STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

July 1, 2019

SENT VIA ELECTRONIC MAIL

The Honorable Pat Hurley, Chair
House Committee on Aging
North Carolina General Assembly
Room 532, Legislative Office Building
Raleigh, NC 27603

The Honorable Jean Farmer-Butterfield, Vice Chair
House Committee on Aging
North Carolina General Assembly
Room 1096, Legislative Building
Raleigh, NC 27601

Dear Chairmen:

NC General Statute 143B-181.1A requires the Division of Aging and Adult Services of the Department of Health and Human Services to submit a regularly updated plan for serving older adults in the State of North Carolina. Pursuant to this requirement, the Department of Health and Human Services' Division of Aging and Adult Services is pleased to provide the attached report.

Should you have any questions about this report, please contact Joyce Massey-Smith, Director for the Division of Aging and Adult Services, at Joyce.Massey-Smith@dhhs.nc.gov.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

cc: Matt Gross, Kody Kinsley, Denise Thomas, Mark Collins, Hattie Gawande, Marjorie Donaldson, Katherine Restrepo, Deborah Landry, Rob Kindsvatter, Joyce Massey-Smith, Erin Matteson, reports@ncleg.net, Steve Owen, Lisa Wilks, Mark Benton, Susan G. Perry, Joyce Jones, Theresa Matula, Zack Wortman, Jessica Meed

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STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

July 1, 2019

SENT VIA ELECTRONIC MAIL

The Honorable Bill Rabon, Chair
Senate Committee on Pensions and
Retirement and Aging
North Carolina General Assembly
Room 2010, Legislative Building
Raleigh, NC 27601

The Honorable Andy Wells, Chair
Senate Committee on Pensions and
Retirement and Aging
North Carolina General Assembly
Room 1028, Legislative Building
Raleigh, NC 27601

Dear Chairmen:

NC General Statute 143B-181.1A requires the Division of Aging and Adult Services of the Department of Health and Human Services to submit a regularly updated plan for serving older adults in the State of North Carolina. Pursuant to this requirement, the Department of Health and Human Services' Division of Aging and Adult Services is pleased to provide the attached report.

Should you have any questions about this report, please contact Joyce Massey-Smith, Director for the Division of Aging and Adult Services, at Joyce.Massey-Smith@dhhs.nc.gov.

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The North Carolina State Plan on Aging
2019-2023

An Age of Opportunity

Verification of Intent

The State Plan on Aging is hereby submitted for the *State of North Carolina, Department of Health and Human Services,* for the period of October 1, 2019 through September 30, 2023. It includes all assurances and plans to be conducted by the *Department of Health and Human Services I Division of Aging and Adult Services* under provision of the Older Americans Act, as amended, during the period identified. The State Agency named above has been given the authority to develop and administer the State Plan in accordance with all requirements of the Act, and is primarily responsible for the coordination of all State activities related to the purposes of the Act, i.e., the development of comprehensive and coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for the elderly in the State.

This Plan is hereby approved by the Governor and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary of Aging, Administration for Community Living, U.S. Department of Health and Human Services.

The State Plan on Aging hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements.

6/25/19 Signed _____
(Date) State Unit on Aging Director

6-21-19 Signed _____
(Date) **State Agency Director, where applicable**

I hereby approve this State Plan on Aging and submit it to the Assistant Secretary of the Administration for Community Living, U.S. Department of Health and Human Services for approval.

6-21-19 Signed _____
(Date) **Governor**

State of North Carolina
Department of Health and Human Services

Roy Cooper
Governor

June 21, 2019

Mandy Cohen, MD, MPH
Secretary

The Honorable Roy Cooper
North Carolina Governor
20301 Mail Service Center
Raleigh, NC 27699-0301

Dear Governor Cooper:

The North Carolina Department of Health and Human Services is pleased to present the 2019-2023 State Plan on Aging as required by N.C.G.S. 143B-181.1A and Section 307 of the federal Older Americans Act (Public Law 109-365). The Division of Aging and Adult Services and its many statewide partners have spent the past year gathering input to develop informed goals and objectives that are responsive to the needs of our growing and ever changing older adult population. This plan will help engage and serve our older citizens over the next four years. I am proud to report that the 2019-2023 North Carolina State Plan on Aging continues to build on your vision of a government that focuses on delivering the best possible outcomes, excellent customer service and the overall goal of improving healthy opportunities for the people of North Carolina.

To prepare for the development of this plan, the Division of Aging and Adult Services partnered with the Governor's Advisory Council on Aging, the North Carolina Coalition on Aging, the North Carolina Senior Tar Heel Legislature, the North Carolina Association of Area Agencies on Aging, and other key partners and citizens to host five listening sessions. These informative sessions were held in May and June 2018 in acknowledgement of Older Americans Month. Over 800 individuals, including seniors, caregivers, providers, businesses, faith community leaders, and public officials responded to our invitation to share their thoughts on the status and future of seniors. Other interested persons from across the state joined in via Facebook live. In addition, there were over 1,000 surveys completed from senior program participants across the state. All involved shared their challenges and hopes, and we listened. The State Plan on Aging reflects this exchange of information and the desire of the department to take the lead in developing better ways for citizens of our state to age with dignity.

Thank you for your leadership, and supporting our commitment to ensuring the health, safety and well-being of older North Carolinians.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

North Carolina Department of Health and Human Services
2019-2023 State Plan on Aging

Table of Contents

I. NARRATIVE

1. Executive Summary: An Age of Opportunity

The State Plan on Aging is hereby submitted for the North Carolina Department of Health and Human Services (DHHS), for the period of October 1, 2019 through September 30, 2023. It includes all assurances and plans to be conducted by DHHS and the Division of Aging and Adult Services under provision of the Older Americans Act, as amended, during the period identified. The state agency named above has been given the authority to develop and administer the state plan, in accordance with all requirements of the act, and is primarily responsible for the coordination of all state activities related to the purposes of the act, i.e., the development of comprehensive and coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as an effective and visible advocate for aging adults.

a. Background: To develop the State Plan on Aging, DHHS undertook extensive efforts to examine how services and program delivery systems for older adults, adults with disabilities, and their families and caregivers can be improved to better meet the needs of North Carolina's aging and disability populations. Five public listening sessions and stakeholder meetings were held across the state that provided invaluable expertise to this process. Input was sought from advocacy organizations, including the North Carolina Governor's Advisory Council on Aging, North Carolina Senior Tar Heel Legislature and North Carolina Coalition on Aging. In addition, an online survey was conducted, and responses were received from over 1,000 individuals across the state.

This four-year plan is a foundation for how DHHS will address the many challenges and opportunities of an aging population, including adults with disabilities. DHHS will track and report on progress on an annual basis. The progress will be reviewed with key stakeholders and amendments made as necessary.

b. Context: North Carolina ranks ninth nationwide in population of adults age 60 and older, and by 2025 one in five NC residents will be older than 65. Despite growing life expectancy, baby boomers experience higher rates of hypertension, high cholesterol, diabetes and obesity. The North Carolina Medicaid program covers more than 2.1 million people, 31.2 percent of which have a disability or are older than 65, yet 64 percent of spending goes for the services and treatment for these individuals. Challenges have been emerging over the last 25 years; however, opportunities to engage in meaningful work, volunteerism and leadership abound.

c. Overview: This plan identifies four focus areas that support:

- Safety and protection of vulnerable and older adults
- Opportunities to lead active and healthy lives
- Communities that are well-informed about choices and opportunities
- A strong and seamless continuum of services and supports

North Carolina's aging and adult population will be free from abuse, neglect and exploitation, and have their rights protected.

Adult maltreatment is a significant public health and human rights issue. National studies suggest that at least 10 percent of older Americans experience some form of maltreatment. Adults with disabilities are four to 10 times more likely to suffer maltreatment than adults without disabilities. There are significant health and mental health outcomes for people who suffer maltreatment.

Older adults who experience maltreatment have higher morbidity and mortality rates than those who do not. The likelihood of entering a nursing home or hospital increases dramatically with victimization. Maltreatment is also likely to be more prevalent among adults who suffer from depression and anxiety.

This population has not been left untouched by the opioid crisis, as there are increasing reports of misuse of these medications among the aging population. Reduced victimization by caregivers who have access to an adult's medications, along with supports and services for vulnerable adults, is a shared community responsibility and one that must be led by the state's commitment to educate people about these issues, and provide for a well-trained, well-funded system of rights and protections.

Create opportunities for older adults and their families to lead active, healthy lives.

The rapid increase of older North Carolinians has placed unprecedented demands on the provision of healthcare, housing, long-term care and other aging-related services. North Carolina will continue to build adequate and quality services and supports through the long-term care continuum and provide consumers choice and flexibility. Efforts to promote optimal health and functional independence are critical. Older adults who practice healthy behaviors, engage in promotion and disease prevention activities are more likely to remain healthy, live independently, incur fewer health-related costs and continue to engage with family and friends. Creating livable, sustainable communities connects people who are low-income with disabilities to supportive housing that is affordable, safe, permanent, integrated, accessible and independent. Opportunities for older adults to have access to employment, health, personal growth and social engagement are critical for the successful aging of older adults and to strengthen our communities.

Support older adults of all backgrounds and their support systems with access to information allowing informed choices that support them at home and in the community.

North Carolina is committed to strengthening support for an increasingly diverse aging population, along with their families and natural support systems. Workforce development and training, community education and engagement strategies will ensure such opportunities exist.

State, regional and local stakeholders, in concert with public and private partnerships, will be engaged to create such opportunities. Intentional efforts will be further developed around supporting family and unpaid caregivers and underserved and underrepresented communities.

Lead efforts to strengthen whole person care by engaging multiple community partners to increase and leverage resources.

Through Medicaid reform and expansion, North Carolina is developing a bold and innovative transformation of how we assist families in gaining access to information and services. Linkages between health, behavioral health, and human services will allow us to create a seamless continuum of care for older adults, adults with disabilities and their families. As this work continues, we will revisit and refine strategies to ensure that we are providing an effective set of services and supports, along with making it easier to access these services for all North Carolinians.

d. Next steps: The 2019-2023 State Plan on Aging bears the title "An Age of Opportunity." While our state faces many challenges, the next four years promise to hold some of the greatest watershed moments regarding the aging of our population. In fact, these changes present great opportunities for our aging adults, from additional resources for those in need to a better job forecast for seniors who wish to continue to work. It is a time of possibilities or "An Age of Opportunity!" We look forward, together with our partners, over the next four years to refining and implementing the goals of this plan.

2. Goals, Objectives, Strategies and Expected Outcomes

The goals, objectives and strategies described in this section represent the mission of DHHS as they relate to older adults, their caregivers and the services they receive. Over the next four years, DHHS will make advances in the areas of access to healthcare, independence of older adults, options for healthy living and aging, individual safety and rights, community collaboration, and accountability of government programs and services. The 2019-2023 plan goals focus on safety and protection, quality of life, well-informed communities and a seamless continuum of care. Each goal contains objectives and strategies that will guide us over the next four years in fulfilling our mission. Also included are the plan's expected outcomes, the culmination of the work that will be completed. The plan was created to ensure consistency with the department's mission and vision of collaboration with our partners to provide essential services that improve the health, safety and well-being of all North Carolinians, as well as advancing innovative solutions that foster independence, improve health and promote the well-being of its people. The goals presented here are the result of a collaboration that included input from North Carolinians, service participants, stakeholders, DAAS staff, DHHS division staff, the Area Agencies on Aging, managers and other subject matter experts. Five listening sessions were held across the state, and a survey was distributed and answered by more than 1,000 individuals. Advocacy organizations, such as the Governor's Council on Aging, the North Carolina Coalition on Aging, Resources for Seniors, the Senior Tar Heel Legislature and others also participated. These goals are representative of that work.

SAFETY AND PROTECTION

<u>Goal 1</u> – Older North Carolinians will be safe from abuse, neglect and exploitation, and have their rights protected.

In North Carolina, there were 30,128 reported cases of abuse, neglect or exploitation in fiscal year 2017-18. There has been a 67 percent increase in reports over the past nine years, and North Carolina must increase its capacity to respond to this growing need.

DAAS oversees the Adult Protective Services (APS) program, as directed pursuant to NC General Statute 108A, article 6. County Departments of Social Services are required to receive, screen, evaluate and provide needed protective services. While reports of abuse, neglect or exploitation are growing, DHHS also knows from national research that adult maltreatment is grossly under-reported. DHHS learned from the listening sessions and surveys that the need for additional resources, enhanced training requirements for social workers, and community education and local partnerships are needed to address the ever-growing maltreatment of vulnerable adults. In partnership with our stakeholders, DAAS will work to implement the US Administration for Community Living National Voluntary Consensus Guidelines for State Adult Protective Services Systems. The guidelines set out practice standards, training requirements, caseload standards, and support for the development of local multi-disciplinary teams, to ensure adults are protected.

Along with protection from maltreatment, we must also ensure that the basic civil and human rights of older adults and adults with disabilities are protected. Adults residing in long-term care facilities and need support meeting their activities of daily living needs making decisions, and adults under guardianship often have their basic rights violated. Much work needs to be done to address the issue of civil and human rights within the long-term care setting, both in-home and at the facility level. For instance, long-term care residential settings have a Resident Bill of Rights. In many cases, however, residents are not aware of this protection. DAAS will

work with stakeholders and the Division of Health Service Regulation (DHSR) to ensure the Resident Bill of Rights is made available to individuals in long-term care settings and their families.

Adult guardianship is designed to support and protect the rights of individuals who are not able to make or communicate decisions about their daily life, health care and finances. In North Carolina, disinterested public agent guardians and corporations are appointed to serve as guardian when there is no other family or individual available or appropriate to serve. NC statute states that directors of County Departments of Social Services are the only disinterested public agents who can serve as guardians. In fiscal year 2017-18, there were 6,487 adults under public guardianship. Although older adults made up a significant number of those under guardianship, 56 percent of adults served were aged 18-59 The majority of adults aged 18-59 had intellectual and other developmental disabilities, or a mental illness. The number of people needing guardianship due to traumatic brain injuries or substance use disorders is also rising.

Amidst the increasing numbers of adults under public and private guardianship, and a growing state and national call for a review of how guardianship is mandated, an initiative was launched in 2015 to understand and address this trend. With funding from the North Carolina Council on Developmental Disabilities, and a partnership with the Jordan Institute for Families at the University of North Carolina at Chapel Hill, and a wide-ranging group of stakeholders, DHHS began rethinking guardianship and building a case for less-restrictive alternatives. The agenda focused on developing a guardianship system that is less restrictive and based on nationally-recognized best practices, a guardianship process in which all stakeholders are involved, options and pathways toward guardianship, alternatives to guardianship, a public and private guardianship system that is accountable, and information about guardianship and alternatives that are easily accessible. Work will continue in the next four years to bring these efforts to fruition.

Finally, opioid addiction and misuse has affected older adults beyond the issues of addiction and overprescribing. Older adults who are prescribed opioids due to illness can become targets of abuse and exploitation by family members and others looking to use these prescriptions illegally. DHHS will work with county, state and local organizations, and continue bringing the latest information to these partners throughout the year and via the Opioid Misuse and Overdose Prevention Summit.

Objective 1.1: Training and outreach regarding the protection of vulnerable and older adults will be provided to community stakeholders.

Strategy 1: Provide training and technical assistance to support the efforts of Area Agencies on Aging, in collaboration with County Departments of Social Services and related stakeholders.

Strategy 2: In collaboration with the Attorney General's office and County Departments of Social Services, develop a training curriculum on indicators of abuse, neglect and exploitation for healthcare providers, social services departments, and community-based organizations.

Strategy 3: In collaboration with the Attorney General's Office and relevant stakeholders, revise the training curriculum on financial exploitation of seniors and other vulnerable adults.

Strategy 4: Develop a communication distribution plan on abuse, neglect and exploitation for stakeholders.

Strategy 5: Outcomes from the communications distribution planning sessions held with stakeholders will be used to develop additional outreach and training materials.

Strategy 6: In collaboration with NC Administrative Office of the Courts (NCAOC), provide training for state hospital staff regarding alternatives to guardianship of adults with disabilities.

Strategy 7: Implement the Administration on Community Living (ACL) Voluntary APS standards.

Objective 1.2: Training and outreach regarding indicators of self-neglect will be provided to a wide variety of people and organizations that come into continued contact with older and disabled people.

Strategy 1: In collaboration with the task force on serious illness care, County Departments of Social Services and the Attorney General's Office, develop a training curriculum to inform healthcare providers, social services departments, first responders and community-based organizations that teaches indicators of and responses to self-neglect.

Strategy 2: Develop a separate communication distribution plan on self-neglect for all materials created and publish a schedule for statewide, instructor-led trainings.

Strategy 3: DAAS and DSS APS systems will share data with law enforcement and others who have contact with individuals found to be self-neglecting.

Objective 1.3: Long-term care residents and adults under guardianship, and those who care for and support the residents will understand and be better-equipped to assist and empower their rights through training and outreach.

Strategy 1: Encourage the inclusion of the Resident's Bill of Rights in the admissions documents given to residents and/or their legal representatives.

Strategy 2: Facilitate resident's rights trainings in community forums and long-term care settings.

Strategy 3: Continue building and fostering partnerships with legal service providers throughout the state to ensure underserved and underrepresented communities have access to information enabling them to make informed decisions.

Strategy 4: Continue support of the Rethinking Guardianship Initiative to improve NC's system of rights and protections for individuals who need support and assistance with decision-making.

Objective 1.4: The aging network, including AAA's and other organizations assisting seniors, will be better-informed regarding exploitation, opioids and the connection between them through training and outreach.

Strategy 1: DHHS will host an annual conference for the aging network focused on opioid use, misuse, and the exploitation of older adults and people with disabilities by caretakers and others.

Strategy 2: Partner with stakeholders in the development of training and informational materials targeted to older adults, people with disabilities and their caregivers.

Expected Outcomes:

- Increased awareness, knowledge and skill-level, regarding the recognition and reporting of abuse, neglect, self-neglect and exploitation of older adults to stakeholders and other organizations, and people that encounter older adults.
- Increased awareness, knowledge and skill-level, regarding preserving and respecting the rights of individuals in long-term care settings.

Older adults prescribed opioid medications will have increased awareness on the risks of opioid medications, their misuse, how to secure them and how to properly dispose of them.

QUALITY OF LIFE

<u>Goal 2</u>: Create opportunities for older adults and their families to lead active and healthy lives.

North Carolina wants to increase awareness and understanding of the existing choices and opportunities that enhance quality of life for all older adults. There are a variety of public benefits and services available to assist older adults to plan for their health, housing and long-term care needs. The rapid increase of older North Carolinians has placed unprecedent demands on the provision of health, housing, long-term care and other aging-related services. Through a variety of funds, including the federal Older Americans Act, federal Social Services Block Grant Funds, and state and local funds, the 16 Area Agencies on Aging (AAA) in North Carolina administers a Home and Community Care Block Grant to serve adults age 60 and older through a wide variety of home and community-based services. Service standards and requirements are under the auspices of the Older Americans Act of 1965, as amended. More than 60,000 older adults were served in the state in fiscal year 2017-18, yet DHHS continues seeing waiting lists for core services, such as home-delivered meals, in-home aide and transportation.

A lack of awareness for services and supports is a documented issue for older adults, particularly in rural areas. Through the department's ground-breaking Medicaid transformation work, DAAS will educate providers and older adults about the Healthy Opportunities initiative that focuses on health drivers and a person's unmet essential needs, such as housing, food security, transportation, interpersonal safety and employment. This initiative creates NC CARE360, the first statewide network to join health care and human services work with a shared technology, allowing for a community-based, person-centered approach to providing health and human services in North Carolina. NC CARE360 will serve as a "no wrong door" to link individuals and families with services and providers to meet a person's needs. The system is being designed to ensure that individuals are linked to the supports they need and are tracked to ensure needs are addressed.

Efforts to promote optimal health and functional independence are critical. Older adults who practice healthy behaviors, use health promotion and disease prevention services are more likely to remain healthy, live independently, incur fewer health-related costs, and continue to engage with family and friends. Creating livable, sustainable communities supports connecting low-income people with disabilities to supportive housing that is affordable, safe, permanent, integrated, accessible and independent. Opportunities for older adults to have access to employment, personal growth and social engagement are critical for the successful aging of older adults and strengthening of our communities.

Objective 2.1: Promote expansion of home and community-based services to support older adults aging in the least-restrictive setting.

Strategy 1: Strengthen the capacity of local agencies providing services and explore alternative funding opportunities and business models as a road map to more effective, community-based service delivery.

Strategy 2: Analyze and assess current Home and Community Care Block Grant wait lists and utilize the Risk Assessment Tool as a means of determining an individual's greatest need.

Strategy 3: Support, through the provision of technical assistance, the operations of senior centers in the effective co-location of services, educational programs, wellness activities and evidence-based health promotion programs.

Strategy 4: Support programs that increase the availability of subsidized and moderate-income housing for seniors and those with disabilities by writing letters of support, assisting with grant applications, providing data, technical assistance and training.

Strategy 5: Encourage participation in the targeting program among older adults and people with disabilities through partnerships with funded providers and local DSS offices to promote aging populations successfully moving into affordable housing.

Strategy 6: In Partnership with the NC Division of Health Benefits and the NC Program for All Inclusive Care for the Elderly (PACE), provide outreach to members during enrollment and training to local DSS staff to ensure eligible individuals are made aware of the PACE option.

Objective 2.2: Long-Term Care (LTC) settings will allow residents to live in minimally restrictive environments while protecting their rights.

Strategy 1: Implement local and national best practice initiatives that empower residents to exercise autonomy over their lives in long-term care settings.

Strategy 2: Share with other LTC settings the work of those facilities that have exceled in their efforts to promote resident-centered and -focused practices.

Strategy 3: Work with the NC Division of Health Benefits, the Transition to Community Initiatives and state hospital staff to provide training for family and public guardians to ensure that Medicaid recipients in LTC residences are aware of, and have access to, independent living options in the community.

Objective 2.3: DHHS and community partners will employ system and community level strategies to improve food security for low-income older adults.

Strategy 1: Educate providers and older adults about NC Medicaid Transformation work and assist in developing partnerships and participation in the NCCARE360 initiative and Healthy Opportunities pilots.

Strategy 2: Collaborate with agencies, stakeholders, community organizations, senior centers and other DHHS divisions to assist in the state's efforts in food security for vulnerable older adults.

Strategy 3: Publicize the Senior Farmers' Market Nutrition Program (SFMNP) providing coupons and discounts to seniors that can be used to purchase fresh produce at local farmers' markets.

Strategy 4: Working with DSS and data from the Benefits Data Trust (BDT), ensure that seniors have access to and understand their ability to apply for food and nutritional services.

Strategy 5: Partner with NC DSS to provide community outreach and increase the number of older adults enrolled in the Supplemental Nutritional Assistance Program (SNAP).

Objective 2.4: Older adults will have access to evidence-based health promotion, wellness and disease prevention programs.

Strategy 1: In collaboration with NC Senior Games and local senior games programs, develop a plan for promoting participation in senior games programs across the state.

Strategy 2: Collaborate with key stakeholders to increase the vaccination rates for those aged 65 years and older by disseminating educational materials and conducting a statewide media campaign.

Strategy 3: Address the issue and negative impacts of falls among older adults through a partnership with the North Carolina Falls Prevention Coalition to develop an updated, best practices fall prevention plan.

Strategy 4: Research marketing and outreach programs, as well as best practices, to increase the number of older adults and adults with disabilities participating in evidence-based health promotion and disease prevention programs.

Objective 2.5: Increase employment of older adults seeking to re-enter or remain in the workforce.

Strategy: 1: Collaborate with NC Works, the Department of Commerce, the Division of Vocational Rehabilitation and other DHHS divisions to align older adult workers with job-training opportunities.

Strategy: 2: Increase opportunities among aging networks and workforce partners to expand participation among older adult workers.

Expected Outcomes:

- Increased utilization of existing community-based services that support the older adult population.
- More old and disabled adults will exercise their right of choice about living arrangements in long-term care environments.
- More older adults will have increased access to resources and services that support access to food, transportation and affordable housing.

Increased number of older adults that re-enter and remain in the workforce.

WELL INFORMED COMMUNITIES

Goal 3: Support and encourage older adults of all backgrounds and their support systems to access information that helps them make informed choices about support services at home or in the community.

Programs that provide free information and referral services to connect North Carolinians in all 100 counties with health, human and social service organizations will certainly make a difference. However, there is more work to be done. Use of social media as an alternative to reach specific target audiences is one of many effective approaches that DHHS will continue using, but with a more aggressive approach. Well-informed communities will also depend on effective implementation of Medicaid transformation. DAAS will partner in all opportunities of this important work and inform communities and partners along the way.

Senior centers play an important role as a community hub for many activities beyond the health and wellness opportunities they are known for. DAAS will educate older adults and partner agencies about

the benefits and opportunities that senior centers can provide to the broader community. NC has many rural and somewhat isolated communities. DAAS will explore efforts to ensure individuals in these areas receive the same level of information and quality of service as other parts of the state. Critical partners in this work will be our AAAs and County Departments of Social Services.

As with many Eastern Seaboard states, North Carolina continues to be hit by powerful, devasting hurricanes that result in flooding, loss of life and property. Snow and ice storms plague our western counties and spring tornadoes impact the entire state. North Carolina has a strong and well-trained emergency response system but planning for disaster and response during times of disaster for older and disabled adults is of special concern. In the coming four years, DAAS will work with sister agencies, AAAs and local partner agencies to ensure we are preparing older adults and adults with disabilities for these disasters.

Consumer Directed Services (CDS) is a concept of home care characterized by individuals who need personal care and home management assistance and can take charge of the assistance they receive by hiring workers of their own choosing, negotiating the rate of pay, and directing/supervising them in the way and when they want services provided. DAAS' CDS program is Home Care Independence (HCI), which is but one of several DHHS and locally supported programs that can enhance an older adult's community experience and help them remain independent. Services such as transportation, easier access to services and their application processes, information and assistance during an emergency, caregiver support and many others will all be explored over the next four years.

Supporting family caregivers will be increasingly important as we see the older population grow in North Carolina. Not only do informal, unpaid caregivers provide the bulk of care, but many of them are in the workforce and their ability to maintain full-time employment has been severely strained. DAAS currently serves family caregivers through an array of services and supports. The federally supported Family Caregiver Support Program (FCSP) promotes the health of caregivers, provides for paid respite, offers counseling and support groups, and supplemental services. Project C.A.R.E. (Caregivers Alternatives to Running om Empty) is a state funded project that also works to promote the well-being of caregivers through education, information, respite care and connections to social support networks.

According to North Carolina's Strategic Plan for Addressing Alzheimer's Diseases and Related Dementias, these diseases affect one in seven North Carolinians age 65 and older. In 2016, more than 160,000 were living with disease. That number is projected to rise to 210,000 by 2025. The disease is devastating for the victims, as well as their family caregivers. DAAS is committed to implementing the recommendation of the plan over the coming four years.

Objective 3.1: Older adults and the community networks who serve them will be educated on the availability of services that foster independence, self-sufficiency, and enhance planning for long-term needs.
Strategy 1: DAAS will develop and distribute statewide outreach materials to educate the community and other service/healthcare providers. **Strategy 2:** DAAS will provide caregiver training and educational resources to caregivers to strengthen a family's capacity to provide care. **Strategy 3:** Increase education and awareness of No Wrong Door/211 and how it can assist caregivers with respite resources, and access to long-term services and supports. **Strategy 4:** Collaborate with NCCARE 360 to increase referrals by the aging network to food, transportation, housing and personal safety resources.

Strategy 5: Educate older adults and community networks about an information and options counseling service designed to link people with available resources to meet their needs.

Strategy 6: In partnership with the Department of Transportation (DOT), expand public awareness of driver safety resources and promote safe driving among older adults.

Strategy 7: In partnership with the NC Division of Health Benefits, convene a workgroup to review the options under Medicaid Administrative Claiming (MAC) to ensure County DSS offices can access MAC funds to provide a broader array of services to Medicaid applicants and beneficiaries**.**

Strategy 8: Collaborate with the NC Division of Health Benefits to increase Medicaid Administrative Claiming spending and provide eligible individuals access to Medicaid services and treatment.

Objective 3.2: Foster equity and inclusion by educating and supporting underserved and underrepresented populations and their community networks.

Strategy 1: Increase the knowledge and skills of staff in the aging network to cultivate participant diversity.

Strategy 2: Identify organizations that have dedicated holocaust survivor programs and disseminate information to the aging network.

Strategy 3: Collaborate and provide technical assistance to Native Americans and advocates in their communities to promote access to available services.

Strategy 4: Increase outreach through the AAA area plans to consumers with limited English proficiency.

Strategy 5: Through training, increase the awareness of professionals to work with the aging LGBTQ community in collaboration with Services and Advocacy for Gay Elders (SAGE).

Strategy 6: Work with the Division of Services for the Deaf and Hard of Hearing, Division of the Blind and the Division of Vocational and Rehabilitation Services to provide training to aging service providers about the unique needs of the older adults they serve.

Strategy 7: Review, evaluate and revise as appropriate all policies within DAAS to ensure the language promotes equity and inclusion of marginalized populations.

Strategy 8: Ensure that professionals in rural areas have access to training and technical support.

Objective 3.3: Emergency preparedness and the safety of older adults and people with disabilities will be strengthened.

Strategy 1: Collaborate with the AAA's and other older adult stakeholders to encourage the expansion of the "call-down" logs system that contacts vulnerable adults prior to and following a hurricane or other natural event.

Strategy 2: Collaborate with the Emergency Operations Center Emergency Preparedness for People with Disabilities Committee to help educate and inform the target populations.

Objective 3.4: Older adults and caregivers will understand available resources and exercise options to choose and manage caregiver staff.

Strategy 1: Support public education and awareness of the needs of family caregivers.

Strategy 2: Expand public awareness of caregiver resources, consultation and respite services through the aging network.

Strategy 3: Develop educational and training materials for providers to help them direct caregivers to the most appropriate support services.

Strategy 4: Evaluate the capacity of individuals to use consumer direction for respite services.

Strategy 5: Educate county planning entities, AAAs and local service providers on consumer directed services.

Strategy 6: Continue supporting implementation recommendations in the Strategic Plan for Addressing Alzheimer's Disease and Related Dementias to create a Dementia Friendly NC that supports caregivers.

Objective 3.5: Expand public awareness regarding the benefits of Senior Centers and their role in the community.

Strategy 1: Develop marketing and training materials for use by senior centers to promote and educate individuals on their benefits.

Strategy 2: Support the Senior Center Alliance in the promotion and advocacy of senior centers.

Objective 3.6 Increase awareness of opioid addiction among older adults and adults with disabilities.

Strategy 1: Continue participation in accomplishing goals set out in the opioid action plan.

Strategy 2: Increase involvement and assist with the expansion of the "Lock Your Meds" campaign.

Expected Outcomes:

- Increased awareness and knowledge of older adults about the expectations of their caretakers, stakeholders, and other organizations and people that encounter older adults.
- People in caretaker roles will be supported with training and technical assistance.
- Underserved and underrepresented populations within the older adult community will have equal access to information and resources to meet identified needs.
- Older adults will know and understand available resources to ensure their safety and wellness during states of emergency.
- Older adults will understand the value and resources available through senior centers.

Older adults prescribed opioid medications will have increased awareness on the risks of opioid medications, their misuse, how to secure them and how to properly dispose of them.

STRONG AND SEAMLESS CONTINUUM OF SERVICES

Goal 4: DHHS will lead efforts to strengthen service delivery and capacity by engaging community partners to increase and leverage resources.

The mission of DAAS is to promote the independence and enhance the dignity of North Carolina's older adults, people with disabilities, and their families through a community-based system of opportunities, services, benefits and protection. DAAS has begun playing a larger and more significant role in the social services delivery system. As predicted, the number of older adults in our state has increased. Older adults are increasingly engaged in their communities, living longer and in need of services that not only provide the ability to live and work, but also ensure their well-being. As referenced in Goal 3, the growth in the number of people with dementia will require a concerted effort to support them and their caregivers. Communities must also be educated about dementia and sensitive to the needs of those impacted by the disease.

Communities must ensure that the needs of this significant portion of the population is served without sacrificing other needs. DHHS and DAAS will identify stakeholders, educate service providers and the public at large, and partner with other agencies engaged with seniors to provide positive outcomes for those programs that are essential to quality of life.

DAAS, the AAAs and other partners will collaborate in this effort, under the leadership of DHHS and subject matter experts in the field of aging to strengthen the service delivery system for seniors and make use of existing systems from other divisions that can be modified to meet the needs of this population.

It will be important, over the next several years, that partners are engaged in the process of improving outcomes for older adults and adults with disabilities. This work will begin at the department level through education and collaboration with our internal partners. Part of this work will include planning to devise stronger performance measures and contracts

Objective 4.1 DHHS, through the Division of Aging and Adult Services, will institute a multi-disciplinary advisory group that includes relevant divisions and strategic, system-level stakeholders to provide support and guidance on matters related to the aging community.
Strategy 1: Identify internal stakeholders from the various disciplines within DHHS to establish an advisory group that will both assist and involve the division in areas that would affect, or be of benefit to, individuals served by the division. **Strategy 2:** Educate other divisions regarding programs available through DAAS and how the division may assist through partnering. **Strategy 3:** Provide data, systems processing information and leadership involvement under the Division of State Operated Facilities (DSOF), NC Division of Health Benefits and NC Families Accessing Services through Technology (NC FAST) to streamline the process for individuals being discharged from state hospitals to receive Special Assistance (SA).
Objective 4.2 DAAS will improve performance-based outcomes for older adults by adopting an active contracts management framework to educate vendors and providers.
Strategy 1: The division will work towards developing a plan to employ an active contracts management framework.

Strategy 2: Will collaborate with contractors and vendors to develop performance measures that are measurable, achievable and reflect the needs of the people we serve.

Strategy 3: Investigate grant opportunities with NC DOT's Public Transportation Division, Meals on Wheels America, Healthy Aging NC, Geriatric Workforce Enhancement Programs and others that expand access to services.

Objective 4.3 Provide effective leadership for Dementia-Capable North Carolina, a strategic plan for addressing Alzheimer's disease and related dementias.

Strategy 1: Develop a plan for dementia education and resource information to be included on the DHHS website.

Strategy 2: Convene the Coalition for a Dementia-Capable NC to focus on furthering the recommendations included in the Dementia-Friendly NC plan.

Strategy 3: Provide leadership to a dementia-friendly communities workgroup for community leaders interested in beginning or growing a dementia-friendly community.

Strategy 4: Inform AAA's, community networks and interested individuals on the Dementia-Friendly America (DFA) framework.

Strategy 5: Coordinate with agencies and organizations that assist people with dementia and their caregivers to address common concerns

Strategy 6: Develop a basic, introductory training workshop for dementia-friendly hospital practices in interested communities.

Objective 4.4 Address the needs of individuals living with serious illness and their caregivers across North Carolina by partnering with the Institute of Medicine and other organizations working on issues of aging, palliative care, hospice care, and long-term supports and services in the Task Force on Serious Illness Care.

Strategy 1: Establish quarterly task force meetings to develop recommendations for a workable plan of action during fiscal year 2019-2020.

Strategy 2: Collaborate with the Institute of Medicine and other partners to issue a final report in 2020 with recommendations, including action steps.

Expected Outcomes:

- Vendors and contractors' scope of work will be aligned with the priorities of the department.
- Expanded access to services and resources through successful grant-funding opportunities
- Effectively lead efforts to create a dementia-capable state.

Routinely integrate the voices of strategic stakeholders and recipients of services for future planning for older and vulnerable adults through a DAAS-led task force.

3. Quality Management

The Division of Aging and Adult Services uses the "DHHS DAAS Plan for Monitoring Subrecipients" as a guide to manage quality of service programs for subrecipients. The plan provides the basis for programmatic and fiscal compliance monitoring in response to state and federal requirements. DAAS monitors HCCBG and non-HCCBG-based services, social services block grant eligibility, services and contracts funded by SSBG funds, the Special Assistance Program, Medicaid Administrative Claiming, the State Adult Day Care Fund – Social Services Block Grant, Alzheimer's disease grants, and cash assistance.

The DAAS's lead monitor will continue coordinating all monitoring activities for the agency. This position is responsible for ensuring the division's monitoring plan is maintained and implemented. The lead monitor is responsible for subrecipient audit reviews and audit-finding resolutions, financial management monitoring, compliance audit supplement development, and provides training, technical assistance, and consultation to division staff, the 16 Area Agencies on Aging (AAA's) and their subrecipients. The lead monitor is also the liaison between the division, and DHHS' Internal Auditor and other state agencies. The lead monitor acts as a "clearinghouse" for monitoring reports and corrective actions.

Each program is proactive in developing monitoring tools and data specific to their program areas. Federal and state guidelines are used as a standard for monitoring these program areas. These program tools are very effective and used on a consistent basis. Data collection is used via federal and state systems for several program areas. For example, our Senior Community Service Employment Program (SCSEP) uses a system called SPARQ (SCEP Performance and Results QPR system). This system is used to manage data collection reports and monitoring. Staff can use this system in addition to their monitoring tools to assess ongoing implementation and remediation of problem areas. Our Ombudsman program uses a similar system called ODIS. This system also manages data collection reports and monitoring.

During the next four years, DAAS will continue to strive for excellence in quality management. The new DAAS Monitoring Plan FY19 is currently being drafted and will include updates for this fiscal year. Each program will continue to improve monitoring tools as needed based on feedback from subrecipients and staff, as well as recommendations from the lad monitor and DAAS management. Also, an annual risk assessment meeting will be conducted every January to evaluate the level of risk for HCCBG and Non-HCCBG programs in all 16 regions.

The DAAS risk assessment team includes Ombudsman, SCSEP, service operations, and fiscal staff. The team considers the information in AAA self-assessment tools (submitted annually by the AAAs in December), along with other factors such as staff turnover, compliance history, and the amount of time since the last site visit.

Based on the level of risk, appropriate staff is assigned to conduct on-site monitoring visits. Regardless of the level of risk, however, each AAA is visited by at least one DAAS staff member annually.

4. Conclusion

DAAS is committed to meeting the diverse needs of North Carolina's fast-growing older adult population. DAAS looks forward to working with the various stakeholders, those that represent state government and with the many local and private partners. The four goals set forth in this plan provide the vision and structure for moving North Carolina forward. DAAS will develop baseline data on which to measure future progress and share updated data on an annual basis to document growth, challenges, and areas of opportunity. To achieve the goals defined in this plan, actions are required by state, regional, and local agencies and interests. As we move forward, we are confidently aware of the needs of our state and its people.

5. Acknowledgements

DAAS appreciates the individuals who contributed ideas and information during the development of the 2019-2023 State Aging Services Plan. Specifically, we would like to recognize the support of the Coalition on Aging, Governors' Advisory Council, Resources for Seniors, Senior Tarheel Legislature and the 16 Area Agencies on Aging. The State Plan on Aging also benefited from the invaluable assistance of the DAAS Service Operations section, Elder Rights section, Adult Services section, Housing section and Budget section. We'd also like to thank the DAAS Planning section and leadership team, who were responsible for the overall development of the plan.

II. ATTACHMENTS

Attachment A
STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2016

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2016.

ASSURANCES

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—

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

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

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan; (F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G)(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;

(c) An area agency on aging designated under subsection (a) shall be--…

(5) in the case of a State specified in subsection (b) (5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general-purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

Note: STATES MUST ENSURE THAT THE FOLLOWING ASSURANCES (SECTION 306) WILL BE MET BY ITS DESIGNATED AREA AGENCIES ON AGENCIES, OR BY THE STATE IN THE CASE OF SINGLE PLANNING AND SERVICE AREA STATES.

Sec. 306(a), AREA PLANS

(a) Each area agency on aging…Each such plan shall--

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

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

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

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

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

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

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

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

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

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

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

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared -(I) identify the number of low-income minority older individuals in the planning and service area;

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

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

(B) provide assurances that the area agency on aging will use outreach efforts that will— (i) identify individuals eligible for assistance under this Act, with special emphasis on-- (I) older individuals residing in rural areas;

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

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

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

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

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

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and (C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

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

(11) provide information and assurances concerning services to older individuals who are

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

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

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

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency--

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

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced because of such contract or such relationship;

(E) on the request of the Assistant Secretary or the State, for monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to older individuals because of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used--

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(a) . . . Each such plan shall comply with all the following requirements: …

(3) The plan shall--

(B) with respect to services for older individuals residing in rural areas— (i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000… (7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that--

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

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

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

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

(11) The plan shall provide that with respect to legal assistance -- (A) the plan contains assurances that area agencies on aging will

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

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

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

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

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

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

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals –

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

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

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

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

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

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area— (A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language

spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

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

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

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

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on— (i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

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

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

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

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

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

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

(B) are patients in hospitals and are at risk of prolonged institutionalization; or (C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a). (20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall--

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

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

(23) The plan shall provide assurances that demonstrable efforts will be made--

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

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

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

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

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

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

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

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

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

(a) ELIGIBILITY. —In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307--

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

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

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

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

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

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

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

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

(ii) receipt of reports of elder abuse;

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

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

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

(C) all information gathered while receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

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

(iii) upon court order…

State Plan Guidance
Attachment A (Continued)
REQUIRED ACTIVITIES

Sec. 305 ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .

(2) the State agency shall—

(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals; and

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

Sec. 306 – AREA PLANS

(a) . . . Each such plan shall— (6) provide that the area agency on aging will—

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

(6)(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate;

Sec. 307(a) STATE PLANS

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and (B) be based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES <u>NOT</u> REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The plan shall provide that the State agency will --

(A) evaluate, using uniform procedures described in section 202(a) (26), the need for supportive services (including legal assistance pursuant to 307(a) (11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and meet such need; …

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

Note: "PERIODIC" (DEFINED IN 45CFR PART 1321.3) MEANS, AT A MINIMUM, ONCE EACH FISCAL YEAR.

(5) The plan shall provide that the State agency will:

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a) (10); and (C) afford an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

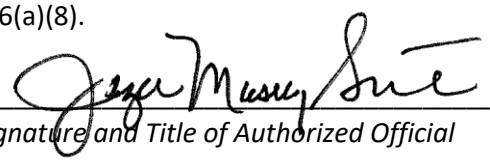
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals—

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and (C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

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



Signature and Title of Authorized Official

6/27/19

Date

Attachment B
INFORMATION REQUIREMENTS

IMPORTANT: States must provide all applicable information following each OAA citation listed below. Please note that italics indicate emphasis added to highlight specific information to include. The completed attachment must be included with your State Plan submission.

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

RESPONSE:

- The division will continue to emphasize service provision to older adults with the greatest economic and/or social needs, with attention paid to low-income minority older adults and older adults residing in rural areas. In the development of the 2019-2023 State Aging Services Plan, input was solicited from a variety of advocacy groups representing the interests of low-income older adults, low-income minority older adults, and older adults residing in rural areas through regional listening sessions and surveys.
- The division has targeted resources to the populations with special needs by using an approved intrastate funding formula based on these factors: general population aged 60 and older (50 percent); low income population aged 60 and older (30 percent); minority population aged 60 and older (10 percent); and rural population aged 60 and older (10 percent).
- The division requires each Area Agency on Aging to develop specific service objectives associated with low-income and low-income minority older adults, older adults residing in rural areas, and other populations at risk and with special needs.
- The division also maintains the Aging and Resource Management System (ARMS) database of clients served, which further analyzes the outreach to clients who are socially and economically needy, living in rural areas, or minorities.
- The division also maintains a website which includes state and county demographic profiles, including economic and social indicators and other special reports (www.ncdhhs.gov/divisions/daas/datareport).
- Objective 3.2 of the 2019-2023 State Aging Services Plan works to enhance outreach and reduce barriers for consumers with limited proficiency in English.

Section 306(a) (17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

RESPONSE:

- Objective 3.3 in the 2019-2023 State Aging Services Plan emphasizes comprehensive disaster preparedness and response for older adults and people with disabilities.
- The division requires that the AAAs include comprehensive emergency preparedness and disaster response plans to identify and respond to the needs of older adults in their region.

Section 307(a)(2)

The plan shall provide that the State agency will --…

(C*) specify a minimum proportion* of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306

(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). *(Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)*

RESPONSE:

- The division specifies the following minimum proportion of the funds received by each area agency on aging to provide part B services listed below:
    - Access: 30 percent
    - In-home: 25 percent
    - Legal assistance: two percent

  This requirement is included in the area plan.

Section 307(a)(3)

The plan shall--

..

(B) with respect to services for older individuals residing in rural areas--

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;

(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such*

services (including the cost of providing access to such services); and

(iii) *describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*

RESPONSE:

- The division requires each service provider to submit annually a completed DOA-733 form, titled "Methodology to Address Service Needs of Low-Income Minority Elderly and Rural Elderly."

- For each of fiscal years 2017 through 2019, a State and therefor the AAA's are allotted an amount that is less than 99 percent of the amount allotted to the State for the previous fiscal year.
- For fiscal year 2020 and each subsequent fiscal year, the State shall be allotted an amount that is less than 100 percent of the amount allotted to the State for fiscal year 2019. The same will hold true for the AAA'
- While North Carolina's Older Americans Act Intrastate Funding Formula does not include a rural factor, other non-Older Americans Act grants include a rural factor to target older adults residing in rural areas.
- While the division expects the need and total cost for aging services to increase between FY 2019-2023 as the number of older adults increases, the division is anticipating level funding. DAAS will continue to actively work with AAAs to maintain the costs for each jurisdiction to within the grant-funded amounts and supplemental funds obtained through other methods.

Section 307(a) (10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*

RESPONSE:

- The division's Intra-state Funding Formula (IFF) allocates funds in part (10 percent) based on the numbers of older adults residing in rural areas.
- The division requires each service provider to submit a completed DOA-733 form, titled "Methodology to Address Service Needs of Low-Income Minority Elderly and Rural Elderly" annually.
- The division requires each Area Agency on Aging to develop specific service objectives associated with low-income and low-income minority older adults, older adults residing in rural areas, and other populations at risk and with special needs.
- The state has 39 percent of older adults aged 60 and over living in rural areas (US Census 2010) and 14 counties are 100 percent rural. All the services provided in these areas are targeted towards older adults residing in rural areas.

Section 307(a) (14)

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) *identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency*; and

(B) *describe the methods used to satisfy the service needs* of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

RESPONSE:

- The division provides state and county profile demographic information and identifies the minority, low-income and limited English proficiency older adults in the state and counties and encourages targeted outreach and delivery of services.

- The division's Aging and Resource Management System (ARMS) captures the profiles of all the clients served in the state. The data collection and analytic team reviews the data for outreach to the minority and low-income and limited English proficiency older adults in the state.
- The division's staff monitoring the AAAs further enforces the outreach to the limited English proficiency older adults in the state and reviews the documents.
- The division has targeted resources to the populations with special needs by using an approved intrastate funding formula based on these factors: general population aged 60 and older (50 percent); low-income population aged 60 and older (30 percent); minority population aged 60 an older (10 percent); and rural population aged 60 and older (10 percent).
- The division requires each AAA to develop specific service objectives associated with low-income and low-income minority older adults and limited English proficiency older adults.
- The AAAs with a higher proportion of limited English proficiency older adults in their areas are cognizant of the cultural and linguistic barriers, and often use bilingual staff and perform targeted outreach with language -specific brochures and encourage participation in services.
- Objective 3.2 of the 2015-2019 State Aging Services Plan works to enhance outreach and reduce barriers for consumers with limited English proficiency.

Section 307(a) (21)

The plan shall --

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

RESPONSE:

- The Eastern Band of the Cherokee is the only nationally recognized tribe in North Carolina. The Southwestern Commission Area Agency on Aging (Region A) has a close, working relationship with the Eastern Band of the Cherokee. There are seven tribes recognized by the state.
- Objective 1.3 of the 2019-2023 State Aging Plan outlines how NC will ensure inclusion of diverse cultures and abilities in all aspects of the aging and adult services network. This includes activities with Native Americans.
- The division also provides demographic data on American Indians in each of the 100 counties to AAAs for outreach.

Section 307(a) (28)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services

RESPONSE:

- Future projections of the aging population indicate that not all counties in the state will experience growth at the same rate. Some counties will see rapid growth as expanding parts of metropolitan areas, while others will experience moderate growth and few rural counties will experience a decline. A higher proportion of African-Americans live in rural counties and are linked to lower median household income and level of education, higher rates of poverty and disabilities.
- Compared to urban areas, rural communities often face more unique challenges with transportation options and shortages of healthcare professionals. North Carolina's rural residents continue to face challenges in accessing healthcare, isolation, having higher poverty and mortality rates, and more prevalence of opioid use.
- As described, extra effort will be made toward reducing the waiting list through the possibility of some increased funding and working with agencies to expand their business model to address growth.
- As the population ages, projections are that there will be an increased need for additional services available at the community level. The department strives to work with the NC Division of Health Benefits and the NC Division of Medical Assistance to find new ways of funding supportive programs that allow individuals to remain at home for as long as possible, rather than using the costlier institutional option.

Section 307(a) (29)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE:

Objective 4.2 of the State Aging Services Plan is directed at strengthening emergency preparedness for older adults and adults with disabilities.

- The division maintains an updated disaster plan (see attachment I). The purpose of the plan is to define roles and responsibilities within the division and the aging network, including the AAAs, related to planning preparation, response and recovery during all types of disasters. The ultimate mission of the plan is to assure that the special needs of seniors and adults with disabilities are addressed.
- The division developed a continuity of operations plan (COOP). The plan establishes policy and guidance to ensure the execution of mission-essential functions if the agency is threatened or incapacitated, and the relocation of staff is necessary.
- The division staff serve on the statewide disaster preparedness committee and the human services Special Emergency Response Team (SERT), which is directed by the NC Department of Public Safety Emergency Operations Division, along with other human services-related state and local organizations.

Section 307(a) (30)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE:

The division, under the guidance of the director for the State Unit on Aging, works with its external and internal partners to continuously review and develop tools that inform and support both seniors and people with disabilities prior to an emergency.

- In the event of a public health crisis and through its work within the NC Emergency Management State Emergency Response Team, the division is involved in continuous development, revision and implementation of preparedness plans that address the specific needs of the elderly and disabled.
- The division takes part in state-sponsored Emergency Operations Center drills and receive scenarios that address potential issues during a public health or natural disaster emergency.

Section 705(a) ELIGIBILITY –

To be eligible to receive an allotment under this subtitle, a State shall *include in the State plan submitted under section 307--*

(7) a description of the way the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).

(Note: Paragraphs (1) of through (6) of this section are listed below)

To be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307--

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

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

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

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

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

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

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

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

(ii) receipt of reports of elder abuse;

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

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

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

(C) all information gathered during receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

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

(iii) upon court order.

RESPONSE:

- The division works closely with, and effectively uses, the opinions of the Governor's Advisory Council on Aging, the Senior Tar Heel Legislature, and the NC Coalition on Aging as reflected in the 2019-2023 State Aging Services Plan. These organizations hold public hearings and forums, often in conjunction with DAAS and the AAAs.
- DAAS management is cognizant and respectful of the required assurances referenced in Section 705(a)(7).
- The 2016-2020 Area Plan requires each AAA to develop an action plan for prevention of elder abuse, neglect and exploitation.
- Goal 1 of the 2019-2023 State Aging Services Plan is to ensure the safety and rights of older and vulnerable adults, and prevent their abuse, neglect, and exploitation. The strategies and outcomes related to these goals are related to APS, the Ombudsman program, elder abuse prevention, and partnerships with legal agencies.

C. Intrastate Funding Formula (IFF)

1. Funding subject to the Intrastate Funding Formula includes: III-B, III-C1, III-C2,

III-E, State Match and State Block Grant Funds.

2. Regional Intrastate Funding Formula elements:

50 percent Regional aged 60 and older/State aged 60 and older

30 percent Regional aged 60 and older Poverty/State aged 60 and older Poverty

10 percent Regional 60 and older Minority/State 60 and older Minority

10 percent Regional aged 60 and older Rural/State and older Rural

3. The Intrastate Funding Formula has functioned since fiscal year 1990-1991. In 2004, the formula was reviewed in consultation with AAAs, community service providers, and local elected officials to ensure that funding distribution reflected aging demographic trends identified in the 2000 Census. The conclusion of the study review group was that formula elements should remain unchanged.

IFF Population Data Methodology:

Population 60 and older: Numbers are extracted from the NC Office of State Budget and Management's certified population estimates and projections https://www.osbm.nc.gov/facts-figures

Below poverty, minority and people aged 60 and older living in rural areas: This data is extracted from decennial US Census and American Community Survey (ACS) five-year estimates https://www.census.gov/.

SFY 2020 Planning and Administration

	Federal	State	Total Fed/State
AAA P&	3,810,122	208,795	4,018,917
P&A State			0
Total	3,810,122	208,795	4,018,917
	0.948047	0.051953	

	Federal	State	Total Fed/State
AAA Support		772,200	772,200
SFY 2019 Amount		3,985,456	33,461

Region	Rate	SFY 2019	SFY 2020 Total	Local Match SFY 2019	Fed AAA P&A	State AAA P & A	Total State/Fed/Local SFY 2019	State Admin	Total SFY 2019 P&A	AAA P & A for Title III-B	AAA P & A for Title III-C1	AAA P & A for Title III-E	
A	3.0700%	151,515	152,542	40,281	144,617	7,925	192,823	48,262	241,085	30,008	86,770	27,839	128,607
B	4.8588%	204,274	205,900	54,371	195,203	10,697	260,271	48,262	308,533	40,505	117,122	37,577	169,673
C	3.0238%	155,712	156,724	41,385	148,582	8,142	198,109	48,262	246,371	30,831	89,149	28,602	132,763
D	2.9028%	152,978	153,949	40,652	145,951	7,998	194,601	48,262	242,863	30,285	87,571	28,096	130,660
E	3.9547%	176,873	178,196	47,055	168,938	9,258	225,251	48,262	273,513	35,055	101,363	32,521	148,357
F	16.9722%	528,328	534,007	141,011	506,264	27,743	675,018	48,263	723,281	105,050	303,758	97,456	418,087
G	17.2842%	617,768	623,551	164,657	591,156	32,395	788,208	48,262	836,470	122,665	354,694	113,798	501,537
J	14.0754%	434,678	439,388	116,026	416,560	22,828	555,414	48,262	603,676	86,436	249,936	80,188	342,893
K	3.1238%	163,352	164,397	43,411	155,856	8,541	207,808	48,263	256,071	32,340	93,514	30,002	139,371
L	4.3922%	205,834	207,304	54,741	196,534	10,770	262,045	48,263	310,308	40,781	117,920	37,833	173,347
M	4.7223%	206,302	207,882	54,894	197,082	10,800	262,776	48,262	311,038	40,895	118,249	37,938	172,313
N	3.9845%	186,617	187,950	49,630	178,185	9,765	237,580	48,263	285,843	36,973	106,911	34,301	157,263
O	5.4628%	210,081	211,909	55,957	200,900	11,009	267,866	48,263	316,129	41,687	120,540	38,673	172,458
P	6.5814%	280,659	282,861	74,693	268,166	14,695	357,554	48,263	405,817	55,644	160,900	51,622	234,183
Q	3.4300%	179,507	180,655	47,704	171,269	9,386	228,359	48,263	276,622	35,538	102,762	32,969	153,163
R	2.1612%	130,977	131,700	34,777	124,858	6,842	166,477	48,263	214,740	25,908	74,915	24,035	113,653
Total	100%	3,985,455	4,018,917	1,061,245	3,810,121	208,794	5,080,160	772,200	5,852,360	790,601	2,286,074	733,450	

SFY 2020 Ombudsman Funding Formula										
Region	LTC BEDS	LTC Bed Share	70% Weight LTC BEDS	Advisory Committees	Ad. Comm. Share	20% Weight Adv. Comm.	Sq. Miles	Sq. Mile Region Share	10% Weight Sq. Miles	Ombudsman Formula share
A	2,297	2.4849%	1.7394%	8	5.5172%	1.10%	3052	5.72%	0.5717%	3.4146%
B	5,483	5.9315%	4.1521%	5	3.4483%	0.69%	1857	3.48%	0.3479%	5.1896%
C	3,054	3.3038%	2.3127%	8	5.5172%	1.10%	1708	3.20%	0.3200%	3.7361%
D	2,190	2.3692%	1.6584%	9	6.2069%	1.24%	2512	4.71%	0.4706%	3.3704%
E	3,631	3.9280%	2.7496%	5	3.4483%	0.69%	1639	3.07%	0.3070%	3.7463%
F	16,905	18.2879%	12.8016%	15	10.3448%	2.07%	4195	7.86%	0.7859%	15.6564%
G	17,894	19.3578%	13.5505%	18	12.4138%	2.48%	5909	11.07%	1.1070%	17.1402%
J	13,773	14.8997%	10.4298%	10	6.8966%	1.38%	3953	7.41%	0.7405%	12.5497%
K	2,246	2.4297%	1.7008%	10	6.8966%	1.38%	2098	3.93%	0.3930%	3.4732%
L	3,794	4.1044%	2.8731%	9	6.2069%	1.24%	2677	5.01%	0.5015%	4.6159%
M	3,923	4.2439%	2.9707%	6	4.1379%	0.83%	2194	4.11%	0.4110%	4.2093%
N	2,858	3.0918%	2.1643%	9	6.2069%	1.24%	3007	5.63%	0.5633%	3.9690%
O	4,102	4.4376%	3.1063%	5	3.4483%	0.69%	3265	6.12%	0.6117%	4.4076%
P	5,805	6.2799%	4.3959%	13	8.9655%	1.79%	6103	11.43%	1.1433%	7.3323%
Q	2,717	2.9393%	2.0575%	5	3.4483%	0.69%	3175	5.95%	0.5948%	3.3419%
R	1,766	1.9105%	1.3373%	10	6.8966%	1.38%	6036	11.31%	1.1308%	3.8474%
TOTAL	92,438	100%	70%	145	100%	20%	53380	100%	10%	100%

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Cherokee	10,696	1,041	654	10696	16.81%	5,832	16.45%	9.73%	6.11%	100%
Clay	4,319	447	67	4319	6.39%	2,342	6.61%	10.35%	1.55%	100%
Graham	2,705	318	97	2,705	4.32%	1,499	4.23%	11.76%	3.59%	100%
Haywood	20,136	1,718	648	11,276	27.28%	10,967	30.94%	8.53%	3.22%	56%
Jackson	10,973	1216	961	9,217	18.38%	5,615	15.84%	11.08%	8.76%	84%
Macon	12,652	1,216	557	10,375	18.81%	7,221	20.37%	9.61%	4.4%	82%
Swain	3,844	490	770	3,844	8.01%	1,975	5.57%	12.75%	20.03%	100%
Region A	65,325	6,446	3,754	52,432	**100%**	35,451	**100%**	**9.9%**	**5.7%**	**80.3%**
Buncombe	68,138	5,063	5,399	17,035	53.65%	33,743	50.57%	7.43%	7.92%	25%
Henderson	38,510	2,772	1,877	11,553	28.99%	21,781	32.65%	7.20%	4.87%	30%
Madison	6,604	848	186	6,142	6.93%	3,218	4.82%	12.84%	2.82%	93%
Transylvania	13,243	926	323	8,078	10.43%	7,977	11.96%	6.99%	2.44%	61%
Region B	126,495	9,609	7,785	42,808	**100%**	66,719	**100%**	**7.6%**	**6.2%**	**33.8%**
Cleveland	24,506	3,235	4,482	13,233	42.96%	11,794	36.73%	13.20%	18.29%	54%
McDowell	12,567	1,232	497	8,797	18.12%	6,250	19.46%	9.80%	3.95%	70%

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Polk	7,872	530	379	7,006	10.75%	4,395	13.69%	6.73%	4.81%	89%
Rutherford	18,836	1,832	1,769	11,678	28.16%	9,674	30.12%	9.73%	9.39%	62%
Region C	63,781	6,829	7,127	40,714	**100%**	32,113	**100%**	**10.7%**	**11.2%**	**63.8%**
Alleghany	3,679	423	50	3679	6%	2,019	6.52%	11.5%	1.36%	100%
Ashe	8,809	945	87	7400	13.59%	4,665	15.08%	10.73%	0.99%	84%
Avery	5,024	630	129	4873	8.72%	2,669	8.63%	12.54%	2.57%	96.99%
Mitchell	4,685	554	37	3,935	7.4%	2,573	8.32%	11.82%	0.79%	83.99%
Watauga	11,840	943	331	8,880	17.78%	5,911	19.1%	7.96%	2.8%	75%
Wilkes	19,387	2,621	1,070	13,959	36.62%	9,997	32.31%	13.52%	5.52%	72%
Yancey	5,796	716	119	5,796	9.88%	3,109	10.05%	12.35%	2.05%	100%
Region D	59,220	6832	1823	48,522	**100%**	30,943	**100%**	**11.5%**	**3.1%**	**81.9%**
Alexander	9,951	866	489	7065	10.84%	4,996	10.96%	8.7%	4.91%	71%
Burke	24,011	2,459	1,810	9,845	26.22%	12,054	26.45%	10.24%	7.54%	41%
Caldwell	21,431	2,626	1,254	7,715	24%	10,556	23.16%	12.25%	5.85%	36%
Catawba	37,170	3,291	3,652	11,151	38.95%	17,969	39.43%	8.85%	9.83%	30%

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Region E	92,563	9,242	7,205	35,776	**100%**	45,575	**100%**	**10%**	**7.8%**	**38.7%**
Anson	6,041	980	2,203	4,470	2.33%	2,898	1.56%	16.22%	36.47%	73.99%
Cabarrus	37,720	2,954	6,222	9,053	8.88%	17,541	9.42%	7.83%	16.5%	24%
Gaston	48,128	4,995	6,953	10,107	12.13%	22,557	12.11%	10.38%	14.45%	21%
Iredell	37,763	2,936	4,770	15,483	9.41%	17,825	9.57%	7.77%	12.63%	41%
Lincoln	19,947	1,796	1,360	10,173	5.28%	9,220	4.95%	9%	6.82%	51%
Mecklenburg	170,656	13,944	55,555	3,413	39.61%	74,417	39.94%	8.17%	32.55%	2%
Rowan	33,007	3,170	4,882	12,873	8.76%	15,883	8.53%	9.6%	14.79%	39%
Stanly	15,742	1,304	1,613	10,547	4.4%	7,760	4.17%	8.28%	10.25%	67%
Union	40,143	2,237	6,197	14,853	9.18%	18,200	9.77%	5.57%	15.44%	37%
Region F	409,147	34,316	89,755	90,972	**100%**	186,301	**100%**	**8.4%**	**21.9%**	**22.2%**
Alamance	37,426	3,700	7,392	10,854	9.51%	18,798	9.91%	9.89%	19.75%	29%
Caswell	6,527	975	2,263	6,462	2.38%	3,081	1.62%	14.94%	34.67%	99%
Davidson	39,791	3,689	4,002	19,498	9.97%	19,327	10.18%	9.27%	10.06%	49%
Davie	11,438	797	699	7,206	2.71%	5,739	3.02%	6.97%	6.11%	63%

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Forsyth	79,621	7,669	19,398	7,166	19.4%	37,944	19.99%	9.63%	24.36%	9%
Guilford	108,695	9,484	30,494	17,391	26.79%	51,584	27.18%	8.73%	28.05%	16%
Montgomery	7,479	871	1,245	6,058	2.25%	3,757	1.98%	11.65%	16.65%	81%
Randolph	33,708	3,280	2,867	19,214	8.7%	16,540	8.72%	9.73%	8.51%	57%
Rockingham	24,478	2,518	4,512	14,687	6.8%	12,070	6.36%	10.29%	18.43%	60%
Stokes	12,639	1,270	718	9,606	3.42%	6,276	3.31%	10.05%	5.68%	76%
Surry	18,932	2,489	1,059	12,116	5.42%	9,639	5.08%	13.15%	5.59%	64%
Yadkin	9,832	923	448	8,161	2.64%	5,015	2.64%	9.39%	4.56%	83%
Region G	390,566	37,665	75,097	138,419	**100%**	189,770	**100%**	**9.6%**	**19.2%**	**35.4%**
Chatham	23,306	1,466	3,489	13,517	7.17%	12,287	7.57%	6.29%	14.97%	58%
Durham	53,569	4,548	21,223	4,821	16.34%	23,506	14.48%	8.49%	39.62%	9%
Johnston	35,852	3,293	6,112	19,719	12.29%	16,006	9.86%	9.18%	17.05%	55%
Lee	13,189	1,452	2,978	5,935	4.75%	6,530	4.02%	11.01%	22.58%	45%
Moore	31,903	2,120	3,678	12,761	9.12%	18,354	11.3%	6.65%	11.53%	40%
Orange	27,923	1,632	5,017	11,448	7.96%	11,951	7.36%	5.84%	17.97%	41%

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Wake	170,716	9,522	40,286	13,657	42.37%	73,739	45.41%	5.58%	23.6%	8%
Region J	356,458	24,033	82,783	81,858	**100%**	162,373	**100%**	**6.7%**	**23.2%**	**23%**
Franklin	15,359	1,571	4,544	13,209	26.04%	7,080	26.31%	10.23%	29.59%	86%
Granville	13,716	1,836	4,562	7,681	24.38%	6,238	23.18%	13.39%	33.26%	56%
Person	10,336	1,090	2,684	7,545	17.14%	4,971	18.47%	10.55%	25.97%	73%
Vance	10,847	1,485	4,630	5,749	19.87%	5,285	19.64%	13.69%	42.68%	53%
Warren	6,208	902	3,108	6,208	12.56%	3,338	12.4%	14.53%	50.06%	100%
Region K	56,466	6,884	19,528	40,392	**100%**	26,912	**100%**	**12.2%**	**34.6%**	**71.5%**
Edgecombe	14,126	2,092	7,287	6,215	18.81%	6,610	17.69%	14.81%	51.59%	44%
Halifax	14,102	2,400	7,175	8,320	20.16%	6,858	18.35%	17.02%	50.88%	59%
Nash	23,815	2,767	7,949	11,431	28.46%	11,050	29.57%	11.62%	33.38%	48%
Northampton	6,339	1063	3,166	5,768	9.51%	3,443	9.21%	16.77%	49.94%	90.99%
Wilson	19,519	2,262	6,938	7,808	23.05%	9,406	25.17%	11.59%	35.54%	40%
Region L	77,901	10,584	32,515	39,542	**100%**	37,367	**100%**	**13.6%**	**41.7%**	**50.8%**
Cumberland	57,896	5,776	25,188	10,421	57.61%	26,089	59.01%	9.98%	43.51%	18%

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Harnett	22,966	2,471	5,208	13,550	24.64%	10,782	24.39%	10.76%	22.68%	59%
Sampson	15,034	1,711	4,875	12,178	17.74%	7,337	16.6%	11.38%	32.43%	81%
Region M	95,896	9,958	35,271	36,149	**100%**	44,208	**100%**	**10.4%**	**36.8%**	**37.7%**
Bladen	9,262	1,572	3,228	8,243	15.07%	4,566	15.69%	16.97%	34.85%	89%
Hoke	7,492	1030	3,698	4,046	11.17%	3,048	10.47%	13.75%	49.36%	54%
Richmond	10,727	1,967	3,132	4,720	16.36%	5,103	17.54%	18.34%	29.2%	44%
Robeson	27,083	4,845	16,197	16,250	44.92%	12,373	42.52%	17.89%	59.81%	60%
Scotland	8,670	1,203	3,573	3,815	12.48%	4,010	13.78%	13.88%	41.21%	44%
Region N	63,234	10,617	29,828	37,074	**100%**	29,100	**100%**	**16.8%**	**47.2%**	**58.6%**
Brunswick	49,534	3,272	4,293	18,328	34.06%	25,058	38.41%	6.61%	8.67%	37%
Columbus	14,229	2,215	4,375	11,525	16.26%	7,154	10.97%	15.57%	30.75%	81%
New Hanover	52,374	4,572	7,344	1,571	36.03%	25,886	39.68%	8.73%	14.02%	3%
Pender	15,004	1,568	2,917	9,603	13.65%	7,145	10.95%	10.45%	19.44%	64%
Region O	131,141	11,627	18,929	41,027	**100%**	65,243	**100%**	**8.9%**	**14.4%**	**31.3%**
Carteret	22,520	1,504	1,403	6,756	12.75%	11,449	16.43%	6.68%	6.23%	30%

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Craven	23,479	1,800	4,937	6,574	14.72%	12,487	17.92%	7.67%	21.03%	28%
Duplin	13,993	1,892	4,595	11,754	12.25%	7,094	10.18%	13.52%	32.84%	84%
Greene	4,765	624	1,485	4,765	4.22%	2,147	3.08%	13.1%	31.16%	100%
Jones	2,911	403	1029	2,911	2.66%	1,399	2.01%	13.84%	35.35%	100%
Lenoir	15,173	2,118	5,691	5,917	12.58%	7,381	10.59%	13.96%	37.51%	39%
Onslow	26,061	2,362	5,625	9,382	17.5%	12,030	17.26%	9.06%	21.58%	36%
Pamlico	4,744	379	856	4,744	3.5%	2,564	3.68%	7.99%	18.04%	100%
Wayne	27,056	2,620	9,343	11,634	19.83%	13,149	18.87%	9.68%	34.53%	43%
Region P	140,702	13,702	34,964	64,437	**100%**	69,700	**100%**	**9.7%**	**24.8%**	**45.8%**
Beaufort	14,880	1,770	3,227	10,267	22.72%	7,647	24.71%	11.9%	21.69%	69%
Bertie	5,314	747	2,807	4,464	9.52%	2,660	8.59%	14.06%	52.82%	84%
Hertford	6,222	1,114	3,367	4,231	11.83%	2,947	9.52%	17.9%	54.11%	68%
Martin	7,060	915	2,846	5,507	11.84%	3,411	11.02%	12.96%	40.31%	78%
Pitt	31,799	3,135	10,470	9,858	44.08%	14,285	46.16%	9.86%	32.93%	31%
Region Q	65,275	7,681	22,717	34,327	**100%**	30,950	**100%**	**11.8%**	**34.8%**	**52.6%**

SFY 20 Intrastate Funding Formula

Weighting %	50%	30%	10%	10%	100%					
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Camden	2,334	59	506	2,287	4.25%	1,125	4.98%	2.53%	21.68%	97.99%
Chowan	4,394	676	1,194	2,944	12.02%	2,390	10.58%	15.38%	27.17%	67%
Currituck	6,072	300	528	5,951	11.31%	2,687	11.89%	4.94%	8.7%	98.01%
Dare	10,508	390	428	3,152	15.78%	4,888	21.64%	3.71%	4.07%	30%
Gates	3,122	219	1,144	3,122	7.25%	1,566	6.93%	7.01%	36.64%	100%
Hyde	1,485	26	489	1,485	2.81%	669	2.96%	1.75%	32.93%	100%
Pasquotank	8,502	1005	2,929	3,486	20.96%	4,102	18.16%	11.82%	34.45%	41%
Perquimans	4,640	582	339	4,640	11.22%	2,606	11.54%	12.54%	7.31%	100%
Tyrrell	1,134	358	350	1,134	4.63%	619	2.74%	31.57%	30.86%	100%
Washington	3,865	426	1,433	2,667	9.76%	1,939	8.58%	11.02%	37.08%	69%
Region R	46,056	4041	9340	30,868	**100%**	22,591	**100%**	**8.8%**	**20.3%**	**67%**
NC	**2,240,226**	**210,066**	**478,421**	**855,317**		**1,075,316**		**9.4%**	**21.4%**	**38.2%**

	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	% of funds, $969,549	70+ (Age)	Over 70 Formula
A	65,325	6,446	3,754	52,432	0.0307005	$ 29,766	35,451	0.0329680
B	126,495	9,609	7,785	42,808	0.0485876	$ 47,108	66,719	0.0620459
C	63,781	6,829	7,127	40,714	0.0302378	$ 29,317	32,113	0.0298638
D	59,220	6832	1823	48,522	0.0290284	$ 28,144	30,943	0.0287757
E	92,563	9,242	7,205	35,776	0.0395468	$ 38,343	45,575	0.0423829
F	409,147	34,316	89,755	90,972	0.1697224	$ 164,554	186,301	0.1732523
G	390,566	37,665	75,097	138,419	0.1728416	$ 167,578	189,770	0.1764784
J	356,458	24,033	82,783	81,858	0.1407544	$ 136,468	162,373	0.1510003
K	56,466	6,884	19,528	40,392	0.0312382	$ 30,287	26,912	0.0250271
L	77,901	10,584	32,515	39,542	0.0439215	$ 42,584	37,367	0.0347498
M	95,896	9,958	35,271	36,149	0.0472232	$ 45,785	44,208	0.0411116
N	63,234	10,617	29,828	37,074	0.0398449	$ 38,632	29,100	0.0270618
O	131,141	11,627	18,929	41,027	0.0546276	$ 52,964	65,243	0.0606733
P	140,702	13,702	34,964	64,437	0.0658136	$ 63,809	69,700	0.0648182
Q	65,275	7,681	22,717	34,327	0.0342999	$ 33,255	30,950	0.0287822
R	46,056	4041	9340	30,868	0.0216116	$ 20,953	22,591	0.0210087
NC	**2,240,226**	**210,066**	**478,421**	**855,317**	**1.0000000**	$969,549	**1,075,316**	**1.0000000**

Sources:
Certified numbers, population 60 and older from NCOSBM, retrieved in December 2018
US Census. 2012-2016 American Community Survey. Tables
Poverty: American Community Survey 2012-2016. B17020 Poverty status in the past 12 months by age
Rural: US Census 2010. P12 Sex by age. Urban and Rural
Minority: American Community Survey 2012-2016 five-year estimates. S0102. Population 60 years and older is used for 73 counties (methodology includes subtracting white alone (non-Hispanic or Latino) percentages from 100 percent. For 27 counties tables. Sex by age - white alone (non-Hispanic or Latino) is used to calculate 65 percent and used.

2020 Medically Underserved	2020 Medically Underserved									
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Cherokee	10,696	1,041	654	10696	16.81%		0%	9.73%	6.11%	100%
Clay	4,319	447	67	4319	6.39%		0%	10.35%	1.55%	100%
Graham	2,705	318	97	2,705	4.32%		0%	11.76%	3.59%	100%
Haywood	20,136	1,718	648	11,276	27.28%		0%	8.53%	3.22%	56%
Jackson	10,973	1216	961	9,217	18.38%		0%	11.08%	8.76%	84%
Macon	12,652	1,216	557	10,375	18.81%		0%	9.61%	4.4%	82%
Swain	3,844	490	770	3,844	8.01%		0%0%	12.75%	20.03%	100%
Region A	65,325	6,446	3,754	52,432	**100%**	0	**0%**	**9.9%**	**5.7%**	**80.3%**
Buncombe	68,138	5,063	5,399	17,035	53.65%		0%	7.43%	7.92%	25%
Henderson	38,510	2,772	1,877	11,553	28.99%		0%	7.2%	4.87%	30%
Madison	6,604	848	186	6,142	6.93%		0%	12.84%	2.82%	93%
Transylvania	13,243	926	323	8,078	10.43%		0%	6.99%	2.44%	61%
Region B	126,495	9,609	7,785	42,808	**100%**	0	**0%**	**7.6%**	**6.2%**	**33.8%**
Cleveland	24,506	3,235	4,482	13,233	42.96%		0%	13.2%	18.29%	54%
McDowell	12,567	1,232	497	8,797	18.12%		0%	9.8%	3.95%	70%
Polk	7,872	530	379	7,006	10.75%		0%	6.73%	4.81%	89%
Rutherford	18,836	1,832	1,769	11,678	28.16%		0%	9.73%	9.39%	62%
Region C	63,781	6,829	7,127	40,714	**100%**	0	**0%**	**10.7%**	**11.2%**	**63.8%**
Alleghany	3,679	423	50	3679	6%		0%	11.5%	1.36%	100%
Ashe	8,809	945	87	7400	13.59%		0%	10.73%	0.99%	84%
Avery	5,024	630	129	4873	8.72%		0%	12.54%	2.57%	96.99%
Mitchell	4,685	554	37	3,935	7.4%		0%	11.82%	0.79%	83.99%
Watauga	11,840	943	331	8,880	17.78%		0%	7.96%	2.8%	75%

2020 Medically Underserved	2020 Medically Underserved									
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Wilkes	19,387	2,621	1,070	13,959	36.62%		0%	13.52%	5.52%	72%
Yancey	5,796	716	119	5,796	9.88%		0%	12.35%	2.05%	100%
Region D	59,220	6832	1823	48,522	**100%**	0	**0%**	**11.5%**	**3.1%**	**81.9%**
Alexander	9,951	866	489	7065	10.84%		0%	8.7%	4.91%	71%
Burke	24,011	2,459	1,810	9,845	26.22%		0%	10.24%	7.54%	41%
Caldwell	21,431	2,626	1,254	7,715	24%		0%	12.25%	5.85%	36%
Catawba	37,170	3,291	3,652	11,151	38.95%		0%	8.85%	9.83%	30%
Region E	92,563	9,242	7,205	35,776	**100%**	0	**0%**	**10%**	**7.8%**	**38.7%**
Anson	6,041	980	2,203	4,470	2.33%		0%	16.22%	36.47%	73.99%
Cabarrus	37,720	2,954	6,222	9,053	8.88%		0%	7.83%	16.5%	24%
Gaston	48,128	4,995	6,953	10,107	12.13%		0%	10.38%	14.45%	21%
Iredell	37,763	2,936	4,770	15,483	9.41%		0%	7.77%	12.63%	41%
Lincoln	19,947	1,796	1,360	10,173	5.28%		0%	9%	6.82%	51%
Mecklenburg	170,656	13,944	55,555	3,413	39.61%		0%	8.17%	32.55%	2%
Rowan	33,007	3,170	4,882	12,873	8.76%		0%	9.6%	14.79%	39%
Stanly	15,742	1,304	1,613	10,547	4.4%		0%	8.28%	10.25%	67%
Union	40,143	2,237	6,197	14,853	9.18%		0%	5.57%	15.44%	37%
Region F	409,147	34,316	89,755	90,972	**100%**	0	**0%**	**8.4%**	**21.9%**	**22.2%**
Alamance	37,426	3,700	7,392	10,854	9.51%		0%	9.89%	19.75%	29%
Caswell	6,527	975	2,263	6,462	2.38%		0%	14.94%	34.67%	99%
Davidson	39,791	3,689	4,002	19,498	9.97%		0%	9.27%	10.06%	49%
Davie	11,438	797	699	7,206	2.71%		0%	6.97%	6.11%	63%
Forsyth	79,621	7,669	19,398	7,166	19.4%		0%	9.63%	24.36%	9%

2020 Medically Underserved	2020 Medically Underserved									
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Guilford	108,695	9,484	30,494	17,391	26.79%		0%	8.73%	28.05%	16%
Montgomery	7,479	871	1,245	6,058	2.25%		0%	11.65%	16.65%	81%
Randolph	33,708	3,280	2,867	19,214	8.7%		0%	9.73%	8.51%	57%
Rockingham	24,478	2,518	4,512	14,687	6.8%		0%	10.29%	18.43%	60%
Stokes	12,639	1,270	718	9,606	3.42%		0%	10.05%	5.68%	76%
Surry	18,932	2,489	1,059	12,116	5.42%		0%	13.15%	5.59%	64%
Yadkin	9,832	923	448	8,161	2.64%		0%	9.39%	4.56%	83%
Region G	390,566	37,665	75,097	138,419	**100%**	0	**0%**	**9.6%**	**19.2%**	**35.4%**
Chatham	23,306	1,466	3,489	13,517	7.17%		0%	6.29%	14.97%	58%
Durham	53,569	4,548	21,223	4,821	16.34%		0%	8.49%	39.62%	9%
Johnston	35,852	3,293	6,112	19,719	12.29%		0%	9.18%	17.05%	55%
Lee	13,189	1,452	2,978	5,935	4.75%		0%	11.01%	22.58%	45%
Moore	31,903	2,120	3,678	12,761	9.12%		0%	6.65%	11.53%	40%
Orange	27,923	1,632	5,017	11,448	7.96%		0%	5.84%	17.97%	41%
Wake	170,716	9,522	40,286	13,657	42.37%		0%	5.58%	23.6%	8%
Region J	356,458	24,033	82,783	81,858	**100%**	0	**0%**	**6.7%**	**23.2%**	**23%**
Franklin	15,359	1,571	4,544	13,209	26.04%		0%	10.23%	29.59%	86%
Granville	13,716	1,836	4,562	7,681	24.38%		0%	13.39%	33.26%	56%
Person	10,336	1,090	2,684	7,545	17.14%		0%	10.55%	25.97%	73%
Vance	10,847	1,485	4,630	5,749	19.87%		0%	13.69%	42.68%	53%
Warren	6,208	902	3,108	6,208	12.56%		0%	14.53%	50.06%	100%
Region K	56,466	6,884	19,528	40,392	**100%**	0	**0%**	**12.2%**	**34.6%**	**71.5%**
Edgecombe	14,126	2,092	7,287	6,215	18.81%		0%	14.81%	51.59%	44%

2020 Medically Underserved	2020 Medically Underserved									
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Halifax	14,102	2,400	7,175	8,320	20.16%		0%	17.02%	50.88%	59%
Nash	23,815	2,767	7,949	11,431	28.46%		0%	11.62%	33.38%	48%
Northampton	6,339	1063	3,166	5,768	9.51%		0%	16.77%	49.94%	90.99%
Wilson	19,519	2,262	6,938	7,808	23.05%		0%	11.59%	35.54%	40%
Region L	77,901	10,584	32,515	39,542	**100%**	0	**0%**	**13.6%**	**41.7%**	**50.8%**
Cumberland	57,896	5,776	25,188	10,421	57.61%		0%	9.98%	43.51%	18%
Harnett	22,966	2,471	5,208	13,550	24.64%		0%	10.76%	22.68%	59%
Sampson	15,034	1,711	4,875	12,178	17.74%		0%	11.38%	32.43%	81%
Region M	95,896	9,958	35,271	36,149	**100%**	0	**0%**	**10.4%**	**36.8%**	**37.7%**
Bladen	9,262	1,572	3,228	8,243	15.07%		0%	16.97%	34.85%	89%
Hoke	7,492	1030	3,698	4,046	11.17%		0%	13.75%	49.36%	54%
Richmond	10,727	1,967	3,132	4,720	16.36%		0%	18.34%	29.2%	44%
Robeson	27,083	4,845	16,197	16,250	44.92%		0%	17.89%	59.81%	60%
Scotland	8,670	1,203	3,573	3,815	12.48%		0%	13.88%	41.21%	44%
Region N	63,234	10,617	29,828	37,074	**100%**	0	**0%**	**16.8%**	**47.2%**	**58.6%**
Brunswick	49,534	3,272	4,293	18,328	34.06%		0%	6.61%	8.67%	37%
Columbus	14,229	2,215	4,375	11,525	16.26%		0%	15.57%	30.75%	81%
New Hanover	52,374	4,572	7,344	1,571	36.03%		0%	8.73%	14.02%	3%
Pender	15,004	1,568	2,917	9,603	13.65%		0%	10.45%	19.44%	64%
Region O	131,141	11,627	18,929	41,027	**100%**	0	**0%**	**8.9%**	**14.4%**	**31.3%**
Carteret	22,520	1,504	1,403	6,756	12.75%		0%	6.68%	6.23%	30%
Craven	23,479	1,800	4,937	6,574	14.72%		0%	7.67%	21.03%	28%
Duplin	13,993	1,892	4,595	11,754	12.25%		0%	13.52%	32.84%	84%

2020 Medically Underserved	2020 Medically Underserved									
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Greene	4,765	624	1,485	4,765	4.22%		0%	13.1%	31.16%	100%
Jones	2,911	403	1029	2,911	2.66%		0%	13.84%	35.35%	100%
Lenoir	15,173	2,118	5,691	5,917	12.58%		0%	13.96%	37.51%	39%
Onslow	26,061	2,362	5,625	9,382	17.5%		0%	9.06%	21.58%	36%
Pamlico	4,744	379	856	4,744	3.5%		0%	7.99%	18.04%	100%
Wayne	27,056	2,620	9,343	11,634	19.83%		0%	9.68%	34.53%	43%
Region P	140,702	13,702	34,964	64,437	**100%**	0	**0%**	**9.7%**	**24.8%**	**45.8%**
Beaufort	14,880	1,770	3,227	10,267	22.72%		0%	11.9%	21.69%	69%
Bertie	5,314	747	2,807	4,464	9.52%		0%	14.06%	52.82%	84%
Hertford	6,222	1,114	3,367	4,231	11.83%		0%	17.9%	54.11%	68%
Martin	7,060	915	2,846	5,507	11.84%		0%	12.96%	40.31%	78%
Pitt	31,799	3,135	10,470	9,858	44.08%		0%	9.86%	32.93%	31%
Region Q	65,275	7,681	22,717	34,327	**100%**	0	**0%**	**11.8%**	**34.8%**	**52.6%**
Camden	2,334	59	506	2,287	4.25%		0%	2.53%	21.68%	97.99%
Chowan	4,394	676	1,194	2,944	12.02%		0%	15.38%	27.17%	67%
Currituck	6,072	300	528	5,951	11.31%		0%	4.94%	8.7%	98.01%
Dare	10,508	390	428	3,152	15.78%		0%	3.71%	4.07%	30%
Gates	3,122	219	1,144	3,122	7.25%		0%	7.01%	36.64%	100%
Hyde	1,485	26	489	1,485	2.81%		0%	1.75%	32.93%	100%
Pasquotank	8,502	1005	2,929	3,486	20.96%		0%	11.82%	34.45%	41%
Perquimans	4,640	582	339	4,640	11.22%		0%	12.54%	7.31%	100%
Tyrrell	1,134	358	350	1,134	4.63%		0%	31.57%	30.86%	100%
Washington	3,865	426	1,433	2,667	9.76%		0%	11.02%	37.08%	69%

2020 Medically Underserved	2020 Medically Underserved									
County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	**70+***	**70+ Formula Rate**	**60+ Poverty Rates**	**60+ Minority Rates**	**60+ Rural Rates**
Region R	46,056	4041	9340	30,868	**100%**	0	**0%**	**8.8%**	**20.3%**	**67%**
NC	**2,240,226**	**210,066**	**478,421**	**855,317**		**0**		**9.4%**	**21.4%**	**38.2%**

Attachment D
NC State Aging Profile 2017

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Aging and Adult Services

North Carolina is Aging!

- The state's total population has exceeded 10 million!
- North Carolina ranks 9th nationally, both in total population and in the number of people 65 and over.
- In 2025, one in five North Carolinians will be 65 and over.
- Effective this year (2019), the state is estimated to have more people 60 and over than under 18 years.
- In 2017, 78 counties in the state had more people 60 and over than under 18 years. By 2025, this number is expected to increase to 89 counties and by 2037 to 94 counties.
- In 2017, an estimated 39,381 people 60 and older migrated from other states and abroad to North Carolina.
- In the next two decades, our 65 and over population will increase from 1.6 to 2.6 million, a projected growth of 64%. The projected growth among the age groups 65-74 (38%), 75-84 (100%) and 85+ (111%) indicates that as the baby boomers continue to age, there will be an increased proportion of older adults in the state creating challenges for long-term services and supports.

NC Population Change 2017-2037

	2017		2037		% Change 2017-2037
Age	#	%	#	%	
Total	10,283,255		12,684,352		23%
0-17	2,312,886	23%	2,606,213	21%	13%
18-44	3,658,073	36%	4,419,187	35%	21%
45-59	2,072,070	20%	2,304,524	18%	11%
60+	2,240,226	22%	3,354,428	26%	50%
65+	1,617,993	16%	2,660,084	21%	64%
85+	181,695	2%	382,686	3%	111%

Source: NC Office of State Budget and Management, Facts and Figures

Race and Hispanic or Latino Origin, 2017

Race/Ethnicity, age 65 and over	NC	US
White alone	80.4%	83.5%
Black or African American alone	16.3%	8.9%
American Indian and Alaska Native alone	0.9%	0.5%
Asian alone	1.3%	4.2%
Some other race	0.4%	1.7%
Two or more races	0.6%	1.0%
Hispanic or Latino origin (of any race)	1.8%	7.9%

*As a % of age 65 and over

Source: US Census. 2013-2017 American Community Survey, 5-year estimates

Social and Economic Characteristics of population, 2017

Characteristics, age 65 and over	NC	US
Living alone	26.6%	26.2%
Veterans	19.7%	19.4%
Speak English less than "very well"	2.1%	8.7%
Have a disability	36.6%	35.5%
Have less than high school education	18.6%	17.2%
Have high school, GED/Alternative education	31.6%	32.1%
In labor force	16.2%	16.8%
Income is below poverty level	9.4%	9.3%
Income is between 100%-199% of the poverty level	22.4%	20.0%
Median household income (householder 65 and over)	$38,466	$41,876

*As a % of 65 and over

Source: US Census. 2013-2017 American Community Survey, 5-year estimates

- Of the estimated 94,821 grandparents responsible for grandchildren under 18, 40% are age 60 and over.

Health Profile

- According to the Alzheimer's Association, North Carolina currently (2018) has 170,000 adults 65 and over with **Alzheimer's disease** and this number is projected to rise to 210,000 by 2025, an increase of 24%. Alzheimer's disease is the fifth leading cause of death among people age 65 and over.
- NC Division of Public Health, Office of the Chief Medical Examiner, reported **104 opioid related deaths among people 60 and over, in 2018**, a 60% increase from previous year. 78% of them were White and 57% were males.
- Of the **people 65 and over**, according to the Behavioral Risk Factor Surveillance System (BRFSS) survey, 2017:
  - 82% had at least one chronic disease, 55% of them had 2 or more chronic diseases;
  - 66% had an adult flu shot/spray and 72% had a pneumonia shot ever;
  - Only 10% reported that their health is poor and 65% reported exercising in the past 30 days.

Rank	Leading causes of death, age 65 and over, 2017	Number of deaths	% of Total deaths
1	Diseases of the heart	14,710	22%
2	Cancer	13,656	20%
3	Chronic lower respiratory diseases	4,599	7%
4	Cerebrovascular disease	4,295	6%
5	Alzheimer's disease	4,245	6%
6	Diabetes mellitus	1,973	3%

Source: North Carolina State Center for Health Statistics

Type of disability, age 65 and over, 2017	% with a disability
Ambulatory difficulty	24%
Independent living difficulty	15%
Hearing difficulty	15%
Cognitive difficulty	10%
Self-care difficulty	8%
Vision difficulty	7%

Source: US Census, ACS, 5-year estimates

- Given the potential social and economic impact of this unprecedented growth in the aging population, it is critical that NC focus efforts to improve those social determinants of health shown to have a direct positive effect on the health and well-being of individuals as they age including food security, access to health care services and transportation, availability of home and community-based services and other supports that promote aging within the community and postpone or avoid the necessity for long-term care.

Attachment E
Demographic Data

Demographic Trends

North Carolina reached an important demographic milestone in 2019, with the population aged 60 and older outnumbering children 18 and younger. An estimated 78 counties have more people aged 60 and older than under 18, and it is projected to be 89 counties by 2025. [2] The total population has exceeded 10 million and nationally the state ranks tenth in the total population, ninth in the size of the population 60 and older, and tenth in the population 85 and older. [1] The state is experiencing growth in the proportion of population 60 and older due to the impact of the aging of the 2.4 million baby boomers, increase in life expectancy, and migration of people from other states and abroad. By 2037, one in four people will be 60 and older and the proportion of population 85 and older is projected to double, creating challenges for long-term supports and services. [2]

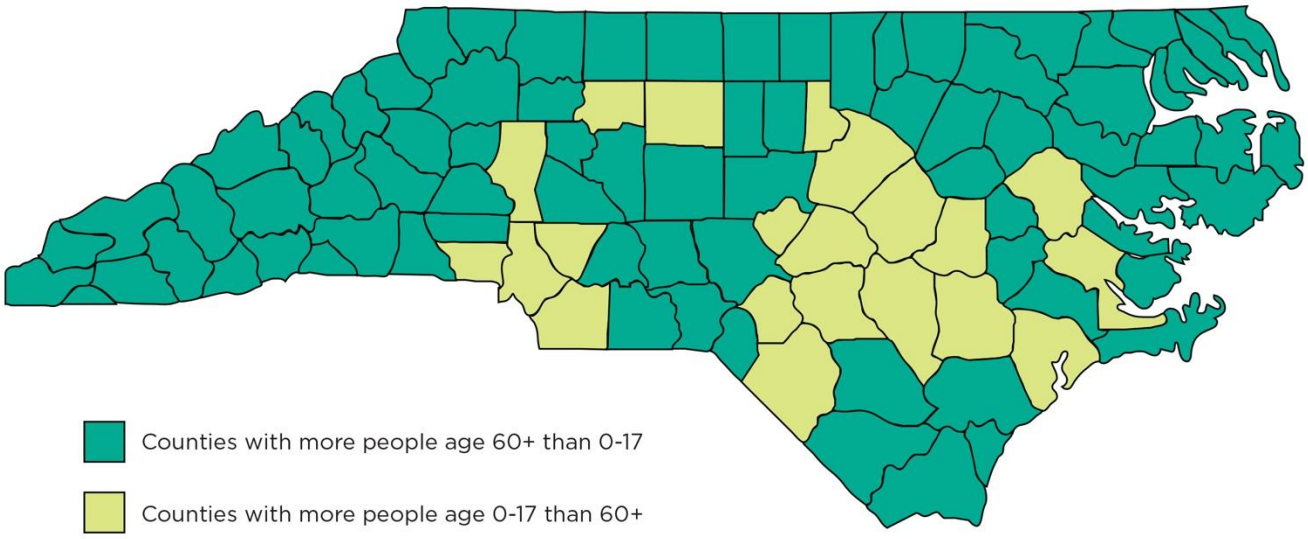
Population Change, 2017-2037

	2017		2037		
Age	Number	Percent	Number	Percent	Percent Change 2017-2037
Total	10,283,255		12,684,352		23%
0-17	2,312,886	23%	2,606,213	21%	13%
18-44	3,658,073	36%	4,419,187	35%	21%
45-59	2,072,070	20%	2,304,524	18%	11%
60+	2,240,226	22%	3,354,428	26%	50%
65+	1,617,993	16%	2,660,084	21%	64%
85+	181,695	2%	382,686	3%	111%

Source: North Carolina Office of State Budget and Management

Future projections of the aging population indicate that not all counties in the state will experience growth at the same rate. Some counties will see rapid growth as expanding parts of metropolitan areas, while others will experience moderate growth, and few rural counties will experience a decline. [2]

Counties with more people age 60 and over than 0-17, 2017



Source: North Carolina Office of State Budget and Management

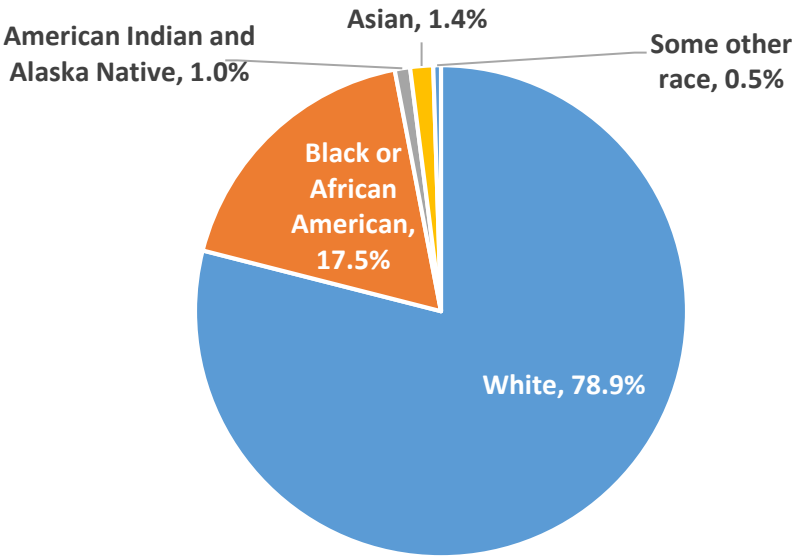
Selected Social Determinants of Health

To address social determinants of health and improve health outcomes, it is critical to understand the socio-economic status, health and environmental characteristics of the population. Research has consistently shown that health inequities exist among populations. Some disparities among North Carolina's older adults relate to gender, ethnicity/race, income, education, rurality and health status, among others.

Gender: Women and men owing to their biological differences and gender roles have different needs, challenges, and opportunities which contribute to different life and health experiences. [3] Women have higher life expectancy and live longer than men, live alone and face challenges towards older age. Of the population 60 and older: women represent 55.5 percent of the age group [4]; According to The Williams Institute, North Carolina is home to 250,000 lesbian, gay, bisexual and transgender (LGBT) adults, and many experience discriminations because of their sexual orientation and gender identity. [5]

Race and Ethnicity: North Carolina's ethnic and racial diversity is increasing. Of all North Carolinians age 60 and older, 21.1 percent are members of minority groups, and 17.5 percent of them are African-Americans. Around 3.6 percent of the minority population 60 and older belong to other groups, including American-Indians, Asians and some other races. Around 2 percent of the people 60 and older are of Hispanic or Latino origin (of any race) in the state. In addition, many immigrants and refugees from other countries have made the state rich in diversity. A higher proportion of African-Americans live in rural counties and are linked to lower median household income and level of education, higher rates of poverty, and disabilities. [4]

Diversity of population 60 and older



*As a percentage of age 60 and over - Source: US Census, American Community Survey 2013-2017, 5-year estimates

Selected Economic and Social Characteristics:

According to the American Association of Retired Persons (AARP), social isolation is associated with more chronic diseases, cognitive decline, increase in risk of death and detrimental to health, and costly to Medicare. [6] An estimated 27 percent of people 65 and older live alone in the community in the state. [7]

Status of Population age 60 and older

Characteristics	NC
Speak English less than "very well"	2.3%
Veterans	17.4%
Have a disability	32.5%
Have less than a high school diploma	16.5%
High school graduate, GED, or alternative	30.6%
Income below the poverty level	10.1%
In labor force	26.5%
Own their homes	80.2%

*As a percentage of age 60 and older - Source: US Census, American Community Survey 2013-2017, five-year estimates

Caregivers: An estimated 466,600 caregivers in the state provided 531 million hours of unpaid care in 2018. [8] Caregivers are very diverse with respect to race/ethnicity, age group, gender, socioeconomic status, and have unique needs based on their strengths and challenges. According to the Behavioral Risk Factor Surveillance System (BRFSS) 2017, 19 percent of the caregivers 65 and older provided regular care/assistance to friend or family members in the past 30 days. Of these caregivers aged 65 and older, 79 percent cared for an aging older adult, 31 percent cared for spouse, 21 percent provided care for more than five years, and 42 percent reported their care included managing personal care. [9] Of the grandparents responsible for raising grandchildren aged 18 and younger, an estimated 40 percent are aged 60 and older. Of these adults aged 60 and older responsible for raising grandchildren, 59 percent are women, 36 percent have a disability, 21 percent are below the poverty line, and face challenges in accessing services. [10]

Rurality: Compared to urban areas, rural communities often face more unique challenges, such as a lack of transportation options or shortages of healthcare professionals. North Carolina's rural residents continue to face challenges in accessing healthcare, face isolation, have higher poverty and mortality rates, and an increased prevalence of opioid use.

Health Status: According to the NC State Center for Health Statistics, if age-specific mortality remains unchanged, North Carolinians age 60 and older are expected to live, on average, an additional 23 years. [11]

Heart disease is the leading cause of death among older adults in the state, with cancer and chronic lower respiratory diseases coming second and third. The fifth leading cause of death in the state is Alzheimer's disease. [12] The number of older North Carolinians with Alzheimer's disease is projected to increase from 170,000 in 2018 to 210,000 in 2025. [8]

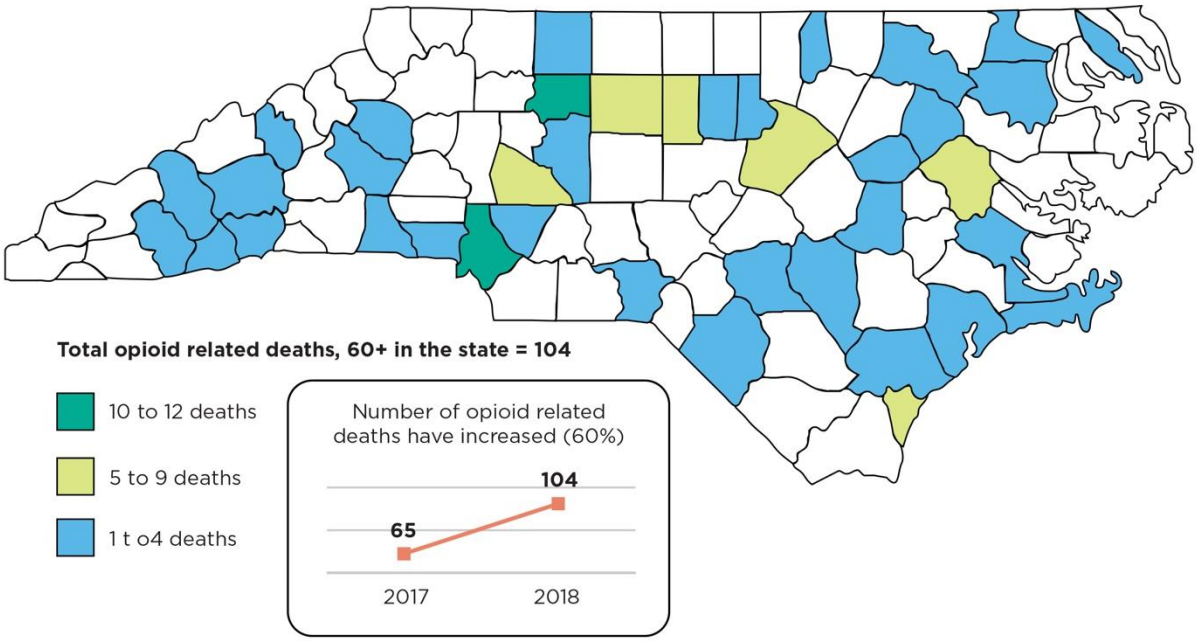
Top leading causes of death among people age 60 and older, 2017

Rank	Leading causes of death	Number of deaths	% of Total deaths
1	Diseases of the heart	16,176	22%
2	Cancer	15,947	21%
3	Chronic lower respiratory diseases	5,041	7%
4	Cerebrovascular disease	4,570	6%
5	Alzheimer's disease	4,276	6%
6	Diabetes mellitus	2,275	3%

Source: NC State Center for Health Statistics

Opioids: The state is facing a growing epidemic of opioid misuse, abuse and addiction, especially among older adults with chronic conditions. According to the NC Division of Public Health's Office of the Chief Medical Examiner, there were 104 opioid-related deaths among the population aged 60 and older in 2018. Seventy-eight percent were white, and 57 percent were male. The aging network and stakeholders have already begun taking addressing this impending health crisis.

Opioid related deaths among adults 60 and over, SFY 2018



Source: NC Division of Public Health, Office of the Chief Medical Examiner, provisional results

The current demographics and projections of the aging population is important to analyze the implications of the change on healthcare and support services. In addition, the comprehensive data on socio-economic and health characteristics is meant to guide programmatic planning and investing in resources. Currently, what are the disability and poverty rates in adults 65 and older? How many are living alone and facing isolation and loneliness? Can we increase workforce opportunities? What are the leading causes of death? How can we collaborate to promote better health outcomes? How can we identify and connect to available resources, and build an infrastructure to better support our communities? This data is available for all the counties in the state and is updated annually (https://www.ncdhhs.gov/divisions/daas/data-reports) for programmatic and planning purposes in the communities we serve.

The necessity to plan for this changing older population and address the social determinants of health is critical. It is imperative to mobilize resources, collaborate and work together to ensure that not only the needs of the older adults are met, but they are provided with opportunities to be involved and engaged in meaningful activities.

Home and Community Care Block Grant

Research has shown that broader population-based approaches that address social, economic and environmental factors promote health equity. Providing social support, alleviation of food insecurity, housing, access to services and addressing basic needs has more impact on health outcomes. [13]

Established in 1992 under NCGS 143B-181.1(a) (11), the Home and Community Care Block Grant (HCCBG) was devised to provide a common funding stream for a comprehensive and coordinated system of 18 home and community-based services for adults aged 60 and older with a preference toward those who are economically and socially needy. HCCBG services are targeted to older adults (60 and older) who are low-income and/or a minority. Priority is given to eligible older adults who (1) have a substantiated case with Adult Protective Services, (2) are at risk of abuse, neglect or exploitation, (3) are at-risk of placement or substitute care, or (4) have extensive activity of daily living (ADL) and instrumental activity of daily living (IADL) needs. Services provided under HCCBG allow individuals to remain in their homes and communities, rather than moving to a costlier residential or nursing setting.

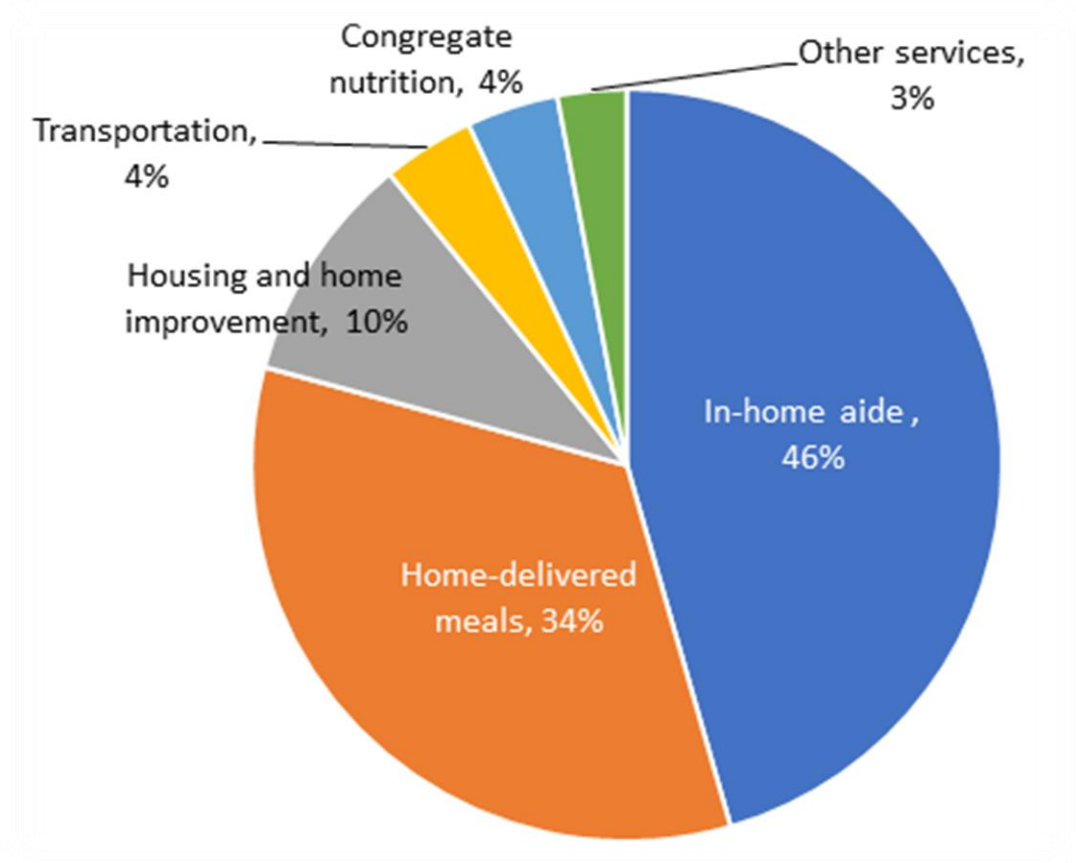
Critical HCCBG Services, Clients Served and Expenditures - SFY 201			
In-home aide services	**Home-delivered meals**	**Congregate nutrition**	**Transportation**
• 6,436 clients served • 1,182,887 hours • $19.6 million	• 18,252 clients served • 2,621,044 meals • $15.6 million	• 24,027 clients served • 1,568,658 meals • $10.6 million	• 9,328 clients served • 630,536 one-way trips • $6.8 million

Source: North Carolina Division of Aging and Adult Services

Of the total $66.7 million spent for HCCBG services (SFY 2018), 29 percent was spent on in-home aide services, 23 percent on home-delivered meals, 16 percent on congregate nutrition and 10 percent on transportation services. [14]

Client waitlist - What services are needed the most?

The growth of the population aged 60 and older will increase by 50 percent over the next two decades, creating more fiscal challenges in providing critical services. The increase in waiting lists for HCCBG services continues to rise. There are an estimated 10,300 adults aged 60 and older waiting for services, and the most critical services continue to be in-home aide (46 percent), home-delivered meals (34 percent), housing and home improvement (10 percent), transportation (four percent), congregate nutrition (four percent), and other services (three percent). [19]



Source: North Carolina Division of Aging and Adult Services

In addition, annual reports on expenditures and clients served age 60 and older through programs and services from seven NC DHHS divisions are published, and can be found at (https://www.ncdhhs.gov/divisions/daas/data-reports). This data is useful for communities to analyze and look at the trends from past years, how many dollars are spent on people in nursing homes vs. those living in the communities, what are the cost of the services, how can we serve more clients or reduce costs, what aging services are provided by other divisions, and can we collaborate with other agencies on some of those services.

All the data provided is intended to inform the status of adults 60 and older in our communities, so that we can make better decisions, strategize and enhance our programs and services, and provide better opportunities for good health.

In summary, North Carolina has a large, economically and ethnically diverse older population. With this diversity come both opportunities and challenges. The opportunities to use the skills of older adults for civic engagement and volunteerism, engage in innovation and redesigning services, identify and fund effective programs that provide high returns on investment and improve outcomes, maximize the use of resources, and rise to the challenges through collaborative approaches to improve lives and achieve health equity.

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Attachment F
Listening Session Data

In addition to the listening sessions, DAAS conducted a survey of listening session attendees along with senior center participants and members of advocacy groups, such as the Governors' Advisory Council, Resources for Seniors and the Senior Tarheel Legislative. More than 1,000 individuals were surveyed. Below are the top five needs as expressed by survey participants.

Location	Topic	Topic	Topic	Topic	Topic
Asheville	Transportation	Prevent elder abuse	Higher pay for CNA's	CAP DA support	Elder Care
Kernersville	Senior Center funding	Adult Day Care funding	Community Based Program Support	***Family caregiver funding***	Health services support
Wilmington	Transportation	Affordable housing	Prevent elder abuse	APS Support	Opioids
Greenville	Transportation	Affordable housing	Senior Center funding	Higher pay for CNA's	Adult Care home background checks
Charlotte	Senior Center funding	Affordable Housing	Community Based Program Support	***Family Caregiver funding***	APS Support

The Top Five Needs

Top topics	Percentage
Transportation	87%
Health Care	80%
Housing	72%
Support for Caregivers	70%
Exercise/Nutrition	68%

The Survey Top Eight Requested Services

Top topics	Percentage
Elder adult assistance	85.76
Personal care assistance	88.11
Hot meals delivered	90.28
Prevent elder abuse	87.01
Dementia Education programs	86.08
Transportation to appointments	84.15
Elder care support	81.66
Respite care	77.77

Attachment G

NC State Aging Plan 2019-2023 Survey

1. Please indicate how important each service is to you:

SERVICES	Very Important	Somewhat Important	Less Important
Support for people who provide unpaid care to family members			
Assisting older adults and persons acting on behalf of older adults with accessing needed services and information			
Transportation (to medical appointments and other services)			
Hot meals delivered to older adults (who can't leave home because they are sick or due to disability)			
Help to prevent elder abuse and neglect			
Personal care services that help people stay in their homes (e.g. help with bathing, getting dressed, making meals)			
Programs that help people with dementia (including Alzheimer's disease)			
Healthy living classes, including disease prevention and self-management for your condition, e.g., diabetes, heart disease			
Help to get information about health insurance and how to sign up for plans like Medicare, Medicaid, long-term care			
Group meals served at senior centers			
Legal assistance services			
Other residential and in-home care options			
Help getting home and staying at home after a hospital or nursing home stay			
Programs that give families a break, such as respite care or adult day care programs			
Access to mental health services			
Help to prevent misuse of drugs and alcohol			
Help finding older adult job training and placement			
How to prevent falls and exercise programs in the community for older adults			
Support for grandparents/other relatives who are raising children			

2. Below is a list of services for older adults that are currently available. Please mark an X in the box for each service to show how much you know about each program:

SERVICES	Very Much	Quite a bit	Some	Very little	None
Adult Day Care (day services in a community group setting supporting personal independence)					
Adult Day Health Care (day services in a community group setting which includes health care services)					
Care Management (assistance with complex care needs)					
Congregation Nutrition (meals at senior centers)					
Consumer-Directed Support (assistance provided to keep older adults in their own home/community)					
Group Respite (provides caregivers a break from their caregiving responsibilities)					
Health Promotion and Disease Prevention (health and wellness programs)					
Health Screening (medical testing, screening, and referral for early detection and prevention)					
Home-Delivered Meals (Meals on Wheels)					
Skilled Home (Health) Care (physical, occupational and/or speech therapy)					
Housing and Home Improvement (obtaining or retaining adequate housing and basic furnishings)					
Information and Case Assistance (assist with obtaining appropriate services to meet older adults needs)					
In-Home Aide (help with personal care at home)					
Institutional Respite Care (provide unpaid, primary caregiver relief)					
Mental Health Counseling (consultation, evaluation and outpatient treatment)					
Senior Companion (volunteer opportunity for community service)					
Senior Center Operations (recreation programs, health classes, and other activities)					
Transportation (to medical appointments, Senior Center activities, nutrition sites, other areas)					
Volunteer Program Development (volunteers of all ages to support community services for older adults)					

3. Are you an unpaid caregiver for an adult who needs regular care and assistance?
   ☐ Yes
   ☐ No

4. What services do you feel would be needed to allow an older adult to live independently? Check all that apply

   ☐ Transportation
   ☐ Health Care
   ☐ Housing
   ☐ Financial Assistance
   ☐ Exercise/Nutrition
   ☐ Support for Caregivers
   ☐ Prescription Assistance
   ☐ Legal
   ☐ Abuse Prevention
   ☐ Employment
   ☐ Volunteer Opportunities
   ☐ Other: _____ (please specify)

5. What other community programs or services would you like to see for older adults and/or people with disabilities?

   _____

   _____

6. What are your hopes and concerns about aging for you or a loved one? Check all that apply

   ☐ Access to healthy food
   ☐ Access to transportation
   ☐ Affordable healthcare
   ☐ Declining health
   ☐ Inadequate savings or income
   ☐ Medication Management
   ☐ Safe, reliable, trustworthy caregiving
   ☐ Isolation or loneliness
   ☐ Other: _____ (please specify)

7. Have you ever, even once, used **any prescription pain reliever** in any way **a doctor did not direct you to use it**? Please do **not** include "over-the-counter" pain relievers such as aspirin, Tylenol, Advil or Aleve.
   ☐ Yes
   ☐ No

8. How concerned are you about prescription medication abuse among older adults in your community?
   - ☐ Very concerned
   - ☐ Concerned
   - ☐ Not very concerned
   - ☐ Not sure

9. What type of residence do you live in?
   - ☐ Rental Apartment
   - ☐ Rental House or Condominium
   - ☐ Own House or Condominium
   - ☐ Live with relatives/friends
   - ☐ Residential Facility w/care
   - ☐ Shelter

10. Are you now or have you ever been homeless?
    - ☐ Yes
    - ☐ No

11. What would you say that in general your health is?
    - ☐ Very Good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

12. What is your Age?
    - ☐ Younger than 50
    - ☐ 50-59
    - ☐ 60-64
    - ☐ 65-74
    - ☐ 75-84
    - ☐ 85 or older
    - ☐ Prefer not to answer

13. What is your sex?

☐ Female

☐ Male

☐ Prefer not to answer

14. What is your race/ethnicity?

☐ African American

☐ American Indian or Native Alaskan

☐ Asian/Pacific Islander

☐ Hispanic/Latino

☐ White

☐ Other (please specify)_____

☐ Prefer not to answer

15. What county do you live in?

_____

Attachment H
NC State Aging Plan 2019-2023 Survey Analysis

1. Please indicate how important each service is to you:

	Very Important	Somewhat Important	Less Important	Response Total	Points	Avg
Support for people who provide unpaid care to family members	81.66% (828)	14.1% (143)	4.24% (43)	1014	n/a	n/a
Assisting older adults and people acting on behalf of older adults with accessing needed services and information	85.76% (867)	11.77% (119)	2.47% (25)	1011	n/a	n/a
Transportation (to medical appointments and other services)	84.15% (855)	12.01% (122)	3.84% (39)	1016	n/a	n/a
Hot meals delivered to older adults (who can't leave home because they are sick or due to disability)	90.28% (920)	7.95% (81)	1.77% (18)	1019	n/a	n/a
Help to prevent elder abuse and neglect	87.01% (864)	9.77% (97)	3.22% (32)	993	n/a	n/a
Personal care services that help people stay in their homes (e.g. help with bathing, getting dressed, making meals)	88.11% (889)	8.82% (89)	3.07% (31)	1009	n/a	n/a
Programs that help people with dementia (including Alzheimer's disease)	86.08% (872)	11.55% (117)	2.37% (24)	1013	n/a	n/a
Healthy living classes	59.8% (607)	32.02% (325)	8.18% (83)	1015	n/a	n/a
Help to get information about health insurance and how to sign up for plans like Medicare, Medicaid, long-term care	75.1% (760)	19.57% (198)	5.34% (54)	1012	n/a	n/a
Group meals served at senior centers	65.03% (662)	26.82% (273)	8.15% (83)	1018	n/a	n/a
Legal assistance services	62.81% (630)	29.91% (300)	7.28% (73)	1003	n/a	n/a
Other residential and in-home care options	70.93% (705)	22.54% (224)	6.54% (65)	994	n/a	n/a
Help getting home and staying at home after a hospital or nursing home stay	81.36% (825)	14.1% (143)	4.54% (46)	1014	n/a	n/a
Programs that give families a break, such as respite care or adult day care programs	77.77% (787)	17.49% (177)	4.74% (48)	1012	n/a	n/a
Access mental health services	74.7% (753)	18.95% (191)	6.35% (64)	1008	n/a	n/a
Help to prevent misuse of drugs and alcohol	64.22% (648)	23.89% (241)	11.89% (120)	1009	n/a	n/a
Help finding older adult job training and placement	46.83% (465)	35.95% (357)	17.22% (171)	993	n/a	n/a
How to prevent falls and exercise programs in the community for older adults	72.23% (731)	22.73% (230)	5.04% (51)	1012	n/a	n/a
Support for grandparents/other relatives who are raising children	65.64% (663)	23.47% (237)	10.89% (110)	1010	n/a	n/a
			Total Respondents	1030		
			(skipped this question)	38		

2. Below is a list of services for older adults that are currently available. Please mark an X in the box for each service to show how much you know about each program:

	Very Much	Quite a bit	Some	Very little	None	Response Total	Points	Avg
Adult Day Care (day services in a community group setting supporting personal independence)	30.97% (301)	30.97% (301)	20.37% (198)	25.1% (244)	16.36% (159)	7.2% (70)	972	n/a
Adult Day Health Care (day services in a community group setting which includes health care services)	28.78% (278)	28.78% (278)	18.12% (175)	23.19% (224)	20.81% (201)	9.11% (88)	966	n/a
Care Management (assistance with complex care needs)	30.33% (293)	30.33% (293)	16.25% (157)	22.88% (221)	20.7% (200)	9.83% (95)	966	n/a
Congregation Nutrition (meals at senior centers)	41.59% (403)	41.59% (403)	21.47% (208)	17.85% (173)	12.9% (125)	6.19% (60)	969	n/a
Consumer-Directed Support (assistance provided to keep older adults in their own home/community)	33.88% (328)	33.88% (328)	17.77% (172)	21.59% (209)	18.7% (181)	8.06% (78)	968	n/a
Group Respite (provides caregivers a break from their caregiving responsibilities)	28.39% (272)	28.39% (272)	17.64% (169)	24.32% (233)	18.16% (174)	11.48% (110)	958	n/a
Health Promotion and Disease Prevention (health and wellness programs)	31.74% (305)	31.74% (305)	21.54% (207)	24.35% (234)	16.44% (158)	5.93% (57)	961	n/a
Health Screening (medical testing, screening and referral for early detection and prevention)	33.3% (319)	33.3% (319)	21.92% (210)	24.32% (233)	14.09% (135)	6.37% (61)	958	n/a
Home-Delivered Meals (Meals on Wheels)	53.57% (518)	53.57% (518)	21.2% (205)	15.62% (151)	7.24% (70)	2.38% (23)	967	n/a
Skilled Home (Health) Care (physical, occupational, and/or speech therapy)	34.82% (335)	34.82% (335)	20.17% (194)	24.43% (235)	14.66% (141)	5.93% (57)	962	n/a
Housing and Home Improvement (obtaining or retaining adequate housing and basic furnishings)	26.55% (257)	26.55% (257)	18.18% (176)	24.28% (235)	20.14% (195)	10.85% (105)	968	n/a
Information and Case Assistance (assist with obtaining appropriate services to meet older adult's needs)	33.37% (322)	33.37% (322)	16.27% (157)	22.18% (214)	19.79% (191)	8.39% (81)	965	n/a
In-Home Aide (help with personal care at home)	39.85% (381)	39.85% (381)	18.2% (174)	20.92% (200)	14.44% (138)	6.59% (63)	956	n/a
Institutional Respite Care (provide unpaid, primary caregiver relief)	25.76% (246)	25.76% (246)	15.92% (152)	21.88% (209)	22.41% (214)	14.03% (134)	955	n/a
Mental Health Counseling (consultation, evaluation and outpatient treatment)	25.05% (240)	25.05% (240)	15.97% (153)	23.7% (227)	21.92% (210)	13.36% (128)	958	n/a
Senior Companion (volunteer opportunity for community service)	25.99% (250)	25.99% (250)	16.11% (155)	22.35% (215)	20.58% (198)	14.97% (144)	962	n/a
Senior Center Operations (recreation programs, health classes and other activities)	35.95% (348)	35.95% (348)	22.52% (218)	19.42% (188)	14.36% (139)	7.75% (75)	968	n/a
Transportation (to medical appointments, senior center activities, nutrition sites, other areas)	39.61% (383)	39.61% (383)	19.44% (188)	19.75% (191)	13.96% (135)	7.24% (70)	967	n/a
Volunteer Program Development (volunteers of all ages to support community services for older adults)	30.85% (298)	30.85% (298)	15.11% (146)	22.57% (218)	19.57% (189)	11.9% (115)	966	n/a
						Total Respondents	988	
						(skipped question)	80	

3. Are you an unpaid caregiver for an adult who needs regular care and assistance?					
		Response Total	Response Percent	Points	Avg
Yes		165	17%	n/a	n/a
No		807	83%	n/a	n/a
	Total Respondents	972			
	(skipped this question)	96			

4. What services do you feel would be needed to allow an older adult to live independently? (CHECK ALL THAT APPLY)					
		Response Total	Response Percent	Points	Avg
Transportation		885	87%	n/a	n/a
Health Care		817	80%	n/a	n/a
Housing		731	72%	n/a	n/a
Financial Assistance		687	67%	n/a	n/a
Exercise/Nutrition		696	68%	n/a	n/a
Support for Caregivers		715	70%	n/a	n/a
Prescription Assistance		682	67%	n/a	n/a
Legal		502	49%	n/a	n/a
Abuse Prevention		544	53%	n/a	n/a
Employment		293	29%	n/a	n/a
Volunteer Opportunities		388	38%	n/a	n/a
Other, please specify		106	10%	n/a	n/a
	Total Respondents	1018			
	(skipped this question)	50			

5. What other community programs or services would you like to see for older adults and/or people with disabilities?	
Total Respondents	319
(skipped this question)	749

6. What are your hopes and concerns about aging for you or a loved one? (CHECK ALL THAT APPLY)

	Response Total	Response Percent	Points	Avg
Access to healthy food	682	67%	n/a	n/a
Access to transportation	746	73%	n/a	n/a
Affordable healthcare	769	76%	n/a	n/a
Declining health	624	61%	n/a	n/a
Inadequate savings or income	583	57%	n/a	n/a
Medication Management	534	52%	n/a	n/a
Safe, reliable, trustworthy caregiving	737	72%	n/a	n/a
Isolation or loneliness	604	59%	n/a	n/a
Other, please specify	57	6%	n/a	n/a
Total Respondents	1018			
(skipped this question)	50			

7. Have you ever, even once, used any prescription pain reliever in any way a doctor did not direct you to use it? Please do not include "over-the-counter" pain relievers, such as aspirin, Tylenol, Advil or Aleve.

	Response Total	Response Percent	Points	Avg
Yes	113	12%	n/a	n/a
No	853	88%	n/a	n/a
Total Respondents	966			
(skipped this question)	102			

8. How concerned are you about prescription medication abuse among older adults in your community?

	Response Total	Response Percent	Points	Avg
Very concerned	367	38%	n/a	n/a
Concerned	322	33%	n/a	n/a
Not very concerned	193	20%	n/a	n/a
Not sure	85	9%	n/a	n/a
Total Respondents	967	100%		
(skipped this question)	101			

9. What type of residence do you live in?

	Response Total	Response Percent	Points	Avg
Rental apartment	153	16%	n/a	n/a
Rental house or condominium	71	7%	n/a	n/a
Own house or condominium	702	72%	n/a	n/a
Live with relatives/friends	50	5%	n/a	n/a
Residential facility w/care	5	1%	n/a	n/a
Shelter	0	0%	n/a	n/a
Total Respondents	981	100%		
(skipped this question)	87			

10. Are you now or have you ever been homeless?

	Response Total	Response Percent	Points	Avg
Yes	62	6%	n/a	n/a
No	921	94%	n/a	n/a
Total Respondents	983			
(skipped this question)	85			

11. What would you say in general your health is?

	Response Total	Response Percent	Points	Avg
Very Good	256	26%	n/a	n/a
Good	452	46%	n/a	n/a
Fair	236	24%	n/a	n/a
Poor	43	4%	n/a	n/a
Total Respondents	987	100%		
(skipped this question)	81			

12. What is your age?

	Response Total	Response Percent	Points	Avg
Younger than 50	111	11%	n/a	n/a
50-59	141	14%	n/a	n/a

60-64		94	10%	n/a	n/a
65-74		304	31%	n/a	n/a
75-84		219	22%	n/a	n/a
85 or older		98	10%	n/a	n/a
Prefer not to answer		8	1%	n/a	n/a
	Total Respondents	975	100%		
	(skipped this question)		93		

13. What is your sex?

		Response Total	Response Percent	Points	Avg
Female		756	77%	n/a	n/a
Male		217	22%	n/a	n/a
Prefer not to answer		9	1%	n/a	n/a
	Total Respondents	982	100%		
	(skipped this question)		86		

14. What is your race/ethnicity?

		Response Total	Response Percent	Points	Avg
African American		189	19%	n/a	n/a
American Indian or Native Alaskan		9	1%	n/a	n/a
Asian/Pacific Islander		4	0%	n/a	n/a
Hispanic/Latino		12	1%	n/a	n/a
White		711	73%	n/a	n/a
Prefer not to answer		32	3%	n/a	n/a
Other, please specify		19	2%	n/a	n/a
	Total Respondents	976	100%		
	(skipped this question)		92		

15. What county do you live in?

Total Respondents	991
(skipped this question)	77

Attachment I
Housing Data

- Housing needs of people aged 60 and older in NC

In NC, an estimated 238,654 homeowner households and 110,689 renter households with an elderly member have one or more housing problems, i.e., lacking complete plumbing, lacking complete kitchen facilities, more than one person per room, and/or greater than 30 percent housing cost burden. This accounts for 6.3 percent and 2.9 percent, respectively, of the total households in NC (3,775,565).

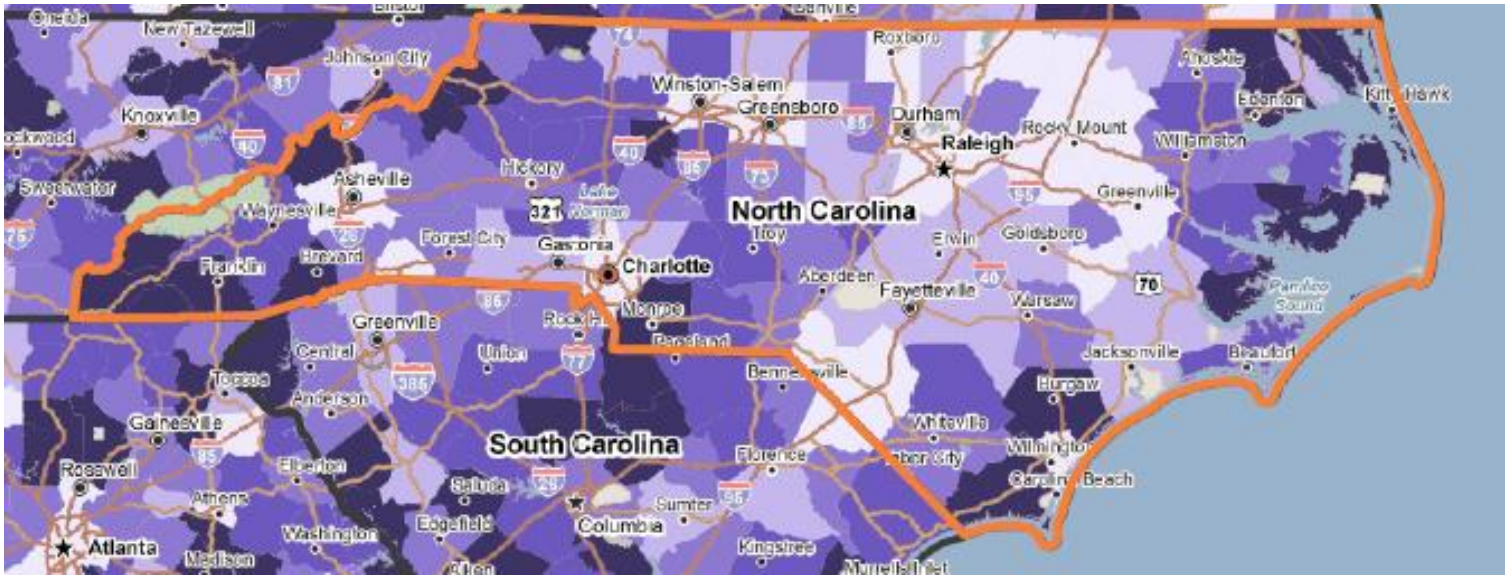
Source: CHAS 2011-2015 data, Table 5 (Comprehensive Housing Affordability Strategy)

Generally, most housing is designed for younger adults, and not suitable for seniors who struggle with mobility and manual dexterity (Badger, 2014). Although homebuilding trends are moving toward accessibility, most older homeowners are living in older homes, not new, aging-friendly ones. These older homes become even less habitable as they age and require maintenance, which many senior homeowners are physically and financially unable to handle. A 2011 study found that adults who lived in homes they owned, as opposed to those who rented or lived in institutional care, reported better mental health—an effect that increased as they aged (Howden-Chapman et al, 2011). However, owning a home in disrepair without the means to repair it was identified as a mental health stressor among owner-occupiers. Housing quality affects the physical health of older people as well, because susceptibility to illnesses associated with low temperatures and time spent in the home both increase with age. Wealth differences add another layer of impact. In a recent case study, indoor home environments were found to differ more widely between poor and wealthy people than the surrounding neighborhood environment (Lejeune et al. 2016).

More resources:

- For a good method for calculating demand for affordable senior housing, see https://ced.sog.unc.edu/finding-the-hard-numbers-for-a-rising-problem-a-method-of-calculating-demand-for-affordable-senior-housing/
- For maps on elderly households by tenure, visit https://www.policymap.com (see example maps below). Some maps of interest may include:
  - Demographics > Age > Age 65 or Older
  - Incomes & Spending > Poverty > People in Poverty > By Age > Age 65 or Older
  - Incomes & Spending > Affordability > Location Affordability > Retired Couple
  - Incomes & Spending > Affordability > Affordable Housing Units
  - Housing > Owners & Renters > By Age
  - Housing > Affordability (can break down by homeowner vs. renter and age)

Estimated percent of householders 65 or older who own a home between 2013-2017.



Percent HHs 65 or Older Who Own a Home

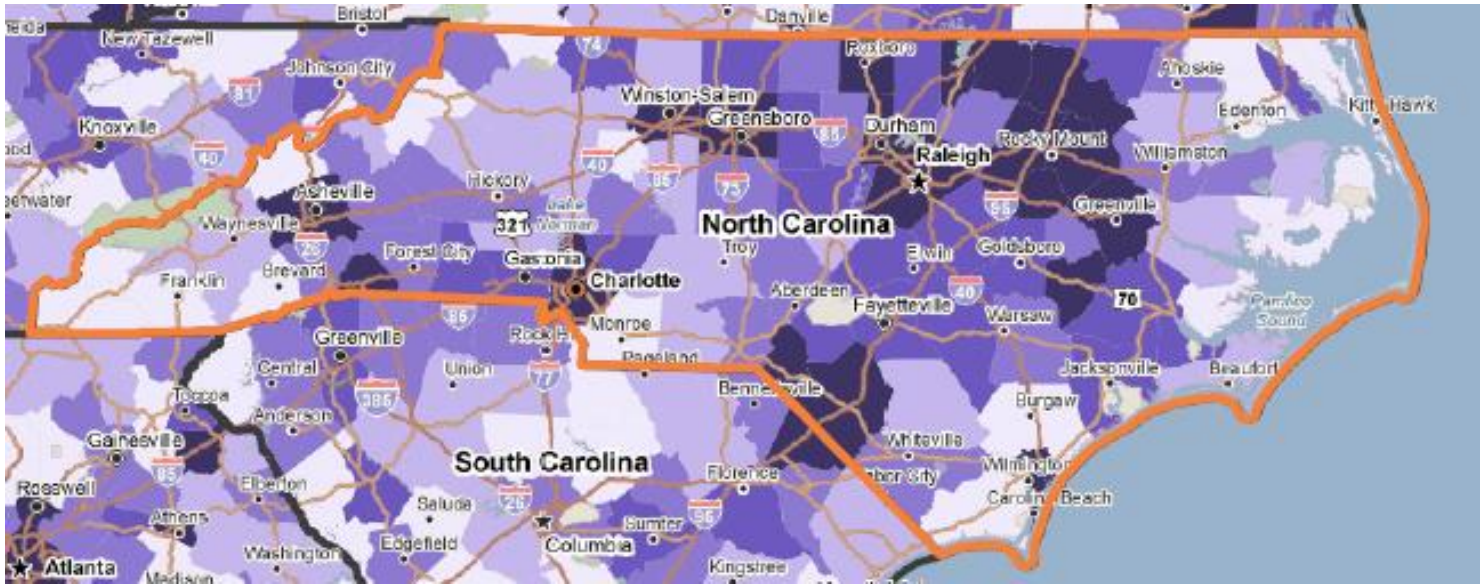
Year: 2013-2017

Shaded by: County, 2010

- Insufficient Data
- 78.50% or less
- 78.51% - 81.98%
- 81.99% - 84.71%
- 84.72% - 87.55%
- 87.56% or more

Source: Census

Estimated percent of householders 65 or older who rent a home between 2013-2017.



Percent HHs 65 or Older Who Rent a Home

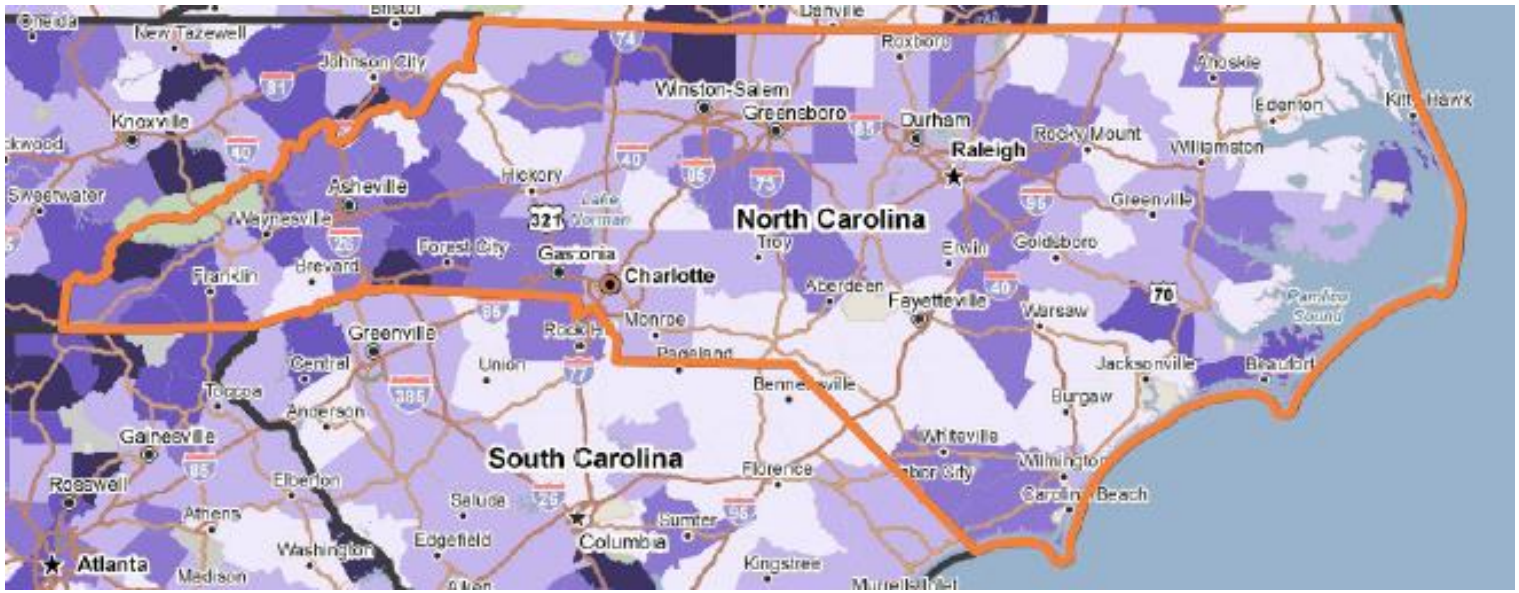
Year: 2013-2017

Shaded by: County, 2010

- Insufficient Data
- 12.44% or less
- 12.45% - 15.27%
- 15.28% - 18.00%
- 18.01% - 21.48%
- 21.49% or more

Source: Census

Percent of households living in subsidized housing where the head or spouse is age 62 or older in 2018.



Percent Households in Subsidized Housing Age 62 or Older

Year: 2018
Shaded by: County, 2010

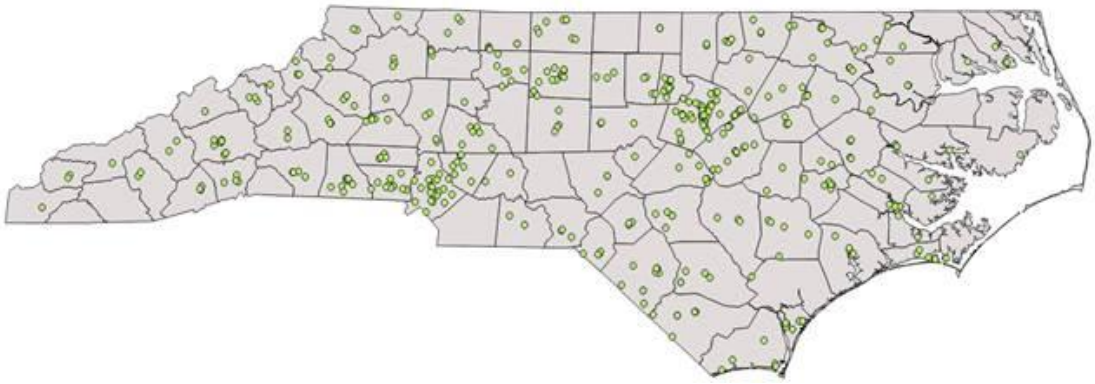
- Insufficient Data
- 25% or less
- 26% - 31%
- 32% - 37%
- 38% - 46%
- 47% or more

Source: HUD

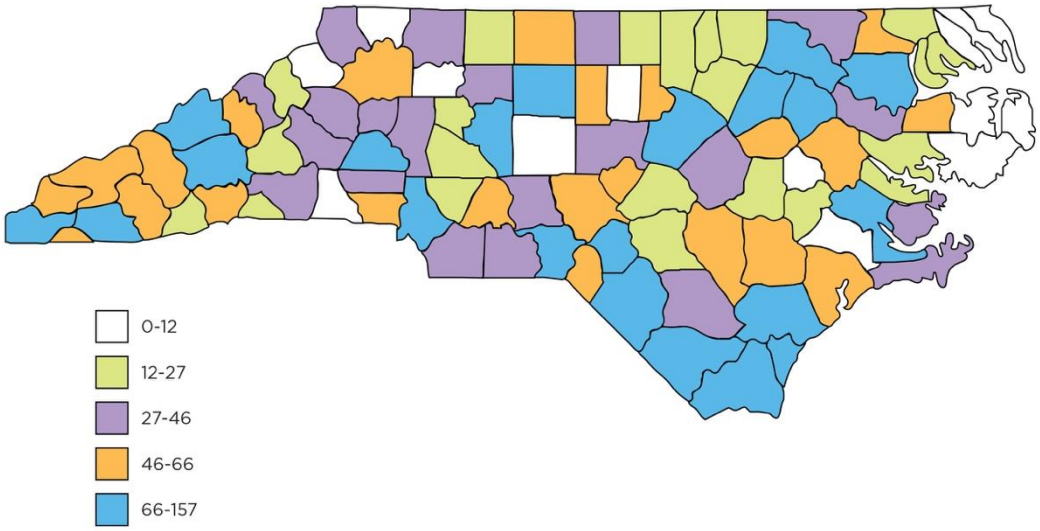
- Available elderly housing stock in NC
  See policy map resources above. Other resources of interest may include:
  - NCHFA's State of Housing Map
  - NC Housing Coalition's Housing Carolina Resource Manual
    - "[Rocky Mount] has also recognized a particular need for low-income housing for the elderly. Rocky Mount is home to almost 3,000 people age 65 or older who are below the poverty line. However, there are currently only 250 affordable housing units for the elderly in the city. [6] The city projects that Rocky Mount will need 1,119 housing units for the elderly to meet this increasing need. [6] This is a particular problem for Rocky Mount, as its population is aging more than the other cities examined."

- Stats on elderly housing funded by NCHFA on an annual basis
  From 2013-2017, an average of 12 affordable elderly rental properties financed by NCHFA were placed in service each year. The definition of "elderly" for these properties varies; for some, occupants are 55+ and for others they are 62+. NCHFA also finances home repairs to about 950 units occupied by low-income elderly households per year, on average (based on data from 2013-2017).

- Housing options for people aged 60 and older in urban vs. rural areas
  Approximately 60 percent of NCHFA-financed elderly rental properties (that are still being monitored by NCHFA) are in "rural" areas, as defined by USDA (note that this definition includes some rural parts of urban counties). When using the NC Rural Center's definition of "rural" (which is county-wide), 57 percent of properties fall in rural areas, while 26 percent are in urban counties and 17 percent are in suburban counties. Below is a map of all NCHFA-financed elderly rental properties.



As for home repairs, 70 percent of NCHFA-financed repairs made from 2013-2017 for elderly homeowners were in rural counties (per the Rural Center definition), 17 percent were in suburban counties and 13 percent were in urban counties. Below is a color-shaded map of NCHFA-financed home repairs for elderly homeowners completed between 2013-2017 (numbers in the ledger refer to the number of units in each county).

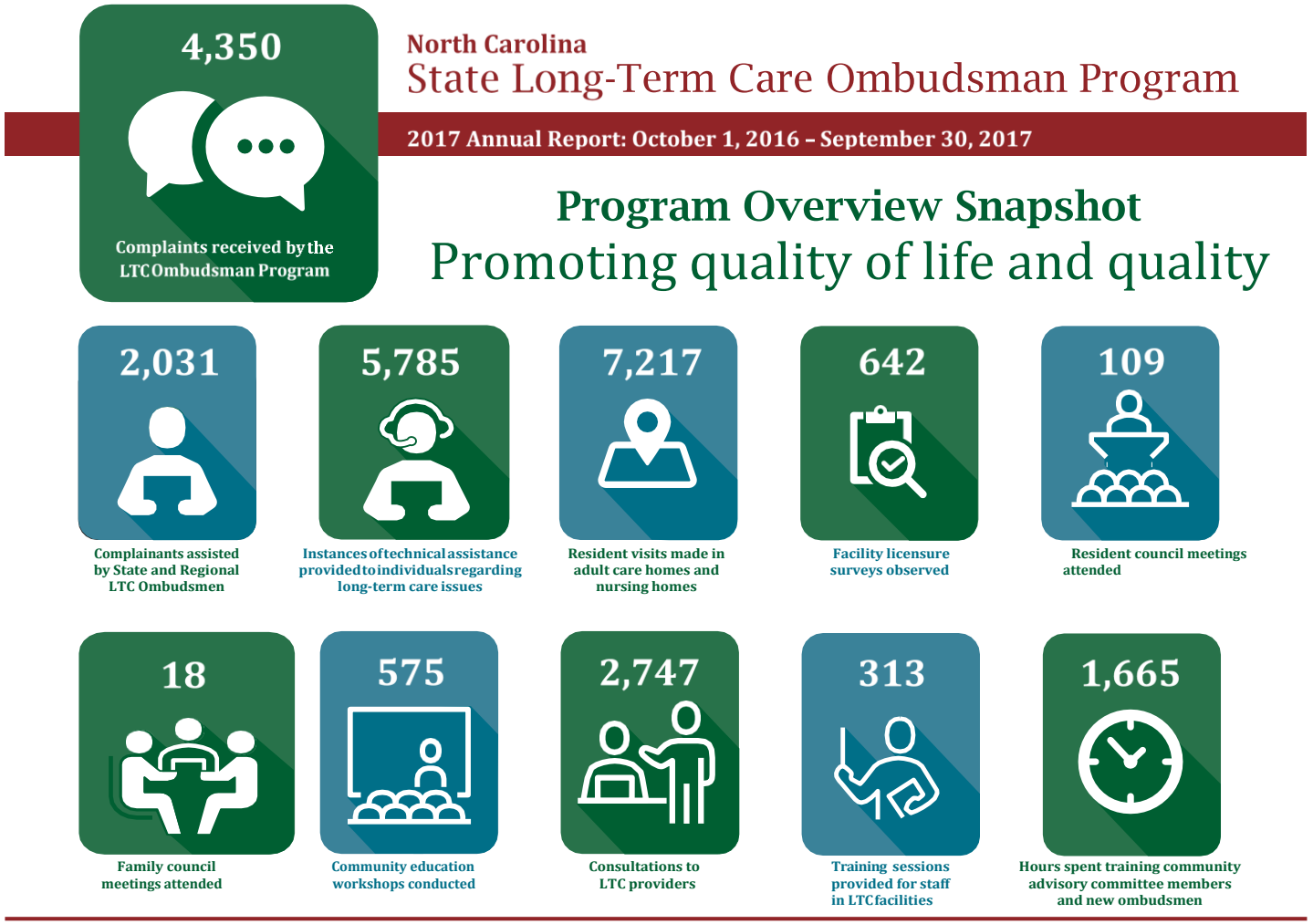


Attachment J
Adult Protective Services

DEMOGRAPHICS AND OUTCOMES FOR ADULT PROTECTIVE SERVICES FY 2017-2018

Who Are the Adults and Their Families?	What Is Happening to Them?	What Do These Adults and Their Families Need?
• In FY 2017-2018 **30,128** reports were received by County Departments of Social Services alleging abuse, neglect or exploitation of adults. • **15,563** of the reports were screened-in for Adult Protective Services (APS) to determine whether the adults reported as being abused, neglected or exploited needed protective services. • Older adults comprised the majority of those receiving APS; 73 percent were 60 or older, 27 percent were aged 18-59. • Women comprised 56 percent of the total reports screened-in, and men 44 percent. • Sixty-eight percent of the adults reported were white, 27 percent were black, one percent was Hispanic, and the remaining four percent were Native American, Asian and others. • Many of the adults reported were living in our communities. Eighty-six percent lived alone or with family members, while 14 percent lived in a facility, institution or shelter.	• Abuse, neglect or exploitation was found for 6,066 (45 percent) of the reports screened-in. • Neglect (88 percent) was the most common form of mistreatment found. Sixty-four percent of the neglect situations involved self-neglect. Twenty-four percent involved caretaker neglect. • Abuse was found in four percent of the situations. • Exploitation was found in 14 percent of the situations. • When mistreatment was found, the most frequently named perpetrator was the self-neglector, followed by an adult child, parent, non-relative caretaker and other relatives. • The most common disabilities experienced by mistreated adults were: --Physical illness -- Multiple disabilities --Alzheimer's disease --Other physical impairment --Mental illness	• Factors which may have contributed to the abuse, neglect or exploitation of adults living at home included: -- Mental/Emotional impairment -- Physical impairment -- Dependent/Physically frail -- Inadequate health care -- Unsafe environment -- Substance use/Misuse -- Inadequate knowledge of the health care needs of the disabled adult -- Unstable living arrangement • The primary factors identified as contributing to mistreatment in facilities included: -- Inadequate knowledge or training of care needs -- Inadequate supervision or management • The most frequently identified services needed to address the abuse, neglect or exploitation included: -- Placement -- Medical or health care -- In-home aide services -- Legal/Surrogate decision maker -- Money management -- Mental health

Attachment K
Ombudsman



Attachment L

Emergency Planning and Management Policy

NORTH CAROLINA

DIVISION OF AGING AND ADULT SERVICES

EMERGENCY OPERATIONS PLAN

2018-2019

Table of Contents

Acronyms

AAA	Area Agency on Aging
ACL	Administration for Community Living
AoA	Administration on Aging
DAAS	Division of Aging and Adult Services
DHHS	Department of Health and Human Services
DSS	Division of Social Services
EOC	Emergency Operations Center
ESF	Emergency Support Function
NCEM	North Carolina Emergency Management
SERT	State Emergency Response Team

I. Mission

To ensure that the NC Division of Aging and Adult Services, and the aging and adult services network will address the functional and accessible needs of older people and adults with disabilities in preparation for, and during times of, disaster and recovery.

II. Authority for Disaster Role

A. Older Americans Act References

Section 307 (a)

(29) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

The Division will offer guidance as requested by area agencies on aging in their development of long-range preparedness plans (referenced in the Older Americans Act Section 306 (a) and will keep copies of each plan including yearly updates on file.

(30) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

The Division will maintain an Emergency Operations Plan which will be updated yearly and be available for review upon request.

B. United States Administration for Community Living (ACL) Administration on Aging (AoA)

Emergency Preparedness and Response

Disasters or emergencies can happen anywhere at any time. Over the past two years alone, more than 130 Presidential Disaster Declarations have been made in 45 states and territories. When a disaster strikes, older people and people with disabilities may experience public health and human service needs that threaten their well-being. In many cases, existing physical or mental impairments may worsen, and needed family and community-based supports may be disrupted by the emergency. Though no two disasters are ever alike, the system of response must remain as uniform and consistent as possible to ensure that, regardless of where you work or to whom you report, all efforts complement rather than conflict with one another.

It is critical that:

- All individuals, including older people and adults with disabilities, their caregivers, as well as aging services network professionals, develop personal preparedness plans.
- All sectors of the national aging services network and other professionals become full participants in coordinated preparedness and response planning between federal, state, tribal, and local governments, as well as the private, voluntary and faith-based sectors.

III. Division Responsibilities

A. Efforts for Preparedness, Response and Recovery

The N.C.G.S. §143B-181.1 reads: "the Division of Aging (and Adult Services) is designated as the state unit on aging as defined in the federal Older Americans Act of 1965, as amended, and shall exercise all responsibilities pursuant to that act," North Carolina General Statutes 166A "North Carolina Emergency Management Act of 1977" sets forth the authority and responsibility of the Governor, state agencies, and local governments in prevention of, preparation for, response to and recovery from natural or man-made disasters, or hostile military or paramilitary action to:

- Reduce vulnerability of people and property of this state to damage, injury, and loss of life and property
- Prepare for prompt and efficient rescue, care and treatment of threatened or affected people
- Provide for the rapid and orderly rehabilitation of people and restoration of property
- Provide for cooperation and coordination of activities relating to emergency and disaster mitigation, preparedness, response and recovery among agencies and officials of this state, and with similar agencies and officials of other states, with local and federal governments, interstate organizations, and other private and quasi-official organizations.

B. State Emergency Operations Plan

To address obligations in the Older Americans, Act Section 307 (a) (29) cited above, the division will act in accordance with responsibilities included in the State of North Carolina Emergency Operations Plan, as follows:

- Promote the exchange of technical and statistical information relevant to needs and outcomes of the aging and disabled populations from North Carolina Emergency Management (NCEM) to area agencies on aging and County Departments of Social Services
- Collaborate as requested with NCEM Emergency Support Function 6 (ESF 6), NC Division of Social Services and other human service agencies to assist local jurisdictions in meeting the needs of individuals needing functional support sheltering services

- Collaborate as requested with NCEM ESF 8, NC Division of Health Service Regulation and NC Division of Public Health for individuals needing medical support sheltering services
- Support recovery efforts by assigning and deploying appropriate personnel to assist County Departments of Social Services, area agencies on aging, and other local entities as requested.

IV. Advanced Planning

The division is responsible for developing and maintaining a plan of operation that applies to its staff and the aging network.

Planning for circumstances that directly affect the division staff and the building in which normal operations are handled can be impacted outside normal hours of operation. Should an event occur a telephone tree will operate in the following order:

- DIRM Contact Representative
- Director of the Division of Aging and Adult Services
- Emergency Coordinating Officer/Section Chief of Planning, Budget, Information & Systems Support
- Section chiefs: Adult Services, Service Operations and Elder Rights
- Division supervisors/Designated personnel
- Other staff

Information to be disseminated:

- Announcing the activation of the division's emergency operations plan
- Informing staff members of the situation
- Announcing plans for interruptions in day-to-ay operations
- Conveying other pertinent information, as necessary

Planning for circumstances which may directly or indirectly affect area agencies on aging, County Departments of Social Services and other local agencies must occur prior to a disaster.

Responsibilities of the division during the advanced planning stage include:

- Assigning central office and field staff to the disaster team
- Developing and updating, at least annually, a directory listing names of division staff and area agency on aging staff responsible for disaster duties. The directory should include office, home and cellular numbers.
- Providing area agencies on aging appropriate disaster-related materials, as requested
- Providing area agencies on aging guidance on updating disaster plans of operation, as requested
- Providing sensitivity education as counties develop functional needs shelter plans
- Maintaining a web presence with appropriate disaster information and links

V. Preparedness

A. Call-Down System

A disaster is considered imminent when the NC Division of Emergency Management/State Emergency Response Team (SERT) is activated at the Emergency Operations Center (EOC). The NC Division of Aging and Adult Services is a member of the emergency response team in the human services section. Members of the SERT-related disaster team will be notified of alerts or activations by the Emergency Coordinating Officer or his/her designee related to the impending event. The division disaster team is composed of the Director, Emergency Coordinating Officer, section chiefs, Preparedness and Recovery Coordinator, Adult Services Coordinator, Ombudsman Support Coordinator and the division/AAA liaisons.

To communicate the details of the impending event to regional offices, the division/AAA liaisons and the Ombudsman Support Coordinator will do a call-down using the pre-event call down report to the AAA 72 hours in advance and as conditions change in the affected regions. AAA's will be responsible for:

- Informing staff and maintaining operations
- Reviewing the local emergency operations plan and contacting local emergency management
- Calling local service providers
- Determining overall readiness and making final preparations for interruptions in operations.

B. Reporting by Aging Network

Uniform, essential information recorded on the pre-event and post-event reporting forms by the AAAs and service provider network may be needed daily by the division before, during and after each disaster, concerning:

- Status of older people, and their known or anticipated needs
- Approximate locations and numbers of affected people
- Status of immediate and anticipated needs of the service provider network

AAAs will work with county emergency management personnel in their region and local service providers to contact older adults who may be on a functional-needs registry, or otherwise isolated and require more personal communication to help ensure safety as the event unfolds. Information from this contact will be recorded and relayed to the division for assistance when needs cannot be met with local resources.

Although DAAS will receive actual reporting information on seniors within the network, adults younger than 60 and have a disability will be served by the division in a supportive capacity with other DHHS divisions, their local partners, and potentially with other state, local or non-profit agencies.

VI. Response

Response will begin as soon as communication can be established between the division/AAA liaison and AAA's immediately following the event.

The division/AAA liaison responsibilities include:

- Conducting a post-event call down to each AAA involved and compiling the responses for AoA reporting
- Daily communication with each AAA involved, utilizing information gained on the post-event reporting form to determine what impact the disaster has had on older adults and the service provider network, and what actions are to be initiated in response to needs

AAA responsibilities include:

- Coordinating daily response to division/AAA liaison reporting requests
- Determining changes needed to assignments because of the disaster
- Maintaining a log of requests, responses and referrals
- Continued coordination with local emergency management for requests for assistance

VII. Recovery

Recovery begins once normal operations have resumed. During the recovery phase, conference calls may be the arranged as a method of communicating with key division staff and participating AAA's. This ensures that everyone is hearing the same information in a timely way and common issues can be addressed as a group.

Division responsibilities during recovery include:

- Advocate for older people and adults with disabilities who are victims of the disaster
- Assess the status of adults with disabilities
- Assist with personnel outreach/field assistance
- Provide support for grant opportunities and special initiatives

AAA responsibilities during recovery include:

- Assess status of older people and service providers
- Assist with resources, information and outreach
- Coordinate with local emergency management, other local agencies and volunteer organizations
- Debrief staff, evaluate resultsand determine necessary changes to the emergency operations plan

VIII. Staff

To ensure that an appropriate level of business continuity is in place, all Division of Aging and Adult Services staff should report to work, unless doing so would jeopardize personal or family health and safety. Staff members should contact their immediate supervisor when reporting to work is not feasible. Staff use of personal cell phones for work-related activities will be reimbursed in accordance with the continuity of operations plan.

A. Disaster Team – Nine Members

The disaster team is made up of the following individuals:

Division Director, Assistant Director, DAAS Emergency Coordinating Officer and section chiefs.

The Active Disaster Team will include the Adult Services Coordinator, Adult Services APS/APR Coordinator, the Ombudsman Support Coordinator and division AAA liaisons.

During imminent threats when the EOC is operational, the DAAS disaster contact is designated as the DAAS Emergency Services Coordinator. Other disaster members may be called upon to take a lead role in the event the Emergency Services Coordinator is unavailable.

The following is the most current list of DAAS staff assigned to the described roles:

Division Director

Assistant Director

Emergency Coordinating Officer

- Coordinates all disaster operations
- Triggers activities of the division disaster team
- Serves as primary point of contact with the DHHS lead agency
- Serves as primary intermediary with the US Administration for Community Living
- Represents the division at NCEM/SERT meetings
- Coordinates division field assistance
- Ensures regular division disaster team/general staff meetings
- Coordinates publicity and press releases

Disaster Preparedness and Recovery

- Directs call-downs to AAA's and ensures regular contact is maintained
- Disseminates disaster-related information and updates to the AAA liaisons and or AAAs
- Advises AAA's about time and procedure for reporting
- Maintains the AAA reports provided to division AAA liaisons for AoA
- Oversees information flow between the division and the aging and adult services network
- Works with other staff in their specific disaster role to gather and quickly disseminate information on resources
- Keeps AAA's and service providers current on available volunteer resources to assist older people and adults with disabilities, as requested

<u>Non-Emergency Related Duties in Support of Emergency Operations</u>:

- Updates the division disaster contact list and AAA contact list every June
- Represents the division at DHHS meetings, general disaster meetings and committees, as needed
- Coordinates updates of disaster plan and operating procedures for the division, as requested
- Keeps disaster notebooks current
- Assists with standardizing forms and procedures for reports by AAAs and service providers, as requested
- Assists the aging and adult services network in updating their disaster plans, as requested
- Coordinates maintenance and updating of disaster information on the division website, in conjunction with the division web master.

Adult Services/APR-APS Coordinator

- Coordinates status reports with the NC Division of Social Services while the Emergency Operations Center is operational
- Collaborates, as requested, with state and county functional and medical support population coordinators - ESF 6 and ESF 8
- Coordinates response of the APR and APS staff, as needed

Ombudsman Support Coordinator

- Directs call-downs to regional Ombudsman staff members to contact facilities for situational updates, and gather pertinent details and information regarding residents' needs
- Acts as an advocate for long-term care residents
- Coordinates with other DHHS divisions to ensure information is shared in a timely manner

The Division/AAA Liaisons, Adult Services Coordinator

When informed by the Emergency Coordinating Officer that an emergency event is likely, the division/AAA liaisons, the Ombudsman Support Coordinator(s) and the Adult Services Coordinator will provide key information, as necessary, to regional area agencies on aging and County Departments of Social Services as they activate emergency plans and provide support to local aging and disability service providers, in a coordinated effort with their local emergency management offices.

Division/AAA Liaisons:

As designated, the division/AAA liaison will be the primary point of contact for AAA and will:

- Coordinate call-downs to affected AAAs within their regions
- Compile AAA's and aging network responses
- Report updates to the lead liaison

DAAS Physical Plant Coordinator:

- Coordinates in-house activities and needs for faxing, printing, telephoning, mailing and other office assistance
- Coordinates disaster-related needs for division equipment, materials, travel arrangements and state cars
- Assists disaster team with routine paperwork, timesheets, special expense reports and other requirements that may be necessary for reimbursement from the federal government, specific to the disaster

B. Section Chief Responsibilities/Roles

- Ensures that disaster responsibilities are adequately carried out
- Ensures communication with section staff during a disaster to learn their status and share important information
- Assists with needs that disaster team members may have to perform individually. These needs may include providing additional supplies or equipment, printing, special assistance from support staff, travel authorization, changes in schedule or other needs
- Assists the section's disaster team member(s) with planning for routine job duties to be carried out by another person or postponed, when necessary

Other Staff

Subject matter experts within the division will coordinate and aid the aging and adult services network and emergency officials for specific services, as needed (such as housing and nutrition).

IX. Emergency Operations Center

The NC Division of Aging and Adult Services is a member of the State Emergency Response Team (SERT) and is expected to be present in the Human Services Section at the Emergency Operations Center (EOC), 1636 Gold Star Drive Raleigh, NC 27607-3371 during a state of emergency. While at the EOC, division staff can expect to:

- Attend briefings, and Human Services team and Emergency Management coordination meetings;
- Communicate information from Emergency Management to the division and division liaisons and from the aging and adult services network to Emergency Management
- Respond to specific needs from the aging network, and from older people and adults with disabilities
- Keep records about phone calls and other requests and indicate how each issue is resolved on forms provided in the division notebook at the EOC. This form should be completed for each request. Unresolved requests should be followed up by the next person staffing the EOC or until resolved
- Prepare activity reports and email to Emergency Management/Human Services every four hours, or as requested.

When the EOC is activated and staff is called to report, the following procedures should be followed:

- Bring appropriate SERT identification to the EOC
- Sign in at the front desk and again at the Human Services desk; sign out when leaving
- The first person who arrives will provide reference and other division materials to the Aging and Adult Services desk - Human Services section, as needed
- Brief incoming staff when shifts change about current situations and any unresolved issues

Staff may call the DAAS representative at the EOC 919-825-2480 for updates, to report news or request assistance.

X. Coordination with Other DHHS Divisions

As directed by the Secretary of the NC Department of Health and Human Services, the NC Division of Aging and Adult Services will participate as a member of the Department of Health and Human Services Disaster Coordination Team. The NC Division of Social Services will be the lead agency for this effort.

XI. Equipment and Supplies

One emergency operations notebook will always remain at the division for in-house use during a disaster. This notebook will stay in the Emergency Coordinating Officer's office. Other copies will be provided to division staff, as needed.

Division laptops and cars may be used by disaster staff if necessary to perform work-related activities with the section chief's approval and strict accountability measures in place.

XII. Training

A. Aging and Adult Services Networks

The Emergency Coordinating Officer will coordinate with the disaster team and key players, such as AAAs and service providers, to determine annual training needs and develop a plan for accomplishing training. The officer may also conduct or coordinate trainings outside the aging and adult services network, regarding functional and access needs for older adults and people with disabilities.

B. The Division of Aging and Adult Services Staff

The Emergency Coordinating Officer will involve the disaster team in meetings and activities, relaying current information on division activities, resources, programs and other information. Annual in-house orientation and training will be held for all division staff and is required for new disaster team members. Orientation and training are coordinated by the Emergency Coordinating Officer, with input from the disaster team. Updates will be offered as needed.

Periodic training coordinated by DHHS/NC Division of Social Services will be offered for all staff who work in the EOC. New division disaster team members will accompany an existing team member to the EOC during a drill or actual event before being sent for the first time.

XIII. Sections

A. Adult Services Chief

This section manages the operation of programs providing services and benefits to older people and adults with disabilities, primarily through the 100 County Departments of Social Services. These programs include adult protective services, guardianship, state/county special assistance for adult care homes and in-home, adult placement, at-risk case management, adult care home case management, and several counseling and case management services to support older people and adults with disabilities living at home. The section uses both central office- and field-based representatives for consultation and oversight of County Departments of Social Services and other participating providers. It also manages the Department of Health and Human Services' Blanket Bond for guardianship, and the housing and homelessness programs. This section uses both central office and field representatives for consultation and oversight of these programs.

B. Planning, ESG and Systems Support Section Chief and Emergency Coordinating Officer

This section is responsible for the development of the State Aging Services Plan, as required by the NC General Assembly and the state's Title III plan, as required by the Older Americans Act. This section is responsible for reviewing and assisting the work of Area Agencies on Aging in implementing their plans and providing technical assistance to local service providers and others. This includes support of local planning for the Home and Community Care Block Grant. The section is also responsible for the long-term services and supports initiative through Community Resource Connections (for Aging and Disabilities), whereby individuals of all disabilities and incomes can make informed, cost-effective choices regarding the services they may need. The section also serves as a vehicle for identifying, developing, analyzing and presenting information that instructs, guides and supports the diverse work of the division, including emergency operations planning. Overall coordination of the division's website is also the responsibility of this section.

This section is also responsible for the development, operation and oversight of the budget and information systems for the NC Division of Aging and Adult Services. This includes preparation and management of a funding plan for allocation of federal and state funds, to be used by the division, AAAs, local service providers and other entities. The section's work also involves management and maintenance of the Aging Resource Management Systems (ARMS), which is the division's automated client tracking and reimbursement system. ARMS track clients and services, computes and triggers reimbursement due to community service providers, and produces reports for use in program and fiscal management. In addition, this section coordinates the division's compliance-monitoring functions.

C. Service Operations Chief

In support of the mission, vision and values of the NC Department of Health and Human Services, the NC Division of Aging and Adult Services works to promote independence and enhance the dignity of the state's older adults, people with disabilities, and their families through a community-based system of opportunities, services, benefits and protections, to ready younger generations to enjoy their later years, and to help society and government plan and prepare for the changing demographics.

The Service Operations section is responsible for overseeing the planning, organization, financing and implementation of the statewide service delivery system for older adults and their families. This program of in-home and community-based services, which provide care options for older adults and their families, is a major priority for DAAS. This section has management responsibilities pertaining to the identification, analysis and evaluation of issues impacting the development of program service standards, eligibility criteria, quality assurance requirements, APA rules, procedure manuals, and differentiating requirements of multiple funding sources. Section staff are involved with policy development and maintenance, provision of technical assistance and training, quality assurance, assessment/evaluation, compliance monitoring, and state certification of certain programs.

D. Elder Rights Chief

This section is responsible for the statewide administration and supervision of programs, under Title VII of the Older Americans Act. The section's Long-Term Care Ombudsman Program advocates on behalf of residents in nursing homes and adult care homes. The elder rights section also provides information, and in some cases assists with public benefits counseling and assistance, elder abuse prevention, legal assistance, living wills, power of attorney and other types of legal documents, employment discrimination, and consumer protection issues. The section administers the Senior Community Service Employment Program (Title V of the Older Americans Act) for certain regions in North Carolina.

Event: Call-Down to AAA

Division/AAA Liaisons and Ombudsman Support Coordinator advise AAAs:

Your region is likely to be in an affected area. The situation is _____.

- Activate your emergency operations plan (or monitor the situation and use your judgment about local conditions)
- Plan for a possible disruption in services
- Contact local emergency management to coordinate activities
- Prepare to record needs and other statistical information from service providers for a daily report to the division
- Review the post-event call-down report for pertinent information to be gathered
- Begin call-downs to key service providers. Advise them to:
    - Activate emergency procedures
    - Prepare for potentially being closed
    - Have key information with them
    - Coordinate with local emergency officials as needed
    - Begin call-downs to at-risk older adults to ensure they have someone to help them or their essential needs can be met for a 72-hour period (water, food, heat/cool, light source, medications or other medical needs)
- Maintain a log of requests, responses, and referrals and all unmet needs for daily reporting to AAA, or more often
- The liaison should give a contact number and a designated time frame to gather daily information (next day, etc.) to report back

Give AAAs emergency contact numbers of pertinent division staff and EOC Human Services section number (919-825-2480) for emergencies.

Post-Event: Call-Down Report from

Area Agencies on Aging

1. Date of incident _____ Type of disaster _____
2. Describe area affected by the disaster (urban, rural, etc.):
3. Scope of disaster (town, county, regional):
4. Number and name of counties involved:
5. Give the best estimate of number of older people affected:
6. Number of older people thought to be homeless due to disaster. How many have been or are being evacuated? Describe the situation.
7. How many senior centers have been damaged or destroyed? Please list and describe.
8. How many congregate nutrition sites have been damaged or destroyed? Please list and describe.
9. Have senior apartment buildings been damaged? Have evacuations been made to shelters?
10. Describe the status of services to homebound older adults, including home-delivered meals and in-home aide services. What is the status of follow-up with recipients of these services?
11. When will disrupted services be restored?
12. Have other aging facilities been damaged or destroyed? Please list and describe.
13. Have nursing homes or adult care homes been damaged or destroyed? Are Ombudsmen responding to resident/family requests for services?
14. Give the best estimate of how many older adults have been evacuated to shelters? Are their needs being met? Has DSS or DPH asked for your assistance?
15. Are the AAA and other local agencies collaborating with emergency management, American Red Cross, Salvation Army, etc.? Are there problems?
16. Are there adequate resources available for the local agencies to meet identified needs for older adults or people with disabilities that you are aware of? Describe the type of assistance/support they may need.

Attachment M

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

Final Evaluation Report

on the

Care Management Quality Initiative

A Partnership between North Carolina's
Money Follows the Person Demonstration Project and the North Carolina Division of Aging and Adult Services
July 1, 2016 – Dec. 31, 2017

May 2018

Table of Contents

Care Management Quality Initiative

Executive Summary

The Care Management Quality Initiative (CMQI), a partnership between the North Carolina Money Follows the Person (MFP) Demonstration Project and the North Carolina Division of Aging and Adult Services (DAAS) was designed to improve the quality and consistency of care management services administered through DAAS. The goal was to help caregivers continue to provide care in the community for their loved ones who were at risk for facility placement. The objectives of the CMQI were to:

- Develop, test and evaluate new care management tools that address assessment and care planning for the caregiver
- Examine the role of respite (provided through $500 respite vouchers) in caregiver's satisfaction with the caregiving role and their intent to pursue facility placement

The CMQI was supported through MFP Demonstration Project Rebalancing Funds from July 1, 2016 – Dec. 31, 2017. MFP provided funding for 10 hours per week of DAAS staff time to support the initiative and for 108 respite vouchers (valued at $500 each) for participating caregivers. The CMQI Team at DAAS was responsible for program and evaluation design, training, implementation and final evaluation. The Team focused initial CMQI efforts on Project C.A.R.E. (Caregiver Alternatives to Running on Empty), a state-funded program supporting family caregivers of individuals living with Alzheimer's disease or related dementias.

The target group included caregivers who were new to Project C.A.R.E. or had not received Project C.A.R.E. services in at least a year. The North Carolina General Assembly approved new funding to expand Project C.A.R.E. beginning in state FY 2016/17, including funding for new respite vouchers. Ninety-six additional caregivers receiving these new vouchers were included as part of the CMQI target group, bringing the total number to 204 participating caregivers.

The CMQI Team at DAAS designed the CMQI program based on the unique challenges and experiences of dementia caregivers. The team developed:

- New care management tools focusing on the caregiver
- A process for awarding, tracking and reimbursing consumer-directed respite vouchers
- An evaluation plan, including pre- and post-surveys and protocols for both, designed to collect information for program improvement
- Training for Project C.A.R.E. family consultants on new tools and protocols

The care management process began with a person-centered assessment designed to result in a written action plan/care plan. Care management addressed the caregiver's need for information, resources, and support to build caregiving skills and confidence. Project C.A.R.E. family consultants also offered at least one respite voucher to each caregiver and discussed how to plan for and use it. Caregivers had 90 days to use the voucher, with a possible 30-day extension. The protocol called for family consultants to make follow-up calls every 30 days to check in, answer questions and encourage the use of the respite voucher.

Caregivers participated in a pre-survey before the care management process began and they were awarded their first respite vouchers. The target date for conducting post-surveys was 120

days after the respite voucher award dates. The pre- and post-surveys both included basic demographic questions, as well as questions on caregiver's:

- Confidence in handling the challenges of caregiving
- Level of stress and burden
- Intent to place their care recipients in a facility

Because of the CMQI, the caregiver assessment and care planning process are now embedded in Project C.A.R.E., and there is greater quality and consistency in the services provided by family consultants across the state. The process of awarding and tracking the use of respite vouchers worked well and allowed the Project C.A.R.E. director to access real-time data on voucher use and generate needed reports.

Most importantly, caregivers of individuals with dementia received support through the improved care management processes and had access to much-needed respite vouchers. Two measures of caregiver self-efficacy, confidence in locating available community resources and confidence in knowing where to turn for answers to questions showed a statistically significant increase from pre-survey to post-survey. There were also marked decreases from pre- to post-survey in the percentage of caregivers considering or taking steps toward facility placement or discussing the possibility of placement with family members or care recipients.

In addition, caregivers reported very positive experiences with both care management and respite:

- 95 percent of responding caregivers received a respite voucher
- 95 percent of those receiving a respite voucher spent at least half of it
- 97 percent were either extremely satisfied or very satisfied with their respite services
- 94 percent reported that their Project C.A.R.E. family consultant talked to them about effective ways to plan for and use their respite voucher
- 84 percent either strongly agreed or agreed that they used their respite plan to do something they enjoyed and felt that the respite time was "time well spent"
- 96 percent reported that it was not at all or only slightly difficult to locate and hire a respite provider
- 99 percent reported that it was not at all or only slightly difficult to get reimbursed
- 95 percent were either extremely satisfied or very satisfied with the care planning process
- 91 percent either strongly agreed or agreed that Project C.A.R.E. was playing a role in keeping their care recipient at home and out of a long-term care facility

The CMQI also helped identify challenges and areas for program improvement/next steps. Because of the successful experience with the use of standard care management tools in Project C.A.R.E., DAAS will next examine the adoption of these tools for caregivers of individuals with dementia in the Family Caregiver Support Program.

Care Management Quality Initiative
Final Evaluation

Background

The Care Management Quality Initiative (CMQI) was designed as a partnership between North Carolina's Money Follows the Person (MFP) Demonstration Project and the North Carolina Division of Aging and Adult Services (DAAS). The purpose of the initiative was to improve the quality of care management services administered through DAAS and to focus on consistency in service delivery across the state with the goal of helping family caregivers continue to provide care in the community for their family members who were/are at risk for facility placement.

From the initial planning stages of the CMQI during fall 2015, the focus has been on caregivers. The literature strongly supports the value of assessing the needs of family caregivers in the plan of care. If family caregivers are not connected to needed services and support, their own health and well-being may be compromised, increasing the risk that they will not be able to continue to provide care in the community (Kelly, Wolfe, Gibson & Feinberg, 2013).

The objectives of the CMQI were to:

- Develop, test and evaluate new care planning/care management tools that addressed assessment and care planning for the caregiver, and that were designed to result in a written plan of care
- Examine the role of respite (provided through $500 respite vouchers) in caregiver's satisfaction with the caregiving role and their intent to pursue facility-based placement.

The CMQI was supported through MFP Project rebalancing funds from July 1, 2016 – Dec. 31, 2017. MFP provided funding for 10 hours per week of DAAS staff time to support the initiative and for 108 respite vouchers (valued at $500 each) for participating caregivers. MFP stakeholders have consistently identified supporting family caregivers as one of the project's top priorities and MFP has been committed to underwriting demonstration efforts that address this priority.

The CMQI team at DAAS was responsible for program and evaluation design, training, implementation and final evaluation. The CMQI team included:

- Family Caregiver Support Program Consultant/Lifespan Respite Project Director
- Lifespan Respite Project Specialist
- Alzheimer's Support Specialist/Project C.A.R.E. Director
- Dementia Services Coordinator
- Program Consultant for Information and Options Counseling and Care Management
- Program Assistant for Service Operations
- Planning and Evaluation Team Planner/Evaluator

After examining the care management programs administered through DAAS, the CMQI Team decided to focus initial CMQI efforts on Project C.A.R.E. (Caregiver Alternatives to Running on Empty), a state-funded program supporting family caregivers of people living with Alzheimer's disease or related dementias. The team identified the target group as 108 caregivers of individuals with dementia who were either new to Project C.A.R.E. or who had not engaged Project C.A.R.E. services for a least a year.

The intent was that the caregiver assessment and planning tools developed with Project C.A.R.E. would be applicable to care management services funded through the Home and Community Block grant, and eventually to the Family Caregiver Support Program, thereby enhancing the quality and consistency of these DAAS services, as well.

In June 2016, the North Carolina General Assembly approved new funding to expand Project C.A.R.E., including funding for about 550 respite vouchers for FY 2016-17. The CMQI Team at DAAS decided to include 72 additional caregivers receiving these new vouchers, as part of the CMQI target group, bringing the number of participating caregivers to 180. Each of the six Project C.A.R.E. Family Consultants were assigned to follow the CMQI protocol with 30 caregivers. Several of the family consultants exceeded that requirement, bringing the total number in the target group to 204.

CMQI Program Design

The CMQI program design focused on the needs and experiences of caregivers for individuals with Alzheimer's disease or a related dementia. In 2016, 5.4 million Americans of all ages were estimated to have Alzheimer's disease. Five-point-two million were 65 and older, with about 200,000 younger than age 65 and experiencing early onset dementia. Caregivers were providing an estimated $18.1 billion of unpaid care for these individuals (Alzheimer's Association, 2016). While caregiving for individuals with dementia is in many ways like caregiving for individuals without dementia, it also poses its own unique and significant challenges.

Research shows that dementia is an independent risk factor for nursing home admission for older adults living in the community, even when controlling for other co-occurring conditions. The functional disability of the individual with dementia, and the physical and emotional strain of the caregiver, are the most significant predictors of nursing home placement (The Gerontological Society of America, 2015).

Dementia caregivers typically provide more extensive care and spend more years in the caregiving role. They often experience more stress than those caring for people without dementia because of the physical and emotional demands of assisting with activities of daily living, managing challenging behaviors, and adjusting to the progressive and often unpredictable needs of their loved ones. They also report more isolation and greater financial burdens than caregivers of individuals without dementia (Feinberg, 2017).

In addition to leading to higher rates of nursing home placement for an individual with dementia, caregiver strain also results in worse health outcomes for caregivers. Caregivers who report low self-efficacy for dementia caregiving (i.e. the extent of the caregiver's belief, or confidence in, his/her ability to carry out the needed caregiving tasks and responsibilities) also experience greater caregiver strain and more depressive symptoms (Jennings, et al., 2015).

The CMQI team at DAAS designed the CMQI program based on the unique challenges and experiences of dementia caregivers. The team decided that the care management process would begin with a person-centered assessment, focusing on the caregiver's specific needs, challenges, strengths, resources and goals, as identified by the caregiver. The assessment would result in a written action plan/care plan developed jointly by the family consultant and the caregiver. Care management efforts would focus on addressing the caregiver's individual needs for information, resources, services, and support to build the caregiver's skills and confidence in managing the challenges of caregiving. Family consultants would work with each caregiver to help them:

- Understand their loved one's condition and know what to expect as the condition worsens/deteriorates over time
- Use respite and other strategies to deal with stress/strain/burden of caregiving
- Learn to deal effectively with his/her loved one's challenging behaviors
- Locate and connect with community resources for information and support
- Plan

Family consultants would also offer at least one $500 respite voucher to caregivers, explain how to use it, and discuss with the caregiver how the caregiver might choose to use it in the most beneficial way. Caregivers were given 90 days to use the voucher, with the possibility of a 30-day extension. Family consultants would make follow-up calls every 30 days during the 90- or 120-day period to check in, answer questions, and encourage the use of the respite voucher.

Care Management Tools

DAAS staff reviewed the literature on best practices in caregiver assessment and care planning, as well as the components that should be included in caregiver assessment and planning tools. In addition, DAAS staff reviewed more than two dozen assessment tools from around the country that focused either entirely or partially on caregivers, some of which specifically addressed the needs of caregivers of individuals with dementia. Project C.A.R.E. family consultants offered feedback on draft care management tools and emphasized the need for the tools to capture and reflect the unique needs and experiences of caregivers for individuals with dementia.

The caregiver assessment tool adopted for use includes referral information, a caregiver profile, a care recipient profile, a section on financial information, and a one-page care needs assessment tool developed specifically for caregivers of individuals with dementia by Alzheimer's Los Angeles. The care needs assessment tool includes sections on challenging behaviors, activities of daily living and functional needs, safety, and caregiver needs.

The caregiver action plan/care plan was modified from the action plan used in North Carolina's options counseling program. The plan addresses the needs identified in the care needs assessment tool, developed by Alzheimer's Los Angeles so that it is directly linked to the assessment. Copies of the caregiver assessment tools and caregiver action plans/care plans are included in Appendix A.

Additional resources for developing the action plan include standardized care plans from Alzheimer's Los Angeles's dementia care management toolkit, as well as plain language fact sheets (in English and Spanish) designed to be shared with caregivers. The standardized care plans address each of the issues identified in their care needs assessment tool and provide a resource for family consultants and caregivers to use when working together to develop the action plan.

All materials from Alzheimer's Los Angeles were used with their permission and modified to include North Carolina information and resources. Their dementia care management toolkit can be found at https://www.alzgla.org/professionals/dementia-care-management-toolkit/.

Process for Awarding and Reimbursing Respite Vouchers

The CMQI team at DAAS developed a process for awarding and tracking respite vouchers and reimbursing caregivers, very similar to the process used by the Lifespan Respite Voucher Program. Both use a caregiver-directed service model, which allows caregivers to choose who provides the respite service and where and when it is provided. Both are also reimbursement-based. DAAS selected the Southwestern Commission Area Agency on Aging as the fiscal agent for voucher administration and set up spreadsheets to track respite voucher use. More detailed information about the respite voucher process is included in the respite voucher packet in Appendix B.

Evaluation Plan

Under the leadership of the DAAS planner/evaluator, the CMQI team developed an evaluation plan for the care management quality initiative to collect information for program improvement. This is distinguished from research in that the purpose of evaluation is to improve a specific program, not to prove that an intervention caused an effect or to generalize findings from a specific sample of a population to the whole population.

Based on the CMQI program design, the CMQI team at DAAS determined that the evaluation needed to measure changes in the following:

- Caregiver knows how to get community services
- Caregiver is confident he/she can handle challenging behaviors related to dementia
- Caregiver knows where to turn to get answers to his/her questions
- Caregiver is confident he/she can deal with the frustrations of caregiving
- Caregiver is confident he/she can plan for future needs
- Caregiver experiences a positive change in stress/strain/burden
- Caregiver continues to provide care for his/her loved one in the community

The CMQI was designed so that caregivers would participate in a pre-survey before the care management process began and before the first respite vouchers were awarded. Caregivers completed the pre-surveys either by email, mail or in person at the time of the family consultant's first home visit with the caregiver. Instructions for introducing the pre-survey to caregivers are included in Appendix C.

The target date for conducting post-surveys was 120 days after the respite voucher award dates to allow 90 days for the caregiver to use the voucher, with the possibility of a 30-day extension. Post-surveys were conducted by DAAS staff. To maximize the response rate, our DAAS planner/evaluator developed a protocol for the post-survey process, which included electronic, mail and phone response options, as well as time frames for follow-up. A copy of this protocol is included in Appendix D.

Pre-and post-surveys both included basic demographic questions, as well as questions on a caregiver's:

- Confidence in handling various challenges of caregiving (caregiver self-efficacy)
- Level of stress and burden
- Intent to place their care recipients in a facility

The questions on caregiver confidence in handling the challenges of caregiving were modified from a nine-item caregiver dementia care and self-efficacy survey used by UCLA's Alzheimer's and Dementia Care Program (Jennings, et al., 2015). Questions on the level of caregiver stress/burden were from the Zarit four item scale of caregiver burden.

The pre-survey included the open-ended question, "Is there anything you would like to tell us about your caregiving experience?" The post-survey also included additional questions on the caregivers' experience with the care management process and with the use of respite vouchers. The pre- and post-surveys are included in Appendix D.

The pre- and post-surveys were not matched, according to individual caregivers. Comparative analysis of pre- and post-survey responses was based on aggregate data.

Training for Project C.A.R.E. Family Consultants

As the initiative was getting underway during fall 2016, new funding for Project C.A.R.E. from the NC General Assembly doubled the number of family consultants from three to six. The first CMQI training session for established Project C.A.R.E. family consultants were held Oct. 24, 2016. A second training for newly hired family consultants was held Nov. 29, 2016. The established family consultants had the opportunity to provide feedback on the new care management tools prior to and during their training session in October. Areas of focus for both trainings included the respite voucher process, the caregiver assessment process, the checklists for family consultants to follow in carrying out the CMQI with caregivers, the importance of a person-centered approach in carrying out the assessment and care planning processes with caregivers, and the evaluation tools and protocols. Agendas for both training sessions as well as the checklists for family consultants are included in Appendix C.

Evaluation/Survey Results

During June and July 2017, DAAS staff scheduled phone conversations with all Project C.A.R.E. family consultants to get their feedback on the caregiver assessment tool and caregiver plan of care/action plan. The care management tools were revised in July 2017 to incorporate the family consultants' feedback. Copies of the original and revised care management tools are included in Appendix A.

Pre-surveys were completed from Nov. 2016 – May 2017. One hundred sixty-two pre-surveys were submitted from caregivers in 58 counties, a 79 percent response rate. Post-surveys were completed by the end of Sept. 2017, with 146 post-surveys submitted from caregivers in 55 counties, a 72 percent response rate. Not all respondents answered every question; percentages shown for each question in the following tables are based on the number of respondents for that question and do not include those caregivers who did not respond to that question. Percentages are rounded to whole numbers.

RESPONSES TO QUESTIONS ON PRE-SURVEY ONLY

Is there anything you would like to tell us about your care giving experience?

Complete responses to this question are included in Appendix D. Representative comments from 12 caregivers are listed below:

- The past two years have been overwhelming and somewhat more than I can handle. Any assistance is needed for me as an 80-year old caregiver.
- Impossible to plan, sleep sound and feel safe. Worry about the safety of both of us, as well as my health and mental state.
- Mom is changing rapidly, in that her memory and skills are on the decline; however, her need for continuous attention and socialization has skyrocketed. Coupled with the fact that our monthly income has decreased by 18 percent and I am not sure what I can do to supplement it, since I am receiving Social Security disability.
- I had a professional career in accounting before I took over the care for my parents. I managed several departments and supervised numerous employees. But caregiving for two elderly parents, one with dementia and one struggling with depression and anxiety, makes this the most challenging experience of my life.
- It has been so stressful, at times it is hard to see the light at the end of the tunnel.
- I have been caring for my husband for six years and we have two young children. He has early onset dementia. There are very little resources or support to keep a loved one in the home. It has been very difficult.
- I just feel that I have no clue what resources are available, nor do I feel I am educated enough about my mom's illness and feel that I/we are not equipped to give her the care she needs, because we do not know what to expect from her illness and what we are facing in the future.
- This situation has been way more stressful than I ever imagined.
- Most humbling experience of my life.
- It's a full-time job that I love doing.
- I have issues with not feeling resentful because of the situation.
- I have cared for my sister-in-law with the help of her brother (my husband). Now, my husband has had a stroke and I must care for him, too. I need respite.

RESPONSES TO QUESTIONS ON BOTH PRE- AND POST-SURVEYS		
Basic Demographic Information	**Pre-Survey**	**Post-Survey**
Age of Caregiver		
Age range	42-92	29-87
Average age	65	63
Age 90 or above	1%	0%
Age 80-89	14%	9%
Age 70-79	22%	22%
Age 60-69	30%	32%
Age 50-59	24%	25%
Under age 50	9%	12%
Gender		
Female Male	83% 17%	83% 17%
Annual Household Income		
$5,000 to $9,999	7%	4%
$10,000 to $14,999	10%	8%
$15,000 to $19,999	5%	8%
$20,000 to $24,999	11%	11%
$25,000 to $29,999	11%	13%
$30,000 to $34,999	8%	10%
$35,000 to $39,999	7%	6%
$40,000 to $44,999	9%	13%
Over $45,000	32%	27%
Relationship to Care Recipient		
Wife	28%	28%
Husband	11%	8%
Daughter	39%	43%
Daughter-in-law	4%	2%
Son	6%	7%
Sister	3%	3%
Brother	1%	1%
Niece	1%	1%
Mother	2%	1%
Father	0%	1%
Aunt	1%	0%
Uncle	.5%	0%
Granddaughter	2%	0%
Granddaughter-in-law	.5%	1%
Non-relative	.5%	1%
Other	.5%	3%

Basic Demographic Information (continued)	Pre-Survey	Post-Survey
Age of Care Recipient		
Age range	30-102	34-102
Average age	81	80
Age 90 or above	18%	14%
Age 80-89	45%	49%
Age 70-79	28%	25%
Age 60-69	6%	8%
Age 50-59	1%	3%
Under age 50	2%	1%

Respite and Care Management Services in the Past Year	
Pre-Survey	**Post-Survey**
Respite Services in the Past Year	**Respite Services other than Project C.A.R.E. in the Past Year**
Yes 25%	Yes 22%
No 72%	No 74%
Unsure 3%	Unsure 4%
Care Management in the Past Year	**Care Management other than Project C.A.R.E. in the Past Year**
Yes 19%	Yes 25%
No 75%	No 72%
Unsure 6%	Unsure 3%

Managing the Challenges of Caregiving/ Caregiver Self-Efficacy	Pre-Survey	Post-Survey
How confident are you locating available community services such as support groups, home-delivered meals or in-home aide?		
Extremely confident	9%	12%
Very confident	28%	38%
Slightly confident	40%	39%
Not at all confident	23%	11%
How confident are you handling challenging behaviors related to dementia?		
Extremely confident	8%	11%
Very confident	38%	33%
Slightly confident	40%	46%
Not at all confident	14%	10%
How confident are you knowing where to turn to get answers to your questions?		
Extremely confident	6%	18%
Very confident	35%	41%
Slightly confident	41%	35%
Not at all confident	18%	6%
How confident are you dealing with the frustrations of caregiving?		
Extremely confident	7%	8%
Very confident	32%	39%
Slightly confident	47%	43%
Not at all confident	14%	10%
How confident are you planning for your care recipient's future needs?		
Extremely confident	13%	8%
Very confident	27%	34%
Slightly confident	33%	40%
Not at all confident	27%	18%

Evaluators ran a paired sample t-test on the questions above to see if average scores on the scales differed significantly from the first administration of the survey (pre) to the second (post). Two questions showed statistically significant differences.

How confident are you locating available community services such as support groups, home-delivered meals, or in-home aide? For this question, the significance was at the 95 percent confidence level. This means that if the survey were administered 100 times, one would expect significance 95 times out of 100.

How confident are you knowing where to turn to get answers to your questions? For this question, the significance was at the 99 percent confidence level. This means that if the survey were administered 100 times, one might expect the same results 99 times out of 100, a much stronger significance than for the question on confidence in locating available community services above.

Caregiver Strain/Burden Zarit Four Item Scale of Caregiver Burden	**Pre-Survey**	**Post-Survey**
How often do you feel that because of your care recipient that you don't have enough time for yourself?		
Never	2%	1%
Rarely	4%	2%
Sometimes	29%	36%
Quite frequently	35%	42%
Nearly always	30%	19%
How often do you feel stressed between caring for your care recipient and trying to meet other responsibilities (home, work)?		
Never	0%	1%
Rarely	3%	4%
Sometimes	33%	30%
Quite frequently	32%	45%
Nearly always	32%	20%
How often do you feel strained when you are around your care recipient?		
Never	5%	4%
Rarely	12%	16%
Sometimes	49%	49%
Quite frequently	25%	27%
Nearly always	9%	4%
How often do you feel uncertain about what to do about your care recipient?		
Never	6%	10%
Rarely	20%	22%
Sometimes	45%	45%
Quite frequently	24%	18%
Nearly always	5%	5%

The differences between pre- and post-survey responses on these questions did not reach a level of statistical significance.

Intent to Place Care Recipient in a Facility	Pre-Survey	Post-Survey
Would you ever consider placing your care recipient in a nursing home or assisted living facility?		
Yes	24%	26%
No	31%	33%
Unsure	35%	29%
Prefer not to answer	10%	7%
Have already placed in nursing home or assisted living facility	N/A	5%
Have already placed in another type of living arrangement	N/A	0%
If you could not provide care, would your friend/family member have to be placed in a long-term care facility such as a nursing home or assisted living facility?		
Yes	64%	61%
No	5%	7%
Don't know/unsure	29%	29%
Prefer not to answer	2%	3%
Which of the following apply to you? (Select all that apply.)	**In the past six months, I have:**	**Currently I am:**
Considered/Considering a nursing home or assisted living facility for the care recipient	24%	12%
Felt/Feeling the care recipient would be better off in a nursing home or assisted living facility	13%	7%
Discussed/Discussing the possibility of a nursing home or assisted living facility with family members or others	36%	15%
Discussed/Discussing the possibility of a nursing home or assisted living facility with care recipient	12%	2%
Taken/Taking steps toward placement	11%	2%
Wanted/Wanting to move the care recipient to another type of living arrangement such as a home of their friend or relative	10%	2%
None of these apply	44%	61%
Prefer not to answer	7%	8%
In the next six months, are you likely to move the care recipient to another living arrangement?		
Yes, a nursing home or assisted living facility	7%	4%
Yes, another home such as that of a friend or relative	1%	1%
No	53%	60%
Don't know	35%	30%
Prefer not to answer	4%	5%

The assumption for a paired sample t-test is that the questions should be stated and coded in the same way for each administration of the instrument. Questions in this section were not all stated or coded in the same way in the pre- and post-surveys, so t-tests were not run. However, in the question which begins, "Which of the following apply to you?" there are marked reductions between pre- and post-

surveys in the percentage of caregivers considering placement, discussing the possibility of placement with family members or care recipients, or taking steps toward placement.

RESPONSES TO QUESTIONS ON POST-SURVEY ONLY	
Use of Respite Voucher	**Post-Survey**
Did you RECEIVE a respite voucher provided by your Project C.A.R.E. family consultant?	
Yes	95%
No/unsure	5%
Have you USED a respite voucher provided by your Project C.A.R.E. family consultant?	
Yes	96%
No/unsure	4%
Who did you hire to provide your respite? (Select all that apply.)	
Friend/relative	32%
Other individual	29%
Home care agency/respite service	17%
Adult day care/group respite	16%
Other	16%
"Other" responses included 13 who hired other individuals, five who used nursing homes or assisted living facilities, and three who used home care agencies. Including those who reported using individuals in the "other" category, 70 percent of the caregivers who responded to this question used friends/relatives or other individuals to provide respite.	
How satisfied were you with the respite services you recently received from the Project C.A.R.E. voucher program?	
Extremely satisfied	75%
Very satisfied	22%
Slightly satisfied	3%
Not at all satisfied	0%
Why or why not? A full list of responses is included in Appendix D. Representative comments from five caregivers are listed below: • I have been given time to get out for a few hours a week. I feel as though a ton has been lifted off my shoulders. I thank everyone involved in this. • Hired someone who knew my mother for more than 40 years and knew how to take good care of her. • I left my home and business and friends to come and take care of my mother, and I had no help- so respite care saved my life, because I was able to get out of the house for a few hours. • This program is my only opportunity for respite. My parents are not comfortable with an agency, so to be able to have someone they know come into the home is invaluable to me. • Being able to hire someone enabled me to take off an entire weekend, the first time in three years, to spend with my husband.	

Use of Respite Voucher (continued)		Post-Survey
Did your Project C.A.R.E. family consultant talk to you about effective ways to plan for and use your respite voucher?		
	Yes	94%
	No	0%
	Unsure	6%
How much do you agree with the following statement: I used my respite plan to do something I enjoyed and felt that the respite time was "time well spent"?		
	Strongly agree	50%
	Agree	34%
	Disagree	2%
	Strongly disagree	14%
What activities did respite allow you to do? (Select all that apply.)		
	Rest/relax	54%
	Manage household tasks	46%
	Run errands/go to or make appointments	62%
	Social/recreational activities	35%
	Attend events for family or friends (such as weddings, birthday celebrations)	23%
	Other	29%
A full list of "other" responses is included in Appendix D. Other responses included: work, tend to own medical needs, attend a memorial service for our son, participate in church activities, plan for daughter's wedding, sleep/rest, read, and go away overnight for the first time in two years.		
Please rate the level of difficulty in locating and hiring a respite provider.		
	Not at all difficult	65%
	Slightly difficult	31%
	Very difficult	2%
	Extremely difficult	2%
Please rate the level of difficulty with the process of getting reimbursed for your respite.		
	Not at all difficult	88%
	Slightly difficult	11%
	Very difficult	1%
	Extremely difficult	0%
How much of your Project C.A.R.E. respite voucher did you spend?		
	Less than $250	5%
	$250 or more	95%

Use of Respite Voucher (continued)	Post-Survey
If you did NOT USE your Project C.A.R.E. respite voucher, or if you used less that $250 of it, why? (Select all that apply.)	
Did not have enough time to arrange service	13%
Did not know who to hire/choose for respite provider	20%
Did not understand the voucher process	7%
Did not understand how to be reimbursed	7%
Decided they did not need the respite	7%
The person I care for did not want me to leave	13%
The person I care for moved to a facility	13%
The person I care for passed away	13%
Did not receive a respite voucher	0%
Other, please specify	33%
A full list of “other” responses is included in Appendix D.	

Care Management Process	Post-Survey
Have you received additional services because of your care planning process with Project C.A.R. E.?	
Yes	16%
No	75%
Unsure	9%
Overall, how satisfied are you with the care planning process or help you received from your Project C.A.R.E. family consultant?	
Extremely satisfied	59%
Very satisfied	36%
Slightly satisfied	4%
Not at all satisfied	1%

Overall Support from Project C.A.R.E.	Post-Survey
How much do you agree with the following? The support I receive through Project C.A.R.E. is playing a role in keeping my care recipient at home and out of a long-term care facility.	
Strongly agree	59%
Agree	32%
Disagree	8%
Strongly disagree	1%

How does or how can Project C.A.R.E. support keeping your care recipient at home?

Reponses to this question were very positive. A complete list of responses is included in Appendix D. Representative comments from five caregivers are listed below:

- It is very expensive to hire home care; even a student is $15/hour. For someone on a tight budget, this is a lot of money. My husband is at a full-time job without me having to work, so any amount of money that allows me to take a breather and hire someone is awesome. I have had minimum family support since he got sick. Also, loss of all his friends. That has been devastating. This [Project C.A.R.E.] has been a renewal of faith. Thank you!
- Because without the help your support gave me after surgery, I would have had to put my husband in a nursing home.
- It was very beneficial, because it is very costly paying out of pocket for respite services. The voucher allowed me to have some financial assistance, as well as provided adequate care for my father with people that I trust.
- Sessions with our consultant were informative and gave us many options; she did not judge us as to our wishes or questions regarding care.
- Gives me a much-needed break to care for myself. Respite care consultants are the only ones that have ever helped with anything and I felt like somebody listened to me and cared. I have contacted other agencies I thought would be helpful. Not one time has anyone helped or even pretended to care or offered any kind of support or glimmer of hope for a better life as a caregiver. Thank you!

Overall Support from Project C.A.R.E. (continued)	Post-Survey

Is there anything you would like to tell us about your respite or care management experience?

Responses to this question were overwhelmingly positive both in terms of the value of the respite vouchers and the information and support provided by the Project C.A.R.E. family consultants. A complete list of responses is included in the Appendix D.

Representative comments from five caregivers are listed below:

- I am not only the caregiver for my husband. I am also the caregiver for my mother, who is 89-years-old and father, who is 90-years-old. There is no one else but me to do this; that's why I am so thankful for the program.
- I appreciated the opportunity to take some time for myself, so that I could clear my mind, refresh, and then take up my responsibilities again with a more positive attitude.
- If it had not been for respite care and support, I would have had a breakdown and/or not had my husband at home as long as he was—so needed for all caregivers.
- The voucher that I received from the project helped me immensely. At the time it was awarded, I was completely exhausted. I was so tired, and it really helped me beyond measure.
- The family consultant was extremely helpful. She explained the program and had to repeat things several times, but never became inpatient with me. When the program started, I was very stressed, but she encouraged me and kept giving me ideas on how to utilize the program to our benefit. I probably would not have followed through if it had not been for her. I am very pleased with the experience.

Discussion

Factors Impacting Initiative

During the time frame when the CMQI was being implemented, Project C.A.R.E. was undergoing a major transition. When the initiative was being conceptualized during fall 2015, Project C.A.R.E. had three regional family consultants working with caregivers of individuals with dementia. During state FY 2015-16, these family consultants worked with 220 caregivers in 51 of North Carolina's 100 counties. There were no respite vouchers available for the family consultants to award to caregivers.

In June 2016, the NC General Assembly passed Session Law 2016-94 (House Bill 1030), providing funding to expand Project C.A.R.E., including $550,000 for FY 2016-17. This funding enabled Project C.A.R.E. to double the number of family consultants from three to six, and to expand the reach of the program statewide. The funding also created the new position of Dementia Services Coordinator within DAAS. The long-time Project C.A.R.E. Coordinator moved to this position during fall 2016, and a new Project C.A.R.E. Coordinator began in Jan. 2017.

The legislation also provided funding for about 550 new respite vouchers for FY 2016-17, in addition to the 108 available through MFP funding for the CMQI. The addition of these new respite vouchers, to be used within a limited time frame, necessarily shifted the focus of the Family Consultants more toward the awarding and use of the vouchers, with less emphasis than originally intended on the care management process. This shift resulted in some departures from the planned protocols, including some assessments and care planning being done by phone rather than in person, and more limited time for follow-up with individual caregivers.

As stated earlier, the target date for conducting post-surveys was 120 days after the respite voucher award date to allow 90 days for the caregiver to use the voucher, with the possibility of a 30-day extension. Our intent had been that post-survey responses would be based on all participating caregivers receiving just one $500 voucher. Based on caregivers' needs, family consultants awarded some caregivers two or three vouchers before these caregivers completed the post-survey. Thirty-eight caregivers received two vouchers, and 14 received three vouchers. (Project C.A.R.E. allows up to three $500 vouchers per year). It is not known how these additional vouchers impacted post-survey responses for individual caregivers.

Positive Results

During state FY 2016-17, Project C.A.R.E. family consultants supported 569 caregivers of individuals with Alzheimer's disease or related dementias in 94 counties and awarded 759 respite vouchers. These numbers include those caregivers who were part of the CMQI.

The caregiver assessment and care planning process are now embedded in the program, and there is greater quality and consistency in the Project C.A.R.E. services provided by family consultants across the state. The process of awarding and tracking the utilization of respite vouchers has greatly improved since FY 2016-17, with the creation of real-time reports beginning in FY 2017-18, which reflect the impact in all 100 counties and the number of new caregivers in the program.

Most importantly, those caregivers of individuals with dementia are receiving support through the improved care management processes and have access to often desperately needed respite vouchers.

Two measures of caregiver self-efficacy, confidence in locating available community resources and confidence in knowing where to turn to get answers to their questions, showed a statistically significant increase from pre-survey to post-survey. There were also marked decreases from pre- to post-survey in the percentage of caregivers considering or taking steps toward facility placement or discussing the possibility of placement with family members or care recipients.

In addition, caregivers reported very positive experiences:

- 95 percent of responding caregivers received a respite voucher from Project C.A.R.E., and 96 percent of those used at least part of it
- 97 percent were either extremely satisfied or very satisfied with the respite services they received through Project C.A.R.E.
- 94 percent reported that their Project C.A.R.E. family consultant talked to them about effective ways to plan for and use their respite voucher
- 84 percent either strongly agreed or agreed that they used their respite plan to do something they enjoyed, and felt that the respite time was "time well spent"
- 96 percent reported that it was not at all difficult or only slightly difficult to locate and hire a respite provider
- 99 percent reported that it was not at all difficult or only slightly difficult to get reimbursed for their respite
- 95 percent spent at least half of their respite voucher
- 95 percent were either extremely satisfied or very satisfied with the care planning process or help they received from their Project C.A.R.E. family consultant
- 91 percent either strongly agreed or agreed that Project C.A.R.E. was playing a role in keeping their care recipient at home and out of a long-term care facility

Because of the successful experience with the use of standard care management tools in Project C.A.R.E., DAAS will be examining the adoption of these tools for caregivers of individuals with dementia in the Family Caregiver Support Program.

Areas for Program Improvement/Next Steps

During the CMQI, the Project C.A.R.E. Director found that some family consultants had more experience than others in conducting assessments leading to written, person-centered plans of care. Additional training on this was provided at the semi-annual meetings for Project C.A.R.E. family consultants in Aug. 2017 and Feb. 2018. In addition, the Project C.A.R.E. Director provided on-site technical assistance visits in spring and fall 2017 to all Project C.A.R.E. offices, along with annual monitoring visits in spring 2018 to facilitate the consistent adoption of caregiver assessment and care planning activities.

The DAAS evaluator was able to break out pre- and post-survey responses according to the AAA region where the caregivers lived. Since the Project C.A.R.E. regions are comprised of varying numbers of AAA regions, this made it possible for evaluation results to be compiled according to a Project C.A.R.E. region and family consultant. These regional results will be shared with the family consultants.

Data from the pre- and post-surveys indicated higher caregiver household income levels than might have been expected. While Project C.A.R.E. services are not based on income, the program gives priority to low-income, rural and minority caregivers and actively targets those who may be underserved through a variety of outreach efforts. As the family consultants' experience with the standardized assessment and care planning tools grows, they will be better equipped to determine which caregivers

are most in need of respite vouchers provided by Project C.A.R.E. and which caregivers would benefit most from assistance in locating private pay options.

Only 16 percent of the caregivers responding to the post-survey indicated that they had received additional services because of their care planning process with the Project C.A.R.E. family consultants. It is possible that the caregivers were already connected to the services they needed that were available in their areas, or that the services they needed were unaffordable, not available in their areas or had long waiting lists. As family consultants continue to learn more about the services and resources available in the counties in their regions, they are partnering with AAAs, discharge planners, home care and adult day providers, senior centers and others to find available services and supports, and to help caregivers connect to those services, when appropriate.

On the question related to whether their loved one would have to be placed in a facility if they could not continue to provide care, 61 percent of the caregivers responding to the post-survey indicated that their loved ones would have to be placed and 29 percent did not know, or were unsure, what would happen. These figures show the fragile nature of many caregiving situations and the need to help caregivers plan for future care needs. This is an area that may require additional training to help family caregivers approach planning for future needs, while remaining sensitive to caregivers' emotional and financial readiness to address this topic.

For those caregivers who did not respond to the post-survey by email or mail, DAAS staff made follow-up calls and completed some surveys by phone. From conversations with caregivers, DAAS staff learned that some were using their respite vouchers to purchase extra help with home management tasks and personal care services for their loved ones, rather than taking respite time for themselves. It is not known how many caregivers may have used their vouchers in this way or exactly why. Some caregivers may not have been comfortable leaving their loved ones with someone else, or the home management and personal care services they purchased were unaffordable or unavailable otherwise. It is still common for caregivers to confuse in-home aide services and respite care. While it can be beneficial to caregivers to receive home management and personal care services for their loved ones, family consultants will be encouraged to raise the focus on respite care being a restorative break for caregivers.

Future development areas for Project C.A.R.E. include the implementation of a newly developed screening tool to help family consultants in regions where there are waiting lists and identify those caregivers with the most immediate needs. The Project C.A.R.E. Director and family consultants will also look at capacity issues with this more comprehensive assessment and planning process. In addition, Project C.A.R.E. will work to develop additional sources to refer caregivers to the program and to expand the network of referrals that family consultants make to community service providers.

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Appendices

Appendix A Care Management Tools

- Original Caregiver Assessment Tool (October 2016)
- Original Action Plan/Care Plan (October 2016)
- Revised Caregiver Assessment Tool (July 2017)

Appendix B Respite Voucher Packet

- What Is Project C.A.R.E.?
- What Is Respite?
- Making Respite Time More Effective
- Setting Goals to Maximize Respite Time
- Project C.A.R.E. Guidelines
- Respite Voucher Request Procedures
- Sample Respite Voucher Award Letter
- Sample Respite Care Provider Agreement
- Sample Record of Respite Services

Appendix C Project C.A.R.E. Family Consultant Training

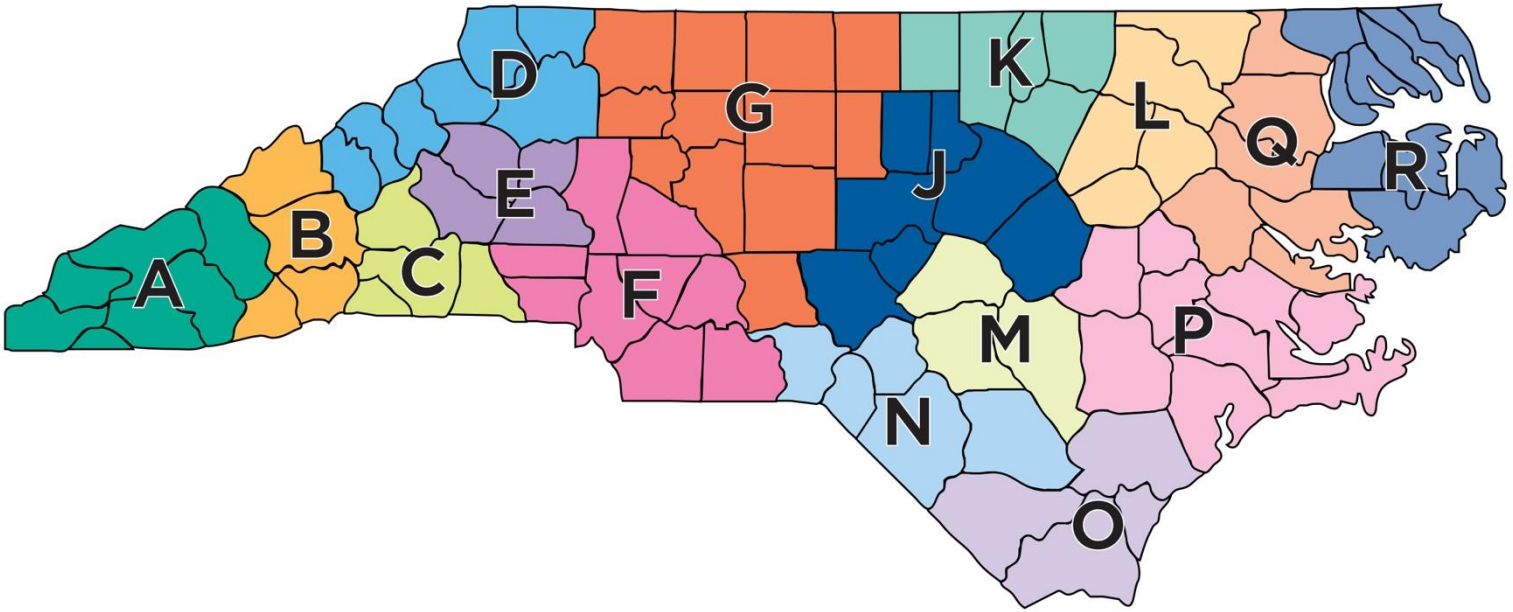
- Agenda for October 24, 2016 Family Consultant Training
- Agenda for November 29, 2016 Family Consultant Training
- Information on Family Caregiver Support Program
- Setting Goals to Maximize Your Respite Time
- Project C.A.R.E. Family Consultant Checklists
- Instructions for Introducing the Pre-Survey to Caregivers

Appendix D Pre- and Post-Surveys

- Pre-Survey
- Pre-Survey Results
- Post-Survey Protocol
- Post-Survey
- Post-Survey Results

Attachment N

North Carolina Area Agencies on Aging Map



- Region A Southwestern Commission
- Region B Land of Sky Regional Council
- Region C Isothermal Planning & Development Commission
- Region D High Country Council of Governments
- Region E Western Piedmont Council of Governments
- Region F Centralina Council of Governments
- Region G Piedmont Triad Regional Council
- Region J Triangle J Council of Governments
- Region K Kerr-Tar Regional Council of Governments
- Region L Upper Coastal Plans Council of Governments
- Region M Mid-Carolina Council of Governments
- Region N Lumber River Council of Governments
- Region O Cape Fear Council of Governments
- Region P Eastern Carolina Council of Governments
- Region Q Mid-East Commission
- Region R Albemarle Commission

Attachment O
Accomplishments of the 2015-2019 NC State Plan on Aging

To move forward, we must look back on the goals established and the work that was accomplished through the 2015-2019 State Plan on Aging. The NC Division of Aging and Adult Services (DAAS) made strides in the areas of health and long-term care options, aging in place, health, safety, collaboration and accountability. The following are some of the significant highlights of the 2015-2019 plan.

Safety and Protection

- Expanded public awareness of driver safety resources for seniors by participating in 14 meetings on this issue between 2015 and 2018. Some of the outcomes that came out of these sessions were:
    - Creation of the ncseniordriver.org website, which is devoted to promoting safety for aging drivers with information for drivers, caregivers and professionals.
    - Secured demonstration grant with National Highway Traffic Safety Administration to develop a state plan that expands upon the Governor's Highway Safety Program's older driver priority. This plan includes:
        - Encouraging and facilitating greater communication and collaboration between the leadership in North Carolina Division of Motor Vehicles (NCDMV), the medical review unit, medical providers, social services, law enforcement, the State Unit on Aging (SUA) and traffic engineering in meeting older drivers' needs.
        - Work to develop and implement educational opportunities for the key elements in driver licensing for the medically at risk, medical providers, law enforcement and social and aging service providers.
        - Older driver safety interactive exhibit at Safety Village on senior day at the NC State Fair.
- Expand the investigation of crimes in long-term care facilities:
    - Work was completed on the Voiceless Victims course for the state's community colleges that began in FY2017. The pilot class was conducted in FY2018.
- In FY2015-16, a statewide Elder Abuse Coalition in North Carolina was formed. The Partnership to Address Adult Abuse held dynamic conferences focusing on various aspects of abuse including financial and physical exploitation. The group continues to meet bi-monthly.
- Implemented the North Carolina Council on Development Disabilities (NCCDD) grant Rethinking Guardianship in 2017. In 2016, the statewide group met five times and established three subgroups. These subgroups included the establishment of a common agenda, the collection of statewide and county data and the selection of a county to pilot a project that would help establish an understanding of issues related to guardianship at the county level.
- DAAS continued to be an active member of North Carolina State Emergency Response Team (SERT). The division has increased the number of staffs participating in drills, meetings and exercises with the emergency operations center, and have 100 percent participation in those exercises that require division input. Staff was deployed to assist during both Hurricane Matthew and Hurricane Florence.
- Five-hundred-forty community education training events were conducted statewide over the four-year period. Subjects included: elder abuse and neglect prevention, identification, reporting

elder abuse, and financial exploitation of seniors through the Long-Term Care Ombudsman program.

- Two-hundred-ninety-one long-term care staff received in-services trainings focusing on elder abuse, neglect and exploitation. Training was completed by DAAS' Long-Term Care Ombudsman Program.
- DAAS was able to expand the availability of legal services by strengthening relationships with legal aid societies and the North Carolina Bar Association. There were 10,409 seniors served with legal aid over the four-year period.

Remaining independent and aging in a place of choice

- DAAS increased awareness of housing and home improvement services and promoted mobility and accessibility services as a means of keeping people in their homes. The number of housing and home improvement providers grew to 29 statewide.
- The number of people served by the housing and home improvement programs between 2015 and 2017, according to DAAS data, totaled 3,254.
- The department, along with the division and County Departments of Social Services programs, increased the availability of the special assistance/in-home (SA-IH) option. The number of statewide active cases rose from 2,980 active cases in 2017 to 3,295 in 2018.
- The DAAS Service Operations Unit utilized wait list information to target regions where enhanced transportation was needed. They worked with the AAAs to create new transportation options, and working with the Eastern Carolina AAA, began a pilot for the implementation of a bus pass program in Wayne County which began Sept. 17, 2018.

Have optimal health status and have a healthy lifestyle

- Total state appropriation for Project C.A.R.E. for FY2018 was $1,033,333, which increased from $850,000 in FY2017. Eight-hundred-eighteen caregivers received care consultation services and 630 caregivers were awarded at least one voucher (max of three) for the fiscal year.
- March 2016: In partnership with NC DAAS, the NC Institute of Medicine published "Dementia-Capable North Carolina: A Strategic Plan Addressing Alzheimer's Disease and related Dementia." At the close of FY2017, action was underway, making progress on the recommendation.
- DAAS received appropriations for two FTEs to coordinate the No Wrong Door (NWD)/2-1-1 Initiative, oversee the strategic plan and work on developing dementia-capable communities.

Senior Center Advocacy

- DAAS worked very closely with the NC Senior Center Alliance to facilitate their reorganization, establish an advocacy subcommittee, and advise on statewide advocacy events. In 2015, an official advocacy subcommittee was formed.
- Established a goal to sponsor a minimum of three statewide advocacy events per year that met Senior Center Operations and Program Evaluation (SCOPE) requirements.
- February 2016, Senior Centers sent valentines to legislators to support senior centers (over 100 senior centers participated, sending more than 1,000 letters).
- Advocacy training was provided to senior center participants across the state.

- Held Many Faces of My Senior Center event for legislators to highlight the importance and diversity of senior centers.
- In 2017, there was a statewide event to invite Senior Tarheel Legislators (STHL) to senior centers.
- Letters were sent to representatives in support of STHL priority for increased senior center general purpose funding.
- Thanksgiving cards were sent to legislators, thanking them for supporting senior centers
- The STHL subcommittee chair presented to the General Assembly subcommittee on aging
- Volunteer requirements were met through Senior Center Certification Program.
- Certified senior centers increased from 163 to 171.
- Three training sessions were held through the Senior Center Leadership Symposium.
- DAAS worked to expand education/awareness of seniors within the Lesbian, Gay, Bisexual and Transgender (LGBT) community. Six learning sessions were offered in 2016 to increase awareness of working with the LGBT Community.
- Held six two-day trainings for senior center certification through the Ann Johnson Institute.

Ensure public accountability and responsiveness

- Implemented standards in the NCI-ID for HCCBG and Medicaid-funded services by conducting surveys and interviews and developing reports. This was accomplished for fiscal year 2016-17, and the results of the survey were posted on the DAAS website and shared with stakeholders.
- Strengthened DAAS's process for fiscal monitoring of grants and contracts by incorporating a tracking system in 2016.
- A process was started in 2018 to ensure AAAs are notified within 30 days of their monitoring site visit.

Attachment P
Acronyms, Abbreviations and Web Resources

North Carolina State Government Offices and Agencies

DCR	Department of Cultural Resources www.ncdcr.gov/
DHHS	Department of Health and Human Services www.ncdhhs.org
DAAS	Division of Aging and Adult Services www.ncdhhs.gov/aging/index.htm
DHSR	Division of Health Service Regulation www.ncdhhs.gov/dhsr/
DIRM	Division of Information Resource Management www.ncdhhs.gov/dirm/
DMA	Division of Medical Assistance www.ncdhhs.gov/dma/
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services www.ncdhhs.gov/mhddsas/index.htm
DPH/CDI	Division of Public Health www.publichealth.nc.gov/
DSB	Division of Services for the Blind www.ncdhhs.gov/dsb/index.htm
DSDHH	Division of Services for the Deaf and Hard of Hearing www.ncdhhs.gov/dsdhh/
DSS	Division of Social Services www.ncdhhs.gov/dss/index.htm
DVR	Division of Vocational Rehabilitation www.ncdhhs.gov/dvrs/
ORHCC	Office of Rural Health and Community Care www.ncdhhs.gov/orhcc/
DOI	Department of Insurance www.ncdoi.com/

DOJ	Department of Justice www.ncdoj.gov/
DOT	Department of Transportation www.ncdot.gov
DES	Division of Employment Security https://desncc.com/deshome
NCBSE	North Carolina Board of State Elections www.sboe.state.nc.us/
NCCCS	North Carolina Community College System www.nccommunitycolleges.edu/
NCCDD	North Carolina Council on Developmental Disabilities http://www.nc-ddc.org/
NCCVCS	North Carolina Commission on Volunteerism and Community Service www.volunteernc.org/
NCHFA	North Carolina Housing Finance Agency www.nchfa.com/

North Carolina Regional or County Government

AAA	Area Agency on Aging www.ncdhhs.gov/aging/aaa.htm
LME/MCO	Local Management Entity/Managed Care Organization, the regional organization that manages the delivery of public mental health services www.ncdhhs.gov/mhddsas/lme-mcomap4-1-14.pdf
EBCI	Eastern Band of Cherokee Indians http://nc-cherokee.com/

Federal Government

ACL	Administration for Community Living, U.S. Health and Human Services www.acl.gov
ADA	Americans with Disabilities Act www.ada.gov/

AoA	Administration on Aging, U.S. Health and Human Services www.aoa.gov
CDC	Centers for Disease Control and Prevention www.cdc.gov
CMS	Centers for Medicare and Medicaid Services www.cms.gov
HHS	U.S. Department of Health and Human Services www.hhs.gov
HUD	U.S. Department of Housing and Urban Development www.hud.gov
IRS	Internal Revenue Service www.irs.gov
MIPPA	Medicare Improvements for Patients and Providers Act
OAA	Federal Older Americans Act www.aoa.gov/aoaroot/aoa_programs/oaa/index.aspx
USDA	U.S. Department of Agriculture www.usda.gov

Other Organizations and Partnerships

AARP NC	AARP NC, the North Carolina chapter of AARP www.aarp.org/states/nc/
CCME	Carolinas Center for Medical Excellence www.thecarolinascenter.org/
DDTI	UNC's Developmental Disabilities Training Institute www.unc.edu/depts/ddti/
FORLTC	Friends of Residents in Long-term Care www.forltc.org
GAC	Governor's Advisory Council on Aging www.ncdhhs.gov/aging/gaclist.htm
NCAOA	North Carolina Association on Aging www.ncaoa.org/

NC4A	North Carolina Association of Area Agencies on Aging
NCACDSS	North Carolina Association of County Directors of Social Services http://www.ncacdss.org/
NCALTCF	North Carolina Association of Long-Term Care Facilities http://www.ncaltcf.com/
NCANPHA	North Carolina Association of Non-Profit Homes for the Aging http://www.ncanpha.org/
NCCOA	North Carolina Coalition on Aging www.nc4a.org
NCCCN	North Carolina Community Care Network www.communitycarenc.com/
NCBAM	North Carolina Baptist Aging Ministries www.ncbam.org/
NCIOM	North Carolina Institute of Medicine www.nciom.org
NCSDSC	North Carolina Senior Driver Safety Coalition www.ncdot.org/doh/preconstruct/traffic/ECHS/groups/older.html
NCSG	North Carolina Senior Games www.ncseniorgames.org/
WDS	Workforce Development System
UNC CARES	Center for Aging Research and Educational Services, Jordan Institute for Families, School of Social Work, University of North Carolina at Chapel Hill http://ssw.unc.edu/cares/cares.htm

Grants, Projects and Programs

ARMS	Aging Resources Management System, Division of Aging and Adult Services www.ncdhhs.gov/aging/arms/armsforms.htm
APS	Adult Protective Services, Division of Aging and Adult Services www.ncdhhs.gov/aging/adultsvcs/afs_aps.htm
BRFSS	Behavioral Risk Factor Surveillance System, Division of Public Health www.epi.state.nc.us/SCHS/brfss/

CAC	Community Advisory Committee volunteer advocates appointed by county commissions who are part of the Long-Term Care Ombudsman Program www.ncdhhs.gov/aging/ombud/cac.htm
CAP-DA	Community Alternatives Program for Disabled Adults, Division of Medical Assistance www.ncdhhs.gov/dma/services/capda.htm
CAP-Choice	Community Alternatives Program for Disabled Adults, consumer-directed option, Division of Medical Assistance www.ncdhhs.gov/dma/services/capchoice.htm
Project C.A.R.E.	Caregiver Alternatives to Running on Empty, Division of Aging and Adult Services www.ncdhhs.gov/aging/ad/NCAlzDemo.htm
CDSMP	Chronic Disease Self-Management Program Grant—known in North Carolina as *Living Healthy,* Division of Aging and Adult Services www.ncdhhs.gov/aging/livinghealthy/livinghealthy.htm
EBP	Evidence-based Programs www.healthyagingprograms.org/content.asp?sectionid=32
FCSP	Family Caregiver Support Program, Division of Aging and Adult Services www.ncdhhs.gov/aging/fchome.htm
FNS	Food and Nutrition Services (formerly known as Food Stamps) www.ncdhhs.gov/dss/foodstamp/
HCCBG	Home and Community Care Block Grant, Division of Aging and Adult Services www.ncdhhs.gov/aging/manual/hccbg/hccbg.htm
Healthy IDEAS	Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), an evidence-based program that develops the capacity of older adult care providers in the community to detect depression and intervene effectively. healthyideasnc.web.unc.edu/
Home Care Independence	Consumer-directed option through Home and Community Care Block Grant, Division of Aging and Adult Services www.ncdhhs.gov/aging/CDS/cds.htm
ILR	Independent Living Rehabilitation, Division of Services for the Blind www.ncdhhs.gov/dsb/services/independent.htm
ILRP	Independent Living Rehabilitation Program, Division of Vocational Rehabilitation www.ncdhhs.gov/dvrs/pwd/ils.htm

LIS	Low-Income Subsidy or “extra-help” provides financial assistance for Medicare beneficiaries with limited income and resources www.ssa.gov/prescriptionhelp/
MFP	Money Follows the Person, Division of Medical Assistance www.ncdhhs.gov/dma/MoneyFollows/
MOB	A Matter of Balance, evidence-based fall prevention program www.ncoa.org/improve-health/center-for-healthy-aging/a-matter-of-balance.html
MOST	Medical Orders for Scope of Treatment www.ncdhhs.gov/dhsr/EMS/dnrmost.html
MSP	Medicare Savings Program is a Medicaid program for people who have Medicare and have limited income and resources, Division of Medical Assistance www.ncdhhs.gov/dma/medicaid/medicare.htm
NWD	No Wrong Door, Division of Medical Assistance www.acl.gov/Programs/CDAP/OIP/ADRC/Index.aspx
NCATP	North Carolina Assistive Technology Program, Division of Vocational Rehabilitation www.ncatp.org/index.htm
PACE	Programs of All-Inclusive Care for the Elderly, Division of Medical Assistance www.ncdhhs.gov/dma/services/pace.htm
PCP	Person-centered Planning www.unc.edu/depts/ddti/pct-training.html
SA-ACH	Special Assistance Adult Care Home Program, Division of Aging and Adult Services www.ncdhhs.gov/aging/adultsvcs/afs_special.htm
SA/IH	Special Assistance In-Home Program, Division of Aging and Adult Services www.ncdhhs.gov/aging/adultsvcs/afs_sa_inhome.htm
S.A.F.E.	Strategic Alliances for Elders in Long-Term Care, Division of Aging and Adult Services www.ncdhhs.gov/aging/pub/safe.pdf
SAGE	Advocacy and Services for LGBT Elders www.lgbtcenterofraleigh.com
SCSEP	Senior Community Service Employment Program www.ncdhhs.gov/aging/scsep.htm
SFMNP	Seniors’ Farmers Market Nutrition Program, Division of Aging and Adult Services www.fns.usda.gov/wic/SeniorFMNP/SeniorFMNPoverview.htm

SHIIP	Seniors' Health Insurance Information Program, Department of Insurance www.ncdoi.com/shiip/default.asp
SMP	Senior Medicare Patrol, NC Department of Insurance www.ncdoi.com/SHIIP/SMP/shiip_smp_home.asp
SSBG	Social Services Block Grant www.acf.hhs.gov/programs/ocs/programs/ssbg
SSI	Supplemental Security Income www.ssa.gov/ssi/
STHL	North Carolina Senior Tar Heel Legislature www.ncdhhs.gov/aging/sthl.htm