net

Alzheimer's Help Line*:* (843) 745-1722

COUNTIES SERVED: Berkeley, Charleston, and Dorchester

REGIONAL OMBUDSMAN: Alice Streetman and Patti Lobik
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REGIONAL I/R&A SPECIALIST: Penny Todd
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REGIONAL FAMILY CAREGIVER ADVOCATE: Gretchen Bair **Phone**: **(**843) 745-1710
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Ms. Tonya Sweatman, Senior's Director
Berkeley Senior's, Inc.
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Moncks Corner, SC 29461
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Ms. Margaret Marshall, Director
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Center, Inc.
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E-Mail:

REGION X - LOWCOUNTRY

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MS. MARVILE THOMPSON, Human Services Director/Aging Unit Director
Lowcountry Council of Governments
634 Campground Road
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Yemassee, South Carolina 29945-0098
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E-Mail: lcogaaa@lowcountrycog.org

COUNTIES SERVED: Beaufort, Colleton, Hampton, and Jasper

REGIONAL OMBUDSMAN: Marvile Thompson
Phone: (843) 726-5536 or (843) 524-2625

REGIONAL I/R&A SPECIALISTS:

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Phone: (843) 846-6472 **Toll Free #**: 1-877-846-8148

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APPENDIX C: STATEWIDE SUPPORT OF OLDER AMERICANS ACT SERVICES

STATEWIDE REPORT OF OLDER AMERICANS ACT SERVICES

	Adult Day Care	Care Mgmt	Congregate Meals	Counseling	Education Information	Escort Service	FollowUp Services	Health Benefits	Health Promotion	Health Screening	Home Delivered Meals	Home Injury	Homebound Support	Information Assistance	Legal Assistance	Level I Homecare	Level II Homecare	Level III Homecare	Nutrition Counseling	Outreach	Physical Fitness	Social Support	Transportation
REGION 01																							
Oconee		X	X				X			X	X	X		X						X	X		X
Pickens		X	X								X			X		X					X		X
Laurens		X	X						X	X	X					X					X		X
Cherokee			X						X		X			X		X			X	X	X		X
Spartanburg	X	X	X						X		X	X				X				X	X		X
Anderson	X	X	X				X			X	X	X	X	X		X				X	X		X
REGION 02																							
Abbeville Senior Center			X								X		X	X						X	X	X	X
Edgefield	X		X	X							X			X		X					X		X
McCormick			X								X										X		X
Piedmont Agency on Aging			X								X		X	X						X	X	X	X
Saluda			X								X						X				X		X
Senior Options, Inc.	X		X								X												X
REGION 03																							
Lancaster			X		X					X	X				X	X					X		X
Chester			X								X				X	X					X		X
Union			X								X				X	X					X		X
York	X	X	X								X			X	X		X				X		X
REGION 04																							
Columbia Urban League															X								
Fairfield			X						X		X					X	X						X
ICRC--Crooked Creek			X								X										X		X
Lexington RAC		X	X			X					X						X			X	X		X
Newberry	X		X								X						X				X	X	X
Respite House	X																						
Senior Resources		X	X								X			X			X				X		X
REGION 05																							
Aiken Council on Aging			X						X		X						X						X
Allendale			X					X			X					X							X
Bamberg Office on Aging			X						X	X	X			X			X				X		
Calhoun			X								X			X			X				X		X
Barnwell			X							X	X			X			X			X		X	X
Orangeburg			X								X					X					X		X
REGION 06																							
Clarendon			X								X					X					X		X
Kershaw			X								X		X			X				X	X		X
Lee			X								X					X					X		X
Santee Senior Services			X								X					X					X		X
REGION 07																							
Chesterfield			X							X	X				X	X							X
Darlington			X								X				X		X				X		X
Dillon			X								X				X	X	X				X		X
Marion			X								X				X	X	X				X		X
Marlboro			X								X				X	X	X				X		X
Florence			X								X				X	X	X				X		X
REGION 08																							
Georgetown			X						X		X					X							X
Horry		X	X						X		X					X				X			X
Vital Aging			X						X		X						X						X
REGION 09																							
Charleston - ARC											X					X	X	X	X				
Berkeley Senior's, Inc.			X								X						X				X		X
Charleston CASC			X						X		X												X
Dorchester		X	X								X						X				X		X
Charleston - Sea Island			X								X										X		X
Charleston - South Santee			X								X		X			X	X				X		X
REGION 10																							
Colleton			X								X						X						X
Hampton			X								X						X						X
Jasper			X								X						X						X
Beaufort			X								X					X	X						X