Mecklenburg County
Status of Seniors Initiative
STRATEGIC PLANNING REPORT

MAY 2004

Fostering a Senior-Friendly Community

Share the Vision: Shape the Future
for Mecklenburg County Senior Citizens

Message from the Executive Committee

Two years ago a small group of professionals in the field of Aging began conversations on how to raise community awareness about issues affecting seniors in Mecklenburg County. Our concerns and those of others across the community would prove to be the genesis of the Status of Seniors Initiative.

With 84,000 people over the age of 59 residing in the county and projections that the number will nearly triple by 2025, the urgent need for community-wide awareness, education and planning was clear. Preparing for tremendous growth in the senior population would require a review of current levels of service to seniors, an identification of gaps in service, and an exploration of innovative ways to meet the added the demands that the baby boomer generation (people born between 1946-1964) will inevitably bring.

A growing concern about seniors led the Board of County Commissioners to direct the Department of Social Services (DSS) and the Social Services Committee (SSC) of the Health and Human Services Council to produce an annual *Status of Seniors* report. The *2003 Status of Seniors Report* was presented to the BOCC and at the Successful Aging Forum in May 2003. The release of this report, which included results from a countywide survey, marked the beginning of the 2003-04 Status of Seniors Initiative strategic planning process.

To provide leadership, which will be essential for the initiative's long-range success, Richard W. "Jake" Jacobsen, Jr., director of the Department of Social Services, recruited Gerald G. Fox, former county manager and Ted Rast, a local attorney and United Way board member to assemble an Executive Advisory Board. Both recognized community leaders, Fox and Rast selected others to help oversee the strategic planning process and to serve as champions for its subsequent recommendations. A Steering Committee, representing a network of public, for-profit and non-profit organizations serving older adults, was also formed to guide the process.

There have been remarkable accomplishments under the Status of Seniors Initiative. Hundreds of community members and field professionals have become better informed about issues affecting seniors. They have also contributed to the planning process by attending forums, such as the interactive workshop at the UNCC Cone Center, by serving on Community-Based Issue Groups, and by participating in surveys and other research activities. Collaboration with Leadership Charlotte and the University of North Carolina at Charlotte Master of Public Administration program have produced two reports that influenced recommendations contained in this document.

One of the most notable accomplishments is how the strategic planning process inspired collaboration within the network of organizations serving older adults. Many of the usual barriers to collaboration ceased to exist, while new alliances formed, discussions grew more open and honest, and passion around issues affecting older adults and adults with disabilities flourished. This new level of collegiality and shared ownership was evident among members of the Steering Committee and Issue Groups. On reflection, the Steering Committee's efforts to create and adopt vision and mission statements and guiding principles generated a spirit of teamwork, solidified positive working relationships, and contributed to the overall success of the planning model.

While much has been accomplished, there also have been challenges. An acknowledged challenge for the committees and groups was the short time frame for collecting data, producing recommendations and preparing reports. Another was the lack of data on some topics. The planning process also revealed the absence or limited presence of important stakeholders on the issue of aging, such as professionals from the legal, financial, higher education, and faith communities. Future planning efforts will benefit from concerted measures to include and engage these and other knowledgeable stakeholders. Despite the challenges, participants prevailed and made great strides in presenting well-researched and actionable recommendations.

This report is one step of many toward creating a senior-friendly community. The recommendations outlined in the report will serve as the basis for further, coordinated planning to launch a comprehensive strategic plan for seniors. The Steering Committee continues to meet and is committed to advancing its recommendations by engaging targeted stakeholders, establishing an assessment and accountability system, and setting time lines.

The Status of Seniors Initiative has created a vision and a roadmap that should serve to influence local decisions and become part of a community plan that extends beyond the aging network. Fulfilling our mission will depend on the civic leadership of such groups the Board of County Commissioners, Charlotte Chamber, United Way, as well as strategic action by other influential community forces such as the banking industry, faith community and higher education. Experiences to date indicate that the community is primed to take proactive steps to elevate the concerns of seniors.

STATUS OF SENIORS INITIATIVE
EXECUTIVE COMMITTEE

Carol R. Baker, Ph.D., Director, Services for Adults Division
Mecklenburg County Department of Social Services

Sindy McCrystle, Chair, Older Adult Wellness
United Way of Central Carolinas

Gayla Woody, Aging Program Administrator
Centralina Council of Governments
Area Agency on Aging

John Highfill, Special Projects Coordinator
Services for Adults Division
Mecklenburg County Department of Social Services

Note: Unless otherwise noted, this report make refers to individuals age 60 and older as “seniors” and “older adults;” for the purpose of this report these terms are interchangeable.

Acknowledgments

The Executive Committee is honored to have played a role in the Status of Seniors Initiative and the development of this report on behalf of older adults in Mecklenburg County.

We would like to express our deepest appreciation to the DSS Committee of the Health and Human Services Council for launching the initiative. We also thank Richard W. Jacobsen, Jr., Director of the Mecklenburg County Department of Social Services, for providing funding for the project and for recruiting former County Manager Jerry Fox and local Attorney Ted Rast, to assemble an Executive Advisory Board to champion the Status of Seniors Initiative.

We are grateful for the support of the Mecklenburg County Board of County Commissioners and the Community Health and Safety Committee, chaired by Commissioner Norman A. Mitchell, Sr. We also acknowledge the partners that provided support and staff for the strategic planning process: United Way of Central Carolinas, Area Agency on Aging, Council on Aging, the Department of Social Services, and the Charlotte Mecklenburg Aging Coalition.

We are indebted to the volunteers and field professionals who contributed many thousands of hours of hard work to this effort. These dedicated groups and individuals include the Executive Advisory Board, the Steering Committee, the conveners and members of the five Community-Based Issue Groups, the UNCC Masters in Public Administration class, and Leadership Charlotte Class XXV.

We extend our thanks and appreciation to The Lee Institute, which served as the facilitator of the planning process. Cyndee Patterson, president of the Lee Institute, and Anne Udall, executive director, provided valuable assistance as needed and guided the flow of the Steering Committee's work. Valaida Fullwood, a consultant to The Lee Institute, prepared this report.

The Board of County Commissioners and the community will receive this strategic planning report in May 2004, and we look to advancing the implementation of the strategies recommended in this report. The county's aging network and the broader community must sustain a strategic focus on seniors by identifying and examining additional topics, crafting innovative plans, and implementing aggressive strategies to ensure we satisfy the needs of seniors and adults with disabilities well into the next decade. With continued collaboration and support across Mecklenburg County, we will realize our vision of a *senior-friendly community*.

Table of Contents

Executive Summary

Vision

To foster a senior-friendly community that values dignity and independence for all older adults.

Mission

To engage the community in creating a dynamic plan that enhances the quality of life for older adults by focusing resources on their needs.

Preparing for the 'Age Wave'

By 2030, the number of Americans 65 and older will more than double to 70 million, or 20 percent of the population. The projections for Mecklenburg County are equally striking. Today approximately 80,440 individuals age 60 or older reside in the county. They represent roughly 11.6 percent of county residents. Based on state projections, this figure will rise to over 115,000 by 2011 – an increase of 43 percent. By 2025, the population will triple to over 200,000. Mecklenburg's older adult population is now increasing at a greater rate than the child population (age 0-17), which is not expected to even double in the next two decades.

This sharp increase in number of older adults in Mecklenburg County will create an unprecedented demand for services and require new ways of conducting business. Significantly contributing to this dynamic is the aging baby boomer generation, defined as people born from 1946 to 1964. Aging baby boomers are reshaping society and will ultimately redefine life over 60. The phenomenon is frequently cited as the "age wave," and it will have vast implications for lifestyles, marketing, services, and the workforce.

Bold, progressive action by communities is required to respond to the present needs of seniors while also preparing for an explosive growth and cultural changes in this population. Policy makers, planners, corporate leaders, advocates, and professionals in the field of Aging must engage in innovative and responsible thinking to prepare for the impact of an aging society on public and private institutions and families of all ages.

Launching a strategic, senior-friendly initiative

The Mecklenburg Status of Seniors Initiative is an ongoing, collaborative effort of public, for-profit and non-profit organizations, comprising the aging network. The 2004 Status of Seniors Strategic Planning Report is intended to elevate the issue of seniors, provide data and recommendations to help local leaders set priorities, and lay the groundwork for strategic, community-wide action.

The catalyst for the initiative was a request by the Board of County Commissioners, in May 2002, for an annual *Status of Seniors* report. The board directed the Department of Social Services and the Social Services Committee (SSC) of the Health and Human Services to produce the report. The *2003 Status of Seniors Report*, which included results from a countywide survey of older adults, was released in May 2003. The 2003-04 Status of Seniors Initiative strategic planning process was launched during the summer, following that report's release.

Guiding Principles, in brief

Senior friendly

Age in place, whenever possible

Opportunities available regardless of income

The planning process relied on findings and priorities of Community-Based Issue Groups, outside research teams, public forums, and leadership from aging network and broader community. An estimated 400 volunteers from across the community dedicated more than 3,600 collective hours to the strategic planning process, which extended from September 2003 to May 2004. The overall initiative is led by an Executive Advisory Board, which was assembled to champion the cause of older adults in county. A collaborative of public, for-profit, and non-profit organizations, guided by a Steering Committee, has undertaken efforts to engage the public, collect and analyze data, set priorities, and formulate recommendations.

Drawing on the identified concerns and profiles of older adults documented in the *2003 Status of Seniors Report*, five Community-Based Issue Groups assessed the level of service provided to the county's seniors and noted gaps in service. They examined five issues that were deemed priorities by older adults. An intentional focus on selected issues was expected to produce initial recommendations and learning that could pave the way for subsequent, expanded strategic planning.

Five defining issues investigated under the initiative

- Facilities and Institutions
- Food and Nutrition
- In-Home Support Services
- Leisure, Education, Recreation and Socialization
- Transportation

Two outside research teams conducted research on the initiative's defining issues as well as other identified concerns. A team from Leadership Charlotte Class XXV surveyed human resources directors of local employers about workplace programs for caregivers and the impact of aging on the current and future workforce. Students from the Master of Public Administration program at UNC Charlotte researched transportation, care costs, public safety, and service provision relative to Mecklenburg's growing senior population.

Leading concerns and recommendations

The strategic planning process revealed numerous areas of concerns that the Mecklenburg community must address to become a more senior-friendly community. Each issue group developed a set of six to ten recommendations for its respective service area. Collectively, issue groups generated over 30 recommendations. In addition, the outside research teams

80,440 individuals age 60 or older reside in Mecklenburg, representing roughly 11.6% of county residents

Source: US Census 2000

produced reports with additional findings. Taking a comprehensive look at the various findings, recommendations, and priorities generated by the initiative, the Executive Committee of the Steering Committee distilled the groups' work into seven leading concerns and recommendations. The leading concerns and recommendations are summarized below and on the following pages; detailed information on the leading recommendations and those of specific groups are contained in the full report.

Leading areas of concern from the planning process:

Based on state projections, this figure will rise to over 115,000 by 2011 – an increase of 43%.

- Fragmentation among the services provided to seniors was found to be a leading concern. Service providers and professionals in the field of Aging experience inefficiencies because the network lacks a centralized structure for ongoing research, coordinated planning and implementation, and shared accountability. Meanwhile, seniors suffer from the absence of a full continuum of care that addresses the myriad of needs brought by aging.

- While a comprehensive range of services for older adults exists, many of these services remain unfamiliar to and underutilized by older adults, family caregivers, field professionals, and the general public.

- Multiple factors – such as income eligibility requirements, inflexible programs, waiting lists, and critical workforce shortages – severely restrict the number of feasible long-term care options for seniors and their families. The resulting gaps in the system leave nursing homes and institutions – preferred as last-resort measures – as the *only* affordable solutions for many seniors who require assistance, especially middle-income seniors.

By 2025, the population of 60+ will triple to over 200,000, creating an unprecedented demand for services and new ways to conduct business.

Source: 2003 Status of Seniors Report

- Growing numbers of family members and other informal caregivers are the primary source of care for seniors. The demands of this responsibility can be daunting, and they are felt mentally, physically, financially and in the workplace. To continue fulfilling this crucial role, caregivers need sustained support.

- Existing services for older adults are limited in scope and fail to provide options that meet the current and projected interests, skills and needs of an increasingly diverse senior population. Seniors are *not* homogeneous, and services provided in the county fail to reflect the dimensions of the population (e.g., economic status, health, culture, and living arrangements).

"There is no support for the family caregiver. It is costly and very tiring. People should be able to (more easily) claim (dependents) parents on their tax returns."

Comments from Meck. 2003 focus group participant age 50-59

- Many seniors live in fear of crime with little or no reassurance of how to protect themselves and prevent victimization. These fears create stress, exacerbate health conditions and reduce their quality of life.
- Access to vital services is limited for older adults who do not drive or who have special needs. They depend on others to transport them, and public and private transportation services are often ill equipped to respond to their need to travel for basic services.

Leading recommendations from the planning process

Based on the concerns identified above, the 2003-04 Status of Seniors Initiative recommends the following actions to help set a systemic reform agenda for older adults and influence community priorities. (Refer to the corresponding page number in the full report for a complete account of each recommendation.)

"If you live uptown you have to have money. All the breakfast places are closed on the weekend so how are we supposed to eat? It's fine if you have money but if you don't it's not a good place to be."

67-year-old resident of low-income senior housing

- Establish a multi-functional organization that will serve as a "focal point" for the aging network's strategic planning, information and assistance, care/case management, education and communication, and advocacy on issues affecting seniors (p. 14).
- Develop systemic, integrated approaches for educating and communicating with key stakeholders about the implications of aging and the availability of services for seniors (p.15).
- Redistribute resources for the long-term care system by: (a) promoting the availability of home care as an alternative to nursing home care and (b) eliminating multiple gaps in the system (p.16).
- Magnify the role of informal and family caregivers as a vital part of the continuum of care for seniors (p.17).
- Multiply options for seniors across service areas by: (a) enhancing existing services with innovative approaches and (b) developing new approaches for a full continuum of care (p.18).
- Launch a crime prevention and education campaign in high-density areas with a focus on seniors (p.19).
- Transform the transportation system of service to create an expanded and coordinated range of senior-friendly travel options that increase the mobility and quality of life among seniors and adults with disabilities (p.20).

"The work is so fast paced and stressful. If you don't have to think about old people, you don't until it happens to you."

Dr. Kim Boyer,
Geriatric Psychiatrist,
Charlotte

"In my role as Long-Term Care Ombudsman, I interact on a daily basis with members of the "baby boom" generation. They are increasingly more savvy consumers and have high expectations. We need to prepare for this generation... Our environment and programs will need to address these high expectations.

Linda Miller, Mecklenburg
County LTC Ombudsman

Concluding comments

"The impact of the age wave will be deep and wide…life's path will be transformed…old age will be postponed…health, youthfulness and longevity will be pursued – with a vengeance…and male and female roles will converge…. The age wave is coming – are you prepared?"

Dr. Ken Dychtwald
Noted Psychologist and Gerontologist
From the "Demography is Destination" video shown at the November 11, 2003 Status of Seniors Initiative interactive strategic planing workshop

Dychtwald's question is crucial one for Mecklenburg County. Our challenge is twofold: respond to present, ongoing needs and prepare for new ones.

The current aging network and other community resources are geared toward serving seniors who rely on assistance, but many older adults in the county still have numerous unmet basic needs. The "age wave" of baby boomers will bring a new set of expectations and demands. While many will have the familiar, frequent concerns of seniors, a significant number will be well educated, financially independent, and physically fit. As a result, the new generation of seniors will likely be a vocal, influential and active force in the community. The demographic and cultural dynamics of the future will require innovative and equitable solutions today.

The Status of Seniors Initiative has created a vision of a senior-friendly community and a road map to address the dramatic changes of an aging society. It is paramount that civic leaders – beyond the aging network – embrace the vision and act to create a community that values older adults and permits every senior to age with dignity.

Priority next steps for the Status of Seniors Initiative:

- Refining strategies and devising a coordinated plan for implementation.
- Engaging civic leaders and diverse stakeholders, such as the Board of County Commissioners, seniors of all ages and incomes, and representatives from corporate, higher education, and faith communities.
- Examining additional issues that influence the lives to seniors.

I. Background

On May 9, 2002, the Mecklenburg County Board of County Commissioners (BOCC) directed the Department of Social Services (DSS) and the Social Services Committee (SSC) of the Human Services Council to develop an annual *Status of Seniors Report*. The intent was to focus on the quality of life for older adults in Mecklenburg County, including but not limited to issues of health, medical care, nutrition, safety, housing, transportation, independence, self-sufficiency and other quality of life factors. The BOCC also directed that the report assess all community services available to meet current and future needs of older adults in Mecklenburg County, including public awareness and involvement in senior issues.

A strategic planning group, comprised of SSC members and others, formed in 2002 to guide the report development. Crucial to the report was an exploratory, telephone survey of 401 Mecklenburg County older adults – individuals over the age 60 and older. The survey was designed to provide a profile of older adults, a snapshot of their needs (met and unmet) and their concerns for the future, and an assessment of how older adults view their overall health. SSC, in partnership with the United Way of Central Carolinas and the Charlotte-Mecklenburg Aging Coalition, sponsored the survey, which was administered by KPC Research.

The 2002 Mecklenburg Older Adults Survey was the first step toward the initial *Status of Seniors* report that was presented to the community at the "Successful Aging Forum" on May 22, 2003. Key findings from the survey results were included the *2003 Status of Seniors Report*.

Key survey findings highlighted in the *2003 Status of Seniors Report*

- Based on the findings from the Older Adults Survey, and reinforced by the five focus groups, it is clear that older adults strongly want to stay in their own homes as long as is feasible.
- For ALL older adults to stay where they are more comfortable physically, mentally, and socially, they need assistance in securing a broad variety of services to help them maintain their independence. Some older adults will not be able to pay the full cost of these services.
- Older adults want (and need) regular social interaction and activities to keep them healthy physically and mentally. But, in order for this to happen, they need increased amounts of the full range of "support" type services from leisure activities to information about services.

The *2003 Status of Seniors Report* served as the catalyst for a community strategic planning process, entitled the Status of Seniors Initiative. The initiative was designed to become an ongoing, community-based effort led by a strategic planning collaborative. Public, private and non-profit organizations joined to form the collaborative and lead the initiative. The issues that surfaced in the 2003 report became driving forces under the Status of Seniors Initiative.

As Mecklenburg's aging network was mobilizing for the Status of Seniors Initiative, the North Carolina Division of Aging and Adult Services (NCDoAAS) was seeking two counties to participate in a long-term planning process with technical assistance by the Division of Aging. NCDoA circulated a Request for Proposals (RFP) and eventually selected Mecklenburg and New Hanover counties to participate in the project, entitled A Communications and Coordination Initiative to Strengthen Long-Term Care. Central to the state planning process was a set of 22 recommended areas of work for care services in every county developed by the North Carolina Institute of Medicine Task Force.

Planning for an improved future for older adults has been a goal in Mecklenburg County for more than a decade. Since 1987, three countywide initiatives have addressed senior adult issues. The previous initiatives are:

1987 Older and Disabled Adults Profile and Needs Analysis

1991 Aging Services Strategic Planning Task Force

1997 Aging Issues Report

The Status of Seniors Initiative marks the county's fourth initiative focused on seniors, and it is intended to forge a path toward the creation of a more senior-friendly community during this and future decades.

"We weren't prepared for the 77 million baby boomers born from 1946 to 1964 – we did not have enough diapers, hospitals, houses, pediatricians, schools, books, teachers or anything else for all of these children. If we are not careful we will not be prepared for the retirement of these boomers."

Dr. Ken Dychtwald
Noted Psychologist and Gerontologist

II. Status of Seniors Strategic Planning Process

A. Planning Structure

In summer 2003, a Steering Committee, comprised of professionals in the field of Aging and advocates for senior issues, was formed to guide the initiative. The committee functioned as a collaborative within the community's aging network. An Executive Advisory Board of widely recognized community leaders was also convened to champion the cause of older adults in Mecklenburg County and to promote the recommendations developed by the Steering Committee and community stakeholders.

The Steering Committee engaged the community in the strategic planning process by soliciting the involvement of service providers, consumers, community volunteers, and other interested citizens to serve on Community-Based Issue Groups. The issue groups that were charged with researching identified topics and recommending specific actions.

B. Scope of Work

The scope of the Status of Seniors Initiative's strategic planning process was designed to be comprehensive and to affect systemic change. The intent of the initiative is to create a more senior-friendly community that ensures dignity, safety and independence. The charge of the collaborative was to accomplish the following tasks:

- To promote awareness of the critical necessity for the community to prepare for an explosion in the senior adult population as "baby boomers" age – boomers are defined as people born from 1946 to 1964.
- To develop and report findings and recommendations to the entire community for changes and improvements that will encompass all areas of older adults' lives.

C. Vision, mission and guiding principles

The collaborative envisions that the Status of Seniors Initiative will "foster a senior-friendly community that values dignity and independence for all older adults." The mission of the ongoing strategic planning process is: "To engage the community in creating a dynamic plan that enhances the quality of life for older adults by focusing resources on their needs.

The Steering Committee established three guiding principles that have served to define and guide the planning process.

- **It is the goal of this project that Mecklenburg County become a "Senior-Friendly Community."** That means that the community provide a wide range of social and economic opportunities and supports for all citizens, including seniors; values seniors' contributions to the community; promotes positive intergenerational relations; considers the needs and interests of seniors in physical environment and community planning; respects and supports seniors' desire and efforts to live independently; and, acknowledges the primary role that families, friends, and

neighbors play in the lives of older adults, enhances their capacity for caring. (N C Division of Aging)

- **The community should allow Seniors the opportunity to "Age in Place" whenever it is reasonably possible.** It is acknowledged that individual situations may preclude the ability to "age in place" if basic comfort and safety cannot be met. According to the Journal of Housing for the Elderly, "aging in place" is not having to move from one's present residence in order to secure necessary support services in response to changing needs. We are using the term "aging in place" in reference to living where you have lived for many years, or to living in a non-healthcare environment, and using products, services and conveniences to allow or enable you to not have to move as circumstances change. "Aging in place" is growing older without having to move. For many, the opportunity to age in Place is associated with a higher quality of life. Some 70% of older adults spend the rest of their life in the place where they celebrated their 65th birthday.

- **It is the intent of this project to review the existence, adequacy, and accessibility of needed services for seniors of all income levels.** The ability to pay should not preclude options for Seniors to Age in Place or otherwise access needed services. Neither should it be assumed that the ability to pay means there are no access issues for service.

D. Identification and definitions of initial Issues

Using the 22 recommendations for care services developed by North Carolina Institute of Medicine Task Force, the Executive Advisory Board and Steering Committee ranked the 22 recommended areas of service and selected five issues on which to focus its 2003-04 research and planning. The groups deemed these issues as the most pressing for the county's seniors – based on previous reports – and as ones on which local organizations could act.

The five defining issues selected for investigation and planning in 2003-04 were:

- Facilities and Institutions
- Food and Nutrition
- In-Home Support Services
- Leisure, Education, Recreation & Socialization
- Transportation

The focus on these initial issues was intended to produce recommendations and learning that could lay the groundwork for subsequent, expanded strategic planning. Defining the five issues was required to facilitate a focused and thorough research process over the nine-month planning period. While the Steering Committee determined the initial definitions, each issue group was given the flexibility to modify them as needed. Below are the definitions and rationale applied by each issue group.

Facilities and Institutions: Licensed Nursing Homes, Assisted Living (AL) Residences (which includes Adult Care Homes, Family Care Homes and Multi-unit Assisted Housing with Services) and Continuing Care Retirement Communities (CCRCs). Although

seniors live in or receive services at other facilities and institutions such as hospitals, retirement apartments, and prisons, these are not included in this summary of work. The issue group chose to determine the adequacy, accessibility, effectiveness, equity and quality of identified facilities and institutions in Mecklenburg County.

Food and Nutrition: Every older adult needs to have his or her basic food and nutrition needs met. Good nutrition promotes good health. Healthy older adults are more independent and have a better quality of life. Access, choices, marketing and image, and resources are the four categories that need to be addressed to provide all older adults of our community adequate food and good nutrition, which in turn promote living a healthy life.

In-Home Support Services: This issue was divided into three sub-categories for in-depth study.

Aide Services & Home Health Services: Focus on the adequacy and accessibility of In-Home Aide Services (this includes but is not limited to Home Health, Personal Care Services, and Hospice Services) and the education of in Mecklenburg County residents as it relates to availability of services.

Caregiver Respite Care & Support/Training: Focus on the existence, adequacy and accessibility of Respite Care in Mecklenburg County (that may include services such as group respite, adult day care/day health, long-term facilities,) as it relates specifically to Family Caregivers. Note: In-home respite service was included in the in-home services sub-committee.

Information and Referral & Case Management: Investigate services available to the broadest spectrum of seniors. This sub-committee focused on agencies that provide Information and Referral or Case Management as the total focus of the agency and agencies for which these functions are a very large component of their activity.

Leisure, Education, Recreation & Socialization: As a "senior-friendly community," older adults should have access to programs that allow them to enrich and prolong their quality of life with dignity and grace. Programs directed to them should accommodate the active as well as the more frail seniors, and should be in safe, accessible places.

Transportation: Transportation provides access from one location to another safely and efficiently with its goal being to enhance quality of life through maintaining independence.

E. Group planning processes

A variety of group processes and approaches were used to engage the community, collect and analyze data, set priorities and formulate recommendations. In total, the 2003-04 Status of Seniors Initiative's strategic planning process engaged approximately 400 volunteers from across the community, who dedicated more than 3600 hours, collectively, to the effort.

Community-Based Issue Groups

Five Community-Based Issue Groups, aligned to the five defining issues, met from November 2003 through March 2004. One or more designated conveners, drawn from the Steering Committee, led each group. Over 80 individuals – a mix of community and organizational representatives – contributed professional expertise, conducted field research, donated resources and shared personal experiences to produce key findings and recommendations for each issue. Issue group members collectively dedicated an estimated 2000 volunteer hours to the research, planning, and reporting process.

At the conclusion of the issue group research, a community forum was held at the Senior Center on March 17. During the forum, a cross-section of issue group members and community representatives ranked and prioritized recommendations from the five groups.

Interactive strategic planning workshop

A public forum to engage community members was as a crucial first step for the 2003-04 strategic planning process. An interactive strategic planning workshop, entitled "Share The Vision: Shape The Future For Mecklenburg County Senior Citizen," was held November 10, 2003 at the UNC Charlotte Cone Center. The workshop had two purposes: (1) to share all of the information on older adults collected to date and (2) to receive input, ideas, suggestions and personal visions for the future.

The workshop included a video of Dr. Ken Dychtwald, a noted psychologist and gerontologist, and a presentation by Richard W. Jacobsen, Jr., director of DSS on the *2003 Status of Seniors Report.* By sponsoring the workshop, the Status of Seniors Initiative engaged approximately 150 individuals who generated ideas and helped identify priorities for creating a senior-friendly community. Many workshop participants remained active in the planning process by becoming members of issue groups.

Leadership

The Steering Committee participated in several of group processes to develop elements of the initiative, plan activities, and engage seniors, field professionals and other community members. The Lee Institute facilitated Steering Committee meetings and guided the flow of work under the initiative. The North Carolina Division of Aging and Adults Services provided the Steering Committee with technical assistance and training in the use of a matrix for community evaluation. The matrix is a planning tool to measure various aspects of local services for older adults (refer to matrix on p. 9). The committee's processes helped produce the vision, mission and guiding principles for the initiative. The Steering Committee also presented interim status reports to the Executive Advisory Board and solicited their feedback and advice.

Marketing and Public Relations Committee

The Steering Committee recruited members for a Marketing and Public Relations Committee to develop a media plan and ensure that the Status of Seniors Initiative received widespread publicity across the community. The committee's accomplishments include securing a domain name for the initiative's website, developing an op-ed piece for *The Charlotte Observer*, writing monthly articles about the initiative for *Senior Directions,* and compiling a briefing book for the Executive Advisory Board and Steering Committee. This committee's communication plan will play a crucial role in the public

rollout of the strategic planning report. Its efforts are expected to engage stakeholders and generate support for the implementation of strategies.

Research teams

The collaborative also engaged the services of two outside research teams to collect data and present reports on specific issues. Students of the Master of Public Administration program at UNC Charlotte researched transportation, care costs, public safety, and service provision relative to Mecklenburg's growing senior population. In addition, a research team from Leadership Charlotte Class XXV surveyed 130 human resources directors of local employers to gauge the existence of workplace programs related to caregiving and to assess awareness about the impact of aging on the current and future workforce.

F. Research methods and activities

The Steering Committee, Community-Based Issue Groups and outside research teams employed numerous research methods to gather qualitative and quantitative information on issues affecting older adults.

Surveys

The two research teams conducted surveys to collect data on specific issues. UNC Charlotte MPA students administered the Senior Service Provider Survey in two stages, first as an Internet survey and then as a mailed survey. The survey produced data on transportation, care costs, public safety and service provision. The Leadership Charlotte research team mailed surveys to 130 Charlotte-based human resource directors and gathered data on the workforce implications of an aging society.

Interviews

One of the sub-committees of In-Home Support Services Issue Group developed a questionnaire and interviewed 17 agencies that provide information, referral and case Management services. The Just1Call database was used to select the agencies that participated in interviews.

Literature review

Issue groups engaged in a substantive review of literature on senior issues in general and on their respective areas of interest. The literature included local, state and national reports, many of which highlight “best practices” in the field of Aging that were integrated into recommendations of issue groups. Included in the review were reports from previous strategic planning initiatives in the county and secondary data from census reports. Most issue groups also conducted Internet searches for tools and data to facilitate their planning process. These sources are cited in their reports. The documents collected and reviewed by issue groups are listed in the Appendix and noted in the full Issue Group Reports.

'Senior-Friendly Communities Matrix' assessments

The North Carolina Division of Aging and Adults Services' Senior-Friendly Community Matrix was central to the initial research of issue groups (refer to matrix on p. 9). The matrix outlines areas of concern and interest among older adults. It also identifies six Dimensions of Community Evaluation (see box to the right). Issue group members devised plans to assess these aspects of their assigned issue. For example, the Leisure, Education, Recreation and Socialization Issue Group administered a survey of local organizations to assess leisure-related services for older and disabled adults, based on the matrix. Data from these assessments were used to identify gaps in services for seniors.

N.C. Division of Aging & Adults Services Senior-Friendly Community Matrix

Dimensions of Community Evaluation

Existence: Are services available to older and disable adults in your community?

Adequacy: Are existing services in sufficient supply for those who need them?

Accessibility: How obtainable are existing services for those most in need?

Efficiency/Duplication: How reasonable are the costs of services? Are options for streamlining available?

Equity: How available are existing services to all that need them without bias?

Effectiveness/Quality: How successful are these services in addressing consumers' needs?

Mapping and map analyses

The Food and Nutrition Issue Group collected maps of area food services such as farmer's markets, nutrition sites, pantries to access community resources and needs. The Facilities and Institutions Issue Group studied maps of facility locations and concentrations of poverty among seniors that the Office of Planning and Evaluation for Mecklenburg County Health and Human Services produced.

Roundtable and group discussions

The Facilities and Institution and In-home Support Services issues groups held roundtable and group discussions to probe issues and tap the expert opinions of group members.

N.C. Division of Aging & Adults Services

Senior-Friendly Communities Matrix*

* Modified for the Mecklenburg Status of Seniors Initiative

SIX DIMENSIONS OF COMMUNITY EVALUATION		
Existence	**Adequacy**	**Accessibility**
Efficiency/Duplication	**Equity**	**Effectiveness/Quality**

AREAS OF INTEREST & CONCERN			
Physical	**Environment**	**Economy**	**Technology**
Transportation Air/Water Quality Housing/Utilities Land Use Neighborhood Org. Road Safety Recreational Facilities Shopping Zoning	Adult Immunization Dental Health Hospitals/Clinics Leisure Nutrition/Meals Mental Health Medicare/caid Accept. Medication Mgt. Preventative Care Primary Care Rehabilitation Vision/Hearing Care Wellness/Fitness Disabilities	Job Training Age Discrimination Financial Planning Health Care Costs Health Insurance Income Job Opportunities Job Retooling Senior-friendly Business Long-term Care Costs Tax Credits/Exemptions	Internet Access Assistive/Adaptive Device Distance Learning Medical Alert Tele-medicine Phone/Cell Phone Access
Safety/Security	**Social/Cultural Involvement**	**Services/Support**	**Resources**
Driver Safety Abuse/Neglect At Risk Population Domestic Violence Emergency Response Fire Safety Fraud/Exploitation Outreach	Volunteerism Community Sensitivity Media Intergeneration Relations Libraries Lifelong Learning Spiritual Growth Race/Ethnic/Lang. Diversity Cultural/Social Programs Advocacy PR on Senior Issues	Information & Assistance Caregiver Support Caregiving Drug Assistance End-of-life Care Legal Services Home & Community Svcs In-Home Care Long-Term Care Facilities Sr. Enrichment/Ctrs Guardianship Care Management Grandparents Raising Grandchildren Adult Day Care/Day Health	Planning/Stewardship Comm'ty Needs Assess. Planning Coordination Program Evaluation Public/Private Svc Fund Taxes Rep. in Public Affairs Retirement Plan'g/Ed.

G. Compelling data

Data that Influenced the Status of Seniors Initiative Strategic Planning Process and Recommendations

Primary Source: 2003 Status of Seniors Report (unless otherwise noted)

Senior Population Growth

- 80,440 individuals age 60 or over living in Mecklenburg County. They represent roughly 11.6% of county residents (Source: US Census 2000).
- This figure is expected to rise to over 115,000 by 2011 – an increase of 43% – based on state projections.
- By 2025, the population of 60+ is going to triple, from 80,440 to over 200,000, creating an unprecedented demand for services and new ways to conduct business.
- Mecklenburg's older adult population is now increasing at a greater rate than the child population. While the senior population is projected to triple over the next 27 years, the 0-17-age population won't even double. This dynamic will create an imbalance in systems like Social Security and Medicare. That is a sobering thought that we must begin preparing for now – especially in terms of the demand for all types of services.
- 8% (or 5,193) of the age 65+ population were living in poverty during 1999. The federal poverty guideline for an individual is $8,800 annually and for a couple it's $12,120.

Health

- While 84% of seniors report their health as good or excellent, there are several areas where racial and income disparities are stark:

  12% of low-income residents reported poor health compared to 3% of respondents with higher incomes.

  Of those earning less than $20,000, 35% stated they felt "down," depressed or hopeless compared to 11% of those earning $20,000 or more.

  21% of older adults living at the poverty level reported a poor diet compared to 11% of those living above the poverty level.

- More than 34,000 older adults in Mecklenburg County (or 43% of the older adult population) can be defined as At Risk or Frail due to their difficulty performing one or more basic tasks of daily living such as meal preparation and bathing.
- According to the Congressional Budget Office the number of people available to provide caregiving declines as the number of frail elderly increases dramatically.
- In 2002, 20% of older adults in Mecklenburg County who needed caregiving help were not receiving the help they needed with tasks that were difficult for them.

Data on seniors, continued

- Wall Street Research estimates that "on average," home health care services are roughly 30-60% less expensive than similar services provided in an institutional setting.

Housing and Home Life

- 45% of seniors in Mecklenburg County live on $20,000 a year or less and spend more than 30% of their income on housing.
- Caregiving also presents enormous challenges to seniors and to the community:

  One-third of all seniors believe they will be a caretaker for a loved one in the next five years.

  46% of seniors reported not receiving the help they need with activities of daily living (walking, bathing, etc.).

  Caregiving costs at least $11.6 billion nationally in lost work hours, reduced pensions, and lost income.

- 5,985 grandparents are responsible for grandchildren. (Source: U.S. Census 2000)
- All data support the fact that a large majority of older adults want to remain in their own homes as long as possible. To do this will require a broad range of affordable community based services that are easily accessible.

Prescriptions

Prescriptions present enormous challenges to many seniors.

- 86% of seniors report taking prescribed medications.
- 45% reported not taking medications as frequently as prescribed.
- 40% reported having made a decision not to purchase prescribed medications at least once.
- 16% reported having gone without other essentials such as rent, food or utilities in order to purchase needed medications.

Information on services and programs

- Over 21% of older adults indicated an unmet need for information about services and programs for older adults. In the UNC Charlotte Urban Institute Annual Survey, approximately 39% of caregivers said they had problems finding needed services.
- Seniors mostly learned of programs and services by word of mouth at places they frequent, groups that they belong to, and from friends and family.

III. Leading Recommendations for Creating a More Senior-Friendly Community

Status of Seniors Initiative

LEADING OBJECTIVES

What we are setting out to do

1. To create and sustain proactive, coordinated initiatives across the aging network that address current needs and account for projected demographic changes among seniors.
2. To increase awareness among key stakeholders – seniors, family caregivers, healthcare workers, field professionals, policy makers and the general public – about: (a) the implications of aging and (b) the availability of services for seniors.
3. To ensure seniors at all income levels can receive appropriate and quality long-term care within the community.
4. To prolong independent living among seniors by educating and supporting informal and family caregivers.
5. To satisfy the increasingly diverse interests, skills, concerns and needs of seniors.
6. To increase the personal safety of seniors.
7. To increase the mobility and quality of life among seniors and adults with disabilities.

The 2003-04 strategic planning process revealed numerous issues that the Mecklenburg community must address to become a more senior-friendly community: The issue groups developed a set of six to ten recommendations for their respective areas of concern. In addition, the outside research teams produced reports with additional findings and recommendations. Many of the recommendations addressed similar needs, such as better coordination of service, increased information and awareness, elimination of gaps in service, and advocacy. The value of several overarching recommendations emerged as a way to address concerns with a comprehensive, integrated approach.

Taking an extensive look at the various findings, recommendations, and priorities generated by the initiative, the Executive Committee of the Steering Committee distilled the groups' work into seven leading concerns, objectives and recommendations. The leading pieces are highlighted in this section. The recommendations of specific groups are presented later in the report. Reports from the issue groups and research teams will be valuable resources as the initiative delves into specific topics.

The following pages contain the seven leading recommendations that comprise the systemic reform agenda under the Status of Seniors Initiative. Each recommendation is accompanied by an objective, a rationale for the concern, and a summary of strategies that will support the recommended action. An acknowledged next step for is refining the recommended actions for the implementation phase. Each recommendation will require additional strategies and tasks; an identification of leaders, stakeholders and resources; a timeline for implementation; and outcome indicators and accountability measures.

Leading recommendations from the 2003-04 strategic planning process

1. Establish a multi-functional organization that will serve as a "focal point" for the aging network's strategic planning, information and assistance, care/case management, education and communication, and advocacy on issues affecting seniors.
2. Develop systemic, integrated approaches for educating and communicating with key stakeholders about the implications of aging and the availability of services for seniors.
3. Redistribute resources for the long-term care system by: (a) promoting the availability of home care as an alternative to nursing home care and (b) eliminating multiple gaps in the system.
4. Magnify the role of informal and family caregivers as a vital part of the continuum of care for seniors.
5. Multiply options for seniors across service areas by: (a) enhancing existing services with innovative approaches and (b) developing new approaches for a full continuum of care.
6. Launch a crime prevention and education campaign in high-density areas with a focus on seniors.
7. Transform the transportation system of service to create an expanded and coordinated range of senior-friendly travel options that increases the mobility and quality of life among seniors and adults with disabilities.

Objective One: To create and sustain proactive, coordinated initiatives across the aging network that address current needs and account for projected demographic changes among seniors.

Leading Recommendation One: Establish a multi-functional organization that will serve as a "focal point" for the aging network's strategic planning, information and assistance, care/case management, education and communication, and advocacy on issues affecting seniors.

Rationale: The current aging network in Mecklenburg County is fragmented. The 2003-04 strategic planning process illuminated the fact that there is no single source of information on senior issues. Service providers and professionals experience inefficiencies because the network lacks a centralized organizational structure for ongoing research and planning, coordinated action, and shared accountability. Meanwhile, seniors suffer from the absence of a full continuum of care that addresses the myriad of needs brought by aging.

Summary of Strategies:

1. Identify and position one focal point organization to operate as the clearinghouse for strategic planning, information and assistance, case management, education and communication, and advocacy.
2. Formalize connections within the aging network by creating a centralized infrastructure for accessing the comprehensive range of existing services for seniors.
3. Institute the "Senior-Friendly Community Matrix" as the chief framework for the aging network's research, strategic planning, and accountability system.
4. Introduce a care/case management component with a uniform assessment tool as a function of the network's focal point organization. Building on the original vision and design of Just1Call, this strategy will allow individuals to: (a) contact the focal point organization for information on an issue; (b) obtain an assessment of their specific service needs; (c) receive a referral to appropriate service providers; and (d) receive information about their eligibility for financial assistance to pay for the identified service. The focal point organization would not provide any direct services to avoid any conflict of interest in allocating funds to individuals.
5. Build into the focal point organization's referral function options for both traditional service delivery (when sufficient) and innovative, personalized service delivery, known as consumer-directed care.
6. Identify and prioritize senior issues for the purpose of advocacy, planning, and public education and communication by tracking data on consumer demands for information/referral and case management.
7. Create internal structures within the aging network and designate leaders for addressing such topics as research, strategic planning, public policy, education and communication, and accountability.

Objective Two: To increase awareness among key stakeholders – seniors, family caregivers, healthcare workers, field professionals, policy makers, and the general public – about: (a) the implications of aging and (b) the availability of services for seniors.

Leading Recommendation Two: Develop systemic, integrated approaches for educating and communicating with key stakeholders about the implications of aging and the availability of services for seniors.

Rationale: While a comprehensive range of services for older adults exists, many services remain unfamiliar to and underutilized by older adults, family caregivers, healthcare workers, field professionals, and the general public. During this initiative, a lack of awareness across the community was a recurring theme among both consumers (seniors, caregivers, and the general public) and people serving seniors (service providers, professionals in the field of Aging, and policy makers).

Past initiatives focused on seniors identified similar needs in the county. Though significant strategies were implemented as a result of each initiative, efforts to date remain inadequate in satisfying the public's growing need for information.

Summary of Strategies:

1. Launch a major public education and information campaign that targets specific audiences, as well as the general public, through the use multiple, ongoing and integrated approaches.
2. Promote Just1Call (tel: 704-432-1111 and website: www.just1call.org) as the community's "go-to" resource for information and assistance, including care management for seniors.
3. Publicize such issues as aging with dignity, the affects of aging on individuals and their families, and the range of services available to the community's seniors.
4. Increase awareness of identified areas of interest, which include health and wellness, transportation, meals and nutrition, in-home care, care facilities and safety.
5. Counter misconceptions and prejudices about seniors and growing older that are widely held by our "youth-oriented" society.
6. Form a "Seniors Speakers Bureau" on issues of aging and older adults.
7. Integrate senior-friendly and multicultural elements into communications (e.g., large print, Braille, services for the hard of hearing, foreign languages).
8. Orient the workforce of the healthcare and aging networks, especially newcomers, on topics such as the range of services available to seniors, how to communicate with seniors, and how to access and share information and resources.

Objective Three: To ensure seniors at all income levels can receive appropriate and quality long-term care within the community.

Leading Recommendation Three: Redistribute resources for the long-term care system by: (a) promoting the availability of home care as an alternative to nursing home care and (b) eliminating multiple gaps in the system.

Rationale: A broad spectrum of services and facilities exists for the long-term care of seniors; however, the accessibility and adequacy of these resources are limited. Options for senior care range from remaining at home or living with family members to assisted-living facilities to nursing homes and other institutions. Currently several factors severely restrict the number of feasible care options for seniors and their families. These factors include income eligibility requirements, waiting lists, workforce shortages, and capitated public services (i.e., a specified maximum number of service recipients). The community must provide a sufficient number of viable options for senior care and ensure accessibility for broad cross-section of the population so that institutionalization is a last-resort measure.

Specific examples of the problem:

- Eligibility requirements for Medicaid, which provides financial assistance for long-term care, are skewed toward low-income seniors and are too inflexible to provide services to many seniors who need them. Middle-income seniors and others fall between the cracks in the long-term care system, and as result they can no longer live at home at a comfortable standard of living. Growing numbers of older adults will dictate the use of "care management," a service that provides professional assistance (typically registered nurses and/or social workers) by identifying, accessing, and coordinating services that are necessary for seniors to remain at home or in the least restrictive environment.
- A critical shortage of expertise and community programs for treating dementia and substance abuse among older adults has recently become an issue as policy changes mandate the redistribution of mental health services from state hospitals to local communities. Statistics show the incidence of suicide among older adults (especially men) is increasing. Adding to the concern is Mecklenburg's critical shortage of geriatricians skilled at dealing with the behavioral aspects of polypharmacy. (i.e., the management of multiple medication and drugs).

Summary of Strategies:

1. Rebalance the long-term care system to promote "community care" versus long-term care facilities and institutions.
2. Advocate for the allocation of funds to provide in-home care management services, when seniors can remain at home with the provision of services. Note: The average cost of nursing home care for an intermediate level client is $2,542 a month. The cost for the same level of care for the home care program (CAP/DA) is $1,876 a month on average. Redistributing resources in the current system will reduce the tax budget burden.
3. Eliminate gaps in services available for middle income consumers, who do not meet income eligibility requirements for the long-term care assistance but can afford a portion of the total cost.
4. Educate stakeholders about care management services and options for seniors in non-emergency situations.
5. Introduce new services when identified needs and demand exist but there is an absence of services (e.g., community programs for treating dementia and substance).
6. Advocate for adequately financed Medicaid waiver programs.

Objective Four: To prolong independent living among seniors by educating and supporting informal and family caregivers.

Recommendation Four: Magnify the role of informal and family caregivers as a vital part of the continuum of care for seniors.

Rationale: Caregiving is an emerging concern at all levels of society. The *2003 Status of Seniors Report* stated that one out of every three seniors felt they would be a caregiver at some point in their life. Seniors also expressed a need for training and assistance in providing care for their loved ones.

Specific example of the problem:

It is not unusual to see a 70-year-old woman caring for a 95-year-old parent or her 75-year-old husband or her disabled adult child or grandchildren under the age of 18. In many cases, it is a combination of the above. None of these scenarios are uncommon and each of them brings additional sets of issues ranging from the need for additional services like respite or healthcare for the caregiver.

Summary of Strategies:

1. Promote the self-identification of caregivers for those who have not recognized the vital role they play in the lives of seniors and others dependent on their support.
2. Develop pilot programs to increase collaboration between faith communities and service providers in delivering services to informal and family caregivers including respite programs.
3. Target employers and provide information about informal and family caregiver issues and resources.
4. Develop partnerships with Employee Assistance Programs (EAP) to identify “best practices” for informal and family caregiver support.
5. Develop ongoing, organized programs, with education and support components, to cultivate an abundant pool of qualified, available informal and family caregivers.
6. Advocate for increases in funding, specifically adult day care/day health, that could provide respite for informal and family caregivers.
7. Seek grant funds to increase services and support to informal and family caregivers.
8. Improve methods for serving hard-to-reach groups of caregivers, such as members of ethnic communities and residents in rural areas.

Objective Five: To satisfy the increasingly diverse interests, skills, concerns and needs of seniors.

Leading Recommendation Five: Multiply options for seniors across service areas by: (a) enhancing existing services with innovative approaches and (b) developing new approaches for a full continuum of care.

Rationale: Existing services for older adults are limited in scope and fail to provide a sufficient range of choices for a multi-faceted senior population. Seniors are not homogeneous. In addition, issues affecting are interrelated and becoming evermore complex as the baby boomers age and as seniors live longer. The boomers will undoubtedly defy conventional wisdom about what it means to "grow older." Seniors' economic status, living arrangements, health, culture, dietary needs, and travel requirements factor into the level of service that must be provided. Services provided in the county do not adequately to reflect these and other dimensions of the population.

Summary of Strategies:

1. Expand transportation options that facilitate travel for food and groceries, medical and healthcare, general wellness, family and social visits, and shopping.
2. Promote and support the use of nontraditional senior nutrition sites, such as YMCA's, libraries, schools, business cafeterias, and intergenerational settings.
3. Promote the use of vouchers as a way to expand options for types of food and settings.
4. Conduct periodic surveys of current older adults and aging baby boomers on their current participation in service areas (e.g., leisure/recreation and transportation) and on their needs and wants.
5. Integrate multi-cultural elements across service areas to address differences in faith, language, dietary habits and lifestyles.
6. Promote intergenerational experiences between seniors of all ages and children, youth, and young and middle-aged adults.

Objective Six: To increase the personal safety of seniors.

Leading Recommendation Six: Launch a crime prevention and education campaign in high-density areas with a focus on seniors.

Rationale: Older adults identify fear for their personal safety as a major concern, cited in the *Status of Seniors Report* and the UNCC MPA *Embracing the Age Wave* report. There are three significant factors that contribute to this concern among seniors: (1) older adults appear to be at greater risk of crime and fraud because of their vulnerability; (2) some geographic areas have both large percentages of older adults and high incidence of crime; and (3) scams and frauds are frequently perpetrated against older adults.

Summary of Strategies:

1. Engage the Charlotte-Mecklenburg Police Department as a lead agency in planning and implementing a crime prevention and education campaign.
2. Initiate senior-oriented Crime Prevention through Environmental Design (CPTED) in communities with significant numbers of seniors.
3. Introduce proactive public safety initiatives that will address issues resulting from projected growth in the senior population.
4. Provide ongoing First Responders training to the police, fire, medic and sheriff departments. Provided by DSS and the Area Agency on Aging, First Responders is a program to train the people who are often first to arrive on a scene on how to communicate with seniors, understand their concerns, and recognize signs of abuse, neglect and exploitation.
5. Promote older adult participation in the Better Business Bureau's annual "Scam Jam" that raises public awareness about crime and fraud schemes.

Objective Seven: To increase the mobility and quality of life among seniors and adults with disabilities.

Leading Recommendation Seven: Transform the transportation system of service to create an expanded and coordinated range of senior-friendly travel options that increases the mobility and quality of life among seniors and adults with disabilities.

Rationale: Transportation was a recurring theme across issue groups when evaluating the accessibility of services for seniors. Accessibility, adequacy and quality of transportation services have far-reaching implications for seniors' access to other services.

Specific example of the problem:

The following anecdote from the Transportation Issue Group illustrates the complications and stress caused to seniors by the current transportation system and the need for increased communication between passengers, transportation services and other service providers:

Recently a woman riding a Special Transportation Services (STS) van appeared visibly upset to her fellow passengers. She related the story that she had scheduled a ride for a test at the doctor's office at 7:00 a.m. Without calling her, STS changed her doctor's appointment to 9:00 a.m. As a result, the service picked her up later that she was expecting. Subsequently, STS drove to another house, picked up a new passenger and began a route to the second passenger's place of employment. By this time, the woman knew that she was going to be late for the 9:00 a.m. appointment. In tears, she began calling STS dispatch by cell phone to let them know that she was going to be late. In the end, both passengers were late to their destinations. (It was not known if STS or the client called the doctor's office to say that she was going to be late for the 9:00 a.m. appointment.)

Summary of Strategies:

1. Convene a Transportation Education and Advocacy Task Force for Seniors in Mecklenburg County that will hear the grievances of seniors, set and meet goals for improving current transportation services, and serve as a voice for the distinct transportation needs of seniors.
2. Form a coalition of for-profit and non-profit transportation service providers to maximize the use of current resources and create a coordinated transportation system for seniors based on "best practices" in the industry (e.g., use of software for efficient trip coordination and scheduling).
3. Evaluate transportation services for seniors and adults with disabilities to reduce duplication of services, streamline scheduling, streamline maintenance and other issues that might be identified.
4. Introduce measures that make Charlotte-Mecklenburg transportation systems and communities more senior-friendly, increase ridership and pedestrian travel, and raise awareness about the overall system (e.g., increase the ease of use of local transportation, improve usage information, enhance signage, and address the safety concerns of seniors).
5. Increase funding for Elderly General Transportation.

IV. SUSTAINING THE FOCUS AND ADVANCING THE PLAN

The 2003-04 Status of Seniors Initiative has examined many complex issues and produced recommendations in a relatively short period of time. Leaders and participants in the strategic planning process concede that this is not a short-term project and additional work remains.

Foremost among the Steering Committee's priorities is completing the implementation plan for the set of recommendations contained in this report. Committee members have begun a process for refining strategies and developing outcome measures. The committee is also identifying specific actions and tasks, engaging potential stakeholders, and soliciting resources and support to implement the strategic plan.

Priority Next Steps for the Status of Seniors Initiative

- Refining strategies and devising a coordinated plan for implementation.
- Engaging civic leaders and diverse stakeholders, such as the Board of County Commissioners, seniors of all ages and incomes, and representatives from corporate, higher education, and faith communities.
- Examining additional issues that influence the lives to seniors.

The role of the Marketing and Public Relations Committee of Status of Seniors Initiative is vital to the further development and implementation of the strategic plan. The committee has supported the Steering Committee and the overall initiative since fall 2003. Its purpose is to inform the community about the initiative and its work. As the strategic planning report is rolled out to the public, committee members will promote the findings and recommendations of the initiative and raise public awareness about issues affecting seniors. The committee has developed a media and public relations plan for presenting the report to several community groups and local media outlets. Its efforts will also assist in recruiting stakeholders and securing resources for the implementation of strategies.

The second priority of the Steering Committee is to identify and engage additional stakeholders and partners for both implementing current recommendations and undertaking additional efforts. The Status of Seniors Initiative will benefit from concerted measures to include and engage other knowledgeable stakeholders on the issue of aging, such as professionals from the legal, financial, higher education, and faith communities. The Board of County Commissioners and other civic leaders will also play pivotal roles in advancing recommendations. Progress will depend on the involvement of a broad and diverse constituency comprised of seniors of all ages and income levels, individuals from various racial and ethnic groups and representatives from all sectors of the community, as well as members of the aging network.

The third priority is to select the next set of issues to examine. While the N.C. Institute of Medicine Report identified 22 areas of care for counties, the 2003-04 strategic planning process focused on only five. The intentional focus on five initial issues produced recommendations and learning that lay groundwork for subsequent, expanded strategic planning. Steering Committee members have begun reviewing which additional issues to address and intend to maintain the current five as priorities. Currently, members anticipate mental health will be one of the new issues, given the Olmstead Supreme

Court decision. It will be necessary to compare the services for people with disabilities with services for older adults to identify duplication or gaps and to seek ways to integrate these services.

The Robert Wood Johnson Foundation's invitation to DSS for a grant opportunity is a promising new development that bodes well for the future of the Status of Seniors Initiative. Mecklenburg County was one of 22 communities, from among 400 initial applicants, invited to submit a grant proposal. If the selected, DSS will receive $150,000 for project development over 18 months, followed by a $750,000 a four-year implementation grant. An award of these grant funds will have a significant and positive impact on the pace of implementing strategies under the Status of Seniors Initiative.

An important factor influencing the community's continued the focus on seniors and on the advancement of recommendations and strategies is an outcome of the planning process itself. The cultivation of collaborative relationships within the aging network is a value-added element of the Status of Seniors Initiative's 2003-04 strategic planning process. The collaborative processes required by the initiative served to generate enthusiasm, foster shared ownership, and increase the will for change among the public, nonprofit, and for-project organizations that participated. Continued and broadened collaboration will be a key factor in to assuring the long-range success for the Status of Seniors Initiative.

Preparing for new expectations and demands brought by the "age wave," while also responding to immediate, ongoing needs among seniors is Mecklenburg's challenge in the coming years. These demographic and cultural dynamics will require innovative and equitable solutions. This report provides both a vision for fostering a senior-friendly community and a roadmap for strategic action. It is paramount that civic leaders – beyond the aging network – embrace the vision and act to create a community that values older adults and permits every senior to age with dignity.

V. Supporting Reports from The Status of Seniors Initiative

A. Community-Based Issue Group Recommendations (abridged versions)

The following section includes excerpts from reports developed by the five Community-Based Issue Groups. Each issue group prepared a report documenting its group processes, research findings and issue-specific recommendations. The excerpts included in this section are the main findings, objectives, recommendations, and indicators and measures of success. Designation of recommendations as "priority" or "high priority" reflects rankings that occurred at a community forum at the Senior Center on March 17, 2003.Complete version of these report narratives can be found in the Appendix.

Recommendations are organized by the following issues:

- Facilities and Institutions
- Food and Nutrition
- In-home Support Services
- Leisure, Recreation and Socialization
- Transportation

Each issue group's recommendations are presented in specific timeframes, which are defined below.

> Recommendations in the short term: 0 to 24 months, which are as those that require limited or no new resources. And can be implemented relatively easily and make an impact in the short term.
>
> Recommendations in the mid-term: 25 to 60 months, which are changes or new programs that are necessary but will require more time to develop of a plan and secure resources.
>
> Recommendations in the long term: 60+ months, which includes things that require significant planning and resource development and probably require a great deal of collaboration between organizations.
>
> Deferred issues deserving attention, which are crucial issues that surfaced during the issue group's work but have not been addressed by their recommendations.

The issue groups were requested to provide the following information for each recommendation. In addition, the groups were instructed to provide a concluding narrative as well as quotes and anecdotes from the strategic planning process. These elements of the recommendation can be found in the full reports prepared by issue groups. (Refer to the Appendix)

Elements of Community-Based Issue Group Recommendations

Rationale: Brief explanations about why the issue group is recommending this action.

Relevant data: Summaries the research findings that influenced the recommendation. This might include instances where no data on the issue was found.

Targeted population/beneficiaries: Identification and descriptions of the senior population who will most benefit from the outcome of this recommended action (i.e., who do you intend to help or support). Descriptions include demographic profiles, geographic area, health status, age range, etc.

Desired outcome: Statements about the changes that the issue group anticipates as a result of this recommended action. Changes might be observed in a variety of ways including knowledge/awareness, behavior, opportunity, mobility, wellbeing, etc.

Potential leaders and conveners for the future: Identification of the organization(s) or individual(s) that the group foresees as a champion(s) for the recommendation, as well as those can be key stakeholders in launching and driving the recommended action.

Additional stakeholders: Lists of the organizations, populations or individuals that have a stake in the implementation and/or outcomes of this recommended action. While these stakeholders may not serve as leaders or conveners, their input and buy-in on the action should be sought.

Resources: Lists of the resources (beyond leaders, conveners and stakeholders) that are needed to support this recommended action. Resources might include specific expertise, demonstrated models, technology, funding, etc.

Targeted start and completion dates (mm/yy): Projected timing of the recommended action. That is, the group's estimation of an optimal timeframe to launch, execute and complete the action.

Indicators and measures of success: Identification of the changes and gains (among individuals and organizations and in the community) that might indicate progress in addressing the present problem.

1. FACILITIES AND INSTITUTIONS

Within a senior-friendly community, services and supports must exist to sustain the entire continuum of needs. While aging in place may be the goal for most people, there will always be the need for facilities and institutions that will provide care and support for those individuals who can no longer stay at home or who choose congregate living.

The issue group examined facilities as described in the N.C. Institute of Medicine Report: "Any responsible public or private system of care must include reliable and effective procedure for monitoring and assuring that services offered meet accepted standards, that clients of these services are not put in harm's way from having used these services, and that the expected outcomes of care are realized." Its considerations on the issue included accessibility, adequacy, effectiveness, equity and quality of Mecklenburg County long-term care (LTC) facilities and institutions.

In summary, the group found the following: (a) a need for timely, accessible and consumer-friendly education on facilities and services; (b) gaps in specialized services in facilities and institutions such as mental health services, substance abuse, dementia care, respite and high acuity medical care; (c) a lower quality of care of nursing homes in Mecklenburg County as compared to the North Carolina average; (d) a need for significant further research into quantifying gaps and identifying models of care that could be replicated in Mecklenburg County.

The group advises that due to the scope of the issue, which reaches beyond Mecklenburg County, their report should serve as a first of many steps to examining and improving long-term care for seniors.

Objectives

- To gain knowledge regarding models of care which have been successful in other communities both to reduce need for institutional care and for improving quality of life within institutions.
- To increase resources and improve access to mental health services for institutionalized seniors including substance abuse and dementia.
- To improve access to and awareness of information about long term care facilities for the consumer, the professional, providers, and those in positions to make referrals.
- To decrease gaps in institutionalized services such as respite care and high acuity care.

Recommendations in the short term: 0 to 24 months

F&I Short-term Recommendation One (Priority): Further quantify gaps in services in order to formulate recommendations regarding: High medical acuity, mental health services, substance abuse services, respite care.

F&I Short-term Recommendation Two: Produce a concise handout/brochure for consumers seeking care in long-term care facility or institution for themselves or a loved one.

F&I Short-term Recommendation One: Develop a website to display quality indicators/measures/survey results of Mecklenburg County Assisted Living Facilities.

Recommendations in the mid-term: 25 to 60 months

F&I Mid-term Recommendation One (Priority): Formulate recommendations regarding: High medical acuity, mental health services, substance abuse services, respite care – once gaps in services have been quantified.

F&I Mid-term Recommendation Two: Improve the quality of care in Mecklenburg County Nursing Homes.

Recommendations in the long term: 60+ months

None.

Deferred issues deserving attention

F&I Deferred Issue One (Priority): Long-term care facilities are suffering from a critical, chronic, and severe labor shortage.

F&I Deferred Issue Two (Priority): Seniors often have multiple providers and points of access into the health care system. There is no centralized case-management system.

Indicators and Measures of Success for Recommendations

- Acute Care Providers/Discharge Planners and Information and Referral providers will report receiving tool, ease of distribution and consumer satisfaction.
- Acute Care Facilities would report ease of transition to appropriate post-acute care services. DSS and Ombudsman would report decrease in challenges related to placement due to high acuity, mental illness, and substance abuse or for respite care.
- Number of hits on the website.
- Assisted Living Facilities report increased awareness of consumers.
- Improved patient care outcomes and reduction in number of deficiencies.

2. FOOD AND NUTRITION

Older adults of the community require adequate food and good nutrition, which in turn promote living a healthy life. The issue group examined four aspects of Food and Nutrition: access, choices, marketing and image, and resources. The group considered traditional approaches, which are commonplace in Mecklenburg County, such as home-delivered meals or "meals on wheels" and congregate meals. With meals on wheels, a meal is delivered to an individual five days a week at lunchtime. Congregate meals provide a lunchtime meal to consumers in a group setting.

The issue group noted that these traditional approaches do not meet the nutritional need for three meals a day, seven days a week among many seniors. In addition, existing programs are inadequate in addressing individuals' nutritional needs due disease and special diets and in satisfying food and dining preferences based on ethnicity, cultural background and lifestyles.

The group found that consumers need better education on food and nutrition, such as what resources are available to help seniors learn about nutritional needs and how to plan and prepare meals for health and wellness. Another consideration in a senior-friendly community is the provision of options for the purchase and delivery of groceries to a frail or homebound person.

Objectives

- To assure that all older adults in our county have their basic need of adequate food and good nutrition met.
- To offer more options for how older adults can meet their food and nutrition needs.
- To eliminate waiting lists.
- To create clearinghouse for data so issue is more specifically defined.
- To eliminate disparities in access to food and food services throughout the county.
- To assure adequate transportation services for access to all food and nutrition options, including senior nutrition sites, farmer's markets, grocery stores, and food pantries.
- To increase awareness of what nutrition services are available to increase usage of these services, eliminate negative stereotypes, make information culturally appropriate and all materials easily understood.

NOTABLE QUOTE

Food and Nutrition Issue Group

"I like most of the food but most of all I like coming to be with my friends everyday."

– Senior nutrition site participant

Recommendations in the short term: 0 to 24 months

F&N Short-term Recommendation One (High Priority): Create collaboration among public and private entities to maximize local community resources.

F&N Mid-term Recommendation Two (High Priority): Increase the number of senior nutrition sites by exploring nontraditional locations, such as YMCA's, libraries, schools, and business cafeterias.

F&N Short-term Recommendation Three: Develop supplemental transportation services to ensure access to food and nutrition programs and services, such as grocery stores, farmers markets, and senior nutrition sites.

Recommendations in the mid-term: 25 to 60 months

F&N Mid-term Recommendation One: Develop a marketing and education campaign to increase awareness of, access to, and use of services.

Recommendations in the long term: 60+ months

F&N Long-term Recommendation One (High Priority): Modify how services are delivered to accommodate boomers' culture and the multicultural population. For example, EBT Flexibility – use EBT card at coffee shops and restaurants.

F&N Long-term Recommendation Two (Priority): Develop and implement centralized and seamless way to track availability and usage of senior food and nutrition services, including faith-based and informal services.

Deferred issues deserving attention

F&N Deferred Issue One (High Priority): Think outside the box as we explore ways to fund and serve older adults in our community. For example, collaborate with summer feeding programs for children, or develop mentoring initiatives between young professionals and retired executives, and serve company-sponsored breakfasts and lunches. What already exists that we can enhance or work from?

F&I Deferred Issue Two: Research North Carolina Support Team Initiative to be used as a model for this community.

F&I Deferred Issue Three: Decreasing number of meals being served at senior nutrition sites. Explore why this is happening. Can older adults select their meal from a menu of many? Can there be choices for special diets or just choices in general?

F&I Deferred Issue Four: The Food and Nutrition workgroup focused on Access to food and nutrition as the priority for its work. While the areas of Choices, Marketing and Resources were discussed and filtered into the developed recommendation there is still work to be done around these issues separately.

Indicators and Measures of Success for Recommendations

- Elimination of waiting list for meal programs.
- Alternative funding received and new food and nutrition program model is being implemented.
- Decrease in those that identify transportation as a barrier
- Increase in the number of older adults access services
- Gaps in services will be identified and addressed on an ongoing basis.
- Service providers will become more knowledgeable about service needs and duplication.

NOTABLE QUOTE

Food and Nutrition Issue Group

"I have to wait for someone to take me to the store. When I go I stock up because I don't know when I'll get there again."

– 76-year-old widow who doesn't drive

3. IN-HOME SUPPORT SERVICES

In home support services are those services and supports that make it easier or possible for seniors to remain in their homes. The issue group examined such traditional services as home health, in-home aides, respite care, sitters, medical alert systems and home modifications and repairs, as well as other, non-traditional services. It did not consider home-delivered meals, as the Food and Nutrition Issue Group examined this service.

Aide Services & Home Health Services

The current structure of Government programs with an institutional bias must be changed. In order to meet the expected growing demand a more prudent allocation of resources must be utilized. In-home aides can provide a variety of ADLs & IADL's to seniors at a lower cost than facilities plus allow them to maintain their independence.

Future education of seniors, family caregivers and other caregivers will be paramount to creating a community that is able to support Mecklenburg County's aging population. There is also a need to raise the awareness of senior care issues with both the adult children and older parents who fail to plan for their continued well being, independent living needs and end of life stages.

Providers of senior services, professionals and clergy with a high senior involvement and Mecklenburg County must develop a method of communicating service information to allow easier access and delivery of services to our seniors and their caregivers.

Caregiver Respite Care & Support/Training

In examining the existence, adequacy and accessibility of Respite Care and Caregiver Training/Support in Mecklenburg County, this sub-group found that there is a need for greater communication among the agencies and groups who are involved in these areas. We also found there is a need to increase the availability of education/training for caregivers, including those in rural settings and specific ethnic groups. Also, respite care is critical to maintaining the essential caregiver population.

North Carolina ranks above the national average in percentage of adults providing care to someone 60 plus and will be seeing a dramatic increase in the aging population as the "Baby Boomer" generation ages. So, we anticipate an even greater need for caregivers and their education/training and support in the future.

Our recommendations address these indicated needs through media campaigns to increase public awareness, through enhancement of inter-agency communications to eliminate gaps and duplications of services and finally, to create a grant –writing center to secure additional funding that is needed to provide adequate respite and caregiver support at this time and meet future needs.

Information and Referral & Case Management

In general, Mecklenburg County has excellent resources for Information and Referrals for seniors. These services are high quality and user friendly in many ways. Unfortunately, many seniors and their caregivers are not aware that they exist. There is an ongoing need for publicity to improve name recognition for Just1Call. Just1Call's

telephone number should be in the Yellow Pages in a section specifically for senior services. It needs to be widely publicized through a variety of venues already accessed by seniors and their caregivers, such as through churches, social clubs, EAP programs, and television.

In addition, Information and Referral information for special populations is lacking. Large print and Braille publications were lacking. There were barriers to services to the hard of hearing. Except for Spanish, resources to non-English speaking consumers were not available.

Case management for middle income clients was lacking. Services were available and probably adequate for those with money or long-term care insurance. Although DSS Services for Adults provides case management without regard to income, the availability of this resource is not widely known, even among professionals. Many consumers may believe that services offered through DSS are only for low-income clients and not be willing to apply.

In addition, there was a lack of collaboration among case management providers. Those providing services for a fee viewed other providers as the competition and did not view collaboration as a need. Collaboration, however, would improve professionals' knowledge of area resources and improve the coordinated community planning needed to identify and provide for gaps in services.

Objective

To address distinct in-home care issues in the areas of (a) Aide Services & Home Health Services; (b) Caregiver Respite Care & Support/Training; and (c) Information and Referral & Case Management.

Recommendations in the short term: 0 to 24 months

IHSS Short-term Recommendation One (High Priority): Establish a senior services network for senior information and referral and case management agencies.

IHSS Short-term Recommendation Two (Priority): Develop a list of agencies providing services to seniors. Provide this list to social workers, home care agencies, and others working with senior citizens.

IHSS Short-term Recommendation Three: Develop media campaign making "family caregivers" a household word by helping family caregivers self-identify as caregivers.

Recommendations in the mid-term: 25 to 60 months

IHSS Mid-term Recommendation One (High Priority): Develop and execute ongoing, organized programs to cultivate a more abundant pool of qualified, available caregivers in Mecklenburg County. Programs must provide caregiver education and support as important components.

IHSS Mid-term Recommendation Two (High Priority): Develop "Information and Referral" materials addressing specific and significant issues aimed at helping seniors remain at home.

IHSS Mid-term Recommendation Three (High Priority): Develop one to two pilot programs to increase collaboration between the faith communities and service providers in delivering services to family caregivers, including respite programs.

Recommendations in the long term: 60+ months

IHSS Long-term Recommendation One (High Priority): Develop care management services for middle income families who can afford some payment but who cannot afford the cost of $80 hr. or more.

IHSS Long-term Recommendation Two (High Priority): Lobby the federal and local government for changes to current laws that restrict the more prudent allocation of resource, expand services, update eligibility criteria to reflect today's markets in order to provide additional services for the same costs in the area of in home aide/ home health care. Also, develop a stronger advocacy voice for increase in funding services, specifically adult day care/day health, that could provide respite that family caregivers request.

IHSS Long-term Recommendation Three: Develop a grant-writing center to secure funding to increase service and support to family caregivers.

Deferred issues deserving attention

IHSS Deferred Issue One (High Priority): Lack of medications is a serious problem among the elderly.

IHSS Deferred Issue Two: Financial resources for people who are waiting to be eligible for disability are lacking. Most resources are one time only and these people may need assistance over a period of many months.

IHSS Deferred Issue Three: Providing services to family caregivers in all ethnic groups.

IHSS Deferred Issue Four: Providing services to family caregivers in rural areas.

IHSS Deferred Issue Five: Technology to enhance communication with the hard of hearing is not widely available. Specific needs include technology that can facilitate face-to-face interviews, conversations across desks, in-home needs of seniors.

Indicators and Measures of Success for Recommendations (selected examples)

- Increased knowledge of agency staff would benefit family caregivers in their search for information and assistance.
- Caregivers would have fewer problems navigating the system themselves and receive services in a more timely manner.

- Most seniors and caregivers will know that Just1Call is the resource to contact for information about area services for seniors.
- Staff awareness and participation in awareness sessions
- Existence of a senior section for the Yellow Pages and the numbers of television spots.
- Increases in the number and quality of caregivers.
- Additional/expanded services provided in-home.
- Increase in reimbursement rates.
- Increase in reimbursement rates to Adult Day Care/Day Health and other respite services initiatives.
- Caregivers will adopt strategies to care for themselves while caring for others.
- Care recipients will be able to stay home safer and happier, longer.

NOTABLE QUOTE

In-Home Support Services Issue Group

"American's health care system is heavily dependent on the direct care family caregivers provide, especially to the aged and people with chronic diseases and disabilities. According to a study published in Health Affairs, caregivers' contribute to the nation's health care system has enormous economic value, estimated at $196 billion annually, compared to $32 billion for paid home care and $83 billion spent on nursing home care. Their services significantly reduce costs to Medicare, Medicaid, and private payers. Without this immense unpaid work force, our fragile health care financing system would be even more strained"

Source: National Family Caregiver Association & National Alliance for Caregiving: *Self-Awareness in Family Caregiving.*

4. LEISURE, EDUCATION, RECREATION AND SOCIALIZATION

The goal of this issue group was to identify services that allow seniors to enrich and prolong their quality of life with dignity and grace. Its work was based on studies showing that people who are involved and connected with a community stay healthier both physically and cognitively.

The issue group promotes the idea that as senior-friendly community, Mecklenburg County must have appropriate physical environments (i.e. safe and accessible place and spaces) that accommodate the active as well as more frail seniors. The community must also provide lifelong learning and programming that encourage psychological and social wellbeing and that contribute to the longevity and quality of life of seniors. Such programs would promote education, health, wellness/physical activities, travel, creative pursuits, social interactions, self-sufficiency and intergenerational experiences.

In addressing the leisure and social needs of seniors, the community can prevent depression and isolation, decrease other health problems and can have a positive impact on the local economy.

Objectives

- To increase awareness of existing Leisure, Education, Recreation and Socialization programs and services for adults 55+ – for consumers as well as for partner providers.
- To enhance partner providers' opportunities to collaborate.
- To enhance partner providers' ability to refer consumers to other Leisure, Education, Recreation and Socialization services.
- To increase awareness of Leisure, Education, Recreation and Socialization services to other providers of 55+ services, enabling them to more easily make appropriate referrals or suggestions.
- To identify gaps in present Leisure, Education, Recreation and Socialization service/programs.
- To identify segments of the county where consumer may be underserved.
- To identify the needs, wants and demands of the "boomers" as they age.
- To educate the community at large of available Leisure, Education, Recreation and Socialization services.

A COMPELLING STORY

Leisure, Education, Recreation and Socialization Issue Group

Alice is in her 80's and suffers from Parkinson's. She took a course offered by Oasis Senior Enrichment Program at the Jewish Community Center. Other Oasis participants encouraged her to begin attending regularly. As a regular participant, Alice now says, "Oasis is everything to me. I would be completely lost without it. Oasis offers me some intellectual stimulation. Without Oasis I would sit at home and vegetate."

Recommendations in the short term: 0 to 24 months

LERS Short-term Recommendation One (Priority): Increase awareness of existing LERS programs and services for older adults by (I) Developing and distributing to partners a systematic cross-referenced, user-friendly, multimedia LERS community resource directory, and (II) Conducting a countywide, demographic appropriate older adult consumer survey on the needs/wants and current participation in this service area.

Recommendations in the mid-term: 25 to 60 months

LERS Mid-term Recommendation One: Identify, establish and prioritize timelines for solutions to service deficiencies and duplications using and/or expanding the relationships established in the first phase.

LERS Mid-term Recommendation Two: Conduct community-wide education on Leisure, Education, Recreation & Socialization services through expanded distribution of Leisure, Education, Recreation and Socialization multi-media directory.

Recommendations in the long term: 60+ months

LERS Long-term Recommendation One: Work on solutions identified and prioritized during Phase II.

LERS Long-term Recommendation Two: Evaluate multi-media directory distribution and effectiveness.

Deferred issues deserving attention

LERS Deferred Issue One: Training for caregivers.

LERS Deferred Issue Two: Flexible staffing for more evening and weekend activities.

LERS Deferred Issue Three: Hosting the North Carolina State Senior Games and the National Senior Games will attract mass media coverage.

LERS Deferred Issue Four: Training for providers' staff on "best practices" for delivering services.

Indicators and Measures of Success for Recommendations

Partner providers will:

- Report increased participation
- Increase cooperation through relationships established during the process
- Consult the completed matrix and mapping, allowing for facilities to be better utilized
- Receive a completed directory and test it for accuracy and viability
- Report the efficiencies they have obtained and/or excesses they have eliminated or combined
- Report increased participation or interest by "boomers"

- Demonstrate awareness of more LERS services through participation as reported by providers and/or re-surveyed (to be determined during the process)

Consumers:

- Survey completed
- Survey analyzed for gaps, needs, trends, etc
- A group of seniors will review the directory for accuracy and usefulness

- 55+ service providers:
- Report increased referrals to LERS programs/service providers

Additional indicators to be identified during each phase of work.

A COMPELLING STORY

Leisure, Education and Recreation Issue Group

We have a senior that comes into the Tyvola Road Senior Center daily to participate in the hot lunch program and wanted to get in shape. She was planning to visit her daughter in Texas and wanted to be able to walk with her when she went down there. Over the past year she has lost 70 lbs. by watching her diet and exercising. She exercises in our health on a regular basis and has been able to improve her overall fitness level.

5. TRANSPORTATION

The community-based group found that transportation is a complex issue, with systemic needs as varied as the individuals who rely on the services. A notable conclusion from the issue group's research is the need for a major shift in the design of transportation systems to respond to the needs of the growing senior population. The present focus on primarily transporting people to and from work and school will need to expand to account for the broad range of travel patterns among retirees and other seniors, such as travel for healthcare services, shopping, family visits, post-retirement employment and volunteerism, and recreational and social activities.

The issue group examined several aspects of how transportation can contribute to a senior-friendly community. It conducted research on the physical environment, including public transit, road safety, pedestrian travel and alternatives to traditional car, bus and van travel. It also studied how to create a continuum of service delivery that can support an individual aging in place. This aspect of transportation not only includes services that provide trips from one location to another, but also how these and other types of transportation must change as individuals become frailer. The group found that transportation must be enhanced to address seniors' increasing requirements for escort services, lift-equipped vehicles, non-ambulance medical trips, and emergency medical/ambulance medical trips.

Based on its findings, the group's recommendations range from creating a more "walkable" community to alleviating burdens on transportation systems to introducing technology that enables the coordination of existing services.

Objectives

- To support the efforts of all local city, county and community leaders to develop senior-friendly transit.
- To encourage information sharing that increases efficiency among transportation providers.
- To increase the use of technology that streamlines and coordinates existing services.
- To educate medical professionals, social workers, senior riders, volunteers, and others as a means to increase understanding of local transportation systems.
- To develop and maintain a more "walkable" community through better land use and planning.

Recommendations in the short term: 0 to 24 months

Transp. Short-term Recommendation One: Establish a Transportation Education and Advocacy Task Force for Seniors in Mecklenburg County. This is a multi-step recommendation. To ensure success, the Task Force should be implemented in stages and designed to be ongoing. (Refer to the subsequent timeframes and the issue group's full report for specific issues and tasks for the Task Force.)

Transp. Short-term Recommendation Two: Make Charlotte-Mecklenburg transportation and communities more senior-friendly (e.g., increase the ease of use of local transportation, improve usage information, enhance signage, and address safety and economic factors concerns of seniors to increase ridership and increase awareness of the current transportation system).

Transp. Short-term Recommendation Three: Create a coalition of for-profit and non-profit transportation service providers that meets periodically for the purpose of creating a coordinated system, determining "best practices" (e.g., use of software for efficient trip coordination and scheduling) and maximizing current services.

Recommendations in the mid-term: 25 to 60 months

Transp. Mid-term Recommendation One (Priority): Support the efforts and goals set forth by the Transportation Education and Advocacy Task Force for Seniors (see short-range recommendations for a complete explanation of this Task Force.)

Transp. Mid-term Recommendation Two: Continue to make Charlotte-Mecklenburg transportation and communities more senior-friendly.

Transp. Mid-term Recommendation Three: Form a coalition to evaluate technology options / costs and to identify funding for coordinated system.

Recommendations in the long term: 60+ months

Transp. Long-term Recommendation One (Priority): Support continued efforts of the Transportation Education and Advocacy Task Force for Seniors in Mecklenburg County.

Transp. Long-term Recommendation Two: Sustain and enhance effort to make Charlotte-Mecklenburg transportation and communities more senior-friendly.

Transp. Long-term Recommendation Three: Obtain necessary approval, funding, and policies to begin implementation of coordinated system.

Deferred issues deserving attention

Transp. Deferred Issue One: Develop affordable wheelchair accessible transportation for special needs seniors.

Transp. Deferred Issue Two: Business sector to take ownership and help with cost-share. Businesses should allow shuttles to enter and drop off individuals at their doorstep.

Transp. Deferred Issue Three: Offer free weekend transportation to and from medical appointments.

Indicators and Measures of Success for Recommendations

1. Creation of a well-formed, active, and efficient Task Force with members committed to setting and implementing goals to improve transportation services for seniors.
1. The successful Task Force shall serve as a voice and advocate for the transportation needs of seniors among the general public, including both the public and private sectors.

- Through advocacy and educational efforts, the successful Task Force shall increase public awareness and sensitivity to the mobility needs of seniors.
- Increased fixed-route ridership.
- Increased awareness of current system and ease of use.
- The Coalition is meeting on a regular basis and has developed a plan of action.
- A Task Force with members committed to providing improved transportation for seniors.
- The Task Force will provide a forum to advocate for the transportation needs of seniors among the general public, including both the public and private sectors.
- A community more aware of and sensitive to mobility needs for seniors
- Greater satisfaction among seniors who use transportation services.
- A service delivery system that is more senior-friendly and accessible
- Increased usage of public transit among seniors as a result of education, training, and volunteer efforts designed to reduce apprehension and foster safe and friendly transportation.
- A safe and accessible transit system for all users, encourages upgrading of existing land uses to make them more transit and pedestrian friendly, provides land uses that attract/generate pedestrian activity, particularly at ground floor level, provides an extensive pedestrian system throughout the station area that will minimize walking distances for pedestrians, and, locates building entrances to minimize the walking distance between transit stations and buildings.
- Software and funding are identified.

B. UNC Charlotte MPA Report: Embracing the 'Age Wave'

Executive Summary

Assisting the Mecklenburg County Department of Social Services (DSS) Services for Older Adults (SFA) division, graduate students from the UNC Charlotte, Master of Public Administration (MPA) program examine issues relevant to senior care and senior service providers in Mecklenburg County. This report presents findings on several topics – transportation, care costs, public safety and service provision – relevant to the elderly population in Mecklenburg County.

As indicated, this research focuses on four relevant issue areas relative to the growing elderly population. First, this research examines transportation alternatives for elderly citizens who otherwise might find themselves unable to drive. Next, this research examines the cost of institutional care versus in-home care. For example, in North Carolina, the cost of caring for a person requiring the maximum amount of in-home care is $43,680 compared to $51,000 for nursing home care. The discussion then turns to public safety issues of consequence to seniors in Mecklenburg County. The majority of incidents committed against seniors consist of three primary types of offenses: residential burglary (578 incidents), larceny from auto (634 incidents) and auto theft (503 incidents), which represent 44.5 percent of all incidents reported against seniors in Mecklenburg County.

Finally, analysis of a survey administered to organizations that provide services to seniors in Mecklenburg County from October 10, 2003 to November 14, 2003, reveals that senior service providers consider the following six services, programs, and issues to be critical to the community:

- Access to Health and Care Services (68%)
- Cost of Prescription Drugs (63%)
- Affordable Housing (58%)
- Transportation (45%)
- Food and Nutrition (44%) and
- Emergency Issues (41.0%).

Based on this research, we offer the following recommendations:

- Mecklenburg County government must partner with private or non-profit organizations to increase service options for seniors;
- Create and implement a public awareness campaign to educate Mecklenburg County residents about the needs of the elderly and the coming population growth;
- Improve transportation options available to the elderly;
- Provide a focused crime education campaign in high density areas with a focus on seniors, provide senior oriented Crime Prevention Through Environmental Design (CPTED) in communities with significant senior populations, and focus on public safety needs associated with a growing senior population; and,
- Determine criteria for establishing senior service provider status.

C. Leadership Charlotte Report on Workforce Implications of Aging Society

Driving Data

- The National Association of Manufacturers released a report that "forecast a skilled worker gap that will begin to appear in 2005 and grow to 5.3 million workers by 2010 and to 14 million by 2020 (if the unskilled are included the number 7 million in 2010 and 21 million in 2020)."
- Currently baby boomers are about 60% of the prime-age workforce (between ages 25 to 54). The age cohorts that follow them are just too small to take the boomers' place. (The shortages will be most critical among managers and skilled workers).

Research Activity

130 surveys were sent to Charlotte-based human resource directors, with 25% return rate (approximately 33 completed surveys). The survey was designed to:

- Determine their awareness of the pending risk to their current/future workforce and what plans they have in place to mitigate this risk.
- Determine if any corporate benefits exist to support employees that have aging family members.
- Determine if the same corporations have retirement planning policies in place for their employees.

Survey Results

- 91% of the respondents agree with the statement: Our company is aware of projections, which suggest that there will be a worker shortage in the near future.
- 85% of the respondents agree with the statement: Our company is aware of the problems employees will likely face in providing care for their senior family members.
- 87% of the respondents agree with the statement: Our company expects that a significant number of current employees will face major responsibilities caring for senior family members in the near future.
- 59% of the respondents have health care coverage for retirees.
- 59% offer a fixed/variable income for retirees.
- 52% of the respondents offer paid-time-off for employees to care for senior family members.
- 70% offer counseling to help employees cope with a senior family member's care issues.
- Only 63% of the respondents offer long-term care insurance for employees.

- Only 33% of the survey respondents maintain a database with the following information:
  - Local agencies that deal with senior care issues
  - Local services available to deal with senior care issues
  - Local services available for retirement planning

- Many of the respondents that do not maintain a database stated that they refer employees to their Employee Assistance Program (EAP) vendor to get information on the above services.

- An average of 44% of the respondents stated that they would be interested in receiving information on the following:
  - Providing care for senior family members
  - Pre-retirement planning for employees
  - Retirement

VI. SUPPORTING INFORMATION

A. Roster of the Executive Advisory Board

Gerald Fox, *Chair* Retired Mecklenburg County Manager

T. Edmund Rast, *Co-Chair* Attorney, Moore & Van Allen

Doug Booth, Retired Duke Power executive; Former Mecklenburg County Commissioner

Carla DuPuy, Director of Environmental Affairs Crescent Resources LLC; Former Chair, Mecklenburg County Commission

The Honorable Ruth M. Easterling, Retired Member North Carolina House of Representatives

Paul Franz, Executive Vice President, Carolinas HealthCare System

Dr. E.K. Fretwell, Jr., Chancellor Emeritus, University of North Carolina at Charlotte

Harvey Gantt, Architect, Principal Gantt-Huberman; Former Mayor of Charlotte

Maryann Gilmore, Managing Editor, *Senior Directions*

Gerald Johnson, Publisher, *The Charlotte Post*

Peter Keber, Retired Bank of America executive; Former Mecklenburg County Commissioner

Gloria Pace King, President, United Way of Central Carolinas

The Honorable Fountain Odom, Former Member of The North Carolina Senate; Attorney, The Odom Firm

Betty Chafin Rash, Retired public affairs executive; Former Charlotte Mayor Pro-tem

Donald C. Sanders, Retired President, United Way of Central Carolinas

Dr. Dena Shenk, Director, Gerontology Program University of North Carolina at Charlotte

Dr. C. Don Steger, Pastor, Reeder Memorial Baptist Church; Former Assistant Charlotte City Manager

Ann Thomas, Retired First Union Bank executive

B. Roster of Steering Committee

Co-Chairs:

Carol Baker, Services For Adults Division, Mecklenburg County Department of Social Services

Sindy McCrystle, Chair, Older Adult Wellness Council of United Way of Central Carolinas, Inc.

Gayla Woody, Area Agency on Aging

Members:

Julie Adams, Mecklenburg County Health Department

Evelyn Berger, Consumer

Connie Bonebrake, Carolinas Healthcare System

Henry Bostic, Henry Bostic & Associates

Natalie Burnham, Eliminating Disparities. United Way of the Central Carolinas

Maryanne Dailey, Better Business Bureau Foundation

Melanie Dove, Presbyterian Community Care Services

Maryann Gilmore, *Senior Directions*

Tom Haselden, Charlotte-Mecklenburg Council on Aging

Mark Henriques, Older Adult Wellness Council of United Way of Central Carolinas, Inc.

John Highfill, Services For Adults Division, Mecklenburg County Department of Social Services

Ruth Huey, Charlotte Mecklenburg Aging Coalition

Olaf Kinard, Charlotte Area Transit System (CATS)

Dennis Knasel, Area Mental Health Authority

Natalie McIver, United Way of Central Carolinas, Inc.

Evelyn Newman, Council on Aging

Trena Palmer, Charlotte-Mecklenburg Senior Centers

Andrea Sturm, City Neighborhood Development Department

Chauna Wall, United Way of Central Carolinas, Inc.

C. Roster of Members: Community-Base Issue Groups, Committees and Research Teams

Facilities and Institutions

Connie Bonebrake, CHS/Administration (Convener)

Ken Adams, Mecklenburg County Department of Social Services–ESD

Nina M. Anderson, Mecklenburg Area Mental Health Geriatric Specialty Team

Melanie Boatwright, CHS, Senior Health Connection

John Daniels, Retired

Angela Ericson, Mecklenburg County Department of Social Services

Karen Johnson, Mariner Health Care

Linda Miller, Centralina Council Government, LTC Ombudsman

Sharon Moore, Hospice at Charlotte

Trina Perry, Mecklenburg Area Mental Health Geriatric Specialty Team

Food and Nutrition

Ruth Huey, Charlotte Community Health Clinic and Charlotte Mecklenburg Aging Coalition (Co-convener)

Natalie Burnham, Eliminating Disparities. United Way of the Central Carolinas (Co-convener)

Bob Dunlap, Alzheimer's Association Western Chapter

Helen Harrill, M.Ed., Substance Abuse Prevention Services

Lisa Hood, Hospice at Charlotte

Judy McLean, Mecklenburg County DSS Senior Nutrition Program

Sally McNeill, North Carolina Cooperative Extension

Ron Michael, Nutrition Focus for Region F, Area Agency on Aging

Carl Pritchard, Auxiliary Services, Davidson College (Retired)

Kate Satchill, Older Adult Volunteer

Rev. Buddy Strickland, Calvary Church

Eric Young, Neighborhood Outreach Program, Mecklenburg County Department of Social Services

In-home Support Services

Julie Adams, Mecklenburg County Health Department (Co-convener)

Maryanne Dailey, Better Business Bureau Foundation (Co-convener)

Patricia Arnold, Community representative

Jerri Barum, Mecklenburg County Department of Social Services

Iris Boyd, Autism Services of Mecklenburg County

Phil Cooley, Homewatch of Piedmont, NC

Beth Croom, Alzheimer's Association

Marilyn Daly, Hospice at Charlotte New South Healthcare

Jane Dawson, Carolinas Homecare

Ronda Deitch, Centralina Area Agency on Aging

Melani Dove, Presbyterian Community Care Services

Leo Estes, Mecklenburg County Department of Social Services

Carol Farley, N.C. Division of Services for the Blind

Paul Gach, Visiting Angels

Marsha Ghent, Mecklenburg County Department of Social Services

Jacqueline Glenn, Health Department

Patricia Graham, Mecklenburg County Department of Social Services

Sue Hancharik, Mecklenburg County Services for Adults

Pamela Honeycutt, Ats Health Services

Nate Huggins, Blessed Assurance Adult Day Care/Day Health

Anne Mann, Senior Volunteer and Consumer

John Mann, Senior Volunteer and Consumer

Lynn Martin, Mecklenburg County Department of Social Services

Pat Marcum, Love INC

Ellen McClure, Mecklenburg County Department of Social Services

Catherine McCoy, Community volunteer

Julie Melchor, Mecklenburg County Department of Social Services

Bruce Melosh, Mecklenburg County Area Mental Health

Louisa Shugart, Community representative

Stacy Hovis Steele, Community Care Services

Andrea Sturm, City of Charlotte Neighborhood Development

Jennifer Torpey, Home Instead Senior Care

Eva Ullo, Responselink

Vincent Ullo, Responselink

Elaine Walker, Mecklenburg County Area Mental Health

Adriana Weaver, Community representative

Susan Wilson, Charlotte Regional Resource Center for the Deaf and Hard of Hearing

Leisure, Education, Recreation and Socialization

Maryann Gilmore, *Senior Directions* (Convener)

Tom Haselden, Council on Aging (Co-Convener)

Naomi Herndon, Jewish Community Center (Scribe)

Jeff Aten, Charlotte-Mecklenburg Senior Centers, Inc.

David Beard, Lance, Inc.

Candy Bridges, Mecklenburg County Park and Recreation

Captain David Chapman, Salvation Army Senior Services

Nancy Culp, Southminster

Myra Haynes, Charlotte-Mecklenburg Senior Centers, Inc.

Willette McLeod, Consumer for parent

H.C. "Woody" Woodward, Mecklenburg County Park and Recreation

Transportation

Evelyn Newman, Council on Aging (Co-convener)

Chauna Wall, United Way of Central Carolinas, Inc. (Co-covener)

Laurie Abounader, AAA

Suzanne Bach, Shining Star Adult Day Respite

Charmaine Belgrave, Senior Health Connection

Vince Brown, Charlotte Area Transit System

Sandy Bumgarner, Charlotte Area Transit System

K. Olaf Kinard, Charlotte Area Transit System

Judy Marshall, Salvation Army

Laura Park-Leach, Metrolina Association for the Blind

Sandra Peake, American Red Cross/Transportation Services

Mary Prunty, Just1Call

Deborah Wallace, MTS

Marketing and Public Relations Committee

Henry Bostic, Henry Bostic & Associates

Keri Carver, Mecklenburg County Department of Social Services

John Highfill, Services For Adults Division, Mecklenburg County Department of Social Services

Suzanne Jeffries, Public Information Office, Mecklenburg County Department of Social Services

Natalie McIver, United Way of Central Carolinas, Inc.

Leadership Charlotte Class XXV – Status Of Seniors Initiative Team

R. James Brietz, Jr., Grant Thorton LLP

Shirell Burris, Wachovia Corporation

Richard L. Campbell, Jr., Sockwell & Associates

Kathy J. Donner, US LEC Corp.

Bill J. Hill, University of North Carolina - Charlotte

Genevieve M. Suchy, TIAA-CREF

Shawn G. Turner, Charlotte-Mecklenburg Schools

Shawn O. Williams, Charlotte-Mecklenburg Schools

UNC Charlotte Master of Public Administration Program Research Team

Linda Canzona, UNC Charlotte

Latoya Chambers, UNC Charlotte

Robin Overcash, UNC Charlotte

Joel Riddle, UNC Charlotte

Ryan Temm, UNC Charlotte

Christina Wagner, UNC Charlotte

Katrina Young, UNC Charlotte

D. Project Chronology and Milestones

2003	
May 20	The first *Status of Seniors Report* completed and submitted to the to the Mecklenburg County Board of County Commissioners.
May 22	2003 Council on Aging's Successful Aging Forum, where Director of DSS Richard "Jake" Jacobsen, Jr. presented highlights of the report.
Summer	Executive Advisory Board recruited to champion the recommendations of the Steering Committee. Steering Committee begins a strategic planning process, facilitated by The Lee Institute, to be implemented over the next two years.
November 10	Share The Vision: Shape The Future For Mecklenburg County Senior Citizens', an interactive strategic planning workshop is held at the UNC Charlotte Cone Center. The purpose of the workshop was two-fold: first, to share all of the information collected to date; and second, to receive input, ideas, suggestions and visions for the future from the 150 workshop participants. As a part of the workshop, five Community-Based Issue Groups formed to contribute in the development of a strategic plan.
November - December	Community-based issue groups undertake research and planning activities.
2004	
Winter	Community-based issue groups continue research and planning activities.
February 10	Executive Advisory Board and Steering Committee meet at the Duke Mansion and hear interim reports from issue groups.
March 17	A community forum at the Senior Center where a diverse group of issue group members and community members gathered on to rank recommendations from the five Community-Based Issue Groups.
May 5	2004 Strategic Planning Report to presented the Mecklenburg County Board of County Commissioners.
Summer	The next steps of the strategic planning process and implementation begin.

E. References

"2002 Mecklenburg Older Adults Survey Report." Results of a KPC Research telephone survey of Mecklenburg County older adults (defined as individuals age 60 and over). Report prepared by Keri Carver, Services for Adults Division, Mecklenburg County Department of Social Services. Survey sponsored by Mecklenburg County Department of Social Services, Social Services Committee of the Mecklenburg County Human Services Council, United Way of Central Carolinas, and Charlotte-Mecklenburg Aging Coalition.

"2003-2007 North Carolina Aging Services Plan: The Aging in North Carolina." North Carolina Division of Aging.

2003 Assisted Living State Regulatory Review, National Center for Assisted Living, May 2003.

2004 Policy Priorities. National Association of Area Agencies on Aging.

"2004 State Medical Facilities Plan." North Carolina Department of Health and Human Services, Division of Facility Services, North Carolina Health Coordinating Council/Medical Facilities Planning Section, 2004.

"A Long-Term Care Plan for North Carolina: Final Report." Submitted to the North Carolina Institute of Medicine Task Force on Long-Term Care to the North Carolina Department of Health and Human Services, January 2001.

"A Portrait of Informal Caregivers in America 2001." National Strategic Indicator Surveys, Robert Wood Johnson Foundation, 2001.

"A Movitational Model of Leisure Participation in the Elderly." By G. Losier and P. Borque*, Journal of Psychology*, 127:2, 2003.

Adult Care Homes Information Sheet. Buncombe County Department of Social Services, February 2004.

"Aging Issues Report." Aging Summit sponsored by the Charlotte-Mecklenburg Aging Coalition, January 16, 1997.

"Aging Services." Final report from the Mecklenburg County Strategic Planning Task Force, January 31, 1991.

"Assessing Our Resources: Survey of the Existing Healthcare Services for the Indigent Population in Mecklenburg County." Compiled by Rachel Smith and Adrienne Vinson in cooperation with the Mecklenburg County Medical Society, August 2002.

Association for Home and Hospice Care of NC report to the House Select Committee on the Rising Costs of Health Care.

CMS OSCAR Data Current Surveys. Health Services Research and Evaluation, American Health Care Association, December 2003.

"Better Transportation Services for Older Persons" (revised). Jon Burkhardt. Prepared for presentation at the 2003 Annual Meeting of the Transportation Research Board, 2002.

"Comparing Nursing Home Quality and Performance: An Evaluation of the Basic Method in Nursing Home Ranking Systems." American Health Care Association, Health Services Research and Evaluation, September 22, 2003.

Consumer Opinion Survey: Aging Services. News release from America Association of Homes and Services for the Aging, December 2003.

DSS Management Information Report-July 2003 – June 2004 (projections). Mecklenburg County Department of Social Services.

"The Effect of Living in a Nursing Home on Socialization in the Elderly," C. Jacelon, *Journal of Advanced Nursing*, 22, 1995.

"Embracing the 'Age Wave'." Prepared by graduate students in the UNC Charlotte Master of Public Administration program for the Mecklenburg County Department of Social Services, Services for Older Adults, December 2003.

Examples from the Federal Transit Administration. Community Transportation. Association of America, Administration on Aging/Area Agencies on Aging Coordinated Programs.

"Financial frailty threatens adult day-care center." Article in *The Charlotte Observer*, May 27, 2003.

"Getting Old and Staying Fit," A. Wellner. American Demographics, 20:3, 1998.

Home and Community-Based Services for Older Adults: Transportation [Fact Sheet]. National Association of Area Agencies on Aging.

"Hunger in America 2001." Report prepared by Mathematica Policy Research Inc. for America's Second Harvest, October 2001.

"Improving Public Transit Options for Older Persons (Final Report). Transit Cooperative Research Program. TCRP Report 82, 2002.

Improving Transit Options Among Older Persons: The Demographic Challenge

"Leisure Activities and the Risk of Dementia in the Elderly." Article by J. Verghese, MD, et al., *The New England Journal of Medical*, June 2003.

"The Leisure of the Aging: We've only just begun." Article by K. Dale Adkins, Illinois Parks & Recreation, November/December 1994.

"Mecklenburg County's Older & Disabled Adults: Profile of Needs Analysis." A report prepared by the Mecklenburg County Adult Services Steering Committee, July 1987.

"The Mobility Needs of Older Americans: Implications for Transportation Reauthorization." Sandra Rosenbloom. Center on Urban and Metropolitan Policy, The Brookings Institution Series on Transportation Reform, 2003.

"More Adults now taking care of elderly parents" *Charlotte Observer* article, December 15, 2003.

"Multi-Agency Information Management for Human Services." APA article by John Highfill, George Mundle, Charles Page, and Edmund Armentrout. Winter 1986.

National Family Caregiver Support Program: From Enactment Action. Selected Issue Briefs, U.S. Administration on Aging Conference, Washington, DC, September 6 – 7, 2001.

National Family Caregiver Support Program: Resource Guide. Administration on Aging, U.S. Department if Health and Human Services, December 2002.

North Carolina 2000 Survey Results Relating to Caregiving, The Behavioral Risk Factor Surveillance System, NC Division of Aging and Adult Services, 2000.

"Obesity Among Older Americans." Data Profile, Number 10, Center on an Aging Society, July 2003.

"OPTIONS: A Consumers Guide to Housing and Long Term Care in Mecklenburg County." Centralina Council of Governments, July 2000.

Planning Guidelines for Coordinated State and Local Specialized Transportation Services. Coordinating Council on Access and Mobility, Office of the Secretary US Department of Health and Human Services and the Federal Transit Administration US Department of Transportation, 2000.

"Secrets to a Long, Healthy Life." Article prepared Jodi Olshevski, Gerontologist, The Hartford Customer Service Group.

"Status of Seniors in Mecklenburg County." A report prepared by the Mecklenburg County Department of Social Services and Mecklenburg County Human Services Council Department of

Social Services Committee for the Board of County Commissioners and County Manager, May 20, 2003.

Self-Awareness in Family Caregiving: A Report on the Communications Environment." Prepared by Melanie Kinney Hoffmann for the National Family Caregiver Association and the National Alliance for Caregiving, February 2002.

"Transportation for Older Adults" (draft). Charlotte-Mecklenburg Council on Aging, 2000.

"The Travel Mode Choice of the Elderly: Effects on Personal, Household, Neighborhood, and Trip Characteristics" (revised). Sungyop Kim and Gudmundur F. Ulfarsson. Prepared for presentation at the 2003 Annual Meeting of the Transportation Research Board and publication in Transportation Research Record, 2003

"Understanding Senior Transportation: Report and Analysis of a Survey of Consumers Age 50+".AARP Public Policy Institute, 2002.

"You're not too old to exercise." Article by Jeannine Stein, *Los Angeles Times*.

Maps

Food Service Agency's and Senior Nutrition Sites. Prepared by the Office of Planning and Evaluation, Mecklenburg County Health and Human Services, February 2004.

Concentrations of Poverty – Seniors Age 65 Years and Older in Mecklenburg County. Prepared by the Office of Planning and Evaluation, Mecklenburg County Health and Human Services, June 2002.

Percent of Individuals Below 200% of Federal Poverty Index. Prepared by the Office of Planning and Evaluation, Mecklenburg County Health and Human Services, July 2003.

Mecklenburg County Adult Day Care/Day Health Centers. Source: Services for Adults, DSS. Prepared by the Office of Planning and Evaluation, Mecklenburg County Health and Human Services, June 2002.

F. Resources on the Web

AARP
www.aarp.org

America Association of Homes and Services for the Aging
www.aahas.org

American Health Care Association
www.acha.org

Assisted Living Federation of America
www.alfa.org

Center on an Aging Society
http://ihcrp.georgetown.edu/agingsociety/

Community Transportation Association of America
www.ctaa.org

Consumer Consortium on Assisted Living
www.ccal.org

Coordinating Council on Access and Mobility
www.ccamweb.org

Council on Aging
www.char-meckcoa.org

Continuing Care Accreditation Commission
www.ccaonline.org

Just1Call
www.just1call.org

Loaves and Fishes
www.loavesandfishes.com

Mecklenburg County Status of Seniors Initiative
statusofseniors.charmeck.org

Medicare
www.medicare.gov

National Association of Area Agencies on Aging
www.n4a.org

National Family Caregiver Alliance
www.nfcacares.org

Office of Planning and Evaluation, Mecklenburg County Health and Human Services
www.co.mecklenburg.nc.us/cohhsplan/

Second Harvest
www.secondharvest.org

Senior Grapevine: Events, Activities and Information for Seniors
www.seniorgrapevine.org

Support Team Network
www.supporteam.org

The Age Wave: Series of series run by the Indianapolis Star newspaper that looks at the emerging senior population.
indystar.com

U.S. Administration on Aging
www.aoa.gov

Appendix

Documents comprising the Appendix, which are listed below, are contained in a supplemental compilation and are available upon request.

A. Facilities and Institutions Issue Group Report (unabridged version)

B. Food and Nutrition Issue Group Report (unabridged version)

C. In-Home Services Issue Group Report (unabridged version)

D. Leisure, Education, Recreation, and Socialization Issue Group Report (Unabridged version)

E. Transportation Issue Group Report (unabridged version)

F. “Embracing the ‘Age Wave’” Report

G. Glossary

Status of Seniors Initiative
Community-Based Issue Group Report
FACILITIES AND INSTITUTIONS

BACKGROUND

Introduction

The 2002 SOSI Older Adults Survey reported that 92% of seniors in Mecklenburg County live in a home that they rent or own. However, there will be those individuals for whom short-term institutional care is necessary or the residential setting of choice. For that reason, the Facilities and Institutions Issue Group chose to determine the adequacy, accessibility, effectiveness, equity and quality of facilities and institutions in Mecklenburg County.

Definition of the Issue

In this report, "Facilities and Institutions" is defined as Licensed Nursing Homes, Assisted Living (AL) Residences (which includes Adult Care Homes, Family Care Homes and Multi-unit Assisted Housing with Services) and Continuing Care Retirement Communities (CCRCs). Although seniors live in or receive services at other facilities and institutions such as hospitals, retirement apartments, and prisons, these are not included in this summary of work.

It was the consensus of the group gathered on November 10 and then upheld by the working issue group to limit the definition of "facilities and institutions" as stated above. Although seniors may live and/or be served in prisons, hospitals or other congregate living sites, they are not the primary customers of these institutions.

Group Processes

The Facilities and Institutions Issue Group outlined the following scope of work:

> Task 1: Agree on a shared understanding of the issue as stated above.
>
> Task 2**:** Compile a current list of providers and group according to the type of home (Nursing Homes, AL and CCRCs).
>
> Task 3**:** Review the definitions of existence, adequacy, accessibility, effectiveness, equity and quality, described by the NC DHHS as the "Six Dimensions of Community Evaluation" and the accompanying suggested questions. Based on these definitions the group further determined what questions for each dimension needed to be and/or could be answered in the timeframe of this phase of the strategic planning process and what data needed to be gathered in order to answer the questions. Group chose to focus on only five dimensions. The existence of facilities and institutions is obvious and the quantity of beds is determined through the Certificate of Need process. It was the consensus of the group not to question this methodology for the purposes of

this report. Therefore, we are assuming that as stated in the 2004 State Medical Facilities Plan the number of beds in Mecklenburg County is adequate through 2007.

Task 4**:** Review data and come prepared to make recommendations. Group then discussed each recommendation for inclusion in this report and for appropriate time frame.

The issue group had eight two-hour meetings held twice a month, November 2003 through March 2004. In addition, group members worked individually and in small groups to complete research and assignments. We were able to quickly limit the scope of the issue but found narrowing the focus to be difficult until relevant data could be collected. The important task of collecting and displaying the data particularly the specific information related to providers and service-lines was challenging and time consuming. These factors limited the time spent on evaluation and in the formulation of recommendations. However, the group believes that this work was necessary and will be foundational for others who further examine this issue.

Data was collected by reviewing publicly accessible information, by conducting a telephone survey and by relying on the professional experience of group members. Data was displayed for ease of evaluation on maps and in a matrix.

Research Methods

- Surveys – see ***attachment # 1*** for summary of findings
- Analyses of existing data
- Web searches
- Group discussions

COMPELLING DATA

A **Nursing Home** is an entity that provides 24-hour medical skilled nursing care and rehabilitation services to people with illnesses, injuries or functional disabilities, according to *NursingHome INFO,* one of many resources for consumers.

- Most facilities in the US serve the elderly. However, some facilities provide services to younger individuals with special needs such as the developmentally disabled, mentally illness, and those requiring drug and alcohol rehabilitation. Although there are issues related to accessibility for these populations, this summary of work will only address issues of those over 60.
- The level of care provided by nursing homes has increased significantly over the past decade. Many homes now provide much of the nursing care that was previously provided in a hospital setting.
- Most nursing homes now focus their attention on rehabilitation, so that their clients can return to their own homes as soon as possible.
- In NC there are 422 Nursing homes with 42,596 beds licensed by DHHS/DFS
- Median Facility Occupancy in NC is 91.67%
- There is a total of 28 facilities with 3,088 nursing home beds in Mecklenburg County
- The 2004 State Medical Facilities Plan projects a surplus of 35 Nursing Home beds in Mecklenburg County through 2007.

- Nursing Homes that are certified for Medicare/Medicaid are heavily regulated by federal and state laws/regulations: OBRA, OHSA, DOL, Life Safety Code, ADA, etc.
- In November 2002 , the Centers for Medicare and Medicaid Services (CMS) made available to consumers the Nursing Home Compare database which provides the results of facility Medicare certification surveys at www.medicare.gov
- According to the Nursing Home Compare database the average number of deficiencies sited in Mecklenburg County is 13. The number of citations range from a low of 4 to a high of 36. The average number of deficiencies in NC is 7.

According to the National Center for Assisted Living**, Assisted Living (AL) Residences** provide group housing with at least one meal per day and housekeeping. Personal care services are provided by agreement with a licensed home care or hospice agency or by facility staff if licensed as an adult care home. Adult Care homes are further categorized as "family care" (housing two to six residents), and "adult care homes" (seven or more residents).

- More than a million Americans live in 20,000 Assisted Living Residences.
- The most important factor adults and older look for in an AL is health and personal care (45%); followed by staff (24%) and location (13%).
- A typical resident is a woman in her eighties and is either widowed or single.
- An estimated 50% of residents have some form of memory impairment
- NC AL are licensed by DHHS/DFS – for summary of licensure requirements see Appendix
- There are 31assisted living facilities with 2,714 beds in Mecklenburg County.
- The 2004 State Medical Facilities Plan projects a surplus of 289 Assisted Living beds in Mecklenburg County through 2007.
- Although considered public record, the results of Mecklenburg County licensure visits are not available on the web.

The American Association of Homes and Services of the Aging explains that **Continuing Care Retirement Communities (CCRCs)** are communities usually sponsored by religious organizations, fraternal groups and other nonprofit agencies. These communities provide comprehensive residential and health care services allowing individuals to live within the same community as their needs progress.

- A CCRC is different from other housing and care options because it offers a long-term contract and commonly requires a one-time entrance fee and monthly payments thereafter.
- 500+ CCRCs in America
- The Continuing Care Accreditation Commission (CCAC) is the nation's only accrediting body for "aging services continuums." Accreditation by CCAC is voluntary.
- In addition to voluntary participation with the CCAC, the nursing home and assisted living facilities in retirement communities are subject to applicable state and federal health care regulations.
- There are 8 CCRCs in Mecklenburg County.
- No Mecklenburg County CCRC accepts Medicaid

Hospice In-Patient Care

- Hospice at Charlotte has filed a certificate of need with DFS to construct an 11-bed in-patient Hospice Facility and six residential beds.
- This will be Mecklenburg County's first free- standing hospice in-patient facility.

OBJECTIVES

1) To gain knowledge regarding models of care which have been successful in other communities both to reduce need for institutional care and for improving quality of life within institutions

2) To increase resources and improve access to Mental Health Services for institutionalized seniors including substance abuse and dementia.

3) To improve access to and awareness of information about long term care facilities for the consumer, the professional, providers, and those in positions to make referrals.

4) To decrease gaps in institutionalized services such as respite care and high acuity care.

ISSUE GROUP RECOMMENDATIONS

The following section includes the recommendations formulated by this Community-Based Issue Group. The recommendations are presented by specific timeframes for implementation, and each includes a supporting case and elements for implementation (e.g. rationale, start/completion dates, resources, indicators and measures of success). Refer to the information below and the box on the following page for an outline of the group's considerations in developing its recommendations.

Timeframes and deferred issues

- Recommendations in the short term: 0 to 24 months are as those that require limited or no new resources. And can be implemented relatively easily and make an impact in the short term.

- Recommendations in the mid-term: 25 to 60 months are changes or new programs that are necessary but will require more time to develop of a plan and secure resources.

- Recommendations in the long term: 60+ months include things that require significant planning and resource development and probably require a great deal of collaboration between organizations.

- Deferred issues deserving attention are crucial issues that surfaced during the issue group's work but have not been addressed by their recommendations.

Elements of Community-Based Issue Group Recommendations

Rationale: Brief explanations about why the issue group is recommending this action.

Relevant data: Summaries of the research findings that influenced the recommendation. This might include instances where no data on the issue was found.

Targeted population/beneficiaries: Identification and descriptions of the senior population who will most benefit from the outcome of this recommended action (i.e., who do you intend to help or support). Descriptions include demographic profiles, geographic area, health status, age range, etc.

Desired outcome: Statements about the changes that the issue group anticipates as a result of this recommended action. Changes might be observed in a variety of ways including knowledge/awareness, behavior, opportunity, mobility, wellbeing, etc.

Potential leaders and conveners for the future: Identification of the organization(s) or individual(s) that the group foresees as a champion(s) for the recommendation, as well as those can be key stakeholders in launching and driving the recommended action.

Additional stakeholders: Lists of the organizations, populations or individuals that have a stake in the implementation and/or outcomes of this recommended action. While these stakeholders may not serve as leaders or conveners, their input and buy-in on the action should be sought.

Resources: Lists of the resources (beyond leaders, conveners and stakeholders) that are needed to support this recommended action. Resources might include specific expertise, demonstrated models, technology, funding, etc.

Targeted start and completion dates (mm/yy): Projected timing of the recommended action. That is, the group's estimation of an optimal timeframe to launch, execute and complete the action.

Indicators and measures of success: Identification of the changes and gains (among individuals and organizations and in the community) that might indicate progress in addressing the present problem.

RECOMMENDATIONS IN THE SHORT TERM: 0-24 MONTHS

Recommendation: Produce a concise handout/brochure for consumers seeking care in long-term care facility or institution for themselves or a loved one.

Rationale

Despite the many resources for consumers there continues to be a general lack of understanding, feeling of being overwhelmed and inability to navigate the "maze" when faced with the need for a facility or institution. For example individuals do not understand the difference between Nursing Hones and AL.

Relevant data

Survey conducted by Opinion Research Corporation for the American Association of Homes and Services for the Aging reports the following:

- Only four in 10 adults 45 and older say they have considered their preferences for additional care for themselves as they age.
- Only one in three 55- to 64-year-olds has talked with their parents who are on their own about additional care
- 40% of those surveyed incorrectly responded that Medicare would cover the costs of assisted living.

Targeted population/beneficiaries

Seniors, or their families/significant others, who are in need of immediate long-term or short-term placement due to illness, injury or increased dependence for activities of daily living.

Desired outcome

Consumers would make more informed decisions related to long-term care facilities and thereby have less anxiety. Concise, easy to read information would improve consumers' ability to navigate the healthcare system.

Potential leaders and conveners for the future

- Long-Term Care (LTC) Providers
- Centralina Area Agency on Aging
- Acute Care providers

Additional stakeholders

- Consumers
- Physician practices
- Senior Centers
- Home Health Providers
- Hospice Providers
- Information and Referral providers

Resources

- Research
- Editors
- Printing
- Publishing
- Distribution
- Funding

Targeted start and completion dates (mm/yy)

7/2004-12/2004

Indicators and measures of success

Acute Care Providers/Discharge Planners and Information and Referral providers will report receiving tool, ease of distribution and consumer satisfaction.

<u>Recommendation:</u> Further quantify gaps in services in order to formulate recommendations regarding high medical acuity, mental health services, substance abuse services, and respite care.

Rationale

Based on the survey conducted and the experience of the group, even though the State Facilities Plan states there is a surplus of both nursing home and AL beds and that occupancy rates are at 91%, certain types of patients remain difficult to serve and/or place in current facilities and institutions**.**

Relevant data

- Refer to issue group appendices "Summary of Survey Findings"
- No nursing homes and only 2 AL report having specialized mental health units
- 2.2%-9.6% of individuals 60 + have problem of alcohol abuse.
- See quote from CHS Clinical Care Management Department.

Targeted population/beneficiaries

Seniors and their families/significant others, who find it difficult to obtain services in Mecklenburg County.

Desired outcome

- Additional knowledge would be gained to make future recommendations
- Improve networking among providers by regular forum for LTC Administrators
- Institutions would offer specialized units/programs to meet the identified needs
- Individuals needing institutionalized care would have additional options in Mecklenburg County

Potential leaders and conveners for the future

- Nursing Home/AL Providers
- Mental Health Service Providers
- Substance Abuse Service Providers
- Ombudsman

Additional stakeholders

- Consumers
- Acute Care Facilities
- Insurance Companies

Resources

This area needs to be researched to see if there are demonstrated programs/models/best practices for any of the areas where gaps in service have been identified.

Targeted start and completion dates (mm/yy)

7/2004-7/2006

Indicators and measures of success

Acute Care Facilities would report ease of transition to appropriate post-acute care services. DSS and Ombudsman would report decrease in challenges related to placement due to high acuity, mental illness, and substance abuse or for respite care.

Recommendation: Develop a website to display quality indicators/measures/survey results of Mecklenburg County Assisted Living Facilities.

Rationale

Quality information for Nursing Homes is plentiful and accessible to consumers. There is a lack of consumer awareness related to the quality and services available in Assisted Livings. Other NC Counties have made this information available

Relevant data

- No publicly reported quality data available for Mecklenburg County's Assisted Living Facilities
- Buncombe County data can be viewed on-line.

Targeted population/beneficiaries

Any individual who is considering assisted living facility for themselves or a loved one.

Desired outcome

Consumers will be more informed when choosing among facilities. Factual information can be reviewed in addition to what can be observed during a visit.

Potential leaders and conveners for the future

- Mecklenburg County DSS Adult Services
- Centralina Area Agency on Aging
- Assisted Living Providers

Additional stakeholders

Consumers

Resources

- Funding
- Web design
- On-going site maintenance

Targeted start and completion dates (mm/yy)

7/2004-7/2005

Indicators and measures of success

- Number of hits on the website.
- Assisted Living Facilities report increased awareness of consumers.

RECOMMENDATIONS IN THE MID-TERM: 25-60 MONTHS

<u>Recommendation:</u> When gaps in services have been quantified, formulate recommendations regarding high medical acuity, mental health services, substance abuse services, respite care.

Rationale

Based on the survey conducted and the experience of the group, even though the State Facilities Plan states there is a surplus of both nursing home and AL beds and that occupancy rates are at 91%, certain types of patients remain difficult to serve and/or place in current facilities and institutions.

Relevant data

- See Appendix: "Summary of Survey Findings"
- No nursing homes and only two AL report having specialized mental health units
- 2.2% to 9.6% of individuals 60 + have problem of alcohol abuse.
- See quote from CHS Clinical Care Management Department.

Targeted population/beneficiaries

Seniors and their families/significant others, who find it difficult to obtain services in Mecklenburg County.

Desired outcome

- Institutions would offer specialized units/programs to meet the identified needs
- Individuals needing institutionalized care would have additional options in Mecklenburg County

Potential leaders and conveners for the future

- Nursing Home/AL Providers
- Mental Health Service Providers
- Substance Abuse Service Providers
- Ombudsman

Additional stakeholders

- Consumers
- Acute Care Facilities
- Insurance Companies

Resources

A Researcher to report on models of care that include both those aimed at reducing reliance on facilities and institutions and those that improve the quality of live within facilities and institutions.

Targeted start and completion dates (mm/yy)

1/2005-3/2005

Indicators and measures of success

None reported.

<u>Recommendation</u>: Improve the quality of care in Mecklenburg County Nursing Homes, as evidenced by a reduction in the number of deficiencies to a level at or below state averages.

Rationale

Currently the average number of deficiencies in Mecklenburg County is twice that of the North Carolina average.

Relevant data

- See individual facility outcomes at www.medicare.gov
- North Carolina average: 7
- Mecklenburg County average: 13

Targeted population/beneficiaries

Seniors living in or receiving care in Mecklenburg County Nursing Homes

Desired outcome

- Increased quality of care as evidenced by decreased in number of deficiencies.
- Facilities reporting increased customer satisfaction

Potential leaders and conveners for the future

Medical Review of North Carolina is the Quality Improvement Organization contracted by CMS to assist NC LTC Facilities to improve quality. A representative from MRNC facilitating a group for the purpose of improving overall care in Mecklenburg County would be recommended.

Additional stakeholders

- NH Providers
- Centralina Area Agency on Aging/Ombudsman Program
- Acute Care Facilities
- Charlotte DFS team

Resources

Funding to research similar initiatives and demonstrated models and develop educational tools, quality improvement programs, etc.

Targeted start and completion dates (mm/yy)

1/2005-1/2008

Indicators and measures of success

Improved patient care outcomes and reduction in number of deficiencies.

CONCLUDING COMMENTS

To age in place may be the goal for many individuals; however, there will always be a need for facilities and institutions to provide care and support for those who can no longer remain in their own home or choose congregate living. In beginning to examine issues of accessibility, adequacy, effectiveness, equity and quality of Mecklenburg County LTC facilities and institutions, the issue group concluded that:

- There is a need for education regarding facilities and services in a timely manner in a format that consumers can easily understand and is accessible.

- There are obvious gaps in specialized services in facilities and institutions such as mental health services, substance abuse, dementia care, respite and high acuity medical care.

- The quality of care of Nursing Homes in Mecklenburg County appears to be below average for North Carolina.

- There needs to be significant further research into quantifying gaps and identifying models of care that could be replicated in our community in order to improve the quality of life for institutionalized senior.

- Due to the scope of the issue which reaches beyond Mecklenburg County, the plethora of information and the time constraints of the participants, we hope this deliverable is just the first of many steps to examining and improving long-term care for our seniors.

NOTABLE QUOTES

In my role as LTC Ombudsman, I interact on a daily basis with members of the "Baby Boom" Generation. They are increasingly more savvy consumers and have high expectations. We need to prepare for this generation to enter our facilities. Our environment and programs will need to address these high expectations.

Linda Miller, Mecklenburg County LTC Ombudsman

The work is so fast paced and stressful. If you don't have to think about old people, you don't until it happens to you.

Dr. Kim Boyer, Geriatric Psychiatrist, Charlotte

We often have great difficulty moving patients from the acute care setting to nursing homes. Particularly challenging are patients who are high acuity, who have mental health diagnosis or behavior problems, those who have only Medicaid or are Medicaid pending and those who have issues around guardianship.

Jane Dawson, BSW, MHA, CHS Clinical Care Management.

Upwards of 40% of those 85 years and older will be affected by some form of dementia. Many of these individuals will experience behavioral alterations that include wandering, delusions, and agitation secondary to disorientation and anxiety. While many facilities in Mecklenburg County care for these individuals, specialized units and programs tailored to assist the demented patient with behavioral problems are limited. These patients are often costly to a facility due to nursing hours used to provide safety that increases the incentive for facilities to avoid admissions of this kind.

However, interdisciplinary programs that incorporate medical, psychiatric, nursing, and social support can increase quality of life in these patients through behavioral and medical management. Therefore, quality programs should be made available to the less fortunate and equally distributed throughout the county.

In addition, Mecklenburg County currently lacks a behavioral or mental health facility specifically geared for the elderly. This population has significantly more complex general medical needs than younger cohorts in the mentally ill population. Unfortunately, when they experience exacerbation in their mental or medical illnesses they are sent to general nursing facilities that are not prepared to care for the psychiatric component. A facility that could provide both medical and psychiatric care for the elderly through inpatient services and outreach consultant programs would benefit our seniors.

Melanie Boatwright, MSN, Senior Health Connection

Status of Seniors Initiative
Community-Based Issue Group Report
FOOD AND NUTRITION

BACKGROUND

Introduction

Access is the area that the group decided to focus on for the five work sessions we scheduled. Access to food is an essential basic need. Areas identified under access included healthy foods, fresh fruits and vegetables, EBT benefits expanded and vouchers to meet nutrition needs with expanded or creative options for the older adults using them, and transportation to get their food and nutrition needs met. Adequate nutrition promotes good health resulting in a better quality of life and older adults being more independent. They can remain in the community and age in place rather than requiring more care, which is costly.

Definition of the Issue

Every older adult needs to have his or her basic food and nutrition needs met. Good nutrition promotes good health. Healthy older adults are more independent and have a better quality of life. Access, choices, marketing and image, and resources are the four categories that need to be addressed to provide all older adults of our community adequate food and good nutrition, which in turn promote living a healthy life.

Group Processes

At the November 10, 2003 a schedule of five meetings was agreed upon. These meeting would be on Wednesday afternoons at 3pm at the Senior Center Shamrock. The first meeting was scheduled December 17, 2003 after the December 10, 2003 meeting that was scheduled to receive the UNCC students report on the data they had collected. Meetings were set for the 2nd and 4th Wed in Jan and February at 3:00 p.m. to 4: 30p .m. It was agreed that whatever work we could accomplish with those five meetings would be the body of work for this segment of the ongoing planning process.

The group decided to focus on access. Group members volunteered to investigate areas of interest to them such as the westside of Charlotte, farmer's markets, North Meck, grocery store deliveries, food banks (both self-referral and referrals by agencies), food stamps, gleaning, senior nutrition programs and more. Information was brought back to each meeting, shared with group members and discussed. The decision was made to look at maps and map current food and nutrition services locations in the county and look at maps with the older adult population and poverty areas as well. These maps were made and shared with the group. Recommendations were formulated in the two February meetings after reviewing the data brought to meetings during January. Minutes were emailed to members.

Research Methods and Activities

- Maps of area food services such as farmer's markets, nutrition sites, pantries were made
- Review of existing data on services offered were review
- Gaps were identified
- Barriers to access were identified
- Disparities in services available in varies parts of the county and city were identified

COMPELLING DATA

The issue group found the following data on the food and nutrition of seniors in Mecklenburg County.

- Waiting lists for meal services for frail older adults
- Fragmentation of services
- Disparities in areas of the county where services are delivered (refer to map). The westside of Charlotte and North Meck have fewer services. (refer to map of food services that were investigated)
- Lack of demographic data available by each service provider. Examples include: Loaves and Fishes has data on what agencies refer but not on ages of clients served; Love INC conducted a survey of 60 churches, but it received only five responses; it is in the process of collecting 250+ email addresses of churches to administer another survey.
- Need to think differently about how services are provided—can older adults receive a monthly food benefit and use it at the grocery store, local restaurants, farmer's markets or nutrition sites of their choice.
- No information available on the older adults served meals or receiving food in the faith community—particularly by age. For example: Church A serves lunch three days a week and dinner one night a week. They know how many are eating but not the ages.
- 22 senior nutrition sites
- 11 Loaves and Fishes Pantries; no self-referral
- 17 self-referral food pantries; 16 provided by the faith community
- 3 grocery stores with delivery service for a fee—two Harris Teeters in Cornelius and South Charlotte with large orders and substantial fees and Reid's uptown
- 12 adult day care/day health centers and homes
- 2 home-delivered meal programs: DSS and Friendship Trays. Friendship Trays is the only one that does specials diets.
- 9 farmers markets; none in Mint Hill at this time
- 1 regional gleaning program
- 1 food bank

OBJECTIVES

- To assure that every older in our county has their basic need of adequate food and good nutrition met.
- To offer more options for how older adults can meet their food and nutrition needs.
- To eliminate waiting lists.
- To create clearinghouse for data so issue is more specifically defined.
- To eliminate disparities in access to food and food services throughout the county.
- To assure adequate transportation services for access to all food and nutrition options, such as senior nutrition sites, farmer's markets, grocery stores, food pantries, and other sites.
- To increase awareness of what nutrition services are available to increase usage of these services, eliminate negative stereotypes, make information culturally appropriate and all materials easily understood.

ISSUE GROUP RECOMMENDATIONS

The following section includes the recommendations formulated by this Community-Based Issue Group. The recommendations are presented by specific timeframes for implementation, and each includes a supporting case and elements for implementation (e.g. rationale, start/completion dates, resources, indicators and measures of success). Refer to the information below and the box on the following page for an outline of the group's considerations in developing its recommendations.

Timeframes and deferred issues

- Recommendations in the short term: 0 to 24 months are as those that require limited or no new resources. And can be implemented relatively easily and make an impact in the short term.

- Recommendations in the mid-term: 25 to 60 months are changes or new programs that are necessary but will require more time to develop of a plan and secure resources.

- Recommendations in the long term: 60+ months include things that require significant planning and resource development and probably require a great deal of collaboration between organizations.

- Deferred issues deserving attention are crucial issues that surfaced during the issue group's work but have not been addressed by their recommendations.

Elements of Community-Based Issue Group Recommendations

Rationale: Brief explanations about why the issue group is recommending this action.

Relevant data: Summaries of the research findings that influenced the recommendation. This might include instances where no data on the issue was found.

Targeted population/beneficiaries: Identification and descriptions of the senior population who will most benefit from the outcome of this recommended action (i.e., who do you intend to help or support). Descriptions include demographic profiles, geographic area, health status, age range, etc.

Desired outcome: Statements about the changes that the issue group anticipates as a result of this recommended action. Changes might be observed in a variety of ways including knowledge/awareness, behavior, opportunity, mobility, wellbeing, etc.

Potential leaders and conveners for the future: Identification of the organization(s) or individual(s) that the group foresees as a champion(s) for the recommendation, as well as those can be key stakeholders in launching and driving the recommended action.

Additional stakeholders: Lists of the organizations, populations or individuals that have a stake in the implementation and/or outcomes of this recommended action. While these stakeholders may not serve as leaders or conveners, their input and buy-in on the action should be sought.

Resources: Lists of the resources (beyond leaders, conveners and stakeholders) that are needed to support this recommended action. Resources might include specific expertise, demonstrated models, technology, funding, etc.

Targeted start and completion dates (mm/yy): Projected timing of the recommended action. That is, the group's estimation of an optimal timeframe to launch, execute and complete the action.

Indicators and measures of success: Identification of the changes and gains (among individuals and organizations and in the community) that might indicate progress in addressing the present problem.

RECOMMENDATIONS IN THE SHORT TERM: 0-24 MONTHS

Recommendation: Expand senior nutrition sites.

Rationale

There is a current waiting list. These older adults are usually the most fragile members of our community.

Relevant data

Senior Nutrition Program Supervisor shared information that all three programs have waiting lists.

Targeted population/beneficiaries

Unserved – Support most fragile older adults and those living in underserved areas such as North Mecklenburg.

Desired outcome

Older adults receive meals, which promote good nutrition resulting in better health.

Potential leaders and conveners for the future

- DSS (provide services)
- Area Agency on Aging (monitor services delivery)
- Friendship Trays (services for the homebound)
- County Commissioners (funding)

Additional stakeholders

- Older Adults that are served and not served
- Volunteers – helping to provide the service
- Providers (Doctors, Nurse Practitioners) – having a resource for patients to have nutrition needs met

Resources

- Increase funding to eliminate waiting lists
- Increase volunteers to deliver home bound meals

Targeted start and completion dates (mm/yy)

Start: July 2004 – Increase funding to provide more meals
Completion: July 2006 – Waiting lists eliminated

Indicators and measures of success

Elimination of waiting list for meal programs.

<u>Recommendation:</u> Create collaboration among public and private entities to maximize local community resources. Examples include local businesses sponsor a meal site and mentoring program for young professionals with retirees.

Rationale

Currently insufficient funding to support programs and services, and with the anticipation of the an increased older adult population, creative and innovation funding methods need to be explored to ensure that every older adult in our community has access to healthy food and nutrition.

Relevant data

- Waiting lists
- Lack of sites
- No menu selection
- Current sites operate 5 days meals are needed 7 days a week
- Limited amounts on EBT cards – restrictions on when, where and what can be purchased

Targeted population/beneficiaries

- Providers
- Older adults at all functional levels
- Businesses

Desired outcome

Alternative resources and partnerships are developed between public and private sectors to support food and nutrition programs and special initiatives. This would also include partnerships with the faith community.

Potential leaders and conveners for the future

- Food service businesses
- Culinary schools
- Existing senior nutrition providers
- United Way
- DSS
- Transportation services
- Local businesses
- Grocery stores

Additional stakeholders

None reported.

Resources

- Project Manager to negotiate creative funding
- Identify best practice models form other communities
- Identify informal food and nutrition support , e.g. Walmart activities

Targeted start and completion dates (mm/yy)

Start: July 2005, begin evaluation of current funding system, best practice models and informal nutrition supports

Interim: July 2007 – Identify model for our community

Completion: July 2008 – Implement model

Indicators and measures of success

Alternative funding received and new food and nutrition program model is being implemented.

Recommendation: Develop supplemental transportation services to ensure access to food and nutrition programs and services (e.g. grocery stores, farmers markets, senior nutrition sites, and other similar destinations).

Rationale

- Transportation has been identified as a barrier to access
- Only Harris Teeter delivers groceries and only in high income areas
- West Charlotte limited grocery stores – services not available

Relevant data

Refer to maps and demographics pertaining to Food and Nutrition.

Targeted population/beneficiaries

Individuals – older adults who do not drive or do not have access to transportation or deliveries

Desired outcome

All older adults have access to convenient transportation so they have access to food and nutrition services.

Potential leaders and conveners for the future

- CATS
- United Way
- County
- DSS
- City

- Faith community
- Love INC
- Grocery store chains

Additional stakeholders

- Sheppard Centers
- Cab companies
- Volunteer drivers
- Neighborhood leaders, groups, support teams

Resources

- Transportation experts
- Demonstrated models
- Funding

Targeted start and completion dates (mm/yy)

Start: July 2004 – Fiscal year 2005

Interim: Fiscal year 2006 – Identify an Action Plan for community

Completion: July 2007 – Implement services

Indicators and measures of success

- Decrease in those that identify transportation as a barrier
- Increase in the number of older adults access services

RECOMMENDATIONS IN THE MID-TERM: 25-60 MONTHS

Recommendation: Increase the number of senior nutrition sites by exploring nontraditional locations, such as YMCA's, libraries, schools, business cafeterias, and by stabilizing the Senior Nutrition Program Manager position.

Rationale

Increase in older adult population – particularly of the old and very old.

Relevant data

- Senior sites have had to move; need for designated space
- Increase in retirement population – both new retirees settling here and the current aging population

Targeted population/beneficiaries

Unserved older adults and up-and-coming boomers

Desired outcome

Increased access to meals/nutrition for all older adults, resulting in improved health or maintaining good health.

Potential leaders and conveners for the future

- DSS
- Area Council on Aging
- Friendship Tray
- United Way

Additional stakeholders

Other agencies or businesses that have space and an interest in hosting senior meals.

Resources

- Explore nontraditional ways to fund – possible businesses to support a site, possible collaboration with Johnson C. Smith and/or with CPCC
- Create programming around people coming together. For example, seniors could be food critics or judges, which would support aging with dignity.

Targeted start and completion dates (mm/yy)

Start: July 2006 – Start to identify possible partners and site

Interim: July 2007 – Open three new sites

Completion: July 2008 – Process in place to open sites based on need

Indicators and measures of success

Goals have been met – See Targeted start and completion date

<u>Recommendation:</u> Develop a marketing and education campaign to increase awareness of, access to, and usage of services.

Rationale

- The need to: (1) eliminate negative stereotypes associated with senior nutrition programs and services; and (2) promote health lifestyle choices, which result in the well being of older adults.
- Increase in usage of food and nutrition services will impact older adults economically and free up dollars for medications or other necessary items.

Relevant data

Currently there are over 80,000 older adults in Mecklenburg County and a relatively small percentage of them access services. Older adults as well service providers reported that there is a negative perception among older adults regarding receiving services which results in decreased access

Targeted population/beneficiaries

- Older adults at all functional levels
- Young old and up-and-coming boomers (begin cultivating image change among these groups)

Desired outcome

Greater participation in senior programs.

Potential leaders and conveners for the future

- Leaders in food business
- Marketing firm

Additional stakeholders

- Older adults and young-old adults
- Government agencies
- United Way
- DSS
- Other service providers

Resources

- Marketing expertise
- Funding,
- Partners such as culinary schools and grocery stores

Targeted start and completion dates (mm/yy)

Start: 2007 – Develop Plan: Change language, develop culturally appropriate materials that markets and has appeal across the segments of the older adult population

Interim: 2008 – Launch Campaign

Completion: 2009 – Evaluate

Indicators and measures of success

- Percentage being served increases
- Older adults willingness to participate increases
- Increase in collaborative efforts

RECOMMENDATIONS IN THE LONGER TERM: 60 MONTHS

Recommendation: Modify how services are delivered to accommodate the cultures of the Baby Boomers generation and multicultural population (e.g., flexibility to use EBT card at coffee shops and restaurants).

Rationale

- Boomers want more choices and will not participate in activities in which they do not have a choice.
- International population will not participate in activities that are not culturally appropriate.

Relevant data

- Increase in older adult population (refer to appendix)
- Increase in multicultural population (refer to appendix)

Targeted population/beneficiaries

- Young old adults
- Multicultural older adults and ethnic population

Desired outcome

By 2009, at least one alternative food and nutrition service delivery model is in place.

Potential leaders and conveners for the future

- DSS
- Friendship Trays
- Area Agency on Aging
- County Commissioners

Additional stakeholders

- Healthcare providers
- Food service providers
- Older Adults
- Boomers
- Aging community members

Resources

Funding and coordinator for focus groups for service delivery model development.

Targeted start and completion dates (mm/yy)

Start: July 2007
Completion: July 2010

Indicators and measures of success

Best practices developed, implemented and evaluated as being culturally appropriate.

<u>Recommendation:</u> Develop and Implement centralized and seamless way to track availability and usage of senior food and nutrition services, including faith-based and informal services.

Rationale

- Currently there is no clearinghouse for food and nutrition services being used or provided to older adults
- Data is critical for assessment, planning and collaboration in developing new programs/services and leveraging funding

Relevant data

As we researched agencies and programs for information on "who" is currently being served and where, we have found that agencies do not have demographic data but referral agencies (refer to issue-group minutes for details)

Targeted population/beneficiaries

- Service providers
- Funders
- Community planners
- Agencies
- Community-at-large
- Older Adult Population

Desired outcome

- Seamless communication and tracking system
- Creation of a database with information

Potential leaders and conveners for the future

- UNCC – Social Capital Institute
- Aging Network Members
- Urban Institute
- DSS
- County Commissioners
- United Way
- Faith and spiritual entities

Additional stakeholders

Aging Network Members

Resources

- Technical support to research and review best practices and to design a system
- Funding

Targeted start and completion dates (mm/yy)

Start: July 2004
Completion: July 2010

Indicators and measures of success

Data available for planning to support changing demographics and needs

DEFERRED ISSUES THAT DESERVE ATTENTION

ISSUE: The Food and Nutrition issue group focused on access to food and nutrition as the priority for its work. While the areas of Choices, Marketing and Resources were discussed and filtered into the developed recommendation there is still work to be done around these issues separately.

Rationale: These other topics need further discussion because they were initially identified at the November 10, 2003 meeting as having an impact food and nutrition for older adults.

ISSUE: Research North Carolina Support Team Initiative to be used as a model for this community

Rationale**:** Community needs support system for older adults

ISSUE: Think outside the box as we explore ways to fund and serve older adults in our community. For example, collaborate with summer feeding programs for children, develop mentoring initiatives for young professionals with retired executives, and organize company-sponsored breakfasts or lunches. Explore the question: What already exists that we can enhance or work from?

Rationale**:** Disparity exists in access to services, therefore current system cannot solely support the needs of the older adult population.

ISSUE: Decreasing number of meals being served at senior nutrition sites. Explore why this is happening. Can older adults select their meal from a menu of many? Can there be choices for special diets or just choices in general?

Rationale: The need to: (1) insure culturally appropriate services are being delivered; (2) insure that services provided are wanted; (3) enhance the quality of services being delivered; and (4) increase number of older adults being served

CONCLUDING COMMENTS

Issue group members believe we have just scratched the surface on the food and nutrition issue within our community. The strategic planning process highlighted the fragmentation of service delivery to older adults. The group recognizes that this is just a start to the ongoing planning process. The level of involvement by group members overall was enhanced by members being able to select their own areas of interest and by the flexibility of participating as their work and personal schedules

Believing our group's work would play a part in creating change to improve the lives of the older adults in our community was important. The beginnings of great ideas were brainstormed during this process. The group believes that through partnerships and collaborations, we as a community can support the needs of the older adult population. The group was inspired by the opportunities that exist to provide services to older adults when we look at nontraditional ways of doing so. If one small change can be made from this initial work to improve the access to food and good nutrition, then we are moving in the right direction.

<u>What worked well</u>

- Bi-weekly meetings
- Group size
- Group members volunteering for areas of interest to them to research
- Data collection
- Documentation process (minutes from meetings helped keeping people on track)

<u>What did not work well</u>

- Time frame – Not long enough
- Would have been helpful to know the expectations for this report prior to getting it
- Large issue with many, many facets

NOTABLE QUOTES

I like most of the food but most of all I like coming to be with my friends everyday.

– Senior nutrition site participant

I know every day I'm going to see them. They are like my family. A lot of them of retired who deliver the meals. They are my angels!

– Home delivered meal recipient

I have to wait for someone to take me to the store. When I go I stock up because I don't know when I'll get there again.

– 76-year-old widow who doesn't drive

I still like to cook. I cook in the morning so my dinner is ready for me in the evening. I like chicken and greens.

– 87-year-old widow

If you live uptown you have to have money. All the breakfast places are closed on the weekend so how are we supposed to eat? It fine if you have money but if you don't it's not a good place to be.

– 67-year-old male resident of low-income senior housing

I get the free bus to the Harris Teeter and then take it back. They treated us so nice at the store. I got everything I need.

– 75-year-old male resident of low-income uptown housing

I go to Hardees every morning for breakfast. It's good! I meet a few friends there. We've been going there for years.

– 78-year-old man living on the eastside of Charlotte

I don't cook much anymore. I use the microwave and just heat something up. My daughter cooks on Sunday and brings me some food to heat up. That's about it.

– 82-year-old widow

I eat cereal for breakfast before I go exercise and then go to my part time job. I eat peanut butter, spaghetti and salad. I don't cook a whole lot because it's just me. I have supper with a friend each week. That's about it.

– 70-year-old widow

I used to go to the big farmer's market but now I go to the little one Kings Dr. I take the bus there and back.

It's not the patients but the patients' family members and caregivers who often will use food services like home-delivered meals. It's a support to them.

– Lisa Hood Hospice at Charlotte Lake Norman Office

Status of Seniors Initiative
Community-Based Issue Group Report
IN-HOME SUPPORT SERVICES

BACKGROUND

Introduction

In-home support services are those services and supports that make it easier or possible for seniors to remain in their homes. The issue group examined such traditional services as home health, in-home aides, respite care, sitters, medical alert systems and home modifications and repairs, as well as other, non-traditional services. It did not consider home-delivered meals, as this service was studied by the Food and Nutrition Issue Group.

The In-Home Support Services Issue Group divided into three sub-committees that examined the following in-home support sub-categories:

- **Aide Services & Home Health Services**
- **Caregiver Respite Care & Support/Training**
- **Information and Referral & Case Management**

The following report includes information generated by each sub-committee and consolidated and prioritized recommendations prepared the full issue group.

Aide Services & Home Health Services

How and why the Issue Group arrived at definition:

How: Consensus from the In-home Services Committee that In-Home Aide and Home Health Services are services that help a person stay in their home, included under this definition is Palliative Care which addresses the management of end of life issues to allow seniors to die in place.

Why: Most Seniors would prefer to spend their final years in their own homes. They do not want to be a burden to family members yet they do not want to be admitted into long term care facilities. The ability to maintain the semblance of independence as one ages creates a greater sense of self-worth and continued dignity.

Scope of Work Included:

- Completing the following tasks outlined by the In-Home Services Committee chairpersons,

- Agreeing on combining In-Home Aide, Home Health and Palliative Care Services as component of In-Home Services
- Collecting and reviewing data from several sources including information from committee members, and identified missing data
- Identifying needed services and duplicated services
- Making short term, mid range, and long range recommendations

Caregiver Respite Care & Support/Training

How and why the issue group arrived at definition:

How: Consensus from the In-home Services Committee that Respite Care for Family Caregivers should be a separate in-home services issue.

Why: Family Caregivers provide 80% of long-term care for families. Respite care was one of the top three priority services for family caregivers. Source: AOA National Family Caregiver Support Program Resource Guide In the 2002 Charlotte-Mecklenburg Annual Survey, 19% of those surveyed have a family member or friend over 60 who is receiving care. Ninety percent (90%) of caregivers rated a break from caregiving as either a very important (74%) or important (16%).

Scope of Work Included:

- Completing the following tasks outlined by the In-Home Services Committee chairpersons,
- Agreeing on definitions of respite care, group respite, adult day care, adult day health, and long-term care facilities.
- Collecting and reviewing data from several sources including information from committee members, and identified missing data
- Identifying needed services and duplicated services
- Making short term, mid range, and long range recommendations

Information and Referral & Case Management

We included those agencies that provided services without regard to the need to be eligible for specialized care. Therefore, we eliminated such agencies as the MS Association or Cancer Society, who specialize in serving people with those illnesses. We also eliminated hospital discharge planners and home care social workers, as I&R and case management are not their primary functions. We did include Alzheimer's Association, however, due to the prevalence of this illness among the elderly. We also included some services in our assessment which provide services specifically for the Spanish-speaking population.

Issues that were considered included the idea that most social service agencies provide some Information and Referral services to customers who come to them for other reasons. Also, many agencies provide case management for special populations or complete a limited number of case management functions. Due to time constraints, we decided to narrow our focus to those agencies to which the general public could apply specifically for Case Management and Information and Referral services.

Definition of the Issue

Aide Services & Home Health Services

Focus on the adequacy and accessibility of In-Home Aide Services (this includes but is not limited to Home Health, Personal Care Services, and Hospice Services) and the education of in Mecklenburg County residents as it relates to availability of services.

Caregiver Respite Care & Support/Training

Focus on the existence, adequacy and accessibility of Respite Care in Mecklenburg County (that may include services such as group respite, adult day care/day health, long-term facilities,) as it relates specifically to Family Caregivers. Note: In-home respite service was included in the in-home services sub-committee.

Information and Referral & Case Management

A decision was reached to investigate services available to the broadest spectrum of Senior Citizens. We focused on agencies which provided Information and Referral or Case Management as the total focus of the agency or for whom these functions were a very large component of their activity.

Group Processes

Information and Referral & Case Management

The sub-committee met a total of five times. Decisions regarding the scope of our research and the recommendations were reached by consensus. It should be noted that team members were knowledgeable already about services within the community. Each team member had assignments to complete between meetings. The team facilitator compiled the results of the individual assignments prior to each weeks meeting.

Utilizing the Status of Seniors in Mecklenburg County report from May 2003, committee members reached a decision that additional information was needed. A decision was made to request additional information in person from the agencies which provided I&R and Case Management services. A list of questions was developed, using the questionnaires developed by the State as a guide. Individual team members also suggested questions and a standardized list of questions was developed. Agencies listed as providing I&R and Case Management were taken from the J1C databases. Each committee member interviewed representatives from 2-3 agencies. The data was compiled and reviewed. Once this review was completed, the group answered the questions from the State questionnaire regarding Availability, Accessibility, etc.

Each team member made individual suggestions for changes and improvements. This list was compiled and the suggestions refined and prioritized by the group.

Caregiver Respite Care & Support/Training

Process of examination of issue was completed by a sub-committee through the following steps:

- Sub-committee group met every other week from January through February 2004.
- Agreed on process and assignments to be completed.
- Reviewed data in Status of Seniors Report, Provider Survey conducted by UNCC MPA students, the Charlotte-Mecklenburg 2002 Annual Survey, and data from national and state resources.
- Collected additional data related to sub-committee member's knowledge and experience with respite care.
- Organized data into respite care categories

Research Methods

Aide Services & Home Health Services

- Status of Seniors in Mecklenburg County – May 20, 2003
- Mecklenburg County Study done by UNCC students
- Association for Home and Hospice Care of NC report to the House Select Committee on the Rising Costs of Health Care
- Analyses of existing data
- Sub-committee roundtable discussions

Information and Referral & Case Management

The group used the following materials to develop the background information:

- Embracing the Age Wave
- Summary from the Senior Summit, November 10, 2003
- DSS Management Information Report July, 2003-June, 2004 (projected)
- Status of Seniors in Mecklenburg County, May 20, 2003

A questionnaire was developed to interview 17 agencies which provided I&R and Case Management services. J1C's database was used to select the agencies and committee members added two resources based on their knowledge of community resources.

The group also utilized round-table discussions to identify key gaps in services.

Caregiver Respite Care & Support/Training

The Respite Care Sub-group used the following methods of research:

- Surveys
- Analyses of existing data
- Media: national and local newspaper articles
- Web searches
- Sub-committee discussions

COMPELLING DATA

Aide Services & Home Health Services

Source: Status of Seniors in Mecklenburg County

- According to the Congressional Budget Office the number of people available to provide caregiving declines as the number of frail elderly increases dramatically.
- Wall Street Research estimates that "on average," home health care services are roughly 30-60% less expensive than similar services provided in an institutional setting.
- In 2002, 20% of older adults in Mecklenburg County who needed caregiving help were not receiving the help they needed with tasks that were difficult for them.
- More than 34,000 seniors in Mecklenburg County (43% of our senior population) can be defined as at risk of frail due to their difficulty of performing one or more activities of daily living such as meal preparation and bathing.
- Seniors mostly learned of programs and services by word of mouth at places they frequent groups that they belong to, and from friends and family.
- The 2002 Older Adults Survey found that over 21% indicated an unmet need for information about services and programs for older adults. In the UNC Charlotte Urban Institute Annual Survey, approximately 39% of caregivers said they had problems finding needed services.
- Based on the 2002 Mecklenburg Older Adults Survey, and reinforced by five Focus Groups, it is clear that older adults strongly want to stay in their own homes as long as is feasible. To do this they need help securing a broad variety of services to help them maintain their independence.

Source: Home & Hospice Presentation

- Medicaid average monthly cost per person served for the first five months of SFY 2003-2004 for home care services were as follows.
    - Home Health Skilled Services $ 586
    - In Home Personal Care Services $ 715
    - Community Alternative Program Disabled $1,876

  Compared to the average monthly cost per person served for Institutional services for the Medicaid Program and State and County Special assistance for the same period were as follows:
    - Hospital Inpatients $4,131
    - Skilled Nursing Home Care $3,151
    - Intermediate Nursing Home Care $2,543
    - Adult Care Home Care $1,545

- In SFY 2002-2003 the Medicaid Budget increased by 7% over the last year. Home Care Services only increased by 2.9% for the same period. If Home Care services

represented a larger percentage of the budget, then overall costs would not rise as fast.

Cited the N.C. Institute of Medicine report to the General Assembly:

- Institutional services account for the largest share of publicly funded expenditures
- Institutional care is usually more expensive than home and community-based care, which explains part of the reason why the state spends so much of its resources on institutional care
- Another reason for this institutional spending is that Medicaid and other program rules make it easier foe people to qualify for financial assistance with institutional or residential care than for services provided at home or in the community.

Source: Mecklenburg County Study done by UNCC students

- Nearly 54% of the elderly population reports having at least one disability, and these disabilities often limit the capacity of those affected to carry out routine activities of daily living.
- Medicare only provides assistance for care in skilled nursing facilities for a short period (up to 100 days after hospitalization).
- While the likelihood of receiving long-term care increases with age, fewer elderly citizens reside in nursing homes.
- According to the 1994 National Long-Term Care Survey, more than 7 million Americans provide 120 million hours of unpaid care. If these caregivers are paid, the cost of their services is estimated to be $45 billion to $94 billion a year.
- The leading criteria used by senior service providers to determine eligibility are age (42%), income (27%), and (23%) Medical diagnosis.

Caregiver Respite Care & Support/Training

Respite Care Services in Mecklenburg County

Type	Number	Capacity
Group Respite	1	6
Adult Day Care/Day Health*	13	356
Institutional Respite * (Assisted Living Facilities)	38	2772

* These facilities are licensed or certified
* The sub-committee did not look at skilled care facilities i.e. nursing home as potential respite care.

- 80% of caregivers in Mecklenburg said it was essential or critical to have community-based services versus Institutional care. Source: UNCC MPA Provider Survey
- Overall 39% of caregivers report needing respite care within the last 12 months; only half that number say they received it. Source: *A Portrait of Informal Caregivers in America 2001* – Roberts Wood Johnson Foundation National Strategic Indicator Surveys

Information/Assistance

Fiscal year 2003 - Just 1 Call – Mecklenburg County

Calls from Caregivers	1,241	Adult Day Care	86
Information/Education only	538	Respite Care	60
Linkage to Services	550	Personal Care	85
Assistance for Caregivers	315	Support Group	33
Assistance for Care Recipient	565		

- 92.4% of caregivers said it was essential or critical to have information to navigate the system. Source: UNCC MPA Provider Survey

Funding

National:
- The value of the services family caregivers provide for "free" is estimated at $257 billion a year. (We need to keep them healthy)
- American businesses lose between $11 billion and $29 billion each year due to employees' need to care for loved ones 50 and older. Source: *AOA Resource Guide and A Portrait of Informal Caregivers in America, 2001.*

State:
- In 2001-02, 61% of Adult Day Care/Day Health most centers ran in the deficit compared to 44% nationally. Source: 2001-02 Partners in Caregiving Study

County:
- 54% occupancy rate, 296 individuals currently enrolled in county Adult Day Care/Day Health facilities. Source: Mecklenburg Co. DSS Fact Sheet
- 46% vacancy rate in Adult Day Care/Health due to limited funding, affecting approximately 275 families, with $2.4 million additional funds needed. Source: Mecklenburg Co. DSS Fact Sheet

Information and Referral & Case Management

Two key issues stood out for the group from the beginning and the research confirmed these assumptions. First is that Information and Referral Services are widely available to Seniors in Mecklenburg County but many Seniors still do not know where to find this information. This information was confirmed by focus groups of seniors and Caregivers who stated that they do not know where to access information about services. Information is difficult to find in the phone book. For instance, Just 1 Call's telephone number is listed in the blue pages, where a consumer would need to know both the name of the agency they wanted to call and that it was a county sponsored service.

Secondly, case management services are not widely available to middle income consumers who cannot afford to pay $90 hr. for these services. The case management services provided by Services for Adults are not widely known by either consumers or professionals and the location of the services within DSS may be a barrier to middle income consumers. CAP services for Medicaid eligible clients usually have a waiting list.

Please see the Appendix for a summary of the data.

OBJECTIVES

To address distinct in-home care issues in the areas of (a) Aide Services & Home Health Services; (b) Caregiver Respite Care & Support/Training; and (c) Information and Referral & Case Management.

Aide Services & Home Health Services

1. Program Administration

Medicare/Medicaid

Lobby the Federal Government for changes to the current laws.

1. Medicare qualifications should be broadened to allow more unskilled personal care services to be provided in home as well as in a skilled facility.
2. Need to update Medicaid income qualification criteria to today's costs.

Program Eligibility

All senior service providers must determine eligibility for a program or service based on a holistic assessment of the senior's physical and mental health, abilities to live independently and financial strength. When determining senior program eligibility:

1. First and foremost qualification should be a review of the applicant's capability of completing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Assessing the senior's capability of completing an activity includes rating the ease or difficulty that a senior experiences in completing the activity.
2. Disposable income after necessary living expenses should be the qualifying element not income alone. Necessary living expenses would include but are not limited to items such as mortgage/rent, utilities, medical expenses, transportation, and incurred debt.
3. If eligible for Hospice benefits the above qualifications are not required.

Duplication of Services

Clear definitions of services should be created. Terms of various caregiving services should be created, i.e. personal care services, housekeeping, nursing services, etc. Service to be provided and the frequency of the services provided should be based upon a holistic care plan regardless of frequency needed. Over lapping of services by different providers should be allowed as long as the times these services are provided are different.

Flexibility of Services

Allow for the customization of care plans based on needs of the care recipient. Assumptions that family members exist, are available, willing or even capable of providing care to seniors on weekends and holidays must be eliminated.

1. Services should not be provided based on a homogeneous numeric allocation to all care recipients, needs vary by recipient and should be determined based on individual requirements.
2. Services should be provided on weekends and holidays.

Create a reimbursement structure that would allow integration of services from different providers in order to create a total care plan. This would include a process that:

1. Creates a unselfish referral network for the betterment of the seniors
2. Shares information regarding services provided by different providers among the different providers and referral sources.
3. Educate the medical profession to enlist home management services in addition to Home Health/Hospice services as part of a senior's rehabilitation and/or care.
4. Create a public awareness of Home Care options and the services provided.
5. Create a faith-based awareness of Home Care/Hospice options and the services provided.

2. Caregiver Programs

Retention

The county must develop a program(s) that will assist in attracting and retaining quality caregivers. This will create a larger work force to meet the growing demand for services. Additionally, it will allow for the retention of the more qualified and skilled caregivers.

1. Create a low cost affinity group health care plan for caregivers.
2. Increase reimbursement rates for caregivers to market rates.
3. Include reimbursement rates for shift differentials for nights, weekends and holidays.
4. Create reimbursement rate differentials for different caregiver skill levels.

County provided continuing education classes could assist in the retention of personnel by addressing topics related to care management to reduce the amount of burnout in the work force. Classes would be open to all types of caregivers and could address topic such as:

1. Physical skills
2. Psychosocial skills
3. Communication skills
4. Personal satisfaction of caregiving

Family Member Caregivers

The utilization of family caregivers would allow the increased ability to provide congruent care to our seniors.

1. Programs should be created or expanded to allow family members to provide care for seniors without imposing restrictions or creating financial penalties.
2. Agencies need to communicate more effectively with the family and care recipient the duties of caregivers and the personal care services to be provided.

Senior and Family Member Education

Education of family members to the realities of caring for aging parents is needed.

1. Conversations should include joint conversations with seniors and family members.
2. Families need to realize that caring for aging parents requires advance planning in order to provide adequate resources.
3. Planning involves determining what services are needed.
4. Planning also involves identifying family member roles in the care plan.
5. Planning includes advance directives.
6. Have county sponsored community education to the above facts.

Seniors need assistance in understanding the various programs, program qualifications and services provided by each program. A process needs to be developed to assist with

1. Educating seniors as to program qualifications.
2. Identifying covered services.
3. Navigating the system to obtain services quickly and effectively.

3. Sponsored Communications/Resources

Communication

Create a low cost or no cost public venue for sharing information with key groups of the community. The event should be held in several county regions to allow access by all citizens. Exhibitors should include private, public organizations that provide services to seniors.

1. Sponsor a Health Fair for professionals and clergy
2. Sponsor a separate Health Fair focused on attracting seniors

Develop a resource manual (hard copy) to be published and distributed in the county to professionals, clergy, and public libraries. Brochures of manual highlights should be distributed all senior service providers. Contents of the manual should contain:

1. Explaining types of services (public and private) available to seniors in the county

2. Outline the various Government programs
3. Recipient Qualifications for program eligibility
4. Services provided
5. Limits on services
6. Explain how to access to programs
7. Provide a listing of service providers

Resources

- Enhance Just 1 Call to include the resource manual information.
- Develop recruitment/education programs for growing multi-cultural initiatives addressing differences in faith, language and dietary habits.

Caregiver Respite Care & Support/Training

- Improve Interagency awareness of services that each provides – NETWORKING
- Increase CAREGIVER awareness of a central source of information and services
- Improve availability of family caregiver training and education to increase their skills and knowledge of caregiving.
- Provide caregiver support in addition to support groups, (telephone helpline, peer support, in-home visits, etc.)
- Develop collaboration with all agencies and interest groups regarding issues requiring legislative change to benefit family caregivers.
- Promote a media campaign to make “Family Caregivers” a household word
- Develop greater awareness and partnership with faith community of their efforts for family caregivers
- Target employers and provide information about family caregiver issues and resources
- Improve methods to reach the caregiver in rural areas
- Improve methods to reach caregivers in ethnic groups
- Develop a grant writing center in Mecklenburg County for additional funding to provide support and services.

Information and Referral & Case Management

- Public awareness of where and to access Information and Referral Services will improve significantly.
- Professionals serving seniors will have a more comprehensive knowledge of resources available to seniors in Mecklenburg County.
- Agencies providing Information and Referral and Case Management to seniors will improve their collaboration.

- Case Management services will be available to all seniors on demand and regardless of income.

ISSUE GROUP RECOMMENDATIONS

The following section includes the recommendations formulated by this Community-Based Issue Group. The recommendations are presented by specific timeframes for implementation, and each includes a supporting case and elements for implementation (e.g. rationale, start/completion dates, resources, indicators and measures of success). Refer to the information below and the box on the following page for an outline of the group's considerations in developing its recommendations.

Timeframes and deferred issues

- Recommendations in the short term: 0 to 24 months are as those that require limited or no new resources. And can be implemented relatively easily and make an impact in the short term.

- Recommendations in the mid-term: 25 to 60 months are changes or new programs that are necessary but will require more time to develop of a plan and secure resources.

- Recommendations in the long term: 60+ months include things that require significant planning and resource development and probably require a great deal of collaboration between organizations.

- Deferred issues deserving attention are crucial issues that surfaced during the issue group's work but have not been addressed by their recommendations.

Elements of Community-Based Issue Group Recommendations

Rationale: Brief explanations about why the issue group is recommending this action.

Relevant data: Summaries of the research findings that influenced the recommendation. This might include instances where no data on the issue was found.

Targeted population/beneficiaries: Identification and descriptions of the senior population who will most benefit from the outcome of this recommended action (i.e., who do you intend to help or support). Descriptions include demographic profiles, geographic area, health status, age range, etc.

Desired outcome: Statements about the changes that the issue group anticipates as a result of this recommended action. Changes might be observed in a variety of ways including knowledge/awareness, behavior, opportunity, mobility, wellbeing, etc.

Potential leaders and conveners for the future: Identification of the organization(s) or individual(s) that the group foresees as a champion(s) for the recommendation, as well as those can be key stakeholders in launching and driving the recommended action.

Additional stakeholders: Lists of the organizations, populations or individuals that have a stake in the implementation and/or outcomes of this recommended action. While these stakeholders may not serve as leaders or conveners, their input and buy-in on the action should be sought.

Resources: Lists of the resources (beyond leaders, conveners and stakeholders) that are needed to support this recommended action. Resources might include specific expertise, demonstrated models, technology, funding, etc.

Targeted start and completion dates (mm/yy): Projected timing of the recommended action. That is, the group's estimation of an optimal timeframe to launch, execute and complete the action.

Indicators and measures of success: Identification of the changes and gains (among individuals and organizations and in the community) that might indicate progress in addressing the present problem.

RECOMMENDATIONS IN THE SHORT TERM: 0-24 MONTHS

<u>Recommendation</u>: Develop a list of agencies providing services to seniors. Provide this list to social workers, home care agencies, and others working with senior citizens. Along with this, establish and execute a program/ system to share information regarding In-Home Care Services to the residents of Mecklenburg County.

Rationale

- Personal experience and survey results show that caregivers have difficulty finding information they need and are unaware of the services available to them.
- With increased awareness of services, more seniors would receive needed assistance to remain independent in their own homes.
- It was the consensus of the issue group that even professionals do not know what services are available to seniors in the county.

Relevant data

- Seniors mostly learned of programs and services by word of mouth at places they frequent, groups they belong to, or from family and friends.
- The 2002 Older Adult Survey found that over 21% indicated an unmet need for information about services and programs for older adults.
- In the UNC Charlotte Urban Institute Annual Survey, approximately 39 % of caregivers said they had problems finding needed services.

Targeted population/beneficiaries

- Making information about services widely available in the places they are frequently served would help seniors and seniors' family members.
- Providers of services to seniors would also benefit.

Desired outcome

- Create a knowledgeable population of both senior service providers/referral sources and senior service users.
- If both the providers/referral sources and users were more knowledgeable of services, a higher success rate of providing services to seniors would occur.
- Also, seniors will benefit from being served by a more knowledgeable core of professionals.

Potential leaders and conveners for the future

- Mecklenburg County Council on Aging
- Aging Resources Network
- Just1Call
- United Way
- Other associations of senior-service providers

Additional stakeholders

All service agencies and businesses that provide senior focused services or have high contact with the senior population including Council on Aging, CMAC, senior centers, hospitals, long term care facilities, drug stores, clergy, and church organizations.

Resources

- Funding
- Just 1 Call website development and maintenance
- Public broadcasting services to produce public awareness/ announcements
- Low cost or no cost facilities to hold exhibits and health fair events
- Low cost or no cost entry fees for senior service/information exhibitors

Targeted start and completion dates (mm/yy)

- Start first information event in 9/04
- This is an ongoing task and has no end date.
- Start effort for resource book June 2004 and end June 2005.

Indicators and measures of success

- Creation of additional resources
- Increased awareness of services amongst seniors
- Increased awareness of services amongst providers and referral sources
- Increased ability to accommodate diversity requirements
- Publication and dissemination of the resource book.

Recommendation: Launch a media campaign making "family caregivers" a household word by helping family caregivers self-identify as caregivers.

Rationale

- Statistics show that caregivers have difficulty identifying themselves as caregivers. They are unaware of the services available to them or have difficulty finding them.
- Information and assistance linking to services is the first step in supporting caregivers.

Relevant data

- 92.4% of caregivers said it was essential or critical to have information to navigate the system. (Source: UNCC MPA Provider Survey)
- 46% of older adults in Mecklenburg County were not receiving the help they needed with personal care tasks. Source: UNCC MPA Provider Survey
- Just1Call received 538 Information/Education calls from caregivers in fiscal year 2003. (Source: Just1Call)

Targeted population/beneficiaries

The media campaign would result in common knowledge of access and availability of support and needed services.

Desired outcome

- The public in general would know that family caregivers are the backbone of long term care in America and a valuable resource that should be supported.
- Common knowledge of access, as well as availability of support and needed services, desired.

Potential leaders and conveners for the future

Agencies already involved in Family Caregiving issues, such as:

- Centralina Area Agency on Aging
- Mecklenburg County DSS Family Caregiver Support Program
- Western Piedmont Alzheimer's Association
- Mecklenburg County Council on Aging
- Just1Call
- United Way of Central Carolina
- NC AARP
- Hospice agencies
- Local media including television, radio, colleges, universities and marketing agencies

Additional stakeholders

- All service agencies and businesses that serve the family caregiver population: hospitals, Mecklenburg County Health Department's CAP/DA Program, long term care facilities, drug stores, medical equipment companies, etc.
- Also, family members of primary caregivers, church congregations and national health organizations would benefit from media information.

Resources

- Two similar media projects were completed in South Central Kansas Area Agency on Aging and the Area Agency on Aging of Pasco-Pinellas, Florida. (Source: The National Family Caregiver Support Program Resource Guide AOA 2002)
- The National Family Caregivers (NFCA) and the National Alliance for Caregiving joined together to conduct a nationwide public education program. (Source: Self-Awareness in Family Caregiving, February 2002)

Targeted start and completion dates (mm/yy)

Start: 7/2004
Completion: 6/2006

Indicators and measures of success

- Increase in media coverage of Family Caregiver issues and services
- Increase in written information about Family Caregivers and services available
- Increase in calls for information and assistance
- Increase in use of services

Recommendation: Establish a senior services network for senior information/referral and case management agencies.

The following ideas will be included in the network:

- Generate greater inter-agency awareness of services provided for seniors in Mecklenburg County including family caregivers, by having one county long-term care committee and one countywide media source.
- Improve public awareness of where to find information about senior services by: (a) Adding "for seniors" to Just1Call's name; (b) Publishing a list of senior service agencies in the yellow pages, lead by Just1Call; (c) Posting a notice of the location of this information in a prominent place in the phone book, perhaps on the front page or by using a peel off label on the front page, noting the page number of the section; and (d) Marketing this information aggressively and on an ongoing basis, especially through churches, EAP programs, and television.

Rationale

- Collaboration among the agencies surveyed by the I & R/ Case Management Sub-Committee was limited. There were some gaps in services.
- Even among professionals, knowledge of these resources was not widespread.
- Customers sometimes have multiple agencies providing services, while others have none at all or fall between the cracks of existing services.
- Also, at the In-Home Support Services Issue Group's larger meetings, it was apparent that the agencies represented were unaware of caregiver services provided by several agencies or the new Family Caregiver Support Program in Mecklenburg County.
- I & R resources in Mecklenburg County are adequate but seniors do not know where to look for information. Just1Call's number is hidden in the blue pages. Seniors and caregivers continue to say they do not know where to find information.

Relevant data

- Few agencies surveyed by the Case Management/ I & R Sub-Committee answered positively that they regularly collaborated with other agencies providing I & R or Case Management services.
- Members of the issue group cited instances of duplication of services to one customer.
- There was a lack of information about key providers, even among this issue group of knowledgeable participants.
- Information from the Status of Seniors focus groups and anecdotal information were used to answer this question.

Targeted population/beneficiaries

- All seniors in Mecklenburg County and their caregivers would benefit if the appropriate agency staff, including non-profit, for-profit, faith community, and government agencies in Mecklenburg County were more knowledgeable about caregiver services or the agencies that provide them.

- Middle income seniors, those who are on a waiting list, or those that fall between the cracks of existing services would benefit.
- Also, service providers would be able to broaden their knowledge of potential services.

Desired outcome

- Gaps in services will be identified and addressed on an ongoing basis.
- Service providers will become more knowledgeable about service needs and duplication.
- Increased knowledge of agency staff would benefit family caregivers in their search for information and assistance.
- Caregivers would have fewer problems navigating the system themselves and receive services in a more timely manner.
- Most seniors and caregivers will know that Just1Call is the resource to contact for information about area services for seniors.

Potential leaders and conveners for the future

- Just1Call
- United Way 211
- Mecklenburg County Services for Adults
- Council on Aging
- Since this is more of an inter-agency recommendation, the Status of Seniors Steering Committee could be the leader in this effort. One county planning committee would provide the vehicle for agency staff education.

Additional stakeholders

Every agency involved with the Status of Seniors Initiative is now involved and could continue as a stakeholder along with CMAC, the United Way of Central Carolinas and Just 1 Call as organizations with agency information. All agencies providing I & R could benefit.

Resources

Since this is an inter-agency recommendation for greater awareness, each agency could take the responsibility to provide information and training about their services.

<u>This effort will need:</u>

- Space to meet
- Information about other networks, such as the Homeless Services Network.
- By-laws to include membership criteria and decision-making authority.
- Continued funding for publicity.
- Buy in from the Yellow Book and Yellow Pages

Targeted start and completion dates (mm/yy)

This recommendation could start as soon as:

- The Status of Seniors completes its work and a county planning committee is developed <u>or</u> an existing agency or coalition such as CMAC, DSS, or United Way acts as the lead. The project will be ongoing.

- The Just1Call component piece should be completed before the next publication of the Yellow Pages.

Indicators and measures of success

- A survey could determine pre- and post-agency staff awareness and participation in awareness sessions would be indicators of success.
- Measurement could be by focus groups, polls, or participants in other senior activities, such as congregate lunch programs or senior center activities.
- Another measure would be the existence of a senior section for the Yellow Pages and the numbers of television spots.

RECOMMENDATIONS IN THE MID-TERM: 25-60 MONTHS

Recommendation: Establish and execute ongoing, organized programs to create a more abundant availability of more qualified caregivers in Mecklenburg County, including the provision of caregiver education and support as an important component.

Rationale

- Means to attract and retain caregivers to this profession need to be implemented in order to meet future demands.
- In order to increase the quality of the workforce, compensation and benefits need to be competitive with other employment opportunities.
- To create a higher congruency of care.
- To educate the family members on the issues of caregiving.
- All studies and surveys indicate that caregivers want and need support and education about care giving. Caregivers need opportunities and permission to take care of themselves even in the midst of stressful care giving. Caregiver can benefit from interaction with other caregivers and also share the rewards of caregiving.

Relevant data

3. Staffing shortages were identified in the Embracing the Age Wave Report as either important or very important by 60% of respondents when planning services.
4. One half of caregivers in this survey experience caregiver burden. Partners (71%), parents (60%), and spouses (56%) experience the most burden; children (50%), other relative (41%), and friends (41%) follow. (Source: A Portrait of Informal Caregivers in America 2001 – Roberts Wood Johnson Foundation National Strategic Indicator Surveys)
5. Support services for caregivers including counseling, information and ongoing support, have been shown to deter institutionalization of care recipient with moderate dementia by nearly a year. (Source: Family Caregiver Alliance, Selected Caregiver Statistics)
6. Caregivers have repeatedly asked for more opportunities to be together and to learn. (Based on evaluations from seven caregiver events sponsored the past two years by the FCSP in Mecklenburg County and Hospice at Charlotte.)
7. A recent study at the University of South Florida found that caregivers who participated in skills training reported reduced stress, more positive feelings about their care giving roles, and increased satisfaction with leisure activities.
8. Mecklenburg County Just1Call received 538 Information/Education calls from caregivers

Targeted population/beneficiaries

The senior population who receives services, family members involved with care giving and the caregivers. Family caregivers would be able to remain caregivers longer with more energy and enthusiasm and care recipients would benefit from a happier, less stressed caregiver.

Desired outcome

- Implementation of these programs would increase the workforce size and quality plus allow services to be provided to a larger population of seniors.
- Increase the awareness/involvement of family caregivers in planning for the care of aging parents.
- Create easy access to programs by educating seniors and families to services and program qualifications.
- Family caregivers will have more knowledge, confidence, energy, and enthusiasm about their care giving role and the rewards.

4. Caregivers will realize reduced stress and continue in their role longer.

Potential leaders and conveners for the future

- Family Caregiver Support Program (Mecklenburg County DSS)
- Hospice at Charlotte
- Centralina Area Agency on Aging
- American Red Cross
- Mecklenburg County Council on Aging
- Mecklenburg County Cooperative Extension Service
- Alzheimer's Association
- CPCC Gerontology program
- NC AARP
- Mecklenburg End of Life Coalition
- Other agency that could provide countywide oversight

Additional stakeholders

3. Private and public providers of senior services and caregiver organizations including the faith communities, long-term care facilities, adult day care/day health programs, and Senior Centers
4. Seniors and family members involved in care giving.

Resources

- Additional funding to increase reimbursement rates
- Low cost access for caregivers to educational materials or forums.
- Funding/sponsors of public education forums.
- Resources for training and education; examples: Powerful Tools for Caregivers (AARP), Caring for You, Caring for Me, (Rosalyn Carter Institute), The American Red Cross Caregiver Training, and Hospice Institute of Florida Suncoast curriculum and other local Caregiver support programs.
- Also an In-Home Support and Education demonstration model has been developed by the Council on Aging of Southwester Ohio and the Alzheimer's Association to provide education/support in-home to those caregivers not able or comfortable attending group programs. (Source: AOA FCSP Resource Guide 2002)

Targeted start and completion dates (mm/yy)

Caregiver education piece
Start: 7/2004
Completion: 6/2006

In-home care/ home health piece
Start: 01/2005

Workforce piece and programming
Ongoing, with no end date

Indicators and measures of success

5. Increases in the number and quality of caregivers
6. Increases in availability of continuing education classes for caregivers
7. Increases in participation of family members as caregivers in programs that limit their participation
8. Caregivers will express more satisfaction with their caregiver roles.
9. Caregivers will adopt strategies to care for themselves while caring for others.
10. Care recipients will be able to stay home safer and happier, longer.
11. Caregivers will use supportive services such as adult day care/day health.
12. Increase group respite programs in the faith community

Recommendation: Develop one or two pilot programs to increase collaboration between the faith communities in Mecklenburg County and service providers in delivering services to family caregivers including respite programs. The pilot program(s) should also train and utilize paid part-time and senior volunteer staff to expand Information/Referral and Case Management services.

Rationale

5. Some congregations already have programs or services for family caregivers such as parish nurses, care teams, and volunteers to provide other assistance to families.
6. Also, some congregations have the Stephen Ministry or other senior programs. Working together with community service providers would enhance both programs by expanding services and reducing duplication of services when possible
7. Cost is a factor in expanding any service. Training local "experts" would expand the hours and accessibility of services.

Relevant data

3. No specific data was available for church supported programs for family caregivers. The Stephen Ministry does not provide listing of churches and other programs were identified through sub-committee members such as Adopt-An-Elder through Love INC., and Care Teams organized and supported by CMC.

4. Research done by the I & R/ Case Management Sub-Committee showed that most agencies cited more staff and funding as a need. Services were also only available by phone during normal business hours. Using volunteers and part time staff might increase the hours when a live person was available to assist.

Targeted population/beneficiaries

7. The senior population that is involved with their faith community would benefit from additional programs and supports within their congregation.
8. Seniors and caregivers in general would benefit. An ideal place to start might be senior high-rises, senior nutrition sites and the senior centers.

Desired outcome

4. Collaboration with the faith community would benefit both the congregations and agencies that provide caregiver services by increasing their awareness of services and support each provides. The family caregiver and care recipient would benefit from more comprehensive, unduplicated services. There would be greater opportunity for help and to be a helper.
5. Information about services would be widely available. Case Management would be more affordable.

Potential leaders and conveners for the future

3. All agencies and faith communities that already have "support family caregivers" as a part of their mission statement.
4. All agencies providing Information and Referral and Case Management to seniors.

Additional stakeholders

8. All family caregivers would have a stake in this recommendation in that it would increase services though sources and individuals they already know.
9. Stakeholders also include Charlotte-Mecklenburg Housing Authority, agencies providing senior volunteers, and churches.

Resources

- Training materials and trainers. Local volunteers. Funding for the trainers and materials. Supervision for the volunteers.
- A demonstrated model in NC is Project Compassion's Care Team Initiative that offers a model of matching a caregiver with a support team within their family and/or congregation/workplace. Also, Pierce County Aging and Long Term Care (Washington AAA) Respite and Crisis Care Coalition of Washington developed community partnerships to expand respite services through volunteer efforts.
- (Source: The National Family Caregiver Support Program Resource Guide AOA 2002)
- Love INC and CMC in Mecklenburg County are also providing some faith-based support.

Targeted start and completion dates (mm/yy)

September 2005 to start training paid part time and senior volunteer staff to expand information and case management services. This would be an ongoing project.
Do the steps necessary to start the pilot programs within a two-year period.

Indicators and measures of success

- Increase number of faith communities that have been identified as providing support to family caregivers through respite programs within their congregations.
- Greater awareness within the faith community and provider agencies of programs and services offered.
- More seniors in Mecklenburg County are aware of services available to them. Assistance in accessing those services is widely available at all income levels.

<u>Recommendation</u>: Develop "Information and Referral" materials addressing specific significant issues relating to helping seniors remain at home. Brochures would be simple flat or single fold and contain only one topic, such as "Transportation for Seniors" or "Assistance with Budgeting." Disseminate this information through professional offices, church lobbies and other public places. Add Just1Call's telephone number and e-mail address to the flyers.

Rationale

This is an effort to provide increased accessibility for information to seniors. Seniors might pick up information, which would be service specific and target their needs. The addition of the Just1Call numbers would provide a link to additional resources and information.

Relevant data

See the summary of relevant data included in prior recommendations.

Targeted population/beneficiaries

All seniors and caregivers in Mecklenburg County.

Desired outcome

Seniors and their caregivers will have access to resources needed for them to remain at home, including information about how to access needed services.

Potential leaders and conveners for the future

- Council on Aging
- Just1Call
- Area Agency on Aging

Additional stakeholders

- Seniors
- Providers of the services

Resources

- Cost of the materials as well as the cost of staff to devise the materials
- Cost of disseminating the materials

Targeted start and completion dates (mm/yy)

Start: June 2005
Completion: June 2006

Indicators and measures of success

Evidence of brochures being placed in professional offices, church lobbies and other public places.

RECOMMENDATIONS IN THE LONGER TERM: 60+ MONTHS

Recommendation: Lobby the Federal and Local Government for changes to current laws that restrict the more prudent allocation of resource, expand services, update eligibility criteria to reflect today's markets in order to provide additional services for the same costs in the area of in home aide/ home health care. Also, develop a stronger advocacy voice for increase in funding services, specifically adult day care/day health, that could provide respite that family caregivers request.

Rationale

- Studies have shown that the cost of services provided to seniors is less expensive than the same services provided at a facility.
- In order to reduce the budget burden funds should be allocated to providing In-Home Services where more services could be provided to more seniors for the same cost or less.
- Also, eligibility rules are outdated and too restrictive in order to provide services to seniors and allow them to live at a comfortable standard of living.
- Many family caregivers request respite services but cannot afford the cost. For instance, adult day care/day health would be the most efficient respite care, but with limited funding, facilities are losing money on current reimbursement rates.

Relevant data

Data For Home Health/ In Home Aide Agencies/CAP/DA

- According to the Congressional Budget Office the number of people available to provide caregiving declines as the number of frail elderly increases dramatically.
- Wall Street Research estimates that "on average," home health care services are roughly 30-60% less expensive than similar services provided in an institutional setting.
- In 2002, 20% of older adults in Mecklenburg County who needed caregiving help were not receiving the help they needed with tasks that were difficult for them.
- Medicaid average monthly cost per person served for the first five months of SFY 2003-2004 for home care services were as follows.

Home Health Skilled Services	$586
In Home Personal Care Services	$715
Community Alternative Program Disabled	$1,876

- Compared to the average monthly cost per person served for Institutional services for the Medicaid Program and State and County Special assistance for the same period were as follows:

Hospital Inpatients	$4,131
Skilled Nursing Home Care	$3,151
Intermediate Nursing Home Care	$2,543
Adult Care Home Care	$1,545

- In SFY 2002-2003 the Medicaid Budget increased by 7% over the last year. Home Care Services only increased by 2.9% for the same period. If Home Care services represented a larger percentage of the budget, then overall costs would not rise as fast.

- Findings cited in the N.C. Institute of Medicine report to the General Assembly:

  Institutional services account for the largest share of publicly funded expenditures.

  Institutional care is usually more expensive than home and community-based care, which explains part of the reason why the state spends so much of its resources on institutional care.

  Another reason for this institutional spending is that Medicaid and other program rules make it easier for people to qualify for financial assistance with institutional or residential care than for services provided at home or in the community.

- Caseload 2002: 405 (this is the year in which CAP/DA instituted a restricted intake). Mecklenburg County CAP/DA Data:

  SNF Cases = 45

  - Nursing home costs = 45 X $19,525 per client annually = $878,625
  - CAP/DA costs = 45 X $17,225 per client annually = $775,125
  - A CAP/DA total caseload cost savings of $103,500 or $2,300 per client

  ICF Cases = 360

  - Nursing home costs = 360 X $20,459 per client annually = $7,365,240
  - CAP/DA costs = 360 X $16,000 per client annually = $5,760,000
  - A CAP/DA total caseload cost savings of $1,605,240 or $4,459 per client

Data for Adult Day Care/ Day Health Facilities

- In 2001-02, 61% of Adult Day Care/Day Health facilities ran in a deficit compared to 44% nationally. (Source: 2001-02 Partners in Caregiving Study)

- 54% occupancy rate; 296 individuals currently enrolled in county Adult Day Care/Day Health facilities. (Source: Mecklenburg County DSS Fact Sheet)

- 46% vacancy rate in Adult Day Care/Health due to limited funding, affecting approximately 275 families, with $2.4 million additional funds needed. (Source: Mecklenburg County DSS Fact Sheet)

- Reimbursement rate for adult day care is $23 per day; the actual cost ranges from $31 to $44. (Reimbursement rate as provided by the NC Health and Human Services under the Home and Community Block Grant funding.)

- Reimbursement rate for one way is $1.50; the actual cost $30 one way. (Reimbursement rate as provided by the NC Health and Human Services under the Home and Community Block Grant funding.)

- Staff ratio 1 to 6 compared to nursing home, assisted living etc., 1 to 10

Targeted population/beneficiaries

- All of the senior population including care recipients and family caregivers
- Taxpayers, who will provide support to an increasing senior population at a lower cost per client
- For the Respite component: Care providers would benefit from greater reimbursement and serve more clients. Working caregivers would be able to continue working full or part time.

Desired outcome

- Allow deserving seniors access to services without causing financial hardships or the need to choose between receiving assistance or paying for necessary living expenses.
- Provide the greatest amount of quality service at the least cost.
- For respite component, fuller capacity and greater use of respite care facilities by family caregivers allowing them to keep the care recipient at home longer and if necessary and desired, continue with their employment. Less stress for family caregivers and less isolation for both caregiver and care recipient

Potential leaders and conveners for the future

Representatives from all agencies, special interest groups and our county government with interest in increasing funding through legislative change, Senior Tar Heel representatives with the Area Agency on Aging, NC AARP, and family caregivers themselves.

Additional stakeholders

- Taxpayers
- Political representatives
- Insurance companies
- Family members
- Employers
- Political action groups for seniors

Resources

- State legislators for home health/ in home care advocacy
- For respite care advocacy: Family Caregiving and Public Policy Principles for Change were developed by a collaborative group of family caregiver advocates in 2003. (See article in Appendix)
- Home & Hospice Care of North Carolina presentation to the House Select Committee on the Rising Costs of Health Care on January 14, 2003.
- Oklahoma Aging Advocacy Leadership Academy – trains volunteers of all ages including caregiver volunteers on aging issues with grants from Southwestern Bell Telephone, Oklahoma Gas and Electric, and other corporate sponsors.

Targeted start and completion dates (mm/yy)

Start date 9/1/04 on-going effort for home health/ in home care advocacy; add advocacy for respite care 1/2006 through 12/2007

Indicators and measures of success

- Additional/expanded services provided in-home
- Increase in reimbursement rates
- Updated qualification criteria based on a holistic review of the senior's status
- Additional service hours
- Increase in reimbursement rates to Adult Day Care/Day Health and other respite services initiatives.

<u>Recommendation:</u> Develop a grant-writing center to secure funding to increase service and support to family caregivers.

Rationale

There is a shortage of funds to pay for needed respite care and the development of new, innovative programs. We can no longer rely on government funding to provide all needed services.

Relevant data

No additional data was fund to influence this recommendation other than the data already sited for increases in the need for respite care and specifically adult day care/day health services.

Targeted population/beneficiaries

Family Caregivers and the care recipient would be the targeted audience as well as the beneficiaries. Also the funding burden on present sources would decrease.

Desired outcome

The establishment a grant writing center in collaboration with interested agencies and family caregivers that would benefit from additional funding.

Potential leaders and conveners for the future

Respite agencies, faith communities, family caregivers, and representatives from local, state and national foundations.

Additional stakeholders

Foundations that support human services initiatives, insurance companies, and government foundations and grant funders.

Resources

The Administration on Aging has several grant opportunities for family caregiver initiatives.

Targeted start and completion dates (mm/yy)

Start: 7/2006
Completion: 6/2008

Indicators and measures of success

A successful grant writing center that continually brings in additional revenue for family caregiver support and care.

Recommendation: Develop case management services for middle income families who can afford some payment but who cannot afford the cost of $80 hr. or more.

Rationale

Research of the existing programs indicated a gap in services for this population. Group members were aware of many situations in which multiple services overlapped or where fragmented, incomplete services were being offered. Seniors who are aware of services may not always have the ability to follow through with accessing and coordinating these resources.

Relevant data

Interviews with providers found that services were available to those with long term care insurance or high incomes or targeted low-income families.

Targeted population/beneficiaries

Middle income families and caregivers who need assistance developing a network of services to allow them to remain in their own homes.

Desired outcome

Seniors and caregivers will have easily accessible and affordable assistance with finding and accessing services in the community.

Potential leaders and conveners for the future

- DSS Services for Adults
- Alzheimer's Association
- Senior Centers
- Centralina Council of Governments
- Council on Aging
- CMAC

Additional stakeholders

- Hospitals
- Medical providers
- Home health providers
- Legal services for older adults

Resources

- Information about programs in other states and counties
- Funding
- A lead agency

Targeted start and completion dates (mm/yy)

Start: June 2005
Completion: June 2007

Indicators and measures of success

Case Management services would be available at all income levels. Their existence would be widely known by seniors and the agencies serving them.

CONCLUDING COMMENTS

Aide Services & Home Health Services

The current structure of Government programs with an institutional bias must be changed. In order to meet the expected growing demand a more prudent allocation of resources must be utilized. In-home aides can provide a variety of ADLs & IADL's to seniors at a lower cost than facilities plus allow them to maintain their independence.

Future education of seniors, family caregivers and other caregivers will be paramount to creating a community that is able to support Mecklenburg County's aging population. There is also a need to raise the awareness of senior care issues with both the adult children and older parents who fail to plan for their continued well being, independent living needs and end of life stages.

Providers of senior services, professionals and clergy with a high senior involvement and Mecklenburg County must develop a method of communicating service information to allow easier access and delivery of services to our seniors and their caregivers.

Caregiver Respite Care & Support/Training

In examining the existence, adequacy and accessibility of Respite Care and Caregiver Training/Support in Mecklenburg County, this sub-group found that there is a need for greater communication among the agencies and groups who are involved in these areas. We also found there is a need to increase the availability of education/training for caregivers, including those in rural settings and specific ethnic groups. Also, respite care is critical to maintaining the essential caregiver population.

North Carolina ranks above the national average in percentage of adults providing care to someone 60 plus and will be seeing a dramatic increase in the aging population as the "Baby Boomer" generation ages. So, we anticipate an even greater need for caregivers and their education/training and support in the future.

Our recommendations address these indicated needs through media campaigns to increase public awareness, through enhancement of inter-agency communications to eliminate gaps and duplications of services and finally, to create a grant –writing center to secure additional funding that is needed to provide adequate respite and caregiver support at this time and meet future needs.

Information and Referral & Case Management

In general, Mecklenburg County has excellent resources for Information and Referrals for Seniors. These services are high quality and user friendly in many ways. Unfortunately, many Seniors and their caregivers are not aware that they exist. There is an ongoing need for publicity to improve name recognition for Just 1 Call. Just 1 Call's telephone number should be in the Yellow Pages in a section specifically for Senior Services. It needs to be widely publicized through a variety of venues already accessed by Seniors and their caregivers, such as through churches, social clubs, EAP programs, and television.

In addition, Information and Referral information for special populations is lacking. Large print and Braille publications were lacking. There were barriers to services to the hard of hearing. Except for Spanish, resources to non-English speaking consumers were not available.

Case management for middle income clients was lacking. Services were available and probably adequate for those with money or long term care insurance. Other agencies which provided case management as a primary service target low income families. Although DSS Services for Adults provides case management without regard to income, the availability of this resource is not widely known, even among professionals. Many consumers may believe that services offered through DSS are only for low-income clients and not be willing to apply.

In addition, there was a lack of collaboration among case management providers. Those providing services for a fee viewed other providers as the competition and did not view collaboration as a need. Collaboration, however, would improve professionals' knowledge of area resources and improve the coordinated community planning needed to identify and provide for gaps in services.

NOTABLE QUOTES

From the Caregiver Respite Care & Support/Training Sub-Committee

There is no support for the family caregiver. It is costly and very tiring. People should be able to (more easily) claim (dependents) parents on their tax returns.

Comments from Mecklenburg 2003 focus group participant age 50-59

Caregivers are a population at-risk. Many caregivers are depressed, and they feel isolated and burdened. Their physical and mental health is worse than the general adult population, and their health status shows classic symptoms of stress. If they burnout, both their loved one and society suffers.

Source*: A Portrait of Informal Caregivers in America 2001* –
Roberts Wood Johnson Foundation National Strategic Indicator Surveys

Compared with other forms of elderly care, day care is economical. A week of day care might run $250. Often, that 's hundreds of dollars less than home care, assisted living centers or nursing homes. "It (Adult Day Care) seems to be the best-kept secret in the community that these places are available.

Anne Tschudy
Charlotte resident using Adult Day Care

American's health care system is heavily dependent on the direct care family caregivers provide, especially to the aged and people with chronic diseases and disabilities. According to a study published in Health Affairs, caregivers' contribute to the nation's health care system has enormous economic value, estimated at $196 billion annually, compared to $32 billion for paid home care and $83 billion spent on nursing home care. Their services significantly reduce costs to Medicare, Medicaid, and private payers. Without this immense unpaid work force, our fragile health care financing system would be even more strained.

Source: National Family Caregiver Association &
National Alliance for Caregiving: *Self Awareness in Family Caregiving.*

Status of Seniors Initiative
Community-Based Issue Group Report
LEISURE, EDUCATION, RECREATION AND SOCIALIZATION (LERS)

BACKGROUND

Introduction

Studies show that people who are involved and connected with a community stay healthier both physically and cognitively. Educational, recreational, health, leisure and socialization programs encourage psychological and physical well being and can contribute significantly to the longevity and quality of life of older adults by preventing depression and isolation.

A proactive approach in the LERS area can have a significant economic impact in the long run:

1) Helping older adults remain independent yet connected to the community, and minimizing the potential for more costly intervention.
2) Enticing more 55+ visitors to the county
3) Enticing more people to retire here

Definition of the Issue

As a "senior-friendly community", older adults should have access to programs that allow them to enrich and prolong their quality of life with dignity and grace. Programs directed to them should accommodate the active as well as the more frail seniors, and should be in safe, accessible places.

Group Processes

I. 37 persons attended the initial workshop on November 10.
II. A smaller committee met monthly November through January, and almost weekly from February on, with lively discussions.
III. Studied the comments and recommendations from November 10, and revised or combined them as appropriate.
IV. Recognized that many of the comments and recommendations centered on lack of awareness of existing programs.
V. Recognized that this is a very broad issue with many services or programs.
VI. Collected data from the more established services aimed at the 55+ population
VII. Evaluated current delivery of services using the six dimensions of a server-friendly community.

Research Methods

There was no useful existing data for this service as provided locally. The issue group decided that it would initially seek information from those programs that are full-time and/or have at least one paid staff person, and have a budget exclusively allotted to senior programming.

To provide some consistency and allow for better analysis, group members revised its matrix, categorizing the service areas as follows:

- Health: Blood pressure screenings, educational lectures, fairs, mammograms, cholesterol screenings, blood sugar level screenings, etc.
- Wellness/physical: Yoga, tai chi, dance/line dance classes, water aerobics, chair exercises, etc.
- Trips: Local, day or overnight
- Education: Classes, lectures, counseling, language seminars, citizenship classes, etc.
- Recreation: Arts and crafts, games, card games, Senior Games, etc.
- Social: Dances, holiday/seasonal events, meals, teas, ice cream socials, etc.
- Intergenerational: Mentoring, grand parenting programs, etc.
- Other: Responders requested to explain sufficiently (See Appendix F-1)

Responses to the matrix confirmed that there are many variations of the services offered in these categories, and that statistics are not uniformly maintained. We concluded there was no way to either compare or compile this information at this time.

The issue group evaluated the existing services using the six dimensions of the Senior-Friendly Communities (refer to Appendix F-2). An intern under the direction of the Council on Aging conducted background research and "best practices" (refer to Appendix G).

COMPELLING DATA

The issue group found the following data related to the leisure, education, recreation and socialization of seniors in Mecklenburg County.

- There is no baseline data established locally; we will be doing this in the next phase.
- This is a prevention issue (refer to Appendix G).
- This is an issue of concern for persons seeking a good place to retire (refer to Appendix G). Community “best practices” #3C – AARP 10 criterion include three directly related LERS and other criteria relate peripherally.

- There are compelling examples from every program providing services, below are a few:

  JCC - Alice is in her 80's and suffers from Parkinson's. She took a course offered by Oasis Senior Enrichment Program at the Jewish Community Center (JCC). Other Oasis participants encouraged her to begin attending regularly. As a regular participant, Alice now says, "Oasis is everything to me. I would be completely lost without it. Oasis offers me some intellectual stimulation. Without Oasis I would sit at home and vegetate.

  We have a senior that comes into the Tyvola Road Senior Center daily to participate in the hot lunch program and wanted to get in shape. She was going to be visiting her daughter in Texas and wanted to be able to walk with her when she went down there. Over the past year she has lost 70 lbs. by watching her diet and exercising. She exercises in our health on a regular basis and has been able to improve her overall fitness level.

OBJECTIVES

1. To increase awareness of existing LERS programs and services for adults 55+ - for consumers as well as for partner providers.
2. To enhance partner providers' opportunities to collaborate.
3. To enhance partner providers' ability to refer consumers to other LERS services.
4. To increase awareness of LERS services to other providers of 55+ services, enabling them to more easily make appropriate referrals or suggestions.
5. To identify gaps in present LERS service/programs.
6. To identify segments of the county where consumer may be underserved.
7. To identify needs/wants/demands of the "boomers" as they age.
8. To educate the community at large of available LERS services.

ISSUE GROUP RECOMMENDATIONS

The following section includes the recommendations formulated by this Community-Based Issue Group. The recommendations are presented by specific timeframes for implementation, and each includes a supporting case and elements for implementation (e.g. rationale, start/completion dates, resources, indicators and measures of success). Refer to the information below and the box on the following page for an outline of the group's considerations in developing its recommendations.

Timeframes and deferred issues

- Recommendations in the short term: 0 to 24 months are as those that require limited or no new resources. And can be implemented relatively easily and make an impact in the short term.

- Recommendations in the mid-term: 25 to 60 months are changes or new programs that are necessary but will require more time to develop of a plan and secure resources.

- Recommendations in the long term: 60+ months include things that require significant planning and resource development and probably require a great deal of collaboration between organizations.

- Deferred issues deserving attention are crucial issues that surfaced during the issue group's work but have not been addressed by their recommendations.

Elements of Community-Based Issue Group Recommendations

Rationale: Brief explanations about why the issue group is recommending this action.

Relevant data: Summaries of the research findings that influenced the recommendation. This might include instances where no data on the issue was found.

Targeted population/beneficiaries: Identification and descriptions of the senior population who will most benefit from the outcome of this recommended action (i.e., who do you intend to help or support). Descriptions include demographic profiles, geographic area, health status, age range, etc.

Desired outcome: Statements about the changes that the issue group anticipates as a result of this recommended action. Changes might be observed in a variety of ways including knowledge/awareness, behavior, opportunity, mobility, wellbeing, etc.

Potential leaders and conveners for the future: Identification of the organization(s) or individual(s) that the group foresees as a champion(s) for the recommendation, as well as those can be key stakeholders in launching and driving the recommended action.

Additional stakeholders: Lists of the organizations, populations or individuals that have a stake in the implementation and/or outcomes of this recommended action. While these stakeholders may not serve as leaders or conveners, their input and buy-in on the action should be sought.

Resources: Lists of the resources (beyond leaders, conveners and stakeholders) that are needed to support this recommended action. Resources might include specific expertise, demonstrated models, technology, funding, etc.

Targeted start and completion dates (mm/yy): Projected timing of the recommended action. That is, the group's estimation of an optimal timeframe to launch, execute and complete the action.

Indicators and measures of success: Identification of the changes and gains (among individuals and organizations and in the community) that might indicate progress in addressing the present problem.

RECOMMENDATIONS IN THE SHORT TERM: 0-24 MONTHS

<u>Recommendation</u>: Increase awareness of existing leisure, education, recreation, and socialization programs and services for older adults:

I. Develop and distribute to partners a systematic, cross-referenced, user-friendly, multi-media LERS Community Resource Directory.

- Get all the right people to participate
- Systematically research existing services and facility utilization.
- Seek partnerships with existing resource/information providers such as Just-1-Call, Council on Aging, Senior Resources, Inc., United Way, Charlotte-Mecklenburg Senior Centers, Inc., The Shepherd Center, The Jewish Community Center, and others.
- Develop format for multi-media directory and determine update needs.
- Develop countywide matrix and mapping of services and include information on facilities (what is available, what is now utilized).

II. Conduct a countywide, demographic appropriate older adult consumer survey on the needs/wants and current participation in this service area.

- Get all the right people to the table
- Find coordinating agency and partners
- Develop and implement the survey

Rationale

There are a number of providers in this issue area, but it is difficult and costly to market the services to potential consumers. Further, not enough consumers are aware of the services/providers and have no easy way to locate them on their own. This was the number one issue at the November 10 meeting; even persons in other senior-service areas were not aware of all the existing programs.

Relevant data

There is no organized data on this issue; however, we identified the following:

- Existing providers, which include C-M Senior Centers (Shamrock and Tyvola), The Jewish Community Center (Oasis and Leisure Learning), Shepherd Centers (of Charlotte, East and South), Senior Games, Salvation Army, Davidson Senior Services, AARP, and many weekly or monthly programs or clubs.
- Others offering programs appealing to some older adults are Mecklenburg County Park and Recreation, YWCA, YMCA's, CPCC, UNCC, Queens College, private fitness clubs, and public arts and museums.
- Some older adult programs, such as SCNP sites, use socialization programs to attract or maintain relationships.

Targeted population/beneficiaries

Adults 55+ who reside in or visit Mecklenburg County.

Desired outcome

- Resident or visiting adults 55+ will be able to more easily locate programs specific to their interests or needs.
- Partner providers will have a comprehensive way to refer consumers to other providers.
- Partner providers will have a resource for collaborative efforts.

Potential leaders and conveners for the future

- Current active committee members
- Consumer representatives - current, potential, caregivers
- Staff/leaders from the the Jewish Community Center (JCC), Senior Centers, Parks & Rec, the Salvation Army, the three Shepherd Centers, the Davidson Services Center, Mecklenburg Count Health Department, corporate and other retiree associations and some of the larger churches with senior clubs or regular activities.

Additional stakeholders

- YMCA's, YWCA's, fitness clubs, recreational clubs
- CPCC, Queens, UNCC, Arts & Science Council/individual arts organizations.
- United Way, Mecklenburg County, City of Charlotte, Chamber of Commerce, Charlotte Convention & Visitors Bureau, Charlotte Sports Commission
- Professional sports (help market to groups): Panthers, Bobcats, Cobras, Sting, Knights.
- Carolinas Healthcare System, Presbyterian Hospital
- Special events
- Businesses
- Retirement/Assisted Living communities
- Disabled adult service provides whom serve/will be serving 55+ population

Resources

- Just-1-Call
- Council on Aging
- Senior Resources, Inc.
- UNC Charlotte (interns)
- Queens University, The Art Institute, Johnson & Wales
- Technology support to be determined

Targeted start and completion dates (mm/yy)

Start: June 2004

Completion: June 2006

Indicators and measures of success

I. Partner providers will:
   - Report increased participation

- Increase cooperation through relationships established during the process
- Consult the completed matrix and mapping, allowing for facilities to be better utilized
- Receive a completed directory and test it for accuracy and viability

II. Consumers:
- Survey completed
- Survey analyzed for gaps, needs, trends, etc
- A group of seniors will review the directory for accuracy and usefulness

RECOMMENDATIONS IN THE MID-TERM: 25-60 MONTHS

<u>Recommendation:</u> Continue to increase awareness of existing leisure, education, recreation, and socialization programs and services for older adults:

I. Conduct community-wide education on LERS services through expanded distribution of LERS multi-media directory.

II. Identify, establish and prioritize timelines for solutions to service deficiencies and duplications using and/or expanding the relationships established in the first phase.

Rationale

- Increased access to and utilization of LERS services will have a positive economic and social impact.
- Continued cooperation and collaboration amongst service providers, will lead to better utilization of the limited funds available to LERS providers.

Relevant data

9. Information gathered in the first phase
10. Additional data collection as may be identified in the first phase

Targeted population/beneficiaries

Adults 55+ who reside in or visit Mecklenburg County.

Desired outcome

- Resident or visiting adults 55+ will be able to more easily locate programs specific to their interests or needs.
- Other 55+ service providers will have a comprehensive way to refer consumers to appropriate LERS services.
- Providers will begin to fill the gaps or needs/wants in services
- Providers will begin to collaborate or condense programs or services that are duplicative or excessive
- Aging “boomers” will begin to utilize LERS services and/or to begin reshaping services to fulfill their needs/wants

Potential leaders and conveners for the future

Same as in first phase; gradual enlargement/replacement of group members as necessary

Additional stakeholders

To be identified through first phase process.

Resources

Per first phase with additions made as identified and needed.

Targeted start and completion dates (mm/yy)

07/01/06 through 06/30/09

Indicators and measures of success

55+ service providers:

- Report increased referrals to LERS programs/service providers

Partner providers will:

- Report the efficiencies they have obtained and/or excesses they have eliminated or combined
- Report increased participation or interest by "boomers"

Consumers will:

- Demonstrate awareness of more LERS services through participation as reported by providers and/or re-surveyed (to be determined during the process)

RECOMMENDATIONS IN THE LONGER TERM: 60+ MONTHS

Recommendation:

I. **Work on solutions identified and prioritized during Phase II.**

II. **Evaluate multi-media directory distribution and effectiveness.**

Rationale

As a preventative issue, constant attention to access utilization and changing needs/wants is imperative.

Relevant data

Information gathered in Phases I and II

Targeted population/beneficiaries

Adults 55+ who reside in or visit Mecklenburg County and/or any needed adjustments identified in previous phases

Desired outcome

- Resident or visiting adults 55+ will be able to easily locate programs specific to their interests or needs.
- Providers will report increased cooperation/collaboration
- "Boomers" will be more involved and comfortable with LERS services

Potential leaders and conveners for the future

To be identified, and "groomed" as necessary, as we become more knowledgeable through information gleaned in prior phases.

Additional stakeholders

As identified through the prior phases.

Resources

As identified through phase I and II.

Targeted start and completion dates (mm/yy)
07/01/09 through forever!

Indicators and measures of success
To be identified as we progress through Phase II.

DEFERRED ISSUES THAT DESERVE ATTENTION

ISSUE: Flexible staffing for more evening and weekend activities

Rationale**:** Adults still working want access, per 11/10/03 participants. Many current providers are limited by staff, space, funding.

ISSUE: Training for providers' staff on "best practices" for delivering services

Rationale**:** Specific training in how to appropriately interact with this population is as essential as the services being provided.

ISSUE: Training for caregivers

Rationale: Caregivers must be educated as to what specific LERS services are available for their clients and how to get their clients involved.

ISSUE: Hosting the North Carolina State Senior Games and the National Senior Games will gain mass media coverage.

Rationale: Would enhance County as a "senior-friendly" community. As reported in the Charlotte Observer, "the visitor most likely to avoid Charlotte is older that 55,with household income above $50,000 and no kids. The group spends money. But it accounts for just 10% of Charlotte {area} visitors, below the national average of 12%." (Refer to Appendix E1)

CONCLUDING COMMENTS

From the November 10th workshop forward, it was clear that lack of awareness of current LERS providers' offerings was the main issue. It was also evident that there was no data or comprehensive listings of services for the consumer or providers to access.

We modified the matrix (survey) to use for data collection from current providers. As responses came in, we saw that the "survey" was inadequate for the real analysis of current offerings. The matrix/survey, however, was invaluable in demonstrating the diversity of this issue's services, and the need for thorough and systematic data collection to use as a baseline for all analysis going forward.

Status of Seniors Initiative
Community-Based Issue Group Report
TRANSPORTATION

BACKGROUND

Introduction

Based on experience, expertise and research, the Transportation Issue Group developed a definition for its issue (refer below). The group also discussed and reached consensus on beliefs and desires for a senior-friendly transportation system.

Definition of the Issue

Transportation provides access from one location to another safely and efficiently with its goal being to enhance quality of life through maintaining independence.

Group Processes

The issue group spent its first five meetings of 10 gathering data and researching existing services. At almost every meeting, we asked for recommendations on who else might we need to involve. Service providers such as DSS, Red Cross, CATS as well social workers and agency staff were asked questions until we felt we had an understanding of current services. We asked to see surveys and demographics as well as information on successes and complaints.

The Department of Health and Human Services Transportation Evaluation Tool and the Just One Call database helped us define our focus to mass, general, medical and special transportation.

Research Methods

Our group spent at least half of our time together understanding what is currently available and where the limitations of current systems exist. We created a spreadsheet of all transportation providers within our four categories with regard to roles and areas served. We reviewed census data on senior demographics, CATS market research survey results, senior population by zip code. We reviewed state and national reports, local quality of life surveys, the Council on Aging Transportation Survey and reviewed four reports from the FTA's Transportation and Research Board's International Conference. Please see Bibliography for more detail. We discussed our findings and prioritized our needs and wants.

COMPELLING DATA

The growth percentage of seniors was very compelling. The FTA reports opened the way for rich discussion. We were stunned to learn that the General Purpose Transportation program had no limitation criteria and allowed for some exploitation. The lack of service to areas deemed "unserved" was a concern.

Seniors are being penalized by the medical profession when they late. Please see story under "Notable Quotes" regarding the stress caused by capacity constraints.

Most compelling was the inefficiency of scheduling the most appropriate mode of transportation in that there is no unified coordination of trips.

OBJECTIVES

1. To support the efforts of all local city/county/community leaders to develop senior friendly transit.
2. To encourage information sharing to increase efficiency among transportation providers.
3. To increase level of technology to streamline and coordinate already existing services.
4. To educate medical professionals, social workers, senior riders, volunteers, and others to increase understanding of transportation systems.
5. To develop and maintain a more "walkable" community through better land use and planning.

ISSUE GROUP RECOMMENDATIONS

The following section includes the recommendations formulated by this Community-Based Issue Group. The recommendations are presented by specific timeframes for implementation, and each includes a supporting case and elements for implementation (e.g. rationale, start/completion dates, resources, indicators and measures of success). Refer to the information below and the box on the following page for an outline of the group's considerations in developing its recommendations.

Timeframes and deferred issues

- Recommendations in the short term: 0 to 24 months are as those that require limited or no new resources. And can be implemented relatively easily and make an impact in the short term.

- Recommendations in the mid-term: 25 to 60 months are changes or new programs that are necessary but will require more time to develop of a plan and secure resources.

- Recommendations in the long term: 60+ months include things that require significant planning and resource development and probably require a great deal of collaboration between organizations.

- Deferred issues deserving attention are crucial issues that surfaced during the issue group's work but have not been addressed by their recommendations.

Elements of Community-Based Issue Group Recommendations

Rationale: Brief explanations about why the issue group is recommending this action.

Relevant data: Summaries of the research findings that influenced the recommendation. This might include instances where no data on the issue was found.

Targeted population/beneficiaries: Identification and descriptions of the senior population who will most benefit from the outcome of this recommended action (i.e., who do you intend to help or support). Descriptions include demographic profiles, geographic area, health status, age range, etc.

Desired outcome: Statements about the changes that the issue group anticipates as a result of this recommended action. Changes might be observed in a variety of ways including knowledge/awareness, behavior, opportunity, mobility, wellbeing, etc.

Potential leaders and conveners for the future: Identification of the organization(s) or individual(s) that the group foresees as a champion(s) for the recommendation, as well as those can be key stakeholders in launching and driving the recommended action.

Additional stakeholders: Lists of the organizations, populations or individuals that have a stake in the implementation and/or outcomes of this recommended action. While these stakeholders may not serve as leaders or conveners, their input and buy-in on the action should be sought.

Resources: Lists of the resources (beyond leaders, conveners and stakeholders) that are needed to support this recommended action. Resources might include specific expertise, demonstrated models, technology, funding, etc.

Targeted start and completion dates (mm/yy): Projected timing of the recommended action. That is, the group's estimation of an optimal timeframe to launch, execute and complete the action.

Indicators and measures of success: Identification of the changes and gains (among individuals and organizations and in the community) that might indicate progress in addressing the present problem.

RECOMMENDATIONS IN THE SHORT TERM: 0-24 MONTHS

<u>Recommendation:</u> Establish a Transportation Education and Advocacy Task Force for Seniors in Mecklenburg County.

This is a multi-step recommendation. To ensure success, the Task Force should be implemented in stages and designed to be ongoing. In this section, we have recommended steps to establish this Task Force. In the mid- and long-range recommendation sections of this report, we have recommended specific issues the Task Force should address.

The creation and successful development of the task force will span the duration of the 0-24 month period. Steps for development are outlined below:

<u>Steps to Develop Task Force:</u>

- Determine an individual or group to oversee the activities of the Task Force. The designated entity will assume responsibility to appoint members to serve on the Task Force and begin making appointments.
- Assign staff from various transportation provider agencies to provide technical support, as necessary.
- Establish regular meeting schedule.
- Identify the existing groups or committees the Task Force should model, survey, or consult while getting established, such as: the Citizens Transit Advisory Group (CTAG), the Transit Services Advisory Committee (TSAC), the Charlotte Mecklenburg Advocacy Council for People with Disabilities Transportation Committee (ACPD Transportation), the Mecklenburg County Council on Aging, etc.
- Set preliminary goals and objectives for the Task Force. These should be developed in response to the needs identified by the Mecklenburg Status of Senior Transportation Issue Group, as well as needs identified by other groups.

Rationale

Transportation is a multi-faceted service facing complex issues, which are often not readily solved in a short time frame. Area seniors have specific transportation needs and issues that are constantly changing and ongoing. Some seniors who utilize transportation services may be reluctant to speak up about problems they encounter or make suggestions to improve service. Others simply may not know how to self-advocate to resolve an issue. Therefore, rather than make a single recommendation to resolve a single transportation issue, we recommend the development of this Transportation Education and Advocacy Task Force to improve transportation service delivery for seniors through ongoing education and advocacy.

Advocacy is necessary to 1) provide a voice for seniors and service providers to share transportation-related experiences and concerns, 2) recognize patterns of problems and identify possible solutions, and 3) share relevant findings and suggested improvements with local decision-makers. Education is equally essential: a general lack of knowledge exists regarding transportation needs specific to seniors, including as the eligibility requirements, usage patterns, and existence of area transportation services. The Task Force should direct efforts to educate specific target groups to increase their knowledge and understanding of transportation services available to seniors. The following groups should be targeted: senior adults and their families, medical professionals, pharmacies, social workers, human service agencies, and the business and retail industries.

Relevant data

This recommendation was realized by researching the existing area transportation services available for seniors, and by identifying barriers and unmet needs. As the committee conducted research, we began to understand the complexity of the existing transportation agencies, funding sources, services, and eligibility requirements that impact the provision of transportation services to senior adults in Mecklenburg County. As a result, because transportation is so dynamic and complicated, we determined that the establishment of an ongoing Transportation Education and Advocacy Task Force would produce more effective and lasting results than a recommendation that addresses only a single issue.

Targeted population/beneficiaries

Although this recommendation has the potential to benefit all Mecklenburg County seniors, the Task Force will advocate for senior adults whose transportation services are not adequate to meet their needs or are not being met at all. Primary beneficiaries will be, therefore, senior adults who have the greatest mobility needs. Through advocacy and education efforts, secondary beneficiaries will include: senior adults and their families, medical professionals, pharmacies, social workers, human service agencies, volunteer-based organizations, employers of seniors and their families, and business and retail industries. The potential benefit to seniors, the general public, and the community is unlimited.

For example:

- By recommending an expansion in a fixed route, the Task Force may be able to assist an older adult to receive needed transportation services in order that he may gain mobility and remain living in his home, and ultimately avoid facility placement.
- A young woman may no longer be forced to take time-off from her job to transport her father to his physical therapy sessions twice a week once the Task Force helps identify volunteers to provide transportation for a human service agency.
- An isolated senior will develop a renewed sense of purpose through volunteering as a “transportation buddy” to help other seniors learn to navigate the public transit system. He may also be able to use the transit system more often than he can currently afford, as the Task Force could help develop a volunteer incentive, which includes free fares for volunteers.
- Through educating the retail industry about seniors’ needs, a shopping center may decide to create a safe and accessible area for transportation vehicles to

enter their parking lot and drop-off seniors, thereby increasing business and revenue for the shopping center.

Desired outcome

The primary outcome of this phase of this recommendation is the development of an active, effective, and ongoing Transportation Education and Advocacy Task Force for Seniors. By the end of the 24-month period, the task force should be well established in terms of membership, agency involvement, governing bodies, educational goals, and plans for advocacy.

Potential leaders and conveners for the future

- Consumers and family members
- Medical professionals
- Advocacy agencies
- Human service agencies
- Transportation services staff
- Aging Service agencies
- Social Workers
- Information and Referral Specialists
- Influential community leaders
- Other interested individuals

Resources

- Support from local officials, County Commissioners and/or County Manager.
- Expertise from those who work in transportation services.
- Agencies who utilize volunteers.
- Agencies committed to advocacy and education.
- Model Task Force development after the Charlotte Mecklenburg Advocacy Council for People with Disabilities Transportation Committee (ACPD Transportation).

Targeted start and completion dates

06/04: Planning for this Task Force should begin immediately. Decisions regarding the logistics of the Task Force, including appointments, meetings, and goals should be made as soon as possible. The Task Force should be well established, meeting regularly, and in the process of setting preliminary goals by the end of the 12-month period. Mid- and long-range recommendations the Task Force should follow in later sections of this report.

Indicators and measures of success

- Creation of a well-formed, active, and efficient Task Force with members committed to setting and implementing goals to improve transportation services for seniors.
- The successful Task Force shall serve as a voice and advocate for the transportation needs of seniors among the general public, including both the public and private sectors.
- Through advocacy and educational efforts, the successful Task Force shall increase public awareness and sensitivity to the mobility needs of seniors.

Recommendation: Make Charlotte-Mecklenburg transportation and communities more senior-friendly.

Rationale

"Senior-friendly" includes, but is not limited to, the following items:

- Ease of use
- Information
- Safety
- Signage
- Economic factors
- Allowing reduced fares for companions on all services could encourage more rider-ship on fixed route transportation.

Relevant data

Seniors and surveys indicate a lack of knowledge about current available services and access to available information.

Targeted population/beneficiaries

Seniors who currently use transportation and would potentially use transportation, those who have companions, and people with disabilities.

Desired outcome

Outcomes would include, but not be limited to, the following:

- Lower fixed route signs to no more than 80" above the ground
- Implementation of reduced fares for senior companions
- Increased distribution of informational and educational materials, such as CATS Rider's Guides

Potential leaders and conveners for the future

- All Charlotte-Mecklenburg transportation providers (including for profit and non-profit)
- Charlotte Neighborhood Development

Additional stakeholders

- Neighborhood leaders/representatives
- Places that would distribute informational and educational materials (i.e. libraries, senior centers, etc)

Resources

- More distributors of educational and informational materials
- Database of bus stop information
- Approval to move/lower signs
- Approval of reduced companion fares

Targeted start and completion dates

6/04: Project should begin upon delivery of this report. The process of developing and maintaining senior-friendly communities should be ongoing.

Indicators and measures of success

- Increased fixed-route ridership.
- Increased awareness of current system and ease of use.

<u>Recommendation</u>: Create a Coalition for profit and non-profit service providers who meet on a regular basis to maximize current resources, decrease inefficiency, and determine and implement best practices for the purposes of creating and supporting a coordinated system.

Rationale

Current services do not allow for maximum trip coordination, which often leads to reduced capacity and service "freezes." The coalition will work to increase communication and cooperation between the service providers.

Relevant data

Lack of technology decreases efficiency among service providers. For example, service sub-contractors have reported that at times there are multiple other taxis in the same neighborhood. With appropriate technology, service providers could better coordinate rides and maximize funding.

Targeted population/beneficiaries

All Mecklenburg seniors, age 60 plus, who currently use or may potentially use transportation services.

Desired outcome

The Coalition will determine steps to coordinate services to maximize current funding and senior ridership.

Potential leaders and conveners for the future

- CATS
- MTS/DSS
- Red Cross
- Other transportation providers as determined by the Coalition.

Additional stakeholders

- Senior Riders
- City Council/County Commissioners
- Metropolitan Transit Commission

Resources

- Coalition members.
- Funding and Technology.

Targeted start and completion dates

06/04: To begin upon receipt of this report.

Indicators and measures of success

The Coalition is meeting on a regular basis and has developed a plan of action.

RECOMMENDATIONS IN THE MID-TERM: 25-60 MONTHS

<u>Recommendation:</u> Support the efforts and goals set forth by the Transportation Education and Advocacy Task Force for Seniors (see short-range recommendations for a complete explanation of this Task Force.)

<u>Suggested efforts Include:</u>

1. Transportation Education

See attached education model.

2. Develop a Transportation Volunteer Corps and Incentives for Volunteers

- Develop a corps of volunteer drivers and "transportation buddies"
- Offer free transit rides to those who volunteer
- Conduct a media blitz to make the community aware of the need for volunteer drivers
- Maintain volunteer driver database as part of the coordinated system
- Educate the general public regarding use of enhanced transportation system
- Develop a Volunteer Coordinator position to recruit and schedule volunteers
- Development of a "bus stop/light rail/STS buddy" system to minimize apprehension in utilizing transportation systems.

3. Establish Priority for Transportation Clients among the Human Service and Medical Communities

- Clients may miss their pre-determined pick-up times because they have to wait a long time at the doctors' office, pharmacy, or human service agency.
- Some physicians' offices charge clients a no-show fee if they are late to an appointment due to transportation delays. Some offices will even insist that clients cannot schedule a return appointment for a month or longer after a missed appointment.
- Medical offices and service agencies need to be informed of the consequences when a transportation client is kept waiting and misses his/her pick-up ride (tax dollars are wasted if the client is late for pick-up time).
- Transportation clients need some way to indicate that the timeliness of their medical or service appointment is a priority because transportation will be picking them up. Perhaps provide paratransit riders "priority cards" to show to medical offices and pharmacies to encourage sensitivity to their transportation schedule.
- In turn, transportation providers need to call if running late for a scheduled appointment.

Rationale

The Transportation Education and Advocacy Task Force for Seniors will be responsible for identifying "seeing the big picture" regarding area transportation services for seniors such as recognizing trends and gaps in services. The Task Force will serve as a unified voice for individuals and service providers to provide advocacy and education to improve overall transportation service delivery and accessibility for seniors.

Relevant data

There is no organized forum for seniors to share concerns and make recommendations regarding transportation systems. There is no education-targeted specifically to seniors. There is a lack of awareness of the available services and specific mobility issues of seniors.

Targeted population/beneficiaries

- All transit-dependent seniors and potential customers.
- Please see short-term #1, target population/beneficiaries for more detail.

Desired outcome

The benefit of creating a community that is more sensitive to the importance of mobility for seniors is limitless. Education and advocacy are the building blocks to that end. Following are just a sampling of some desired outcomes that may result from increased awareness of the transportation needs of older adults, broken into three categories:

1. Education: The overall community will be more knowledgeable and sensitive to transportation services and the specific needs of senior riders. Practice riding seminars will empower customers to ride transit for the first time.

2. Volunteers: Volunteers will be identified to assist transportation programs to provide better service. A volunteer database will be maintained to serve as volunteer drivers or "transportation buddies" which will benefit the volunteer, the customer, and the agency providing the service.

3. Medical and Human Services: Medical professionals will understand the importance of keeping transportation clients on schedule so that they do not miss their scheduled pick-up. Transportation providers will contact physician offices and the customer if running late in order that the medical appointment is not cancelled.

Potential leaders and conveners for the future

- Members of the Transportation Education and Advocacy Task Force
- Consumers and their family members
- Medical professionals
- Advocacy agencies
- Human service agencies
- Transportation services staff
- Aging Service agencies
- Social Workers
- Information and Referral Specialists
- Other interested individuals

Additional stakeholders

- Support from local City/County officials
- Expertise from those who work in transportation services.
- Agencies who utilize volunteers.
- Agencies committed to advocacy and education.

Targeted start and completion dates

06/06: As soon as the Transportation Education and Advocacy Task Force for Seniors is established (see short-range recommendation #1), the Task Force should begin working to provide education and advocacy. This recommendation has no estimated completion date, as the efforts of this committee are expected to be ongoing in response to the ongoing mobility needs of seniors.

Indicators and measures of success

- A Task Force with members committed to providing improved transportation for seniors.
- The Task Force will provide a forum to advocate for the transportation needs of seniors among the general public, including both the public and private sectors.
- A community more aware of and sensitive to mobility needs for seniors
- Greater satisfaction among seniors who use transportation services.
- A service delivery system that is more senior-friendly and accessible
- Increased usage of public transit among seniors as a result of education, training, and volunteer efforts designed to reduce apprehension and foster safe and friendly transportation.

<u>Recommendation</u>: Make Charlotte-Mecklenburg transportation and communities more senior-friendly.

Rationale

It can be difficult to walk or use a wheelchair on the available sidewalks because of intruding trees and uneven or cracked cement. Roundabouts, lack of lighting, lack of Accessible Pedestrian Signals (APS) at street crossings, and lack of detectable warnings for visually impaired at wheelchair ramps can be dangerous to seniors. Some seniors cannot use transportation because they live in the outer reaches of the city or county, where transportation is not available. Some seniors do not ride local fixed route services because there are no guaranteed rides home provided on these services.

Relevant data

The group researched areas served by city, county, for profit, and non-profit transportation and found lack of service in outer reaches. Approximately 24 intersections in Charlotte are equipped with APS. Few recessed ramps at intersections have detectable warnings people who are visually impaired or blind.

Targeted population/beneficiaries

- Seniors would begin to utilize transportation services, or use them more, if available.
- Seniors who are visually impaired, disabled, and in wheelchairs.

Desired outcome

- Increased number of sidewalks/repairs to sidewalks.
- Increased detectable warnings for visually impaired at recessed ramps.
- Increased lighting at bus stops.
- More intersections with accessible pedestrian signals (APS).
- More transportation in outer reaches of city and county
- Provision of guaranteed ride home to seniors on local fixed routes 7 days a week during hours of operation
- Make real time information available on website, at Charlotte Transit Center, and at major bus stops.

Potential leaders and conveners for the future

- All Charlotte-Mecklenburg transportation providers (including for profit and non-profit)
- Charlotte Neighborhood Development
- Charlotte Planning Commission
- Non-profit agencies

Additional stakeholders

- Customers
- Meck-Union Metropolitan Planning Organization

Resources

- Detectable warning system and APS technology
- Funding for sidewalk repair and lighting
- Technology for real time information
- Approval of service to outer reaches and guaranteed ride home

Targeted start and completion dates

6/06 or sooner as time and funding permits.

Indicators and measures of success

A safe and accessible transit system for all users, encourages upgrading of existing land uses to make them more transit and pedestrian friendly, provides land uses that attract/generate pedestrian activity, particularly at ground floor level, provides an extensive pedestrian system throughout the station area that will minimize walking distances for pedestrians, and, locates building entrances to minimize the walking distance between transit stations and buildings.

Recommendation: Coalition evaluates technology options / cost and identifies funding for coordinated system.

Rationale

Would maintain competitive trip costs, enhance customer service for reservations, and improve time performance by contracted vendors.

Relevant data

Lack of technology decreases efficiency among service providers. For example, service sub-contractors have reported that at times there are multiple other taxis in the same neighborhood. With appropriate technology, service providers could better coordinate rides and maximize funding.

Targeted population/beneficiaries

All Mecklenburg seniors 60 plus who currently use or may potentially use transportation services.

Desired outcome

To establish routes and collaborate rides to improve efficiency and customer satisfaction.

Potential leaders and conveners for the future

- CATS
- MTS/DSS
- Red Cross
- Other transportation providers as determined by the Coalition

Additional stakeholders

Software developer

Resources

- Software developer/Demonstrated Models
- Funding and Technology.

Targeted start and completion dates

06/06 or sooner if schedule/funding permits.

Indicators and measures of success

Software and funding are identified.

RECOMMENDATIONS IN THE LONGER TERM: 60+ MONTHS

Recommendation: Support continued efforts of the Transportation Education and Advocacy Task Force for Seniors in Mecklenburg County.

A suggested topic for the Task Force to examine is the safety of older adult drivers and help older drivers resolve driving issues. Below are some considerations, generated by the issue group.

- Are seniors driving because they have no alternate transportation source?
- Consider independence
- Educate medical community – need to revoke drivers license if older driver is unsafe on road? How is this to be effectively enforced?
- Develop support group for seniors – when do you know it's time to give up driving/ how to prepare ahead of time and how to adjust?

Rationale

Driving is independence to many older adults. Giving up driving is often unbearable to a person who has driven his entire life.

Relevant data

Older Drivers share the highest per-mile fatal crash rates with teenagers (The Travel Mode of Choice of the Elderly report by Kim and Ulfarsson). Refer to the Transportation Survey & Innovations from COA.

Targeted population/beneficiaries

All transit-dependent seniors and potential customers

Desired outcome

The benefit of creating a community that is more sensitive to the importance of mobility for seniors is limitless. Education and advocacy are the building blocks to that end. Following are just a sampling of some desired outcomes that may result from increased awareness of the transportation needs of older adults, broken into three categories:

1. Education: The overall community will be more knowledgeable and sensitive to transportation services and the specific needs of senior riders. Practice riding seminars will empower customers to ride transit for the first time.

2. Volunteers: Volunteers will be identified to assist transportation programs to provide better service. A volunteer database will be maintained to serve as volunteer drivers or "transportation buddies" which will benefit the volunteer, the customer, and the agency providing the service.

3. Medical and Human Services: Medical professionals will understand the importance of keeping transportation clients on schedule so that they do not miss their scheduled pick-up. Transportation providers will contact physician offices and the customer if running late in order that the medical appointment is not cancelled.

Potential leaders and conveners for the future

- Experts on Older Adults and Safe Driving
- Members of the Transportation Education and Advocacy Task Force
- Consumers and their family members
- Medical professionals
- Advocacy agencies
- Human service agencies
- Transportation services staff
- Aging Service agencies
- Social Workers
- Information and Referral Specialists
- Other interested individuals

Additional stakeholders

Law enforcement

Resources

55 Alive

Targeted start and completion dates

06/09: To be successful, this Task Force must be ongoing in nature in order to meet the ongoing and ever-changing needs of mobility for seniors.

Indicators and measures of success

- A Task Force with members committed to providing improved transportation for seniors.
- The Task Force will provide a forum to advocate for the transportation needs of seniors among the general public, including both the public and private sectors.
- A community more aware of and sensitive to mobility needs for seniors
- Greater satisfaction among seniors who use transportation services.
- A service delivery system that is more senior-friendly and accessible
- Increased usage of public transit among seniors as a result of education, training, and volunteer efforts designed to reduce apprehension and foster safe and friendly transportation.

<u>Recommendation</u>: Make Charlotte-Mecklenburg transportation and communities more senior-friendly.

Rationale

It can be difficult to walk or use a wheelchair on the available sidewalks because of intruding trees and uneven or cracked cement. Roundabouts, lack of lighting, lack of Accessible Pedestrian Signals (APS) at street crossings, and lack of detectable warnings for visually impaired at wheelchair ramps can be dangerous to seniors. Some seniors cannot use transportation because they live in the outer reaches of the city or county, where transportation is not available. Some seniors do not ride local fixed route services because there are no guaranteed rides home provided on these services.

Relevant data

The group researched areas served by city, county, for profit, and non-profit transportation and found lack of service in outer reaches. Approximately 24 intersections in Charlotte are equipped with APS. Few recessed ramps at intersections have detectable warnings people who are visually impaired or blind.

Targeted population/beneficiaries

- Seniors would begin to utilize transportation services, or use them more, if available.
- Seniors who are visually impaired, disabled, and in wheelchairs.

Desired outcome

- Increased number of sidewalks/repairs to sidewalks.
- Increased detectable warnings for visually impaired at recessed ramps.
- Increased lighting at bus stops.
- More intersections with accessible pedestrian signals (APS).
- More transportation in outer reaches of city and county
- Provision of guaranteed ride home to seniors on local fixed routes 7 days a week during hours of operation
- Make real time information available on website, at Charlotte Transit Center, and at major bus stops.

Potential leaders and conveners for the future

- All Charlotte-Mecklenburg transportation providers (including for profit and non-profit)
- Charlotte Neighborhood Development
- Charlotte Planning Commission
- Non-profit agencies

Additional stakeholders

- Customers
- Meck-Union Metropolitan Planning Organization

Resources

- Detectable warning system and APS technology
- Funding for sidewalk repair and lighting
- Technology for real time information
- Approval of service to outer reaches and guaranteed ride home

Targeted start and completion dates

06/09 or sooner as time and funding permit.

Indicators and measures of success

A safe and accessible transit system for all users, encourages upgrading of existing land uses to make them more transit and pedestrian friendly, provides land uses that attract/generate pedestrian activity, particularly at ground floor level, provides an extensive pedestrian system throughout the station area that will minimize walking distances for pedestrians, and, locates building entrances to minimize the walking distance between transit stations and buildings.

Recommendation: Obtain necessary approval, funding, and policies to begin implementation of coordinated system.

Rationale

Would maintain competitive trip costs, enhance customer service for reservations, and improve time performance by contracted vendors.

Relevant data

Lack of technology decreases efficiency among service providers. For example, service sub-contractors have reported that at times there are multiple other taxis in the same neighborhood. With appropriate technology, service providers could better coordinate rides and maximize funding.

Targeted population/beneficiaries

All Mecklenburg seniors 60 plus who currently use or may potentially use transportation services.

Desired outcome

Implementation of coordinated system.

Potential leaders and conveners for the future

- CATS
- MTS/DSS
- Red Cross
- Other transportation providers as determined by the Coalition

Additional stakeholders

Software developer

Resources

- Software Developer/Demonstrated Models
- Funding and Technology

Targeted start and completion dates

06/09 or sooner if schedule and funding permits.

Indicators and measures of success

Competitive trip costs are maintained, customer service is user friendly and time performance is improved resulting in a safe and accessible transit system for seniors.

DEFERRED ISSUES THAT DESERVE ATTENTION

ISSUE: Offer free weekend transportation to from medical appointments.

Rationale: This is especially needed for Dialysis patients who need to transported on a regular basis 2-3 times weekly.

ISSUE: Business sector to take ownership and help with cost-share Businesses should allow shuttles to enter and drop off individuals at their doorstep.

Rationale: Since Seniors are spending money at pharmacists, grocers, etc. they should compete for and share the cost if they want their business. Often business won't allow buses or shuttles to approach the entrance, which leaves people to walk long distances through unsafe lots and darting traffic

ISSUE: Develop affordable wheelchair accessible transportation for special needs seniors.

Rationale: We have a growing population and need to plan for those who may need wheelchair transportation. Current services are cost prohibitive.

ISSUE: Increase funding for General Purpose Elderly Transportation (MTS/DSS).

Rationale: This is a well-liked program that is meeting many needs. However, as the year-end approaches the program frequently freezes.

CONCLUDING COMMENTS

This issue group worked well together and it was echoed many times that we all learned a lot. We spent an incredible amount of time trying to understand current systems and what was working and not working.

Transportation is a complex issue with needs as varied as the individuals who ride. Our suggestions range from creating a more “walkable” community to alleviate burdens on transportation systems to expensive technology that would enable coordination of existing services.

It was difficult for people with little knowledge to be meeting with people who knew almost all aspects of the system. It was a valuable exercise in bringing us up a level as well as having the experts hear concerns firsthand from those who work with seniors.

We have a huge job ahead of us with regard to meeting the needs of an aging population. In particular the major shift in thinking that transportation will not be primarily designed just to get people to work and to school. Since we are living easily into our 80’s, we now have the ability to create a new life after we retire not just winding down after the career. Many things will change because of this new phase of life.

We would like to see transportation be responsive to this change or better yet pro-active to the ever evolving needs of seniors and the community in general. We believe that good design for seniors will ultimately be good design for all.

A challenge for this group was that the DSS/MTS transit director was in a job transition and only attended meetings in the beginning. We feel we may have missed the ability to capitalize on his knowledge and his vision.

We were also extremely challenged by this time frame. It would have been helpful if we could have received this intensive report template earlier in the meeting process. We are pleased that it came together so well and are hopeful that our recommendations will receive the attention they deserve.

NOTABLE STORY

A Senior Transportation Story

The following anecdote demonstrates the need for increased communication between transportation services and passengers:

Recently, a woman riding a van appeared visibly upset to her fellow-passengers. She related the story that she had scheduled a ride for a test at the doctor's office at 7:00 a.m. Without calling her, the provider changed her appointment to 9:00 a.m. As a result, they picked her up later that she was expecting. Subsequently, they drove to another house, picked up a new passenger and began to take the route to the second passenger's place of employment. By this time, the woman knew that she was going to be late for the 9:00 a.m. appointment. In tears, she began calling the van dispatch by cell phone to let them know that she was going to be late. In the end, both passengers were late to their destinations. (It was not known if the dispatcher or the client called the doctor's office to say that she was going to be late for the 9:00 a.m. appointment.)

Communication among all parties involved in a scheduling change is crucial. Late appointments cause unnecessary stress for passengers and affect the quality of the transportation experience. Educating doctors and employers about the complications passengers face is essential to reducing stress.

Embracing the "Age Wave"

by

Linda Canzona
Robin Overcash
Ryan Temm

Latoya Chambers
Joel Riddle
Christian Wagner
Katrina Young

Master of Public Administration Program
University of North Carolina at Charlotte

A report prepared for
Mecklenburg County
Department of Social Services
Services for Older Adults Division

December 2003

Executive Summary

Assisting the Mecklenburg County Department of Social Services (DSS) Services for Older Adults (SFA) division, graduate students from the UNC Charlotte, Master of Public Administration (MPA) program examine issues relevant to senior care and senior service providers in Mecklenburg County. This report presents findings on several topics – transportation, care costs, public safety and service provision – relevant to the elderly population in Mecklenburg County.

As indicated, this research focuses on four relevant issue areas relative to the growing elderly population. First, this research examines transportation alternatives for elderly citizens who otherwise might find themselves unable to drive. Next, this research examines the cost of institutional care versus in-home care. For example, in North Carolina, the cost of caring for a person requiring the maximum amount of in-home care is $43,680 compared to $51,000 for nursing home care. The discussion then turns to public safety issues of consequence to seniors in Mecklenburg County. The majority of incidents committed against seniors consist of three primary types of offenses: residential burglary (578 incidents), larceny from auto (634 incidents) and auto theft (503 incidents), which represent 44.5 percent of all incidents reported against seniors in Mecklenburg County.[1]

Finally, analysis of a survey administered to organizations that provide services to seniors in Mecklenburg County from October 10, 2003, to November 14, 2003, reveals that senior service providers consider the following six services, programs, and issues to be critical to the community:

- Access to Health and Care Services (68%)
- Cost of Prescription Drugs (63%)
- Affordable Housing (58%)
- Transportation (45%)

- Food and Nutrition (44%) and
- Emergency Issues (41.0%).

Based on this research, we offer the following recommendations:

- Mecklenburg County government must partner with private or non-profit organizations to increase service options for seniors;
- Create and implement a public awareness campaign to educate Mecklenburg County residents about the needs of the elderly and the coming population growth;
- Improve transportation options available to the elderly;
- Provide a focused crime education campaign in high density areas with a focus on seniors, provide senior oriented Crime Prevention Through Environmental Design (CPTED) in communities with significant senior populations, and focus on public safety needs associated with a growing senior population; and,
- Determine criteria for establishing senior service provider status.

Table of Contents

Introduction

When one considers the tremendous growth the elderly population will see in the coming years, it becomes apparent that proactive efforts are in order for the Mecklenburg County government to remain ahead of the "age wave." For example, the elderly population in Mecklenburg County is expected to increase by over 40 percent by the year 2011 to an estimated population of 115,000.[2]

This report focuses on issues relevant to older adults in Mecklenburg County. The MPA students at the University of North Carolina at Charlotte acting in association with DSS, SSC and The Status of Seniors Initiative Steering Committee, examine senior issues to provide insight into the status of seniors in Mecklenburg County for future planning to confront the growth in the elderly population as well as address emerging policy issues accompanying this growth.

First, we address transportation needs among the elderly. While Mecklenburg County has no mass transit program designed specifically for the elderly, other cities and states have taken steps to implement transportation systems to aid the elderly. For example, the city of Philadelphia provides free transportation to and from medical visits through a program called *Wheels for Wellness*. We discuss this program and others in the Transportation section of this report.

Second, we analyze the cost of institutionalization versus in-home care both nationally and in North Carolina. We summarize issues such as the true costs associated with unpaid care giving, the discretion from state-to-state to implement programs and a comparison of costs in North Carolina. We also provide alternatives to the current system and the heavy reliance on institutional care or unpaid caregivers.

Third, we analyze issues relating to crime and public safety affecting Mecklenburg County's elderly population. Currently, certain neighborhoods and communities in the Charlotte area have both high concentrations of elderly citizens and high crime rates. We look at what is being done to protect Mecklenburg County's elderly citizens from harm as well as the preventative steps that the Charlotte-Mecklenburg Police Department have in place to deter crimes against the elderly.

Finally, we present general findings from a survey of senior citizen service providers in Mecklenburg County. Focusing on those providers offering services with a goal to improve or continue the quality of life for seniors, we survey senior service agencies and organizations to discern their perspectives across several issue areas. The areas of interest detailed in the section discussing survey findings include: an overview of service agencies and organizations, public safety and transportation issues, seniors' needs and issues, and operations, planning, and other issues.

Transportation

Transportation is an important aspect of everyday life for any individual, regardless of age; for the elderly, however, this is a very significant issue. Most seniors want to maintain their independence as long as possible and transportation is the primary means by which they are able to do so. However, while many people plan for their financial security in retirement, very few consider their transportation options if this privilege is revoked in their later years. Access to transportation is a crucial aspect of the basic community infrastructure that allows individuals to obtain needed goods and services in order to maintain their quality of life.[3]

Often, as seniors age, they become "transportationally challenged," and find it difficult or impossible to continue to drive, or are prohibited from driving. When deprived of transportation, it is often a struggle for an elderly individual to locate appropriate and affordable transportation.[4] However, there are transportation options available to the elderly. For example, asking a friend or family member for a ride, public transportation and taxis are all transportation options for the elderly.[5]

Many of these options, relating to having their own personal transportation, generate feelings of anxiety. For example, if an elderly person relies on family and friends, he or she might feel as if he/she is becoming a burden. Also, if an elderly individual relies on public transportation or taxis, he or she can become disheartened with the financial burden that they incur in order to get from place to place.[6]

Many states and cities have taken an aggressive and innovative approach to assisting the elderly with their transportation needs. Often, through government

programs and government partnerships with non-profit and private organizations, the community meets the transportation needs of the elderly.

For example, in Philadelphia, Pennsylvania, a program called *Wheels for Wellness* serves every health institution in Philadelphia area. The program provides door-to-door transportation from an elderly resident's home to the health institution to which they need to travel. Relying on a staff of 5 full-time employees and 35 volunteers, the program makes 120 daily trips and approximately 30,000 trips annually. The drivers use their own primary insurance with secondary insurance from *Wheels for Wellness*; they use their own cars and are reimbursed 31 cents per mile.[7]

A second example of elderly specific transportation is from Annapolis, Maryland. The Annapolis Transit staff applied for a Volunteer Coordinator through the Volunteer Maryland program to help develop transportation services for frail and disabled older adults. Through research into community resources, a local non-profit, Partners in Care, was identified with whom the city could work to develop transportation programs for the elderly.[8]

The collaborative effort between Annapolis Transit and Partners in Care created a program called *Ride Partners*. *Ride Partners* is a volunteer transportation program that provides assistance for frail and disabled older adults who are no longer able to use regular public transportation. The goal of *Ride Partners* is to provide long distance and recurrent transportation (three or more times a week) for medical treatment or rehabilitation.[9]

In Rochester, New York two local non-profits, Medical Motor Service and LifeSpan have joined with Wegman's, a local grocery chain to provide a shuttle bus service that allows residents to purchase prescription drugs and groceries. Wegman's

pays for the shuttle service, Medical Motor Service furnishes the vehicles and drivers and LifeSpan provides escorts for the passengers. The program arranges and provides shuttle service to 900 older persons living in high rises and housing complexes designed specifically for seniors.[10]

LifeSpan's involvement as the escort often allows their representative to build a relationship with the elderly individual they escort. As a result, LifeSpan escorts get to know each of the elderly individuals and their needs. Often, LifeSpan is able to lend further assistance to individuals through their case management program.[11]

Other programs throughout the country are geared toward those who, while elderly, are not yet frail. For example, Montgomery County, Maryland[12], and Fairfax County, Virginia[13] both provide taxi vouchers to residents over the age of 65. While there are income restrictions on both programs, an elderly resident can purchase voucher books at significantly discounted fare rates. Citizens can use the vouchers to travel wherever they want to go; the only restriction is that they use a participating taxi service.

No one can determine the age which we become too old to drive. However, it is suspected that older individuals who do not have transportation alternatives continue to drive longer than they feel it is safe because of their lack of alternatives. As a result, elderly transportation programs become more important as the elderly population continues to increase.[14]

In-Home Care vs. Institutional Care

An issue that policymakers must address in the near future is the issue of housing for the elderly. Most elderly citizens want to continue living in their own homes, or "age in place" as they grow older; however, the elderly often find themselves vulnerable to the possibility of being unable to live in their own home. For example, nearly 54 percent of the elderly population reports having at least one disability, and these disabilities often limit the capacity of those affected to carry out routine, daily functions such as bathing, dressing and cooking.[15]

As a result, many elderly Americans eventually depend on some type of long-term care.[16] Long-term care seeks to improve the ability of the elderly and disabled to function as independently as possible for as long as possible. Long-term care involves assistance with basic activities of daily living (ADLs) such as bathing, dressing, eating or other types of personal care; it also encompasses assistance with instrumental activities of daily living (IADLs), which include household chores such as meal preparation and cleaning.[17]

Since most elderly Americans prefer to remain in their own home and since a large majority of the elderly require some type of assistance with ADLs and IADLs, the issue of how to provide the best long-term care possible is a growing policy issue with which policy makers at all levels of government must contend. Many argue, however, that publicly funded long-term care assistance is biased toward institutional care. For example, in 2001 over 71 percent of Medicaid's expenditures for long-term care services

were spent on nursing home care. Further, Medicare only provides assistance for care in skilled nursing facilities for a short period (up to 100 days after a hospitalization).[18]

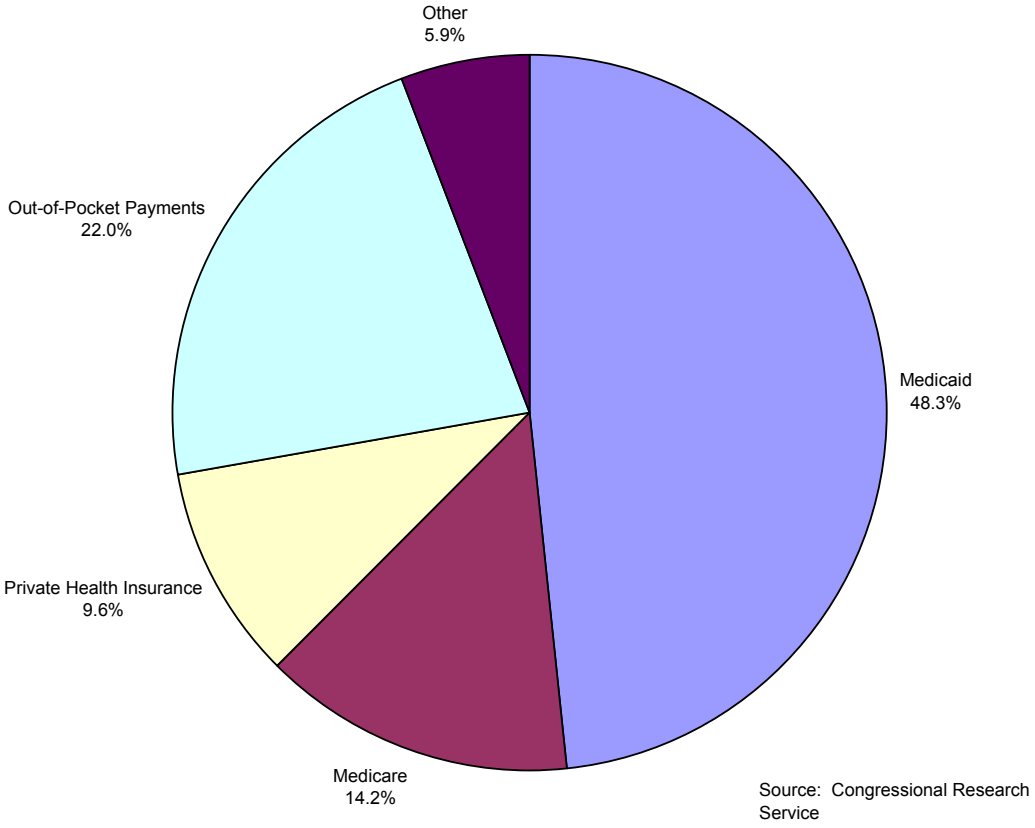
While the likelihood of receiving long-term care increases with age, fewer elderly citizens reside in nursing homes. Consequently, there are many who feel that the federal and state governments should seek to develop home- and community-based long-term care programs. In 1981, Medicaid created the Home and Community Based Waiver Program, which provides assistance to those who, without these services, would be institutionalized. In 2001, spending through the Home and Community Based Waiver Program was $14.5 billion. However, Medicaid's total long-term care spending for 2001 was $73.1 billion with 64.3 percent of Medicaid expenditures going toward institutional care. As Figure 1 illustrates, Medicaid's spending on long-term care is nearly half of all spending for long-term care in 2001.[19]

As Medicaid is administered by state governments, and ultimately by county governments at the local level, the type of assistance varies by state. The United States General Accounting Office (GAO) recently studied the availability of long-term care programs in four states (Kansas, Louisiana, New York and Oregon). Significant variation in the availability of Medicaid covered services exists from state to state. For example, in New York and Oregon all Medicaid eligible elderly can receive home and community based services provided by Medicaid. Comparatively, Kansas has a waiting list with three times as many people on the list than are actually served.[20]

Figure 1

Sources of Long-Term Care Spending, 2001

Total Long-Term Care Spending +$151.2 Billion



Source: Congressional Research Service

The primary reason for the disparity between states relates to the differences in state policies. Louisiana and Kansas have waiting lists for some services whereas New York and Oregon do not. Also, depending upon the state, there are caps for certain services. For example, Louisiana is limited in the number of hours of in-home care the state can provide because there is a cap of $55 dollars per day on in-home services. New York and Oregon have no such restrictions and can offer as much as 24 hours a day in-home care.[21]

A further example of the Medicaid spending disparity that exists among states is seen by the allocation of Medicaid spending in 1999. In 1999, the national Medicaid yearly expenditure average was $996 per person, aged 65 and over, with 81 percent of expenditures going toward nursing home care. In New York, Medicaid expenditures for long-term care services are nearly $2,463 per person, aged 65 or over. Comparatively, Louisiana's Medicaid spending on long-term care service is $1,012 per person, aged 65 or over, with nearly 93 percent going to nursing home care. Oregon spends well below the national average ($604) on Medicaid long-term services, though the state allocates more money toward alternative long-term care services, such as care in alternative residential settings, than the other states in the study.[22]

The cost of nursing home care in North Carolina is $140 per day and $51,000 per year.[23] The cost for home health care in North Carolina averages $11 to $15 per hour. Most service providers in North Carolina provide at least one to two hours of services twice a week. However, the maximum amount of services is approximately eight hours per day for five or seven days per week making funding for in-home care noticeably less even for a person who requires the maximum care at the highest cost. For example, the

cost of caring for a person for 8 hours of care per day, 7 days a week for an entire year at $15 per hour is $43,680 compared to $51,000 for nursing home care.[24]

Also, North Carolina provides a Special Assistance payment supplement that allows qualifying individuals to receive assistance to pay for care. To qualify for a Special Assistance Supplement, an individual must have an income less than $1,147 per month. Eligible recipients, those whose income is less than $1,147 per month and need adult care as verified by a physician, receive a monthly payment for the difference between their income and $1,147. The North Carolina Department of Health and Human Services reports that Special Assistance supplements for individuals in adult care homes was $2,808,568 higher annually than payments for individuals living in their own home. In North Carolina, the average monthly payment is $426 to individuals living in adult care homes. Comparatively, the average special assistance supplement for those living in their own home is $184.[25]

Often overlooked in the debate over in-home care versus institutional care is the role of "unpaid caregivers." Unpaid caregivers are typically family members and friends that provide the majority of care that many elderly receive. As an example, nearly 60 percent of elderly citizens who receive long-term care depend exclusively on unpaid caregivers compared to only 7 percent that depend exclusively on paid services.[26] Further, According to the 1994 National Long-Term Care Survey, more than 7 million Americans provide 120 million hours of unpaid care to elders with functional disabilities; if these caregivers are paid, the cost of their services is estimated to be $45 billion to $94 billion a year.[27]

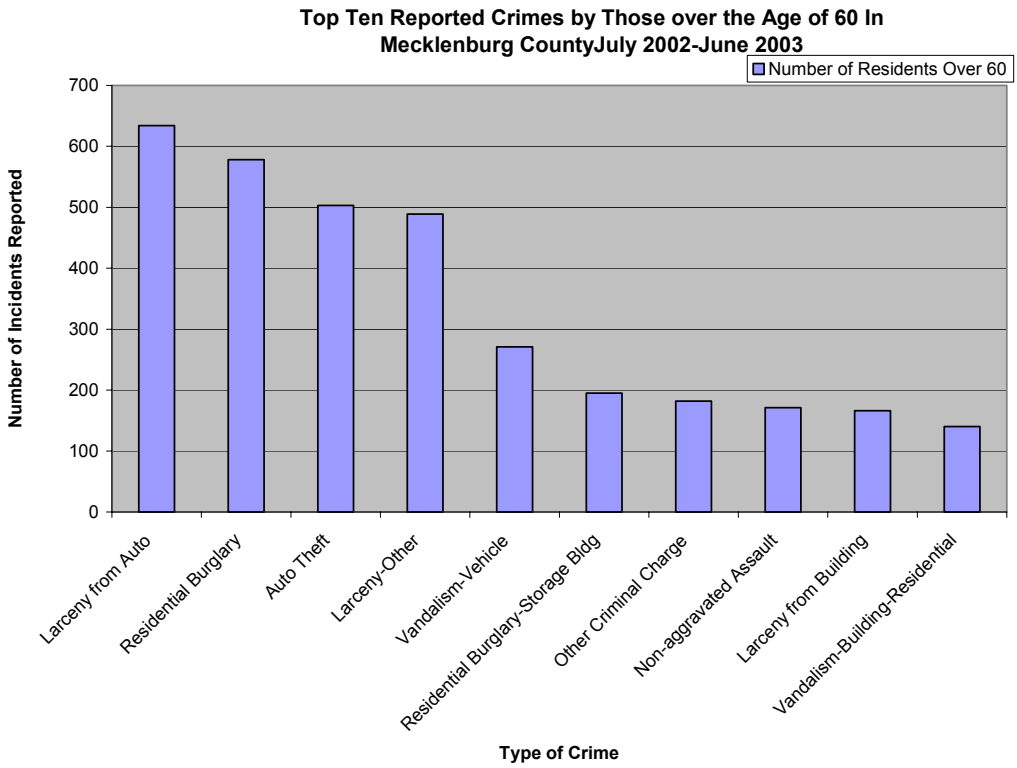
There are many unresolved issues with regard to long-term care for the elderly. Due to the rising growth of the elderly population in America, the issue will continue to dominate the agenda of policy makers at all levels of government for years to come.

Public Safety

Perhaps no issue is more frightening to the elderly population in Mecklenburg County than becoming a victim of crime. The Charlotte-Mecklenburg Police Department (CMPD) does not provide specific services for the elderly and, at present, no specific research is being conducted within the department to determine the effect of an aging population on county public safety services. However, the department is analyzing population growth trends and planning accordingly. Part of the population growth planning revolves around issues relevant to the elderly.

The CMPD is one of the county's largest service providers to those aged 60 and older. Research gathered from July 2002 through June 2003 demonstrates that the elderly are often victims of crime. The majority of incidents are for three primary types of offenses: residential burglary (578 incidents), larceny from auto (634 incidents) and auto theft (503 incidents); these crimes represent 44.5 percent of all incidents reported against the elderly[28] (see Appendix B). Further, non-qualified larcenies comprise nearly 12.5 percent of all remaining incidents. Non-qualified larceny is a larceny other than pocket picking, purse snatching, shoplifting, larceny of bicycle, larceny of building and larceny from auto. As Figure 2 shows, these four crimes (residential burglary, larceny from auto, auto theft and non-qualified larceny) comprise a disproportionate number of incidents reported by the elderly in Mecklenburg County.

Figure 2



While the number of reported incidents in Mecklenburg County is relatively low, fraud is also a threat to elderly citizens in the community. For example, only 87 of 3,852 cases reported involve fraud; while this number is comparatively small, fraud is a potentially devastating crime, for seniors on fixed incomes.[29]

Many crimes against seniors occur in neighborhoods designated as fragile by the Charlotte Neighborhood Quality of Life Study. The Quality of Life study examines every community in Charlotte and places the community into one of three categories: stable, threatened or fragile. Stable neighborhoods score highly on the four dimensions the study examines because the neighborhoods have few social problems, low crime rates, few infrastructure or housing needs and high levels of economic vitality. Threatened neighborhoods are those neighborhoods that score relatively high on most

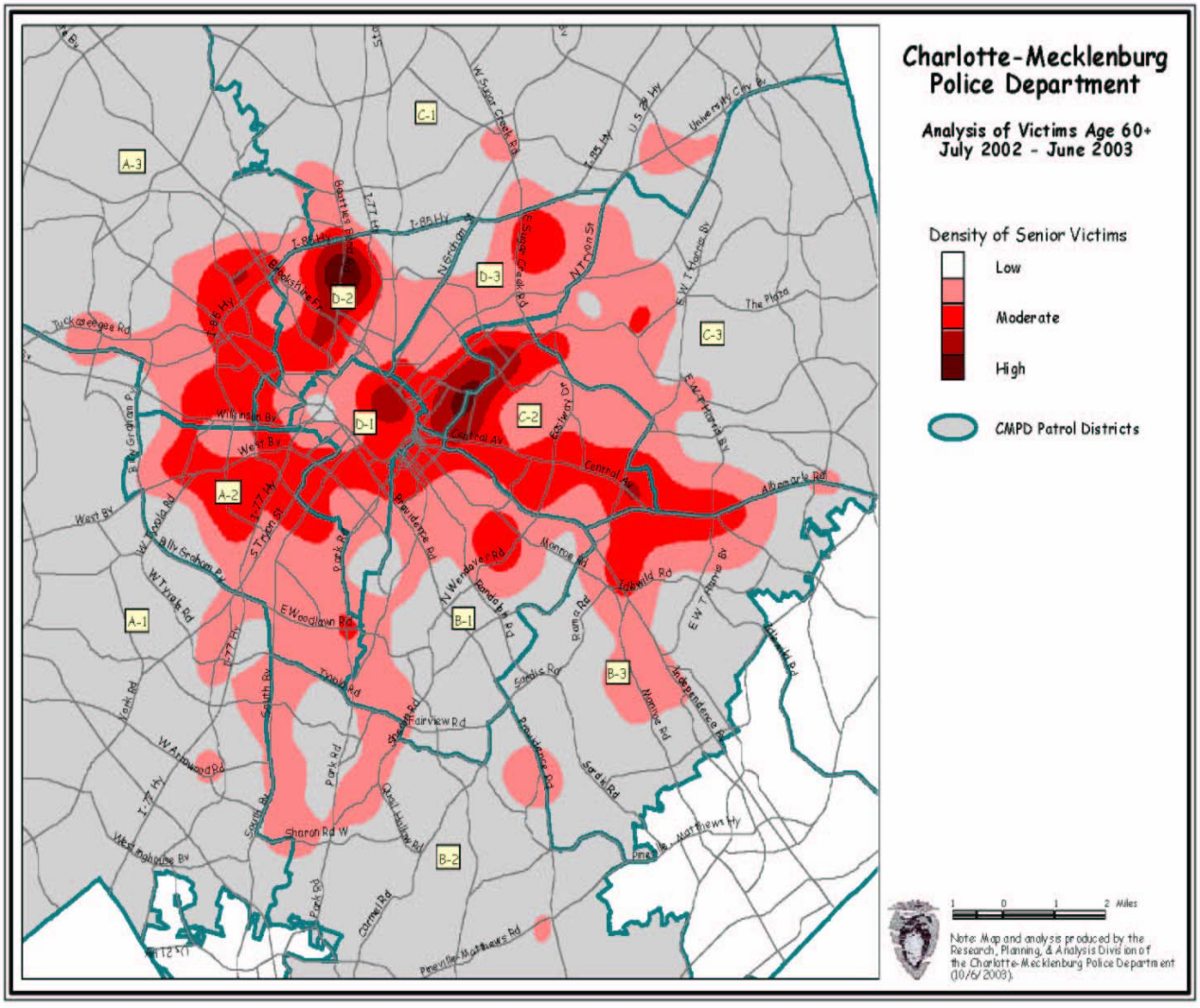
dimensions, but might have a significant problem on one or two dimensions. Fragile neighborhoods have low to moderate scores on each of the four dimensions. A fragile neighborhood has a lower quality of life and is considered an at risk neighborhood because the neighborhood receives lower scores on each of the four dimensions.[30]

The "Hot Spot" map (see Figure 3) from the Research, Planning and Analysis Division of the CMPD depicts areas where victimization of the elderly is most prevalent. Close examination of the map illustrates that there are several areas with high pockets of crime against seniors in Mecklenburg County. Comparing the Hot Spot map with the Charlotte Neighborhood Quality of Life Study, most areas are listed as fragile by the Quality of Life Study.[31] Below are the top five areas:

- Beatties Ford Road area including portions of the University Park, Lincoln Heights University Park Elementary School, the West Charlotte High School Area and the Taylor Avenue/LaSalle Street neighborhoods in the northwest section of Charlotte
- Parkwood Avenue area including portions of the Belmont, Villa Heights and Plaza Midwood neighborhoods in the east central section of Charlotte
- Tryon Street area including portions of the Uptown Street corridor, Fourth and First Ward neighborhoods located in the central section of Charlotte
- Beechwood Acres neighborhood in the Thomasboro/Cheshire area located on the west side of Charlotte
- Eastland Mall area located on the east side of Charlotte

Figure 3

Crime Hot Spot Map



Note: This map is also found in Appendix B.

While the CMPD is only one of many agencies that provide emergency services during disasters or crises, its contribution is significant. For example, during the winter storms of 2002-2003, the CMPD relocated many elderly residents who were without power and telephone services to emergency shelters. As a result, we cannot overlook the role of the CMPD and other public safety agencies for providing assistance to the elderly in times of crisis.

The CMPD does not analyze potential costs associated with services for specific groups of people, such as the elderly, because it must serve a diverse customer base. However, based on our research, it appears that the elderly are a unique group that often has special needs. Further, as one of the stated objectives of the CMPD is to prevent the "next" crime from occurring, analysis on the prevention of crimes against the elderly should be a primary objective of the CMPD.[32]

While the CMPD has many programs to assist Mecklenburg County's elderly, it has no programs that specifically target the elderly. However, the department already has several crime prevention programs in place that can benefit seniors. For example, we list crime prevention tips, which are provided by the CMPD and found in Appendix B, for dealing with the three most reported crimes against seniors: residential burglary, larceny from auto and larceny of auto. Further, the department can analyze crime prone areas in communities by examining the design of the area; through a program called Crime Prevention Through Environmental Design (CPTED) crime reduction factors are often recognized, and as an example, significant areas of poor lighting, allowing crimes to occur more easily, are often identified and targeted for improvement.

Survey Findings

The Mecklenburg County Department of Social Service (DSS) asked students in UNC-Charlotte's Master of Public Administration (MPA) program to assist with assessing the status of senior service provision in the community. The intent of the Senior Service Provider Survey is to ascertain information from agencies and organizations providing senior services pertaining to "quality of life" issues for senior citizens in Mecklenburg County. The Senior Service Provider Survey addresses issues related to health, medical care, nutrition, safety, housing, transportation, independence, and self-sufficiency. Given our objectives, we focus on those providers offering services with a goal to improve or continue the quality of life for seniors. MPA students surveyed these agencies and organizations to discern their perspectives across several issue areas concerning services available to seniors, as well as the provision of these services in Mecklenburg County.

The survey was conducted over a seven-week period, from October 10, 2003, to November 14, 2003. The Senior Service Provider Survey was administered in a two-stage method. The first phase of survey research used an Internet survey, while the second phase used a mail survey. The overall survey success (or response) rate is 31 percent (explained in detail in Appendix A). The Internet survey produced a success rate of 41 percent, while the mail survey yielded only a 15 percent success rate. While the overall success rate is only about one-third of those contacted, one must remain cognizant that we surveyed the entire population of senior service providers, i.e., we did not sample from the population.[33]

We present general findings from the Senior Service Provider Survey. These findings cover general areas of the survey and include: overviews of service agencies and organizations, public safety and transportation issues, seniors' needs and issues, and operations, planning, and other issues. Please see Appendix A for questions appearing on the survey instrument and responses to each question.

Overview of Service Agencies and Organizations

When presented with a host of potential service offerings, most respondents classify their agency or organization as an information or referral service provider (27%) or health care service provider (25%). In addition, advocacy services and general social services are selected by 21 percent of respondents. Impressive in responding to the query seeking specific services provided to seniors are the numbers of respondents (85%) taking time to give specific information about the services they provide. This open-ended question garnered 79 specific replies detailing the services they provide to senior citizens (see Appendix A for listing); these responses reflect the general areas selected from among the host of options provided to respondents. Of those responding to the survey, nearly 50 percent classify their service agency or organization as a "non profit," while 25 and 23 percent, respectively, classify their service agency or organization as "for profit" or a "government."

Relative to planning that is taking place among responding agencies and organizations, the leading choice is program development (from among these choices: committee or task force, fund development, and program development). Though respondents are offered multiple selections from which to choose, program development

is selected by 43 percent of service providers, while the other options achieve no interest more than 25 percent.

Contrary to these indications, senior service providers indicate that several areas are important to their planning for services for next year. Of these areas only two, "planning for funding shortages" and "meeting demands of senior population," are selected by nearly, or more than half of service providers (52%) as "very important" (i.e., it is crucial to the agency or organization) for next year's planning. Planning for "meeting demands of senior population" is deemed "very important" by 49 percent of senior service providers responding to the survey.

Senior service providers in Mecklenburg County can be characterized as mostly non-profit agencies that provide primarily information referral and health care related services. Of interest, and which could be a cause for concern, is the fact that less than one-half of respondents are engaged in planning for senior issues; beyond the 43 percent that indicate they are conducting some program development planning, nearly three-quarters are not conducting plans using committee or task forces, or fund development. However, substantial numbers of respondents indicate that their service agency or organization is planning for the near term.

Public Safety and Transportation Issues

Of interest to the community is how seniors use public services available to them or how these services serve the need of senior citizens, specifically public safety and transportation services. To acquire a perspective of how seniors use these services, we asked service providers to provide information about these services and their use by

senior citizens. The survey findings indicate that senior citizens have access to public transportation and public safety services, but that these services are likely underutilized by senior citizens. To get an idea of the use of public safety services by the senior population, we asked service providers if they use available public safety services. Surprisingly, we find that senior service providers do not take advantage of safety and transportation services, i.e., have not provided public safety services (41%) or performed a Crime Prevention through Environmental Design (CPTED) analysis for their facilities or locations (62%). Yet, most senior service providers indicate that such public safety services are needed by senior citizens. Senior service providers indicate that crime prevention classes (nearly 70%), building or property safety (52%), and crime awareness classes (82%) are needed by senior citizens. Obviously, those most likely to know about senior citizens' needs for public safety indicate that there is a need for awareness and education on crime prevention among the senior population.

Relative to transportation services, we wanted to know if transportation is available to seniors that receive services from providers responding to the survey. While we could not ascertain the use of specific transportation options by senior citizens, we wanted to know if transportation is available to assist seniors in acquiring services from senior service providers. Of service providers offering services to seniors, transportation offerings are split evenly, 36 percent of service providers offer transportation, while 35 percent do not. Amplifying this finding is the fact that nearly 70 percent of senior service providers indicate their agency or organization's location is accessible through the use of public transportation services. Given these findings, it appears that public transportation is a viable option for senior citizens to use to acquire senior services.

Senior Needs: Services, Programs, and Issues

As the "age wave" becomes a reality by the end of the next decade, we are interested in the community needs of this population. To assess the community need required to address the growing senior population, we asked senior service providers to give us an idea of the services they feel are needed by senior citizens. We asked service providers to rate a host of issues based on their perspective of these services being critical, essential, dispensable, or not needed to address community needs of senior citizens. The specific response options available to service providers responding to the survey are:

- Service, Program, or Issue Not Needed at All (needs no attention);
- Dispensable Service, Program, or Issue (may or may not be useful; not needed as much as others);
- Essential Service, Program, or Issue (necessary service);
- Critical Service, Program, or Issue (mandatory, vital service, cannot do without).

For our purposes, to evaluate the intensity of community need, we note only those services, programs, or issues with response rates for the "critical service, program, or issues" near, or above 50 percent (i.e., 40 percent or more select the critical option). Given that four response options of varying intensity are available to service providers, their selection of the "critical" option demonstrates to us that the specific service,

program, or issue is of utmost importance to them vis-à-vis other services, programs, and issues about which we inquire. Those senior service providers responding to the survey indicate six services, programs, and issues as being critical for the community; these six issue areas are (with percent selected noted):

- **Access to Health and Care Services (68%);**
- **Cost of Prescription Drugs (63%);**
- **Affordable Housing (50%);**
- **Transportation (45%);**
- **Food and Nutrition (44%); and,**
- **Emergency Issues (41%)**.

In essence, these areas are those that senior service providers regard as most important for the senior population.

Operations, Planning and Other Concerns

Most senior service providers appear to be in viable fiscal standing. Responses to questions about budgets and funding, indicate that senior service providers fare well in this regard, which should ease their ability to cope with the coming "age wave."

Specifically, nearly half (50%) have annual budgets in excess of $400,000. Funds for their budgets appear to come from various sources. Service providers do not appear dependent on any one source for funding as most indicate that approximately 20 percent of their funds derive from grants (18%), private donations from individuals (27%), private donations from businesses (20%), and client fees (19%). Surprising is the indication of a lack of dependency from government funding; 60 percent do not receive

funds from the federal government, while similar findings are indicated for state (62%) and county (53%) governments. Also, nearly 60 percent of service providers responding to the survey indicate that they do not receive funds from Medicare (69%) or Medicaid (58%).

Most service providers seem to be doing well with regard to personnel; most service providers, i.e., approximately half or more of those responding (50% or more) indicate that they have between 1 and 25 employees and volunteers on staff. Equally important, similar numbers are reported for the number of employees and volunteers dedicated to senior services.

Regarding the demographics of senior citizens receiving their services, senior service providers indicate that their services are dichotomized between serving 1 to 50 seniors (18%) to serving more than 800 seniors (21%) annually. Given these disparate numbers, senior service providers seem able to accommodate those seeking their services. Respondents indicate that not being able to offer a senior citizen service (43%) does not apply to services they provide. Of those indicating that they cannot accommodate a senior citizen seeking to enroll in their service, service providers indicate that they sometimes or always use a waiting list (34%). However, most promising is that service providers also specify that only 2 percent of senior citizens are never, or rarely, placed on waiting lists. Of those providers indicating the use of waiting lists (only 29% of those responding), most specify this wait to be from 1 week to 3 months (76%), but that this wait usually does not exceed 1 month (43%). Again, caution is urged with responses to this question as only about 30 percent of respondents provided information on questions about waiting lists.

The leading criteria used by many senior service providers to determine a senior's eligibility to receive services from their agency or organization are age (42%), income (27%), and medical diagnosis (23%). It appears that eligibility criteria for receiving senior services is not well defined or widely used across service providers. The make-up of those receiving senior services is varied as well. As a percent of seniors receiving their services, service providers responding to the survey offer the following information regarding the demographics of their service recipients.

African-American:

- 32 percent of providers indicate that 21 to 60 percent of those receiving services are African-American.

Hispanic:

- 36 percent of providers indicate that 1 to 10 percent of those receiving services are Hispanic;
- another 24 percent indicate that Hispanics do not receive their services.

Asian:

- 28 percent of providers indicate that 1 to 10 percent of those receiving services are Asian;
- another 31 percent indicate that Asians do not receive their services.

White:

- 18 percent of providers indicate that 80 percent or more of those receiving services are White;
- another 29 percent indicate that 21 to 60 percent of those receiving services are White.

Male:

- 34 percent of providers indicate that 21 to 40 percent of those receiving services are male.

Female:

- nearly 41 percent of providers indicate that 61 percent or more of those receiving services are female.

85 years old or older:

- 35 percent of providers indicate that 1 to 20 percent of those receiving services are over 85 years old.

Recommendations

- **Mecklenburg County government must partner with private or non-profit organizations to increase service options for seniors.**

  Recognizing that nearly 75 percent of agencies or organizations responding to the survey are non-profit or for-profit agencies, a public-private partnership with these entities can yield tremendous results in the long-term care of, and service provision to the elderly. For example, Potter County, Pennsylvania, provides access to many in-home services through the assistance of 52 area agencies on Aging. The program includes such partnership services as homemaker assistance for daily household activities and a home chores service that helps people with heavy cleaning and minor home repairs.[34] Mecklenburg County must explore these partnership options if future needs of senior citizens are to be met.

- **Create a public awareness campaign to educate Mecklenburg County residents about the needs of the elderly and the coming population growth**

  Mecklenburg County must create and implement a public awareness program to educate its residents about the coming "age wave." While those who are familiar with senior issues are aware of the anticipated growth of the elderly population and the resulting demands this growth places on local governments, many organizations, such as the CMPD, are not planning for the tremendous growth this segment of the population will enjoy over the next several years. Mecklenburg County can produce public service announcements (PSAs) featuring local prominent seniors (e.g., former mayors, business leaders, etc.) in advertisements discussing senior issues; for example, a former mayor of Charlotte could be featured discussing a senior issue and close by pronouncing, "I'm "(name of individual)," Senior Class of 1953."

- **Improve transportation options available to the seniors**

  During the course of our research, we observed several areas where public partnerships with non-profits or private organizations enhanced the transportation options available to seniors. For example, in Rochester, New York, the grocery chain Wegman's partners with two local non-profits to provide a grocery and prescription drug transportation service. The grocery chain benefits due to the increased traffic provided by the elderly citizens it serves. Further, the program allows the elderly to maintain a feeling of independence by allowing them to shop for their own groceries and prescription medication. The program also allows the

elderly to build a relationship with a LifeSpan case manager, thereby reducing feelings of isolation. The program allows the LifeSpan case manager to determine the additional areas in which the elderly individual can be helped.

Mecklenburg County must consider public and private transportation options, such as those available in other communities (e.g., Montgomery County, Maryland and Fairfax, County Virginia), for seniors. Given that senior service providers are located near public transportation routes and that they identify transportation as an area of community need, the county must explore public transportation options available to seniors. In those counties featuring program partnerships with private agencies, residents who meet income requirements are able to buy taxi vouchers at a reduced rate. As a result, those whose mobility was once restricted are now able to get from place to place. A public/private partnership between the county government and taxi companies allows increased traffic for the participating taxi companies and permits residents, who might otherwise rely on government services to maintain their independence, to use private, market-based services. Also, in a cooperative effort with the NC Division of Motor Vehicles, transportation officials and the CMPD can gather data on senior citizens who lose their driving privilege. Thereafter, to ease their transition from driver to public transit consumer the county can provide "silver routes." Routes of this type increase senior activity by offering transportation services to seniors who might otherwise be home bound. Perhaps, assuming proper density of seniors, state and local transportation officials can provide routes to service identifiable areas or communities to schedule specific service times and days.

- **Provide a targeted crime education campaign in high density areas with a focus on seniors, provide senior-oriented CPTED in communities with significant senior populations, and focus on public safety efforts needed to accommodate a growing senior population.**

  The CMPD must create an education program focused specifically on the senior population. As noted in the survey and shown on data maps, there is a need for crime education as seniors in Mecklenburg County are often crime victims. Therefore, the CMPD should conduct education programs aimed specifically at seniors to help them understand those crimes by which they are most likely to be victimized, as well as instruct seniors about preventing victimization.

  Further, the CMPD must focus attention on the areas where crime against seniors is most prevalent. The use of CPTED analysis can provide insight as to requisite changes needed to reduce crimes against seniors. By focusing on crime prevention and providing seniors with knowledge to

prevent victimization, the CMPD can reduce the number of crimes committed against seniors.

Finally, the CMPD must partner with other government organizations, such as DSS, as well as with private and non-profit organizations to focus on the growth of the senior population and issues resulting from this growth. The CMPD must establish programs and crime prevention strategies specifically for the senior population. With assistance from other county organizations – public, non-profit or private – the CMPD can position their organization to take proactive steps to confront the anticipated population growth among senior citizens.

- **Define specific criteria for determining exactly senior service provider status**

  In working to establish a list of senior service providers, we uncovered numerous providers that did not feel as though they "qualified" as senior service providers. As a result, several agencies or organizations that serve senior citizens were under the impression that there was no need for them to respond to the survey. Therefore, we recommend the development of senior service provider criteria that distinguishes between those agencies or organizations that truly are not providers of services to seniors or do not receive funding for elderly based programs.

  Further, we advise the DSS, in cooperation with other interested parties, to establish some distinction between service providers according to agency or organization focus or mission. To do this, we suggest that the DSS establish at least two categories of senior service provider – "active" senior service provider and "latent" senior service provider - and base this distinction on percent of services the agency or organization provides to seniors. For example, the DSS can suggest that agencies or organizations providing 25 percent or less of their services to senior citizens to be classified as "latent senior service providers" and that agencies or organizations directing 25 percent or more of their services to senior citizens be known as "active senior service providers." Such a distinction among senior service providers would likely assist DSS in determining future senior needs and improve cooperation and participation from this service sector.

Endnotes

[1] Personal Correspondence with Monica Nguyen of the Research Planning and Analysis (RPA) Bureau of the Charlotte-Mecklenburg Police Department by officers R.C Temm and C.S. Wagner between 9/2003 and 11/2003

[2] *Status of Seniors Initiative:* http://www.charmeck.org/Departments/DSS/Services+for+Seniors+and+the+Disabled/2statusofseniors.htm

[3] *Understanding Senior Transportation: Report and Analysis of a Survey of Consumers 50+.* http://research.aarp.org/il/2002_04_transport_1.html

[4] *Transportation: Reframing the Transportation Problem.* http://www.mnaging.org/mba/som2001/PDF/TransportationIssueBrief.pdf

[5] *Understanding Senior Transportation: Report and Analysis of a Survey of Consumers 50+.* http://research.aarp.org/il/2002_04_transport_1.html

[6] Ibid.

[7] *Forty Year Old Volunteer Driver Program: Wheels for Wellness, Inc., in Philadelphia, Pennsylvania.* http://www.ctaa.org/ntrc/is_innovations.asp

[8] *Annapolis, Transit and Partners in Care: A Public-Private Partnership to Provide Rides for Frail Elderly.* http://www.ctaa.org/ntrc/is_innovations.asp

[9] Ibid.

[10] *Bus Service to Buy Groceries and Prescription Drugs*. http://www.ctaa.org/ntrc/is_innovations.asp

[11] Ibid.

[12] *Discount Taxi Program in Montgomery County, Maryland.* http://www.ctaa.org/ntrc/is_innovations.asp

[13] *Senior Transportation: Progress in the Making.* http://www.fairfaxcounty.gov/comm/trans/seniors.htm

[14] *Research Plan: DOT HS 809 322 (2001) U.S. Department of Transportation National Highway Traffic Safety Administration.* http://www.nhtsa.dot.gov/people/injury/olddrive/OlderRoad/index.htm#toc

[15] Bullock and Osborne (1999). *Seniors', Volunteers', and Families' Perspectives of an Intergenerational Program in a Rural Community*. **Educational Gerontology.** (25): 237-251**.**

[16] O' Shaughnessy Carol. (2003). Report # RS21518: *Long-Term Care Chart Book: Persons Served, Payors and Spending*. **CRS Report for Congress.** Available via Purchase at: http://www.pennyhill.com/healthpolicy/rs21518.html

[17] Stone, R. (2000). *Long-term care for the elderly with disabilities: Current policy, emerging trends and implications for the twenty-first century*. New York, NY: The Milbank Memorial Fund

[18] O' Shaughnessy Carol. (2003). Report # RS21518: *Long-Term Care Chart Book: Persons Served, Payors and Spending*. **CRS Report for Congress.** Available via Purchase at: http://www.pennyhill.com/healthpolicy/rs21518.html

[19] Ibid.

[20] GAO Report to the Chairman, Special Committee on Aging, U.S. Senate (2002) **Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably. GAO-02-1211.** *http://www.gao.gov/new.items/d021121.pdf*

[21] Ibid.

[22] Ibid.

[23] *Nursing Home Cost of Care Study* (2002). http://www.newmanltc.com/docs/average_nh_daily.pdf

[24] North Carolina Division of Aging Information on Home and Community Services. http://www.dhhs.state.nc.us/aging/faq.htm

[25] Special Assistance Demonstration Project Pursuant S.L. 2001-424 (2003) . *Final Report to House of Representatives Appropriations Committee and House of Representatives Subcommittee on Health and Human Services and Senate Appropriations Committee and Senate Appropriations Committee on Health and Human Services.* http://www.dhhs.state.nc.us/dss/docs/SADP.pdf

[26] O' Shaughnessy Carol. (2003). Report # RS21518: *Long-Term Care Chart Book: Persons Served, Payors and Spending*. **CRS Report for Congress.** Available via Purchase at: http://www.pennyhill.com/healthpolicy/rs21518.html

[27] ASPE: The Assistant Secretary for Planning and Evaluation & AoA: The Administration on Aging (1998). *Informal caregiving: Compassion in action*. Washington, DC: Authors

[28] Personal Correspondence with Monica Nguyen of the Research Planning and Analysis (RPA) Bureau of the Charlotte-Mecklenburg Police Department by officers R.C Temm and C.S. Wagner between 9/2003 and 11/2003

[29] Ibid

[30] *Stable Threatened and Fragile Neighborhoods*. http://www.ci.charlotte.nc.us/Departments/Neighborhood+Dev/Quality+of+Life/stable.htm

[31] Only portions fo the top five, 1st Ward, 4th Ward and the Plaza-Midwood neighborhood section, are *not* listed as fragile by the Quality of Life Study

[32] *About Us*. Charlotte Mecklenburg Police Department. http://www.charmeck.org/Departments/Police/About+Us/Home.htm

[33] The survey is of the entire population of senior service providers, thus it is not a statistical sample. Due to the entire population being available, inferential statistics are not required for analytical purposes; however, any use of inferential statistics serves to support the results reported. As a result, the responses represent the perspectives of those agencies and organizations participating in the survey. Despite the acceptable, but low response rates, inferences from the responses can be used with some confidence in assessing the population of senior service providers in the community. The findings reported herein represent general opinions and perspectives of the participating senior service providers.

[34] *In Home Services*. http://www.pottercountyhumansvcs.org/aging/srinhome.htm

Appendix A

Survey Methodology and Frequency Distributions

Introduction

The Mecklenburg County Department of Social Service (DSS) asked students in UNC-Charlotte's Master of Public Administration (MPA) program to assist with assessing senior service provision in the community. As part of this effort, the MPA students developed a comprehensive list of agencies and organizations that provide services to senior citizens in Mecklenburg County (see section below discussion of the provider list). MPA students developed a comprehensive list of 368 agencies or organizations that provide services to seniors in the community. To qualify as a senior service provider, an agency or organization must provide a service directed at senior citizens, no matter the level of service per agency or organization. MPA students surveyed these agencies and organizations to discern their perspectives across several issue areas concerning services available to seniors, as well as the provision of these services in Mecklenburg County.

MPA students developed the survey instrument in collaboration with officials from the DSS and other experts in the field. Administration of the survey occurred during October and November 2003. In an effort to increase participation among senior service provider organizations and contact all providers in the county, the survey was administered in a two-stage method. The first phase of survey research used an Internet survey, while the second phase used a mail survey (which included a mail package consisting of a cover letter explaining the survey, the survey instrument, and a postage-paid return envelope).

The **overall survey success** (or response) **rate is 31 percent** (explained in detail in the next section). While the overall success rate is only about one-third of those contacted, one

must remain cognizant that we surveyed the entire population of senior service providers; we did not sample the population. Since this survey is of the entire population of senior service providers, thus not a statistical sample, the responses represent the perspectives of those agencies and organizations participating in the survey. Since the overall response rate is nearly 30 percent of this population, these results provide confident and accurate representations of the perspectives of all senior service providers in Mecklenburg County.

Due to the entire population being available, inferential statistics are not required for analytical purposes; however, any use of inferential statistics serves to support the results reported. Despite the acceptable, but low response rates, inferences from the responses can be used with some confidence in assessing the population of senior service providers in the community. The findings reported herein represent general opinions and perspectives of the participating senior service providers.

Survey Administration and Success (Response) Rates

The survey was conducted over a seven-week period from October 10, 2003, to November 14, 2003. Prior to the survey being made available for completion on the Internet, each provider agency and organization with an electronic contact (email address) was informed (on October 2, 2003) of the issues of interest on the survey *and* asked to complete a survey for each senior service provided by that agency or organization. Once the survey was made available for completion (on October 10, 2003) on the Internet, we sent follow-up email reminders twice weekly to each agency or organization not completing the survey. For agencies or organizations without electronic resources (email or website information), we sent a survey in the mail (on October 29, 2003, complete with survey instrument and postage-paid, return envelope) requesting completion by November 7, 2003. For agencies or organizations

not completing the mail survey by the requested date, students followed-up with telephone call reminders to complete the survey.

Agencies and organizations providing services to seniors in Mecklenburg County did not complete surveys at desired rates despite repeated attempts to remind agencies and organizations to complete the survey. Agencies and organizations completed 103 surveys. Of this 103, 85 (from 81 provider agencies or organizations) surveys were completed electronically; this total completion rate (85) *includes* multiple surveys completed by an agency providing more than one service for senior citizens. For calculating completion or success rates, however, only the number of agencies completing surveys is used (81), i.e., the 81 agencies or organizations that responded to the survey, not the number of surveys completed. Only 18 mail surveys were completed and returned.

The agency and organization list was culled from 368 to a final list of 324 senior service providers. Agencies or organizations were removed from the list when their contact information proved insufficient (e.g., undeliverable mailing address, disconnected telephone, no other contact information available, etc) and could not be contacted by any means. Of these 324, we administered the survey to 200 agencies or organizations electronically. These agencies and organizations were contacted by email and asked to complete the survey on the Internet; as stated previously, this group received email reminders twice weekly asking them to complete the Internet survey (electronically). The remaining 124 agencies and organizations received the survey by US mail. If these agencies and organizations had not completed the survey by November 7th, students called each agency or organization to personally remind them to complete and return the survey. Of these 124 mail surveys, 3 were returned due to

insufficient addresses; thus these three were removed from the total. There were 121 total mail surveys sent and delivered to senior service providers for completion.

The **overall survey success rate is 31 percent** (the total number of completions divided by the total number of respondents, 99/321 (18 completed mail surveys and 81 completed internet surveys, which totals 99, and is divided by the total number of agencies and organizations surveyed (321); the completion total excludes the 4 surveys completed by an agency responding for more than one service provided. The **Internet survey yielded a success rate of 41 percent** (the total number of completions divided by the total number of respondents contacted, 81/200. The mail survey was visibly less well received; it yielded only a **15 percent success rate** (the total number of completions divided by the total number of respondents contacted, 18/121).

Procedures Used to Develop List of Senior Service Providers

Students received a list of 1,682 service providers in the Mecklenburg County area from Just1Call, a local agency formed to provide information and referral services for citizens needing or seeking social services. This list incorporates organizations that provide a wide variety of services within Mecklenburg County as well as in surrounding areas. Not all of the service providers matched the criteria for inclusion in this project, for instance after school programs, youth athletic programs, and animal shelters. The intent of the Senior Service Provider Survey (SSPS) is to ascertain information from agencies and organizations about "quality of life" issues for senior citizens in Mecklenburg County. The SSPS addresses issues related to health, medical care, nutrition, safety, housing, transportation, independence, and self-sufficiency. Given our objectives, our final senior service provider list (for survey purposes) includes providers offering services with a goal to improve or continue the quality of

life for seniors. Although quality of life is subjective, providers with a "hintline" description (see below for explanation of "hintline") addressing any quality of life issue are included on the final senior service provider list for survey purposes. As an example, most seniors are nearing the end of their professional careers and are likely not in need of job training or counseling; however, given recent lay-offs in our immediate region, we believe such service providers (e.g., providing job retraining for seniors) are necessary for an aging workforce required to continue employment or seek positions in a new employment field; thus, their inclusion on our final list.

In order to develop a comprehensive list of providers specific to seniors in Mecklenburg County, we use basic criteria to develop a reliable and accurate list of senior service providers. Our final list of 324 senior service providers in Mecklenburg County represents those agencies or organizations providing services to senior citizens. To develop this comprehensive list of senior service providers, we began by eliminating service providers that do not serve the citizens of Mecklenburg County. From the resulting list of Mecklenburg County senior service providers, we eliminated those agencies and organizations that provide *no* services to seniors. Decisions concerning whether an agency or organization provided services for seniors were guided and informed by the "hintline" included with the Just1Call list (and supplemented by information gathered by students about specific service providers); the "hintline" cites the organization's targeted service audience and notes the type of service(s) offered. Also, removed from the list of providers are "hot line" services as these 1) are national programs with a national focus rather than a local emphasis; and, 2) have no local contact from which information could be ascertained. Other considerations for developing the final senior service provider list include:

- services to improve seniors' quality of life even if the provider also serves individuals of other age groups;

- services for distributing food;
- services providing health related care and information;
- services oriented to providing health and fitness programs (e.g., YMCA);
- services not generally associated with contributing to the improved quality of life (e.g., libraries); and,
- services offering services on a local level (e.g., neighborhood community centers).

Every effort was made to include as many senior service providers as possible. For example, when a service provider appeared on the Just1Call list without corresponding contact information, students searched other potential sources for contact information (e.g., telephone books, internet search, etc.). When contact information was unavailable from multiple sources, a decision was made to exclude this agency or organization. Decisions to exclude other agencies or organizations were based on additional information acquired once an agency or organization was contacted to verify the status of senior services offered. Upon contacting and discussing with an agency or organization representative the nature of the services provided, a mutual determination between the student and agency/organization representative was reached; generally, the agency no longer provided senior services or no longer was located in Mecklenburg County, thus their exclusion from the list. In some cases, contact (locally) with a local senior service provider determined that their main office should be contacted directly to respond to the survey; in these cases, we removed the local office from the list and retained the main office contact information, i.e., only the main office location remained on the list. Similarly, multiple listings for a single agency or organization (e.g., more than one location in the area) were reduced to include only the main location on the survey list (e.g., the YMCA has several locations in Mecklenburg County, so we contacted only the main branch). In

summary, after verification of each service provider appearing on the initial list of 368 senior service providers, we reduced this number by 44 service providers. Our final comprehensive list yields 324 senior service providers. Below we provide a summary of the reasons for removing service providers from the initial list (of 368); these are:

- 16 providers removed because they do not provide services to seniors;
- 24 providers removed for undeliverable email addresses;
- 3 agencies removed due to duplication, i.e., the agency was listed under different names, thus the duplicate name was removed from the list; and,
- 1 agency was removed at the request of the Department of Social Services.

Reading the Tables

Tables in this appendix provide the frequencies for response categories for each question asked in the survey. Each table provides the frequency, percent, valid percent, and cumulative percent across responses for each question (see sample below). Conspicuous in reviewing tables is the "missing" or "no response" category. Non-responses occur when, for a variety of reasons, respondents fail to offer a response to a question; for example, respondents may inadvertently skip a question, prefer not to answer, etc. Consequently, the "no responses" are treated as missing information. Research protocol requires that no responses be included when reporting results. No response options are not of sufficient numbers to affect the integrity of the findings presented in this report. The "missing" or "no response" category does ***not include*** the "does not apply" response category as "does not apply" is a valid response option for respondents to select.

For open-ended questions, which ask respondents to write in their answers, we have provided a listing of all responses.

Percent is the percent of all responses for this question across response options and includes "does not apply" and "missing" in the calculation.

Valid Percent is the percent of responses for this question exclusive of "does not apply" and "missing."

Cumulative Percent is the "running" percent of responses.

Frequency is the actual number of responses for this answer category

How often do you place people on a waiting list?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	**Never**	29	28.2	40.3	40.3
	Rarely	8	7.8	11.1	51.4
	Sometimes	21	20.4	29.2	80.6
	Always	14	13.6	19.4	100.0
	Does not Apply	31	30.0		
	Total	103	100.0	100.0	

These are the response options per question asked on the survey.

Total responses to this specific question.

Frequency Distributions[1]

How would you classify your agency or organization?
(multiple selections permitted here)

Abuse/neglect services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	100	97.1	97.1	97.1
	Selected	3	2.9	2.9	100.0
	Total	103	100.0	100.0	

Advocacy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	81	78.6	78.6	78.6
	Selected	22	21.4	21.4	100.0
	Total	103	100.0	100.0	

Care Giving

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	88	85.4	85.4	85.4
	Selected	15	14.6	14.6	100.0
	Total	103	100.0	100.0	

Employment/Job Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	91	88.3	88.3	88.3
	Selected	12	11.7	11.7	100.0
	Total	103	100.0	100.0	

[1] An asterisk denotes open-ended responses mentioned more than once.

General Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	85	82.5	82.5	82.5
	Selected	18	17.5	17.5	100.0
	Total	103	100.0	100.0	

Facilities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	96	93.2	93.2	93.2
	Selected	7	6.8	6.8	100.0
	Total	103	100.0	100.0	

Financial Assistance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	97	94.2	94.2	94.2
	Selected	6	5.8	5.8	100.0
	Total	103	100.0	100.0	

Health Care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	77	74.8	74.8	74.8
	Selected	26	25.2	25.2	100.0
	Total	103	100.0	100.0	

Home Health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	91	88.3	88.3	88.3
	Selected	12	11.7	11.7	100.0
	Total	103	100.0	100.0	

Housing (residential facility)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	90	87.4	87.4	87.4
	Selected	13	12.6	12.6	100.0
	Total	103	100.0	100.0	

Information and Referral

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	75	72.8	72.8	72.8
	Selected	28	27.2	27.2	100.0
	Total	103	100.0	100.0	

Legal Services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	98	95.1	95.1	95.1
	Selected	5	4.9	4.9	100.0
	Total	103	100.0	100.0	

Mental Health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	92	89.3	89.3	89.3
	Selected	11	10.7	10.7	100.0
	Total	103	100.0	100.0	

Nutrition Services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	97	94.2	94.2	94.2
	Selected	6	5.8	5.8	100.0
	Total	103	100.0	100.0	

Recreation and Leisure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	89	86.4	86.4	86.4
	Selected	14	13.6	13.6	100.0
	Total	103	100.0	100.0	

Social Services (general)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	81	78.6	78.6	78.6
	Selected	22	21.4	21.4	100.0
	Total	103	100.0	100.0	

Transportation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	87	84.5	84.5	84.5
	Selected	16	15.5	15.5	100.0
	Total	103	100.0	100.0	

What is the service that your agency or organization provides to seniors?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	15	14.6	14.6	14.6
	Selected	88	85.4	85.4	100.0
	Total	103	100.0	100.0	

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- transportation for people in wheelchairs
- Home Health Care
- prescription medication assistance
- Apartment style independent living with meals; housekeeping; transportation; and socialization.
- Employment and Unemployment Services
- Advocacy only
- Substance Abuse Prevention/Education
- emergency medical services
- MANY services (carpentry; home repair; yard work; transportation; house cleaning; grocery shopping; food delivery; etc.; etc.) Cannot fill out a form for each one!

- Home Care Services: Nursing; Infusion; In-home Aide; Nursing Pool;
- Geriatric Primary Medical Care office of Dr. Stephen Powell
- We are a non-profit organized to establish senior centers as focal points where older persons can come together to receive a broad spectrum of services and participate in activities to help improve their health and wellness; decrease loneliness and isolation
- Programs
- Adult Day Care/Day Health
- low-income housing for seniors 62 & older
- home medical equipment
- rehabilitation for the visually impaired
- Free legal assistance
- Room in the Inn; Soup Kitchen; Food Referrals; Prescription Help
- Adult Day and Health Care Services
- Alzheimer's Assisted Living
- Health and Wellness
- continuing care retirement community
- We are not an agency specifically designated for seniors
- Elderly General Purpose - Shopping; Recreation; worship, etc.
- counseling; volunteers; case management; programming
- Our organization's mission is to prevent consumer fraud
- park and recreation facilities
- It is open to seniors; but we do not have any clients.
- For all Mecklenburg County residents; we provide forms
- Assist seniors to continue to live independently
- Pro bono legal services for people 60 and over
- housing; support
- dispensation of Medicare approved diabetic footwear
- Provide services to seniors with disabilities to prevent institutionalization
- Private Section 8 housing
- Arthritis Education
- personal care services
- job placement
- Counseling
- The Red Cross Transportation Service provides transportation
- care management
- Non-medical companionship
- health care services
- in-home living assistance (Home Care)
- Adult Medicaid and FS
- transportation; financial aid; health and nutrition; information
- Affordable Housing
- continue care retirement community(CCRC)-retirement options
- volunteer services
- Transportation to and from medical appointments.
- Affordable Housing Referral Service
- Long-term Nursing Care
- Recreation and Leisure
- Advocacy; financial assistance; information & referral
- HIV/AIDS treatment and services
- SAIL; (Seniors Achieving Integrated Living)

- services to caregivers
- outpatient psychotherapy
- Adult Day Health Services
- Case Management Services to enhance client self-sufficiency
- Comprehensive health care services to seniors who are diagnosed
- Home repair and maintenance referral company
- education; information & referral; support groups; advocacy
- Community; Support; Education; & Recreation & Travel
- Provide family law legal service to persons qualifying for our service
- Home Health Services
- Batterers Intervention (jail alternative)
- home health care
- out patient counseling for issues such as grief; death of a spouse
- veterans benefits information
- Mental HealthCase Management and treatment
- outreach/assessment/referral into the continuum of homeless services
- Audiology Services; Hearing Aids and Aural Rehabilitation
- Recreation and Leisure opportunities
- Senior Programs (Trips; Recreation Programs)
- The Parkinson Association provides support; information; referral and advocacy to patients and caregivers
- hospice and end of life issues
- In-home Aide Services
- Emergency Medical Response Systems / Safety Seminars

Is your agency or organization a government, for-profit, or non-profit?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	For Profit	26	25.2	26.0	26.0
	Non Profit	50	48.5	50.0	76.0
	Government	24	23.3	24.0	100.0
	Total	100	97.1	100.0	
	Does Not Apply	3	2.9		
Total		103	100.0		

Please tell us what type of planning your agency or organization is conducting for senior issues? Committee or Task Force

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	82	79.6	79.6	79.6
	Selected	21	20.4	20.4	100.0
	Total	103	100.0	100.0	

Please tell us what type of planning your agency or organization is conducting for senior issues? Fund Development

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	87	84.5	84.5	84.5
	Selected	16	15.5	15.5	100.0
	Total	103	100.0	100.0	

Please tell us what type of planning your agency or organization is conducting for senior issues? Program Development

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	60	58.3	58.3	58.3
	Selected	43	41.7	41.7	100.0
	Total	103	100.0	100.0	

Please tell us what type of planning your agency or organization is conducting for senior issues? Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	72	69.9	73.5	73.5
	Selected	26	25.2	26.5	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- Our corporate office handles senior issues
- SOS Steering Committee
- Behavioral Health Services and memory assessment as well as medical care
- as a part of planning for services to all of our clients
- **Nursing home transition**
- Planned activities

- Community Integration
- periodic in-service program

Please tell us how important or not important each of the following is to planning your senior services for the next fiscal year?

Funding Shortages

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	18	17.5	17.6	17.6
	Not Important	3	2.9	2.9	20.6
	Somewhat Important	27	26.2	26.5	47.1
	Very Important	54	52.4	52.9	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Budget Cuts

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	22	21.4	21.6	21.6
	Not Important	5	4.9	4.9	26.5
	Somewhat Important	31	30.1	30.4	56.9
	Very Important	44	42.7	43.1	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Lack of Facility Space

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	37	35.9	36.3	36.3
	Not Important	11	10.7	10.8	47.1
	Somewhat Important	33	32.0	32.4	79.4
	Very Important	21	20.4	20.6	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Staffing Shortages

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	25	24.3	24.8	24.8
	Not Important	7	6.8	6.9	31.7
	Somewhat Important	31	30.1	30.7	62.4
	Very Important	38	36.9	37.6	100.0
	Total	101	98.1	100.0	
Missing		2	1.9		
Total		103	100.0		

Volunteer Shortages

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	38	36.9	37.6	37.6
	Not Important	6	5.8	5.9	43.6
	Somewhat Important	38	36.9	37.6	81.2
	Very Important	19	18.4	18.8	100.0
	Total	101	98.1	100.0	
Missing		2	1.9		
Total		103	100.0		

Meeting Demands of Senior Population

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	15	14.6	15.0	15.0
	Not Important	3	2.9	3.0	18.0
	Somewhat Important	32	31.1	32.0	50.0
	Very Important	50	48.5	50.0	100.0
	Total	100	97.1	100.0	
Missing		3	2.9		
Total		103	100.0		

Are there other very important issues for planning your senior services for the next fiscal year? Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	79	76.7	76.7	76.7
	Selected	24	23.3	23.3	100.0
	Total	103	100.0	100.0	

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- specialized training for our employees for Alzheimer's; MDA; etc
- Advocacy for Direct Care Workers & Family Caregiving Concerns
- The bulk of prevention funding from the state is specifically designated for YOUTH services
- Informing the community about the practice
- Proposed Medicare Prescription Legislation
- Available transportation to newly developed communities
- public awareness of our agency
- The development of an intensive outreach
- we plan our facilities for all ages
- No demand for our services in the senior population
- chronic disease management
- Education HIV/AIDS for seniors
- Community Program Development
- new and continuing collaborations
- Community Grants
- Identify Grants and Private Donations
- our services are for all patients; not just seniors
- Comprehensive community information initiative
- Education of seniors families relating to what is/isn't available through Govt programs
- Advocacy for Access; Health & Wellness; Transportation & Leisure
- Extended Health Care (optical; ear and feet) under Medicaid/Medicare
- new grant

Public Safety Issues

Does your agency provide services on public safety (e.g., crime prevention instruction, victimization information, etc)?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	42	40.8	53.8	53.8
	Yes	36	35.0	46.2	100.0
	Total	78	75.7	100.0	
	Does not apply	25	24.3		
Total		103	100.0		

Has your agency or organization performed, or had the police department perform a Crime Prevention through Environmental Design (CPTED) analysis for your facility or location?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	64	62.1	79.0	79.0
	Yes	17	16.5	21.0	100.0
	Total	81	78.6	100.0	
	Does not apply	22	21.4		
Total		103	100.0		

From your perspective, do seniors need any of the following public safety services?

Crime Prevention Classes

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	32	31.1	31.1	31.1
	Selected	71	68.9	68.9	100.0
	Total	103	100.0	100.0	

CPTED (Crime Prevention through Environmental Design)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	73	70.9	70.9	70.9
	Selected	30	29.1	29.1	100.0
	Total	103	100.0	100.0	

Building or property safety

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	50	48.5	48.5	48.5
	Selected	53	51.5	51.5	100.0
	Total	103	100.0	100.0	

Crime Awareness classes (for crimes against seniors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	19	18.4	18.4	18.4
	Selected	84	81.6	81.6	100.0
	Total	103	100.0	100.0	

Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	91	88.3	88.3	88.3
	Selected	12	11.7	11.7	100.0
	Total	103	100.0	100.0	

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- Elder Exploitation
- services to crime victims (after incidents)
- Target audience should include families and children of seniors

Are you aware of specific public safety & crime concerns that those receiving your services may have

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	70	68.0	68.0	68.0
	Selected	33	32.0	32.0	100.0
	Total	103	100.0	100.0	

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- some seniors in wheelchairs do not have proper ramps to allow access in and out of home.
- Yes*
- Telephone fraud

- Seniors living in low-income housing with younger disabled are very frightened & are often victims.
- One participant had his home burglarized a few months ago.
- vehicle thefts
- family abuse of the elderly
- fear of being a victim because they are visually impaired
- predatory lending
- Complaints re: drug dealing
- transportation; medical
- particularly around
- Telemarketing "crimes"
- Scams against the elderly
- Need for hearing alarms
- Telemarketing Scams
- identity theft
- Staying safe inside your home (home hazards)
- Driving fraud
- break-ins
- fear of crime in their community
- consumer fraud
- No*
- Some have asked for more education
- Yes, we hear about them at senior centers and nutrition
- Identify theft
- Car theft and vandalism
- My clients are violent offenders themselves, Although not usually
- ramps and railings to aid seniors so they can prevent falls
- low-income housing in crime areas
- Clients do not hear approach of assailants; traffic; etc.
- All seniors are concerned about being victimized as they are a main target of scams
- Senior fraud

Rating of services, programs, or issues according to community need

Access to Health and Care Services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	4	3.9	4.0	4.0
	Essential Service	25	24.3	25.3	29.3
	Critical Service	70	68.0	70.7	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Food and Nutrition

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	2	1.9	2.0	2.0
	Dispensable Service	4	3.9	4.1	6.1
	Essential Service	47	45.6	48.0	54.1
	Critical Service	45	43.7	45.9	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Mental Health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	5	4.9	5.1	11.2
	Essential Service	56	54.4	57.1	68.4
	Critical Service	31	30.1	31.6	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Cost of Prescription Drugs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	5	4.9	5.1	5.1
	Dispensable Service	3	2.9	3.0	8.1
	Essential Service	26	25.2	26.3	34.3
	Critical Service	65	63.1	65.7	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Caregiving

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	3	2.9	3.0	3.0
	Dispensable Service	9	8.7	9.1	12.1
	Essential Service	45	43.7	45.5	57.6
	Critical Service	42	40.8	42.4	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Abuse, Neglect, and Fraud

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	10	9.7	10.1	16.2
	Essential Service	40	38.8	40.4	56.6
	Critical Service	43	41.7	43.4	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

In-Home Care to prevent institutionalization

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	5	4.9	5.1	5.1
	Dispensable Service	13	12.6	13.1	18.2
	Essential Service	49	47.6	49.5	67.7
	Critical Service	32	31.1	32.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Disabilities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	4	3.9	4.0	4.0
	Dispensable Service	9	8.7	9.1	13.1
	Essential Service	48	46.6	48.5	61.6
	Critical Service	38	36.9	38.4	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Community Based versus Institutional Care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	14	13.6	14.1	20.2
	Essential Service	51	49.5	51.5	71.7
	Critical Service	28	27.2	28.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Leisure and Recreation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	4	3.9	4.1	4.1
	Dispensable Service	30	29.1	30.6	34.7
	Essential Service	46	44.7	46.9	81.6
	Critical Service	18	17.5	18.4	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Value of Seniors in (and to) the community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	6	5.8	6.1	12.1
	Essential Service	49	47.6	49.5	61.6
	Critical Service	38	36.9	38.4	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Socialization/Relationships

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	10	9.7	10.1	16.2
	Essential Service	44	42.7	44.4	60.6
	Critical Service	39	37.9	39.4	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Financial Planning for Retirement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	22	21.4	22.2	28.3
	Essential Service	45	43.7	45.5	73.7
	Critical Service	26	25.2	26.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Health Planning for Retirement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	3	2.9	3.0	3.0
	Dispensable Service	15	14.6	15.2	18.2
	Essential Service	50	48.5	50.5	68.7
	Critical Service	31	30.1	31.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Housing for Retirement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	5	4.9	5.1	5.1
	Dispensable Service	11	10.7	11.2	16.3
	Essential Service	54	52.4	55.1	71.4
	Critical Service	28	27.2	28.6	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Employment and Financial Stability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	5	4.9	5.1	5.1
	Dispensable Service	17	16.5	17.2	22.2
	Essential Service	57	55.3	57.6	79.8
	Critical Service	20	19.4	20.2	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Issue Education and Information (public relations)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	30	29.1	30.3	36.4
	Essential Service	51	49.5	51.5	87.9
	Critical Service	12	11.7	12.1	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Aging in Place (independent living)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	3	2.9	3.0	3.0
	Dispensable Service	11	10.7	11.1	14.1
	Essential Service	55	53.4	55.6	69.7
	Critical Service	30	29.1	30.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Accessibility to Senior Services (i.e., information for navigating the system)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	3	2.9	3.1	3.1
	Dispensable Service	5	4.9	5.1	8.2
	Essential Service	57	55.3	58.2	66.3
	Critical Service	33	32.0	33.7	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Affordable Housing

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	4	3.9	4.0	4.0
	Dispensable Service	6	5.8	6.1	10.1
	Essential Service	38	36.9	38.4	48.5
	Critical Service	51	49.5	51.5	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Transportation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	4	3.9	4.0	4.0
	Dispensable Service	4	3.9	4.0	8.1
	Essential Service	45	43.7	45.5	53.5
	Critical Service	46	44.7	46.5	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Planning Process for Senior Issues

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	7	6.8	7.1	7.1
	Dispensable Service	15	14.6	15.2	22.2
	Essential Service	52	50.5	52.5	74.7
	Critical Service	25	24.3	25.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Emergency Issues

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	5	4.9	5.1	5.1
	Dispensable Service	8	7.8	8.2	13.3
	Essential Service	43	41.7	43.9	57.1
	Critical Service	42	40.8	42.9	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Disaster Issues

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Service Not Needed at All	6	5.8	6.1	6.1
	Dispensable Service	16	15.5	16.2	22.2
	Essential Service	46	44.7	46.5	68.7
	Critical Service	31	30.1	31.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Does your agency or organization have non-English speaking seniors who receive your services?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	42	40.8	47.2	47.2
	Yes	47	45.6	52.8	100.0
	Total	89	86.4	100.0	
	Does not apply	14	13.6		
Total		103	100.0		

How does your organization or agency deal with language issues for non-English speaking seniors receiving your service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Bi/Multi-Lingual Staff	15	14.6	14.7	14.7
	Interpreting Service	8	7.8	7.8	22.5
	Use Staff & Interpreting service	23	22.3	22.5	45.1
	Communicate as best we can	9	8.7	8.8	53.9
	No Non-English speaking clients	31	30.1	30.4	84.3
	Other	16	15.5	15.7	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- Just1Call -Information & Referral
- flash cards with familiar words
- interpreter on as-needed basis

Please tell us how important or not important each of the following items is to addressing your enrollment situation.

Funding

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	23	22.3	23.0	23.0
	Not Important	4	3.9	4.0	27.0
	Somewhat Important	20	19.4	20.0	47.0
	Very Important	53	51.5	53.0	100.0
	Total	100	97.1	100.0	
Missing		3	2.9		
Total		103	100.0		

Staff Availability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	19	18.4	19.2	19.2
	Not Important	4	3.9	4.0	23.2
	Somewhat Important	22	21.4	22.2	45.5
	Very Important	54	52.4	54.5	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Volunteer Availability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	36	35.0	36.4	36.4
	Not Important	11	10.7	11.1	47.5
	Somewhat Important	30	29.1	30.3	77.8
	Very Important	22	21.4	22.2	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Physical Space Availability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not an Issue	36	35.0	36.4	36.4
	Not Important	9	8.7	9.1	45.5
	Somewhat Important	29	28.2	29.3	74.7
	Very Important	25	24.3	25.3	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Are there other very important items that address your enrollment situation?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	92	89.3	89.3	89.3
	Selected	11	10.7	10.7	100.0
	Total	103	100.0	100.0	

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- COA isn't membership or enrollment driven
- Seniors need to know there is help available for them.
- There are 12 adult day care/day health in Mecklenburg County; which seems to be:
- Marketing/PR
- transportation to services
- Overall Health Condition
- Any senior
- Publicity
- have to me
- relationships
- Transportation
- Location of services needed (we may not be able to serve remote or long distance)

How do you handle those people not able to enroll (once you have reached your maximum number of enrollees)?

(multiple selections are permitted here)

Do not offer them service

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	97	94.2	94.2	94.2
	Selected	6	5.8	5.8	100.0
	Total	103	100.0	100.0	

Waiting List

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	70	68.0	68.0	68.0
	Selected	33	32.0	32.0	100.0
	Total	103	100.0	100.0	

Add more space

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	98	95.1	95.1	95.1
	Selected	5	4.9	4.9	100.0
	Total	103	100.0	100.0	

Add more services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	97	94.2	94.2	94.2
	Selected	6	5.8	5.8	100.0
	Total	103	100.0	100.0	

Refer to another agency or organization

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	77	74.8	74.8	74.8
	Selected	26	25.2	25.2	100.0
	Total	103	100.0	100.0	

Does not apply

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	59	57.3	57.3	57.3
	Selected	44	42.7	42.7	100.0
	Total	103	100.0	100.0	

Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	100	97.1	97.1	97.1
	Selected	3	2.9	2.9	100.0
	Total	103	100.0	100.0	

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- Offer financial assistance
- Increase caseload
- We support all seniors in our geographic area; those who are remote we refer to another agency of organization.

How often do you place people on a waiting list?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	29	28.2	40.3	40.3
	Rarely	8	7.8	11.1	51.4
	Sometimes	21	20.4	29.2	80.6
	Always	14	13.6	19.4	100.0
	Total	72	69.9	100.0	
	Does not apply	31	30.1		
Total		103	100.0		

If you have a waiting list, what is the likelihood that those on the list eventually receive the service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	1	1.0	2.2	2.2
	Rarely	1	1.0	2.2	4.3
	Sometimes	14	13.6	30.4	34.8
	Always	30	29.1	65.2	100.0
	Total	46	44.7	100.0	
	Does not apply	57	55.3		
Total		103	100.0		

WaitList

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	5	4.9	16.7	16.7
	1 week	4	3.9	13.3	30.0
	1 month	4	3.9	13.3	43.3
	2-3 months	10	9.7	33.3	76.7
	3-6 months	4	3.9	13.3	90.0
	6-12 months	3	2.9	10.0	100.0
	Total	30	29.1	100.0	
Missing		73	70.9		
Total		103	100.0		

Thinking ahead, let's say to 2005, do you expect to decrease, increase, or provide the same amount of services?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Decrease	1	1.0	1.0	1.0
	Provide the Same Services	21	20.4	21.2	22.2
	Increase Services	77	74.8	77.8	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Does your agency or organization provide transportation for seniors to receive your service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	37	35.9	50.7	50.7
	Yes	36	35.0	49.3	100.0
	Total	73	70.9	100.0	
	Does not apply	30	29.1		
Total		103	100.0		

Is there a public transportation site (e.g., a bus stop) close to your agency or organization's location?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	13	12.6	15.7	15.7
	Yes	70	68.0	84.3	100.0
	Total	83	80.6	100.0	
	Does not apply	20	19.4		
Total		103	100.0		

Are car pools available for seniors to use to participate in your service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	46	44.7	83.6	83.6
	Yes	9	8.7	16.4	100.0
	Total	55	53.4	100.0	
	Does not apply	48	46.6		
Total		103	100.0		

Is parking available for seniors at your site?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	1	1.0	1.3	1.3
	Yes	76	73.8	98.7	100.0
	Total	77	74.8	100.0	
	Does not apply	26	25.2		
Total		103	100.0		

Is your agency or organization handicap accessible?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	7	6.8	8.2	8.2
	Yes	78	75.7	91.8	100.0
	Total	85	82.5	100.0	
	Does not apply	18	17.5		
Total		103	100.0		

Are there crosswalks and sidewalks on the main streets by your agency or organization's location?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	6	5.8	7.5	7.5
	Yes	74	71.8	92.5	100.0
	Total	80	77.7	100.0	
	Does not apply	23	22.3		
Total		103	100.0		

How does your agency or organization inform the senior population of services you provide?

Newspaper

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	53	51.5	51.5	51.5
	Selected	50	48.5	48.5	100.0
	Total	103	100.0	100.0	

Radio

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	83	80.6	80.6	80.6
	Selected	20	19.4	19.4	100.0
	Total	103	100.0	100.0	

Agency or Organization Newsletter

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	51	49.5	49.5	49.5
	Selected	52	50.5	50.5	100.0
	Total	103	100.0	100.0	

Internet

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	42	40.8	40.8	40.8
	Selected	61	59.2	59.2	100.0
	Total	103	100.0	100.0	

Email

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	82	79.6	79.6	79.6
	Selected	21	20.4	20.4	100.0
	Total	103	100.0	100.0	

Telephone

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	62	60.2	60.2	60.2
	Selected	41	39.8	39.8	100.0
	Total	103	100.0	100.0	

Phone Book

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	54	52.4	52.4	52.4
	Selected	49	47.6	47.6	100.0
	Total	103	100.0	100.0	

Word of Mouth (i.e., family and friends)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	17	16.5	16.5	16.5
	Selected	86	83.5	83.5	100.0
	Total	103	100.0	100.0	

Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	70	68.0	68.6	68.6
	Selected	32	31.1	31.4	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- Just1Call & UW 211
- Just1Call and other social service agencies know about us.
- Ad in Senior Living
- Contact with potential referral sources; such as physicians; social workers; churches.
- mailings
- doctors
- 211; other agencies
- magazine
- Referral from neurologists.
- Public speaking; community newsletter
- medical referrals
- Church newsletters/bulletins
- medical community/fliers
- Networking in senior community
- Agency referrals
- group presentations
- medical professionals; DSS
- churches

- participation in wellness fairs
- publicity through churches
- Dissemination of Flyers
- Brochures made available
- community presentations
- through church newsletters
- 211; just one call;
- TV Public Service Announcements
- Listed with county services such as Just1Call
- Referrals
- Resident Council Meetings

About how much of your agency or organization's budget is allocated for providing information (marketing) about your services?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	1.0	1.1	1.1
	0-5%	56	54.4	59.6	60.6
	5-10%	21	20.4	22.3	83.0
	10-20%	11	10.7	11.7	94.7
	20-30%	2	1.9	2.1	96.8
	30-40%	2	1.9	2.1	98.9
	More than 40%	1	1.0	1.1	100.0
	Total	94	91.3	100.0	
Missing		9	8.7		
Total		103	100.0		

What is your agency or organization's total annual budget?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	1.0	1.1	1.1
	$1-24,999	6	5.8	6.5	7.5
	$25,000-49,999	2	1.9	2.2	9.7
	$50,000-74,999	5	4.9	5.4	15.1
	$75,000-99,999	3	2.9	3.2	18.3
	$100,000-149,999	5	4.9	5.4	23.7
	$150,000-199,999	3	2.9	3.2	26.9
	$200,000-249,999	7	6.8	7.5	34.4
	$250,000-299,999	2	1.9	2.2	36.6
	$300,000-349,999	9	8.7	9.7	46.2
	$350,000-399,999	1	1.0	1.1	47.3
	$400,000 and over	49	47.6	52.7	100.0
	Total	93	90.3	100.0	
Missing		10	9.7		
Total		103	100.0		

Given your funding, please tell us the percentage of funds each of the following provide for your overall budget?

Grants

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	49	47.6	62.0	62.0
	1 to 20 percent	18	17.5	22.8	84.8
	21 to 40 percent	4	3.9	5.1	89.9
	41 to 60 percent	1	1.0	1.3	91.1
	61 to 80 percent	3	2.9	3.8	94.9
	81 to 100 percent	4	3.9	5.1	100.0
	Total	79	76.7	100.0	
Missing		24	23.3		
Total		103	100.0		

Private Donations (individuals)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	43	41.7	52.4	52.4
	1 to 20 percent	28	27.2	34.1	86.6
	21 to 40 percent	4	3.9	4.9	91.5
	41 to 60 percent	5	4.9	6.1	97.6
	81 to 100 percent	2	1.9	2.4	100.0
	Total	82	79.6	100.0	
Missing		21	20.4		
Total		103	100.0		

Private Donations (business)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	53	51.5	68.8	68.8
	1 to 20 percent	21	20.4	27.3	96.1
	21 to 40 percent	2	1.9	2.6	98.7
	41 to 60 percent	1	1.0	1.3	100.0
	Total	77	74.8	100.0	
Missing		26	25.2		
Total		103	100.0		

Client Fees

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	42	40.8	53.8	53.8
	1 to 20 percent	20	19.4	25.6	79.5
	21 to 40 percent	5	4.9	6.4	85.9
	41 to 60 percent	1	1.0	1.3	87.2
	61 to 80 percent	5	4.9	6.4	93.6
	81 to 100 percent	5	4.9	6.4	100.0
	Total	78	75.7	100.0	
Missing		25	24.3		
Total		103	100.0		

United Way

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	62	60.2	78.5	78.5
	1 to 20 percent	10	9.7	12.7	91.1
	21 to 40 percent	4	3.9	5.1	96.2
	41 to 60 percent	2	1.9	2.5	98.7
	61 to 80 percent	1	1.0	1.3	100.0
	Total	79	76.7	100.0	
Missing		24	23.3		
Total		103	100.0		

Federal Government

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	64	62.1	82.1	82.1
	1 to 20 percent	7	6.8	9.0	91.0
	21 to 40 percent	3	2.9	3.8	94.9
	41 to 60 percent	1	1.0	1.3	96.2
	61 to 80 percent	3	2.9	3.8	100.0
	Total	78	75.7	100.0	
Missing		25	24.3		
Total		103	100.0		

State Government

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	64	62.1	83.1	83.1
	1 to 20 percent	9	8.7	11.7	94.8
	21 to 40 percent	2	1.9	2.6	97.4
	41 to 60 percent	1	1.0	1.3	98.7
	81 to 100 percent	1	1.0	1.3	100.0
	Total	77	74.8	100.0	
Missing		26	25.2		
Total		103	100.0		

County Government

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	55	53.4	72.4	72.4
	1 to 20 percent	4	3.9	5.3	77.6
	21 to 40 percent	5	4.9	6.6	84.2
	41 to 60 percent	4	3.9	5.3	89.5
	61 to 80 percent	3	2.9	3.9	93.4
	81 to 100 percent	5	4.9	6.6	100.0
	Total	76	73.8	100.0	
Missing		27	26.2		
Total		103	100.0		

Medicaid

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	60	58.3	76.9	76.9
	1 to 20 percent	9	8.7	11.5	88.5
	21 to 40 percent	7	6.8	9.0	97.4
	41 to 60 percent	1	1.0	1.3	98.7
	61 to 80 percent	1	1.0	1.3	100.0
	Total	78	75.7	100.0	
Missing		25	24.3		
Total		103	100.0		

Medicare

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	71	68.9	89.9	89.9
	1 to 20 percent	4	3.9	5.1	94.9
	21 to 40 percent	1	1.0	1.3	96.2
	41 to 60 percent	2	1.9	2.5	98.7
	81 to 100 percent	1	1.0	1.3	100.0
	Total	79	76.7	100.0	
Missing		24	23.3		
Total		103	100.0		

Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	50	48.5	64.1	64.1
	1 to 20 percent	15	14.6	19.2	83.3
	21 to 40 percent	4	3.9	5.1	88.5
	41 to 60 percent	4	3.9	5.1	93.6
	61 to 80 percent	2	1.9	2.6	96.2
	81 to 100 percent	3	2.9	3.8	100.0
	Total	78	75.7	100.0	
Missing		25	24.3		
Total		103	100.0		

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- 50% private
- unable to say as this is on a state level
- Churches (15%) + In-Kind (33%)
- 5%-private insurance
- 20
- 72.5
- 30%
- Senior or family must pay fee for service

Employment and Volunteers (actual numbers)

Full Time Employees

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	4	3.9	4.1	4.1
	1 - 25	64	62.1	66.0	70.1
	26 - 50	7	6.8	7.2	77.3
	51 - 100	12	11.7	12.4	89.7
	101 - 150	1	1.0	1.0	90.7
	151 - 200	1	1.0	1.0	91.8
	201 - 400	8	7.8	8.2	100.0
	Total	97	94.2	100.0	
Missing		6	5.8		
Total		103	100.0		

Full Time Employees for Seniors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	30	29.1	32.3	32.3
	1 - 25	48	46.6	51.6	83.9
	26 - 50	5	4.9	5.4	89.2
	51 - 100	8	7.8	8.6	97.8
	101 - 150	1	1.0	1.1	98.9
	201 - 400	1	1.0	1.1	100.0
	Total	93	90.3	100.0	
Missing		10	9.7		
Total		103	100.0		

Part Time Employees

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	23	22.3	23.7	23.7
	1 - 25	57	55.3	58.8	82.5
	26 - 50	5	4.9	5.2	87.6
	51 - 100	4	3.9	4.1	91.8
	101 - 150	3	2.9	3.1	94.8
	151 - 200	2	1.9	2.1	96.9
	201 - 400	3	2.9	3.1	100.0
	Total	97	94.2	100.0	
Missing		6	5.8		
Total		103	100.0		

Part Time Employees for Seniors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	54	52.4	57.4	57.4
	1 - 25	34	33.0	36.2	93.6
	26 - 50	1	1.0	1.1	94.7
	51 - 100	3	2.9	3.2	97.9
	101 - 150	2	1.9	2.1	100.0
	Total	94	91.3	100.0	
Missing		9	8.7		
Total		103	100.0		

Number of Volunteers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	42	40.8	44.7	44.7
	1-50	32	31.1	34.0	78.7
	51-100	2	1.9	2.1	80.9
	101-150	2	1.9	2.1	83.0
	151-200	3	2.9	3.2	86.2
	201-300	4	3.9	4.3	90.4
	301-400	4	3.9	4.3	94.7
	401-600	2	1.9	2.1	96.8
	more than 800	3	2.9	3.2	100.0
	Total	94	91.3	100.0	
Missing		9	8.7		
Total		103	100.0		

Number of Volunteers for Seniors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	60	58.3	65.9	65.9
	1-50	22	21.4	24.2	90.1
	51-100	4	3.9	4.4	94.5
	151-200	2	1.9	2.2	96.7
	201-300	1	1.0	1.1	97.8
	301-400	2	1.9	2.2	100.0
	Total	91	88.3	100.0	
Missing		12	11.7		
Total		103	100.0		

Annual Number of Volunteer Hours for Seniors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	44	42.7	57.1	57.1
	1-50	6	5.8	7.8	64.9
	51-100	2	1.9	2.6	67.5
	101-150	1	1.0	1.3	68.8
	151-200	4	3.9	5.2	74.0
	201-300	3	2.9	3.9	77.9
	301-400	1	1.0	1.3	79.2
	401-600	4	3.9	5.2	84.4
	601-800	2	1.9	2.6	87.0
	more than 800	10	9.7	13.0	100.0
	Total	77	74.8	100.0	
Missing		26	25.2		
Total		103	100.0		

Number of Seniors Served in Past Year

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	3	2.9	4.2	4.2
	1-50	19	18.4	26.8	31.0
	51-100	7	6.8	9.9	40.8
	101-150	7	6.8	9.9	50.7
	151-200	5	4.9	7.0	57.7
	201-300	7	6.8	9.9	67.6
	301-400	1	1.0	1.4	69.0
	401-600	5	4.9	7.0	76.1
	601-800	2	1.9	2.8	78.9
	more than 800	15	14.6	21.1	100.0
	Total	71	68.9	100.0	
Missing		32	31.1		
Total		103	100.0		

How do you count the number of seniors served? Do you count by the number of times a person uses the service, or do you count by the number of people enrolled for your service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Count by Use of Service	20	19.4	27.4	27.4
	Count by People Enrolled in Service	53	51.5	72.6	100.0
	Total	73	70.9	100.0	
	Does not apply	30	29.1		
Total		103	100.0		

Are seniors permitted to participate in more than one service from your agency or organization

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	6	5.8	9.2	9.2
	Yes	59	57.3	90.8	100.0
	Total	65	63.1	100.0	
	Does not apply	38	36.9		
Total		103	100.0		

Do you use the following criteria to determine a senior's eligibility for your organization?

(multiple selections are permitted here)

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	60	58.3	58.3	58.3
	Selected	43	41.7	41.7	100.0
	Total	103	100.0	100.0	

Income Level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	75	72.8	72.8	72.8
	Selected	28	27.2	27.2	100.0
	Total	103	100.0	100.0	

Residency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	89	86.4	86.4	86.4
	Selected	14	13.6	13.6	100.0
	Total	103	100.0	100.0	

Geography

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	87	84.5	84.5	84.5
	Selected	16	15.5	15.5	100.0
	Total	103	100.0	100.0	

Education Level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	103	100.0	100.0	100.0

Medical Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	79	76.7	76.7	76.7
	Selected	24	23.3	23.3	100.0
	Total	103	100.0	100.0	

Family Dynamic

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	96	93.2	93.2	93.2
	Selected	7	6.8	6.8	100.0
	Total	103	100.0	100.0	

Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Selected	83	80.6	80.6	80.6
	Selected	20	19.4	19.4	100.0
	Total	103	100.0	100.0	

Below are responses to this question; except for spelling, these responses are not edited and appear as these were received.

- as needs arise for transportation
- NA
- Most often we provide programs on request - to be delivered off site
- Tax value of residence
- Does not apply
- insurance
- Health condition and needs
- Disability
- mobility
- The need exists
- All are eligible
- no criteria
- Level Of Care
- court ordered
- mental illness
- homelessness
- no restrictions
- Senior or family must pay fee for service

Demographics of Senior Receiving Services

Black (African-American)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	7	6.8	10.0	10.0
	1 to 10 percent	14	13.6	20.0	30.0
	11 to 20 percent	3	2.9	4.3	34.3
	21 to 40 percent	19	18.4	27.1	61.4
	41 to 60 percent	14	13.6	20.0	81.4
	61 to 80 percent	6	5.8	8.6	90.0
	80 percent or more	7	6.8	10.0	100.0
	Total	70	68.0	100.0	
Missing		33	32.0		
Total		103	100.0		

Hispanic

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	25	24.3	36.8	36.8
	1 to 10 percent	37	35.9	54.4	91.2
	11 to 20 percent	4	3.9	5.9	97.1
	21 to 40 percent	2	1.9	2.9	100.0
	Total	68	66.0	100.0	
Missing		35	34.0		
Total		103	100.0		

Asian

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	32	31.1	51.6	51.6
	1 to 10 percent	29	28.2	46.8	98.4
	21 to 40 percent	1	1.0	1.6	100.0
	Total	62	60.2	100.0	
Missing		41	39.8		
Total		103	100.0		

White

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	6	5.8	8.5	8.5
	1 to 10 percent	5	4.9	7.0	15.5
	11 to 20 percent	2	1.9	2.8	18.3
	21 to 40 percent	13	12.6	18.3	36.6
	41 to 60 percent	17	16.5	23.9	60.6
	61 to 80 percent	9	8.7	12.7	73.2
	80 percent or more	19	18.4	26.8	100.0
	Total	71	68.9	100.0	
Missing		32	31.1		
Total		103	100.0		

Male

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	2	1.9	2.8	2.8
	1 to 10 percent	8	7.8	11.3	14.1
	11 to 20 percent	8	7.8	11.3	25.4
	21 to 40 percent	35	34.0	49.3	74.6
	41 to 60 percent	9	8.7	12.7	87.3
	61 to 80 percent	8	7.8	11.3	98.6
	80 percent or more	1	1.0	1.4	100.0
	Total	71	68.9	100.0	
Missing		32	31.1		
Total		103	100.0		

Female

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	1	1.0	1.4	1.4
	1 to 10 percent	1	1.0	1.4	2.8
	11 to 20 percent	1	1.0	1.4	4.2
	21 to 40 percent	10	9.7	14.1	18.3
	41 to 60 percent	16	15.5	22.5	40.8
	61 to 80 percent	30	29.1	42.3	83.1
	80 percent or more	12	11.7	16.9	100.0
	Total	71	68.9	100.0	
Missing		32	31.1		
Total		103	100.0		

Over 85 year old

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	none	14	13.6	20.0	20.0
	1 to 10 percent	24	23.3	34.3	54.3
	11 to 20 percent	12	11.7	17.1	71.4
	21 to 40 percent	7	6.8	10.0	81.4
	41 to 60 percent	8	7.8	11.4	92.9
	61 to 80 percent	4	3.9	5.7	98.6
	80 percent or more	1	1.0	1.4	100.0
	Total	70	68.0	100.0	
Missing		33	32.0		
Total		103	100.0		

In what zip code do most of the seniors receiving your service live?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	28036	1	1.0	2.3	2.3
	28078	1	1.0	2.3	4.7
	28104	1	1.0	2.3	7.0
	28105	2	1.9	4.7	11.6
	28202	1	1.0	2.3	14.0
	28205	5	4.9	11.6	25.6
	28206	2	1.9	4.7	30.2
	28207	1	1.0	2.3	32.6
	28208	2	1.9	4.7	37.2
	28209	1	1.0	2.3	39.5
	28210	2	1.9	4.7	44.2
	28212	2	1.9	4.7	48.8
	28215	2	1.9	4.7	53.5
	28216	3	2.9	7.0	60.5
	28226	3	2.9	7.0	67.4
	28262	2	1.9	4.7	72.1
	28269	2	1.9	4.7	76.7
	28277	1	1.0	2.3	79.1
	28299	9	8.7	20.9	100.0
	Total	43	41.7	100.0	
Missing		60	58.3		
Total		103	100.0		

Note: zip code 28299 is “all of Mecklenburg County”.

Appendix B

Crime Prevention Tips

Charlotte-Mecklenburg Police Department to Prevent Residential Burglary, Larceny from Auto and Larceny of Auto

Residential Burglary[1]:

- Protect your home with good door and window locks
- Use dead-bolt locks and install peepholes
- Keep all shrubs trimmed below your windows. Trim shrubbery that blocks the view of your doors and windows
- Make sure your house is well lit at night. Install motion lights.
- Consider purchasing an alarm system.
- Always leave your home so that it looks occupied.
- Leave some lights or a radio on.
- When away have a friend pick up your mail or paper and cut your grass.
- Do not leave valuable or expensive items in plain view.
- Report all suspicious activity in your neighborhood.

Larceny from Auto[2]:

- Keep your car in good repair.
- Always lock your doors, even in the driveway.
- Install an alarm.
- Store packages or valuables in the trunk or out of sight.

Larceny of Auto[3]:

- Keep your car in good repair.
- Always lock your doors.
- Park in well lit areas.
- Never leave your keys in your car.
- Never leave your car running to go into a store.
- Use an anti-theft device
- Close garage doors if your vehicle will be parked for any time.

---

[1] *CMPD Safety Guide* provided by the Charlotte-Mecklenburg Crime Prevention Unit.

[2] Ibid

[3] Ibid

Glossary of Terms - Long Term Care in North Carolina

Source: www.dhhs.state.nc.us/ltc/glossary.htm

A

ACTIVITIES OF DAILY LIVING (ADL)
A term used to describe basic self-care tasks that are a part of most people's regular day, such as bathing, dressing, grooming, moving around the house, and eating. ADLs are widely used to assess individual functioning status.

ADOBE PDF
Adobe PDF is a universal file format that preserves all of the fonts, formatting, colors, and graphics of any source document, regardless of the application and platform used to create it. Adobe PDF files are compact and can be shared, viewed, navigated, and printed exactly as intended by anyone with the free Acrobat Reader.

ADULT CARE HOME COMMUNITY ADVISORY COMMITTEE
Members are community citizens who are appointed by the local board of county commissioners to work to maintain the spirit of the Residents' Bill of Rights as well as promote community education and awareness of the operation of adult care homes in that county and the needs of the persons residing in these homes.

ADULT CARE HOMES
An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated, trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes. Adult care homes and family care homes are subject to licensure by the Division of Facility Services.

ADULT DAY CARE
The provision of group care and supervision of adults (who may be physically or mentally disabled) in a place other than their usual residence on a less than 24 hour basis. Services are designed to support the adult's personal independence, as well as their physical, social, and emotional well-being. Adult day care programs are subject to certification by the Division of Aging.

ADULT DAY HEALTH CARE
A community-based day care program that provides health, social and recreational care, along with rehabilitative services. Staffing is by trained professionals and paraprofessionals and is under the supervision of a registered nurse. The program is ideal for the elderly or physically impaired adult who needs assistance in a protective setting during the day. Adult day health programs are subject to certification by the Division of Aging.

ADULT HOME SPECIALIST
The person(s) in the county department of social services given primary responsibility for assessing the need for adult care homes in the county, responding to all inquires regarding licensure, and monitoring homes for compliance with licensure rules.

ADULT PLACEMENT SERVICES
Adult Placement Services help aging or disabled adults find appropriate living and healthcare arrangements when their health, safety, and well-being can no longer be maintained at home. Placement arrangements are made in adult care homes, nursing homes, other substitute homes, residential health care settings, or institutions. Adults and their families receive help to complete medical evaluations and financial applications, and locate and move to new settings. They also may receive counseling to help them adjust to the change.
Adult placement services also help elderly and disabled adults in the following situations:

- Those unable to maintain themselves in their own homes independently or with available community or family supports.
- Those living in substitute homes, residential health care facilities, or institutions and need assistance in relocating due to changes in level of care needed.
- Those who need assistance in returning to more independent living arrangements.
- Those who need assistance in adjusting to or maintaining their placements due to individual or family problems or a lack of resources.
- All 100 county departments of social services provide Adult Placement Services.

ALZHEIMER'S DISEASE
A progressive, degenerative disease that attacks the brain and results in impaired memory, thinking, and behavior.

AMERICANS with DISABILITY ACT (ADA)
Federal law which provides comprehensive civil rights protections for persons with disabilities. The Act defines disability as a physical or mental impairment that substantially limits one or more major life activities.

AREA AGENCY ON AGING
Area Agencies on Aging (AAA) plan, coordinate, and advocate for the development of a comprehensive service delivery system to meet the needs of older people in a specific geographic area. The AAA's provide training and technical support to county agencies that offer services to older adults.

ASSESSMENT
Activities performed by at least one professional (preferably a social worker and/or a nurse) to determine a person's current functional abilities and resources in six areas: physical health, mental health, social support, activities of daily living, environmental conditions, and financial situation. Assessment includes a home visit by a professional. Once the assessment is completed, activities related to developing and implementing a client service plan becomes part of case management.

ASSISTED LIVING

"Assisted living residence" means any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102.

ASSISTIVE LISTENING DEVICES (ALDs)
Devices that increase loudness of specific sounds by bringing sound directly into the hearing aid or ear. ALDs solve three problems: minimizing background noise, reducing the effect of distance between hard of hearing people and the sound source and overriding poor acoustics.

ASSISTIVE TECHNOLOGY
Any technology or device which enables an individual to be more independent and/or enables an individual to accomplish a task. Examples of assistive technology includes motorized wheelchairs, TTY communicators, print readers, computers, voice-activated devices, etc.

ASSISTIVE TECHNOLOGY FOR DEAF AND HARD OF HEARING
The Division of Services for the Deaf and Hard of Hearing (DSDHH) can provide consultation and training on the use of assistive listening devices and other assistive technology for the deaf and hard of hearing. Through their Telecommunications Equipment Distribution Program (TEDP), low income residents with hearing loss may be eligible to receive free telecommunications equipment.

B

BLINDNESS
Only two services provided by the Division of Services for the Blind have eligibility criteria requiring that a consumer be legally blind. They are In-Home Level I and Special Assistance for the Blind. However, DSB provides many other services that only require the consumer to be severely visually impaired and eligibility determination is made based on the consumer's eye report. Contact should be made with the Social Worker for the Blind in the local Department of Social Services for a determination of eligibility for Independent Living Services as well as referral to various other service programs in the agency.

C

CAPTIONING
A process of translating the audio portion of video programming into text that appears at top or bottom of screen. Open captioning is similar to subtitles-available for all to read onscreen; closed captioning requires a decoder device or chip in order to make the

captions visible onscreen. Required of television manufacturers by federal law since July of 1994, closed captioning is most frequently used in TV programming. Other uses include videotapes, advertisements, video paging systems, etc. For more information about obtaining captioning services, contact the National Captioning Institute (NCI) at 1900 Gallows Road, Suite 3000, Vienna, VA, 22182, (703) 91707600 (V/TTY).

CARE-LINE
The information and referral service of the NC Department of Health and Human Services.

CARE MANAGEMENT or CASE MANAGEMENT
This service provides professional assistance (typically registered nurses and/or social workers) to older adults and their families by identifying, accessing, and coordinating services that are necessary to enable the older adult to remain in the least restructured environment.

CERTIFICATE OF NEED (CON)
A competitive application process managed by the Division of Facility Services by which providers acquire new institutional health care services (i.e., nursing home beds, hospital beds, rehabilitative beds, home health agencies and hospices, etc.) in accordance with the State Medical Facilities Plan. This serves as a quality assurance process for the state to manage quantity and costs of medical services.

CHORE SERVICES
See In Home Aide Services

COGNITIVE IMPAIRMENT
A term that refers to damage or loss of intellectual or mental functioning. The act or process of "knowing", including awareness or judgment, is impaired. Alzheimer's disease is the most common cause of cognitive impairment among older adults.

COMBINATION FACILITY
A facility licensed under G.S. 131E-102 providing intermediate care and/or skilled nursing care and adult home care.

COMMUNITY ALTERNATIVES PROGRAM (CAP)
A Medicaid waiver program that provides community-based services to disabled adults, mentally retarded adults, children, and persons with AIDS who meet the medical requirements for nursing home level care. CAP services may include traditional Medicaid home health services (nursing, physical therapy, home health aide, etc.), as well as services not generally available under Medicaid (home delivered meals, respite care, in-home aide services, etc.).

CONGREGATE LIVING
A living arrangement in which two or more unrelated individuals reside in a house or apartment.

CONTINUING CARE RETIREMENT COMMUNITY (CCRC)
A facility that offers a continuum of care-from independent living, assisted-living, or rest home care, to nursing home care. Individuals are offered an independent living lifestyle with the security of knowing supportive and health care services are available if needed.

COST SHARING
The concept of soliciting a portion of the cost of a service provided from the service recipient.

COUNCIL ON AGING (COA)
A private, nonprofit organization or public agency that serves as a county focal point on aging and traditionally provides supportive services to older adults (located in some, but not all counties). Sometimes they serve as advisory boards to the county board of commissioners. Department on Aging is the term typically used when it is a public agency.

COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS)
A public agency that provides a range of services and public assistance to older and disabled adults, as well as children. County DSS's are located in all 100 counties in North Carolina. Services potentially available to adults include: Adult Protective Services, Guardianship, Foster Care Services and Placement, In-Home Aide Services, Transportation, At-Risk Case Management, Individual & Family Adjustment, and Adult Care Home Case Management. DSS's are also responsible for the primary consultation involved in monitoring of adult care homes and adult day care/day health programs. For an overview of county departments of services.

D

DEAF-BLIND
The inability to understand conversation with optimum amplification. Visual acuity usually does not exceed 20/200 in the better eye with corrective lens. Visual acuity is greater than 20/200 if the visual field is constricted to 20 degrees or less or a progressive condition that will lead to significant hearing and vision loss. A deaf-blind individual may prefer a qualified tactile or up-close interpreter.

DEVELOPMENTAL DISABILITY
North Carolina General Statute 122C-3(12a) defines a developmental disability as "a severe, chronic disability of a person which: is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22, unless the disability is caused by traumatic head injury and is manifested after age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following area of major life activity [self-care, receptive understanding) and expressive language learning, mobility (ability to move), self-direction (motivation), the capacity for independent living, and economic self-sufficiency]; reflects the person's need for a combination or sequence of special interdisciplinary services which are of a lifelong or extended duration and are individually planned and coordinated; or when applied to children from birth through four years of age, may be evidenced as a developmental delay."

DURABLE MEDICAL EQUIPMENT
Equipment (often prescribed by a doctor) to serve a medical purpose. Example: wheelchairs, bedside commodes, and hospital beds. Insurance considers payment on rental or purchase of this equipment.

F

FAMILY CAREGIVER SUPPORT PROGRAM (FCSP)
The Older Americans Act Amendments of 2000 established the National Family Caregiver Support Program to assist the aging network to develop a multi-faceted system of supports for caregivers. The Division of Aging and Area Agencies on Aging are administering the program in North Carolina.

FAMILY CARE HOME
"Family care home" means an adult care home having two to six residents. The structure of a family care home may be no more than two stories high and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story. It is licensed by the Division of Facility Services.

FL-2
Long-Term Services prior approval form which gives a summary of the patient's medical requirements and which reflect the attending physician's recommendation for the level of care needed in an institutional setting. An approved FL-2 is required for any Medicaid recipient in a skilled nursing facility (SNF)or an intermediate care facility (ICF). An FL-2 must also be completed by the attending physician prior to admission to an adult care home and at least annually thereafter.

FOOD STAMPS
A federal program that provides a monthly allotment of Food Stamp benefits issued via Electronic Benefit Transfer cards (ATM cards). The Food Stamp Program is an entitlement program, so all eligible individuals and households can receive assistance. Food Stamp benefits may be used to purchase most foods at participating stores. They may not be used to purchase tobacco, pet food, paper products, soap products, or alcoholic beverages. Administrative costs are 50% federal and 50% county. The stamps are 100% federal.

FOSTER CARE SERVICES FOR ADULTS
A service than involves recruiting, developing, and evaluating adult care homes to determine if they meet the needs of residents and to help them improve upon their service. All county DSS's that have an adult care home in their county provide this service.

G

GROUP HOME FOR DEVELOPMENTALLY DISABLED ADULTS
Provides care for 2 to 9 people. These are small residences, usually located in a regular neighborhood. Only adults who are developmentally disabled can live in these homes. They must be able to participate in community activities (ADAP, Sheltered Workshop jobs), be ambulatory, and either have or be able to develop self-help skills. The care provided includes room and board, personal assistance, supervision, and training with goal planning to help people develop self-help skills.

GROUP RESPITE

Uses trained volunteers to offer temporary, part-time relief to family caregivers of older adults and to provide seniors with meaningful activities. (See Institutional Respite, In-Home Aide and Adult Day Services)

GUARDIANSHIP
The legal authority and duty given by the court to a person (guardian) for the purpose of assuming responsibility for the care and maintenance of another person (ward), who has been determined incapable of handling his/her own personal affairs. The powers and authority conferred upon a guardian depend on what type of guardianship is granted by the court.

- Guardian of the Estate - Is responsible for collecting, preserving, and administering the property and income of the ward.
- Guardian of the Person - Is entitled to custody of the ward and is responsible for the ward's care, comfort and maintenance. The guardian makes decisions such as where the ward will live, gives consent for medical or professional treatment of for the ward. The Guardian of the Person is responsible for the basic physical care of the ward and his/her immediate personal effects.
- General Guardian - Performs the duties of both the Guardian of the Estate and Guardian of the Person.
- Additional information related to Guardiship is available at the Division of Social Services and the Division of Aging web sites.

H

HARD OF HEARING
A hearing loss, which interferes with but does not totally preclude auditory and vocal communication. Hearing aids and other amplification or assistive listening devices often significantly assist these individuals.

HOME AND COMMUNITY CARE BLOCK GRANT (HCCBG)
Federal and state funds administered by the North Carolina Division of Aging (DOA). The Division receives funds from the Older Americans Act (OAA), Social Services Block Grant (SSBG), and the State General Assembly.

HOME-DELIVERED MEALS
A nutrition program that utilizes volunteers to deliver at least one hot nutritious meal per day (usually 5 days a week) to homebound adults. The meal offers one-third of the Recommended Daily Dietary Allowance.

HOME HEALTH SERVICES
Health care prescribed by a physician and given in the home to a person in need of medical care. Services may include skilled nursing services, therapy services (physical therapy, occupational therapy and speech therapy), medical social services, health promotion services, and home health aide services. This is a covered service under Medicaid.
See Home Health Client Bill of Rights

HOMEMAKER SERVICES
See In home Aide Services

HOSPICE CARE
A service provided for terminally ill patients and their families. A hospice agency provides medical, nursing, and supportive services to meet the needs of families and patients in the last six months of the patient's life.

I

ICF-MR
Intermediate care facilities for the mentally retarded.

IN HOME AIDE SERVICES
The in-home aide services previously known as Chore, Homemaker, Homemaker-Home Health Aide, Respite, and Personal Care Services have been incorporated into a single service entitled, "In-Home Aide Services". These are paraprofessional services that assist children and adults, their families, or both, with essential home management tasks, personal care tasks, supervision, or all of the above. Their purpose is to allow these individuals to function effectively in their own homes and the community for as long as possible. The four levels of care are:

HOME MANAGEMENT
Level I: In-Home Aide Services at this level are intended to provide support to those needing assistance with basic home management tasks, such as housekeeping, cooking, shopping, and bill paying. Personal care tasks may not be performed at this level.

PERSONAL CARE
Level II: In-Home Aide Services at this level are intended to provide support to persons/families who predominately require assistance with basic personal care (bathing, shaving, toileting, and personal hygiene), and associated home management tasks.

HOME MANAGEMENT
Level III: In-Home Aide Services at this level are intended to provide intensive education and support to persons/families in carrying out home management tasks and improving family functioning skills.

PERSONAL CARE
Level III: In-Home Aide Services at this level are intended to provide substantial activities of daily living (ADL) support to individuals/families who require assistance with health and personal care tasks. Provision of these tasks involves extensive "hands-on" care and potential assistance with a wide range of health related conditions.

HOME MANAGEMENT
Level IV: In-Home Aide Services at this level are intended to provide a wide range of educational and supportive services to persons/families who are in crisis or who require long term assistance with complex home management tasks and family

functioning skills. Provision of the service involves quick and creative response to individual/family crisis situations identified by the case manager. It also may focus on conducting appropriate learning sessions with small groups of persons from different families who have similar needs.

The Divisions of Aging, Social Services, and Services for the Blind have information about this service.

INFORMATION AND ASSISTANCE (I & A)
The provision of I & A for older persons and their families is designed to: assess and evaluate an individual's needs; inform and educate about programs and services available across the long-term care continuum; refer and/or directly connect the individual to appropriate resources; provide assistance to negotiate the service delivery system; work with long distance caregivers in identifying and locating needed services; and advocate on behalf on individuals or a group to obtain change in the delivery or availability of services. Also see CARE-LINE

INSTITUTIONAL RESPITE CARE
Provides temporary facility placement to give needed relief to primary caregivers of individuals who cannot be left alone because of mental and physical problems. (See Group Respite, In-Home Aide and Adult Day Services)

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
Basic tasks that are essential to living independently, such as cooking meals, housekeeping, laundry, paying bills, shopping, and using the telephone.

INTERMEDIATE-LEVEL CARE
A level of care in a nursing facility that provides 24-hour assistance, with a minimum of eight hours of coverage daily by a licensed nurse, but no requirement for 24-hour skilled nursing services. Medicaid pays for skilled and intermediate care. Medicare pays only for skilled care.

INTERPRETERS
Professionals who are trained to facilitate communication between deaf/hard of hearing people and others not familiar with sign language or alternative communication methods. Interpreters are employed in a variety of situations, including one-on-one and group interactions. Because there are several types of interpreters, one must check with participants regarding the best choice(s) for given situation(s):

- American Sign Language (ASL): a manual language with its own vocabulary, syntax and grammar, distinct from spoken languages (e.g., English) and from sign languages in other countries.
- Manually Coded English (MCE), formerly known as Pidgin Signed English (PSE), and Signed Exact English (SEE): different "hybrid" methods of using sign language communication, which combines elements of ASL and spoken (English) language.
- Oral/Aural: Usually work with deaf/hard of hearing individuals who rely primarily or solely on speechreading. These interpreters choose words, phrases, and enunciations that are more easily visible on the lips.

- Tactile: provide services to people who are visually impaired as well as deaf or hard of hearing. Typically, these interpreters work one-on-one, because the signing is done directly in or on the hands of the consumer.

L

LATE DEAFENED
Individuals who have lost their hearing post-lingually (after spoken language development) and who often require the use of assistive listening devices and visually-oriented communication strategies (e.g., CART, written materials). Onset of this type of hearing loss can be sudden or gradual.

LONG TERM CARE INSURANCE
A type of insurance designed to pay some or all of the costs of nursing home, community, or home health care. The Seniors' Health Insurance Information Program provides useful information on this form of insurance, including a fact sheet. SHIIP and the Division of Aging have developed a Consumer Bill of Rights for Buyers of Long Term Care Insurance.

LONG TERM CARE OMBUDSMAN
A professional who serves as an advocate for long-term care residents of nursing homes and adult care homes. Advocacy includes educating individuals about their rights and complex rules or regulations governing the long term care system. An Ombudsman can be requested to investigate concerns and serve as a mediator for conflict resolution should a resident encounter difficulty exercising rights.

Ombudsmen are available to:

- Serve as a resource for anyone who has questions about long term care regulations;
- Be involved in the care planning process or family meetings;
- Provide training to staff, resident councils, or family councils;
- Provide information and referral;
- Provide state survey results on local facilities; and
- Talk about any situation that may arise from being a resident, family member, or staff person of a facility.

The Long Term Care Ombudsman program is federally mandated through the Older Americans Act. There is at least one Ombudsman for each of the 17 aging regions in North Carolina. Each county also has local Community Advisory Committees. These are volunteers who are appointed by the county commissioners to serve as grass roots advocates for residents in the facilities.

M

MEDICAID (TITLE XIX of the Social Security Act)
A Federal- and State-funded health care program for eligible persons. To be eligible a person must meet income and assets limits, and be aged, blind, disabled, a member of a family with dependent children, or a pregnant woman. Some people are covered by both

Medicare and Medicaid. Administered by the Division of Medical Assistance in the North Carolina Department of Health and Human Services, the program provides medical care for qualifying recipients. Applications for Medicaid are made through the County Department of Social Services.

MEDICARE
A Federal health insurance program for persons aged 65 and over who are eligible for Social Security or Railroad Retirement benefits and for some people who are disabled regardless of age. There are two parts: Part A is hospital insurance which is automatic, for those eligible, and Part B covers the physician and other services. Part B is voluntary and requires a monthly premium.

N

NURSING HOME COMMUNITY ADVISORY COMMITTEE
Members are community citizens who are appointed by the local board of county commissioners to work to maintain the spirit of the Residents' Bill of Rights as well as promote community education and awareness of the operation of nursing homes in that county and the needs of the persons residing in these homes. The Ombudsman Program supports the work of these advisory comittees.

NURSING HOMES
Skilled nursing and intermediate-care facilities.

O

OCCUPATIONAL THERAPIST (OT)
Occupational therapists assist in rehabilitation through the design and implementation of individualized programs to improve or restore functions impaired by illness or injury.

OLDER AMERICANS ACT (OAA)
Federal legislation established in 1965 providing broad policy objectives designed to meet the needs of older persons. The key philosophy of the program has been to help maintain and support older persons in their homes and communities and to avoid unnecessary or premature institutionalization.

OMBUDSMAN
A representative of a public agency or a nonprofit organization who investigates and resolves complaints made by or on the behalf of older individuals who are residents of long-term care facilities. In North Carolina the State Long-Term Care Ombudsman is located in the Division of Aging of the Department of Health and Human Services. There are Regional Ombudsmen across the state who are located within the Area Agency on Aging, a part of the regional council of government.

OUTREACH
Agency activities to increase the public awareness of services to older persons and to provide information on available services.

P

PERSONAL CARE
See In Home Aide Services

PERSONAL CARE SERVICES (PCS)
Paraprofessional care (comparable to In-Home Aide Services, Personal Care Levels II and III) covered by Medicaid for eligible persons.

PERSONAL EMERGENCY ALARM RESPONSE
A service that uses telephone lines to alert a central monitoring facility (often a hospital emergency room) of an emergency in the household. This service is predominantly used by older adults who live alone and are at risk of medical emergencies (Example: Life line).

POVERTY LEVEL
An income guideline established federally to define individuals who are economically disadvantaged. In North Carolina, it is also the income level that establishes eligibility for Medicaid.

PRIMARY ADJUSTMENT SERVICES
Services are provided to enable eligible blind or visually impaired individuals to attain and/or maintain the highest level of functioning possible, to promote their well-being, and to prevent or reduce dependency. This is achieved through a focused regimen of counseling and casework assistance to individuals and their families.

PROTECTIVE SERVICES FOR ADULTS
Disabled adults are vulnerable to abuse, neglect, and exploitation. County departments of social services receive and evaluate reports to determine whether disabled adults are in need of protective services and what services are needed (as required by Article 6, Chapter 108A of the North Carolina General Statutes). Disabled adults or disabled emancipated minors present in North Carolina who are reported to be abused, neglected, or exploited, and in need of protective services are eligible to receive this service without regard to income.

Q

QUALIFIED MEDICARE BENEFICIARY/MEDICARE-AID (QMB)
Assistance for those who do not qualify for Medicaid, but whose income is very low (pays Medicare Part B premiums and deductibles for A and B, etc).

R

RESPITE
Provides needed relief to primary caregivers of individuals who cannot be left alone because of mental or physical problems.

RETIREMENT COMMUNITY
A housing complex designed for older adults. Many of the retirement communities allow monthly rental, while others require purchase of the unit. Persons living in retirement communities are generally able to care for themselves; however, assistance from home care agencies is allowed by some communities. Activities and socialization are provided.

S

Senior Care Program
This program is designed specifically to provide assistance to North Carolina seniors diagnosed with one of three diseases, who meet the income guidelines, and who are coping with the rising costs of prescription medicine. At this site, you may find out details concerning the program's benefits, information on eligibility, etc.

SENIOR COMPANION PROGRAM
Provides a stipend to low income older adults to volunteer to provide in-home services to the elderly to help them live independently. Available in a limited number of counties in North Carolina.

SENIOR HEALTH INSURANCE INFORMATION PROGRAM (SHIIP)
Sponsored by the N. C. Insurance Commissioner's Office. Volunteers assist older adults with information about all types of insurance issues, including long-term care insurance.

SKILLED NURSING FACILITY (SNF)
A nursing home that provides 24 hour-a-day nursing services for a person who has serious health care needs but does not require the intense level of care provided in a hospital. Rehabilitation services may also be provided. Many of these facilities are federally certified, which means they may participate in Medicaid or Medicare programs.

SOCIAL SERVICES BLOCK GRANT (SSBG)
Federal funds (Title XX of the Social Security Act, with state and county match) provide a variety of services for children and adults. Examples are Adult Protective Services (APS), Placement, Guardianship, In-Home Aide Services, and Transportation.

SPECIAL ASSISTANCE FOR ADULTS (S/CSA)
Special Assistance is program that provides an income supplement to assist low-income elderly and disabled adults pay for their cost of care (room and board) in an Adult Care Home. SA eligible facilities can include Family Care Homes, Group Homes for the Developmentally Disabled, Adult Care Homes, Group Homes for the Mentally Ill, Combination facilities, and some participating Hospice residential facilities. The two major recipient categories are Special Assistance for the Aged (SAA), for recipients 65 or older, and Special Assistance for the Disabled (SAD), for recipients between the ages of 18 and 64 who are determined disabled based on Social Security guidelines. Recipients in both categories must reside in a licensed adult care home facility and meet all other eligibility criteria. See the State/County Special Assistance for Adults Program Information Brochure for more information regarding this program. Special Assistance for Certain Disabled (SCD) is also available in some counties. These recipients are adults between 18 and 64 who are living in their own homes, are unemployable because of an impairment, but who have not been able to meet the Social Security disability

requirements. The SA program is supervised by the Division of Social Services, Adult and Family Services Section, and administered by the 100 county departments of social services. Funding for SA is 50% state dollars and 50% county dollars with 100% of the administration costs being paid by the counties.

SPECIAL ASSISTANCE FOR THE BLIND

Special Assistance for the Blind (SAB) is available in all 100 counties to persons who are legally blind and whose financial resources are not sufficient to meet his/her daily living demands (as defined by income guidelines of the program). SAB is a joint program of State and County agencies with the funding sources as 50% state and 50% county. There are two types of financial assistance available from Special Assistance for the Blind:

1. Cash payments for eligible blind individuals residing in a rest home
2. Cash payments provided for eligible blind individuals residing in private living arrangements.

An application can be obtained by contacting the Social Worker for the Blind in any County Department of Social Services or by contacting the SAB Eligibility Specialist in the State Office of the Division of Services for the Blind (919-733-9744). The application should then be completed and an eye report should be attached. If the applicant is a resident of a rest home (an adult care home) or a specialized community residential center or is planning to enter one of these facilities, a FL-2 Form (Level of Care Designation Form) which has been completed by a physician should be attached. The application is processed by the SAB Eligibility Specialist in the State Office of DSB and the applicant is notified by mail of the eligibility decision.

SUPPLEMENTAL SECURITY INCOME (SSI)

A federal program that pays monthly checks to people in need who are 65 years or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is 65, or blind, or disabled can have a basic monthly income. Eligibility is based on income and assets. SSI is administered nationally and locally by the Social Security Administration.

SUPPORT GROUPS

Usually made up of caregivers, family members, and friends of a person experiencing an illness such as Alzheimer's Disease, cancer, Parkinson's, etc. People are brought together by a common concern, situation, or experience. A professional usually facilitates group discussion and sharing of experiences and feelings. Educational programs are also common among support groups. Contact the Family Caregiver Resource Specialists at your Area Agency on Aging for information about support groups.

Support groups for severely visually impaired and blind persons have been organized in many counties. They vary in their organization as some are recreational while others are more therapeutic. Many persons benefit from these groups as it is helpful to know that one is not alone in dealing with severe vision loss. Contact should be made with the Social Worker for the Blind at the County Department of Social Services to determine if and when a support group meets in the county.

SUPPORT SERVICES PROVIDER (SSP)
Refers to individuals who assist people who are deaf-blind with a range of tasks such as, but not limited to, visual guide, driver (transportation) and tactile or up-close interpreter.

T

TRANSPORTATION
There is some assistance with general transportation and transportation to medical services. The Divisions of Aging and Social Services have some information about these services.

TRANSPORTATION DEVELOPMENT PLAN (TDP)
A required 5-year county plan for a coordinated system of transportation, submitted to NCDOT (North Carolina Department of Transportation) in order to receive federal funds.

TTY
Telecommunications device for persons who are deaf or hard of hearing (TDD): A device similar to a computer keyboard, either with a cradle to rest a telephone hand set on or connected directly to the telephone. A TDD allows the user to communicate by typing messages on the keyboard and receiving message on the screen about the keyboard. The teletext devise typewriter is usually referred to as a TTY by members of the deaf and hard of hearing community.

V

VOCATIONAL REHABILITATION
Supported by both Federal and State moneys, allocated for the specific purpose of vocational services. The services of the Division of Vocational Rehabilitation include diagnostic procedures, surgery and treatment, prosthetic devices, hospital convalescent, training material, maintenance, occupational expenses, interpreter services, and transportation. The Independent Living Program also provides personal assistant services.

Vocational rehabilitation services are provided to persons who are severely visually impaired and blind by the Division of Services for the Blind (DSB). All services provided by this program are aimed toward employment. However, there are Independent Living Rehabilitation Counselors who serve people who do not plan to go to work but need to improve their independent living skills.

Appendix C

Supporting Documentation
In-Home Care v. Institutional Care

Long-term care has become an increasingly urgent policy issue. The number of elderly Americans and their proportion of the nation's population are growing, and Americans who reach age 65 are living longer (Estes, 2002). The aging of the American population is becoming an increasingly significant issue with which the government must contend. As Groshen and Klitgaard[1] point out, by the year 2030 the elderly population in America will rise from its current figure of 12 percent to almost 20 percent. This number becomes more staggering when one considers that those between 15 to 64 years old will decline as a percentage of the population during the same time.

One of the primary issues that policymakers will face in the near future is housing for the elderly. Most elderly citizens want to continue living in their own homes, or "age in place," as they grow older. Further complicating matters with regard to the elderly is that nearly 54 percent of the elderly population in America reports having at least one disability. These disabilities often limit the ability of those affected to carry out routine daily functions such as bathing, dressing and cooking.[2]

As a result, many elderly Americans need some type of long-term care.[3] Currently, over 70% of government expenditures for long-term care services are spent on nursing home care; thus publicly financed resources are devoted predominantly to institutional care[4]. Institutional care may include assisted living facilities.

The definition of "assisted living" includes facilities that have 11 or more beds; serve a primarily elderly population; provide 24-hour oversight, housekeeping, and at least two meals a day; and supply personal assistance with at least two of the following activities: taking medications, bathing, and dressing.[5] The average cost of a month's stay, including room and board, housekeeping and personal-care assistance, has jumped to $2,379 a month, up to 10.2% in the past 18 months, according to MetLife.Inc[6]. The increasing rise of institutional care will place catastrophic burdens on those family members who have no choice but to place their elderly family members into assisted care.

Many argue that Medicaid shows partiality by financing more for institutional care. For instance, institutional care accounted for nearly 71 percent of Medicaid's spending on long-term care in 2001. Many argue that those in nursing homes often require increased levels of care, the disparity in funding is troublesome to many who feel that the federal and state government should seek to develop home and community based long-term care programs.[7]

In-Home Services

In-home services unlike nursing homes are controlled by state and local jurisdictions. In-home services are not licensed or regulated by Medicaid and Medicare. Residential care can be option for individuals who may not require nursing home assistance but who can no longer remain in their own homes. Those that opt for these services may acquire assistance with bathing, dressing, meal preparation and medication reminders.[8] In-home services available through Medicaid, include case management, respite services for caregivers and personal care services. Medicaid spending, through

the waiver program, has increased significantly in recent years reaching $14.5 billion in fiscal year 2001[9].

As Medicaid is administered by state governments, the type of assistance varies by state. The United States General Accounting Office (GAO) recently studied the availability of long-term care programs in four states (Kansas, Louisiana, New York and Oregon). Significant variation in the availability of Medicaid covered services exists from state to state. For example, in New York and Oregon all Medicaid eligible elderly can receive home and community based services provided by Medicaid. Comparatively, Kansas has a waiting list with three times as many people on the list than are actually being served.[10]

The primary reason for the disparity between states relates to the differences in state policies. Louisiana and Kansas have waiting lists for some services whereas New York and Oregon do not. Also, depending upon the state, there are caps for certain services. For example, Louisiana is limited in the number of hours of in-home care the state can provide because there is a cap of $35 dollars per on in-home services. New York and Oregon have no such restrictions and can offer as much as 24 hours a day in-home care.[11]

A further example of the Medicaid spending disparity that exists among states is seen by the allocation of Medicaid spending in 1999. In 1999, the national Medicaid yearly expenditure average was $996 per person, aged 65 and over, with 81 percent of expenditures going toward nursing home care. In New York, Medicaid expenditures for long-term care services are nearly $2,463 per person, aged 65 or over. Comparatively, Louisiana's Medicaid spending on long-term care service is $1,012 per person, aged 65

or over, with nearly 93 percent going to nursing home care. Oregon spends well below the national average ($604) on Medicaid long-term services, though the state allocates more money toward alternative long-term care services, such as care in alternative residential, settings than the other states in the study.[12]

While most states offer an in home care option, a large number of elderly citizens depend on help from "unpaid caregivers." Unpaid caregivers are typically family members and friends that provide the majority of care that many elderly receive. As an example, nearly 60 percent of elderly citizens who receive long-term care depend exclusively on unpaid caregivers. Alternatively, only seven percent depend exclusively on paid services.[13]

According to the 1994 National Long-Term Care Survey, more than seven million Americans – mostly family members – provide 120 million hours of unpaid care to elders with functional disabilities living in the community. If these caregivers were paid, the cost would run from $45 billion to $94 billion a year. The overwhelming majority of non-institutionalized elders with disabilities – about 95 percent – receive at least some assistance from relatives, friends, and neighbors. Almost 67 percent rely solely on unpaid help, primarily from wives or daughters.[14]

Another option for some is long-term care insurance (O' Shaughnessy, 2003). Nearly 700,000 polices were sold in 2001 with $14.5 billion being paid out by private insurance companies. Of this amount, 52 percent went toward nursing home care and the remaining expenditures were for home health care.[15]

Long-term care insurance covers a portion of the care required for those who live in their own home. For example, many need help with Activities of Daily Living

(ADLs) such as bathing or dressing. Others need assistance with both ADLs and Instrumental Activities of Daily Living (IADLs), which include shopping and doing laundry.[16]

Long-Term in North Carolina

A brief look at North Carolina demonstrates that the state faces many of the same challenges the federal government and other states are facing. For example, the average daily cost of nursing home care in North Carolina is $140 per day and $51,000 per year.[17] The cost for home health care in North Carolina averages $11 to $15 per hour. Most service providers in North Carolina provide at least one to two hours of services twice a week. However, the maximum amount of services is approximately eight hours per day for five or seven days per week making funding for in-home care noticeably less even for a person who requires the maximum care at the highest cost. For example, the cost of caring for a person requiring 8 hours of care per day, 7 days a week for an entire year at $15 per hour is $43,680 compared to $51,000 for nursing home care.[18]

Also, North Carolina provides a Special Assistance payment supplement that allows qualifying individuals to receive assistance to pay for care. To qualify for a Special Assistance Supplement, an individual must have an income less than $1,147 per month. Eligible recipients, those whose income is less than $1,147 per month and need adult care as verified by a physician, receive a monthly payment for the difference between their income and $1,147. The North Carolina Department of Health and Human Services reports that Special Assistance supplements for individuals in adult care homes was $2,808,568 higher than payments for individuals living in their own home.

The average monthly payment is $426 per month to individuals living in adult care homes. Comparatively, the average monthly payment for those living in their own home is $184.[19]

As disability increases, elders will receive more and more informal care. Long-term care expenditures for nursing home care were $83 billion in 1997, and it is projected that these will grow to $98 billion by the year 2020. Over 50% of women and one third of men who live to the age of 65 will spend some time in a nursing home, although on quarter of them will be there less than 3 months[20]. There will be a need for changes in the mix of long-term care services-notably, an increasing demand for community-based care (e.g., in-home and adult day care) and equipment use.[21]

Recommendations

There are many unresolved issues with regard to long-term care for the elderly. With regard to housing, many quality programs already exist. On the national level, HUD provides relief through its Section 202 housing program. The Section 202 program provides rental assistance and access to services that promote independent living for very low-income elderly. Currently, the program only reaches approximately eight percent of low-income elderly. [22]

A universal long-term care system, integrated with a national health program, based in the community, and responding to the interests of users and their families provides a hopeful and contrasting vision to the existing profit and institutionally dominated system.[23]

Another recommendation would be that of what the Pennsylvania Department on Aging has implemented. Potter County provides access to a wide variety of in-home

services with the assistance of 52 Area Agencies on Aging. Several programs covering a wide range of needs are available such as: Homemaker Assistance for daily household activities; Personal Care help for those who can't manage alone and the Home Chore Services that help people with heavy cleaning or make minor repairs to their homes. [24]

Often, even if elderly residents own a home, they find it difficult to pay property tax and maintain a home.[25] North Carolina, and every other state, provides the elderly with a reverse mortgage option. In North Carolina, the state allows an individual 62 or older to convert the equity in their homes into cash or monthly income. This money can be used for any purpose and is not repaid until the last surviving borrower dies.[26]

The movement toward a more consumer-directed care for the elderly could be another possible solution. This model would allow consumers to choose the type of and relative amount of services to be received. Many consumers prefer to have the choice and are generally more satisfied with services when they have control over the type and provider of services. This choice is not recommended for everyone but could be most beneficial for those with cognitive difficulties and some seniors, who may be unaccustomed or uncomfortable with hiring, paying and firing personal assistants.[27]

North Carolina also offers a Homestead Property Tax Exemption to its elderly residents. The Homestead Exemption allows low-income elderly citizens and disabled homeowners to exempt a portion of the value of their home. An elderly or disabled person can qualify for the exemption if their annual income was under $18,000 the previous year.[28]

Also, many elderly can improve the quality of life in their own home with assistive medical equipment. As a result of installing assistive equipment, elderly

citizens who live in their own home can create a cost-effective alternative to human assistance. Items such as jar openers, sock gadgets, clothing with Velcro closures, bath seats, book holders and magnifiers are all low cost items that help the elderly maintain their independence. In a recent study, participating seniors increased their use of in home equipment from seven to eleven items, and the four pieces of equipment they began using cost a total of $76.00[29]

With regard to the issue of unpaid caregivers, O' Shaughnessy, Lyke and Storey argue that changes to the current system must be made. They state that assistance, such as tax incentives, should be offered to unpaid family caregivers. Further, they state that long-term care funding should be the same whether the person lives at their own home or in a nursing home.[30]

Endnotes

[1] Groshen, Erica L. and Klitgaard, Thomas. 2002. Live Long and Prosper: Challenges Ahead for an Aging Population. **Current Issues in Economics and Finance**. 8 (2): 1-8

[2] Bullock and Osborne (1999). *Seniors', Volunteers', and Families' Perspectives of an Intergenerational Program in a Rural Community*. **Educational Gerontology.** (25): 237-251

[3] O' Shaughnessy Carol. (2003). Report # RS21518: *Long-Term Care Chart Book: Persons Served, Payors and Spending*. **CRS Report for Congress.** Available via Purchase at: http://www.pennyhill.com/healthpolicy/rs21518.html

[4] Braden,B.R., Cowan,C.A., Lazenby, H.C., Martin, A.B., McDonnell, P.A., Sensenig, A.L., Stiller, J.M., Whittle, L.S., Donham, C.S., Long, A.M., & Stewart, M.W. (1998). *National Health Expenditures, 1997.* Health Care Financing Review

[5] United Seniors Health Council (2002). *Long-Term Care Planning: A Dollar & Sense Guide*

[6] Greene, K. (2003). *The Cost of Assisted Living.* Raleigh News & Press (taken from *Encore; Wall Street Journal).*

[7] O' Shaughnessy, Carol, Lyke , Bob and Storey, James R. (2002) *Long-Term Care: What Direction for Public Policy?* **CRS Report for Congress.** http://joewilson.house.gov/UploadedFiles/HEALTH%20-%20Long-Term%20Care%20What%20Direction%20for%20Public%20Policy.pdf

[8] Louisiana Dept. of Health & Hospitals, (2003). Community Service Programs Within Louisiana http://www.aarp.org/states/la/Articles/a2003-10-09-la-communityservice.html

[9] O' Shaughnessy Carol. (2003). Report # RS21518: *Long-Term Care Chart Book: Persons Served, Payors and Spending*. **CRS Report for Congress.** Available via Purchase at: http://www.pennyhill.com/healthpolicy/rs21518.html

[10] GAO Report to the Chairman, Special Committee on Aging, U.S. Senate (2002) **Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably. GAO-02-1211.** *http://www.gao.gov/new.items/d021121.pdf*

[11] Ibid.

[12] Ibid.

[13] O' Shaughnessy Carol. (2003). Report # RS21518: *Long-Term Care Chart Book: Persons Served, Payors and Spending*. **CRS Report for Congress.** Available via Purchase at: http://www.pennyhill.com/healthpolicy/rs21518.html

[14] ASPE: The Assistant Secretary for Planning and Evaluation & AoA: The Administration on Aging (1998). *Informal caregiving: Compassion in action*. Washington, DC: Authors.

[15] O' Shaughnessy Carol. (2003). Report # RS21518: *Long-Term Care Chart Book: Persons Served, Payors and Spending*. **CRS Report for Congress.** Available via Purchase at: http://www.pennyhill.com/healthpolicy/rs21518.html

[16] Cohen, Mark and Miller, Jessica. (2002) *The Impact of Private Long-Term Care Insurance on Claimants: Formal and Informal Care in the Community.* The Home Care Research Initiative. Spring 2002 Policy Brief

[17] *Nursing Home Cost of Care Study* (2002). http://www.newmanltc.com/docs/average_nh_daily.pdf

[18] North Carolina Division of Aging Information on Home and Community Services. http://www.dhhs.state.nc.us/aging/faq.htm

[19] Special Assistance Demonstration Project Pursuant S.L. 2001-424 (2003) . *Final Report to House of Representatives Appropriations Committee and House of Representatives Subcommittee on Health and Human Services and Senate Appropriations Committee and Senate Appropriations Committee on Health and Human Services.* http://www.dhhs.state.nc.us/dss/docs/SADP.pdf

[20] Estes, C.L. & Associates (2001). *Social Policy and Aging: A Critical Perspective.* Sage Publications, Inc. Thousand Oaks, CA.

[21] Manton, K.G., Corder, L., & Stallard, E. (1993). Changes in the use of personal assistance and special equipment from 1982 to 1989: Results from the 1982 and 1989 NLTCS. *The Gerontologist*

[22] Testimony Before the Special Committee on Aging, U.S. Senate, (2003). *Elderly Housing: Project Funding and Other Factors Delay Assistance to Needy Households*. *http://www.gao.gov/new.items/d03807t.pdf*

[23] Harrington, C. Carrillo, H. Thollaug, S., & Woolhandler, S., & Himmelstein, D.V. (1991). *A national long-term care program for the United States: A caring visoin* (Working Group on Long-Term Care Program Design, Physicians for a National Health Program)

[24] *In Home Services*. http://www.pottercountyhumansvcs.org/aging/srinhome.htm

[25] Pynoos, Jon, Matsuoka Christy and Liebig, Phobe (2001). *Housing for Older Californians.* California Policy Research Center Brief. University of California. May 2001

[26] North Carolina Division of Aging Consumer Tips. http://www.dhhs.state.nc.us/aging/housing2.htm

[27] Glickman, L.L., Brandt, K.J., Caro, F.G. (1997). *Self-direction in home care for older people: A consumer's perspective*. Boston, MA: Gerontology Institute and Center, University of Massachusetts-Boston.
Issues of Quality in Home and Community-Based Care: 2003

[28] North Carolina Division of Aging Consumer Tips. http://www.dhhs.state.nc.us/aging/housing2.htm

[29] Gottlieb, Alison S. and Caro, Francis G. (2001). *Extending the Effectiveness of Home care for Elders Through Low-Cost Assistive Equipment.* The Home Care Research Initiative. Fall 2001 Policy Brief.

[30] O' Shaughnessy, Carol, Lyke , Bob and Storey, James R. (2002) *Long-Term Care: What Direction for Public Policy?* **CRS Report for Congress.** http://joewilson.house.gov/UploadedFiles/HEALTH%20-%20Long-Term%20Care%20What%20Direction%20for%20Public%20Policy.pdf