



BUILDING A LIVABLE AND SENIOR-FRIENDLY NORTH CAROLINA

GOVERNOR'S CONFERENCE ON AGING

REPORTS FROM THE GOVERNOR'S AGING POLICY ROUNDTABLES

Access and Choice in Services and Supports

Economics of Aging

Health and Aging

Homes and Neighborhoods

Lifelong Engagement and Contributions

Safe Communities



October 13–15, 2010
Sheraton Imperial Hotel, Durham, NC

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Opinions expressed in these essays are those of the authors and do not necessarily reflect the opinions or policies of the Governor's Office, the University of North Carolina Institute on Aging, or NC Division of Aging and Adult Services.

References and additional resources are available on the University of North Carolina Institute on Aging's website, <http://www.aging.unc.edu/service/preparing/papers/>.

1 INTRODUCTION

The Governor's Conference on Aging in North Carolina culminates a year of preparation and activities associated with Governor Perdue's *Living Wise and Aging Well* initiative. As a leader whose passion for aging and health care issues propelled her into public service, Governor Perdue has long recognized the significance of our aging population.

While North Carolina ranks nationally 10th in total population, we rank 9th in the size of the population age 60 and older, 10th in the size of the population age 85 and over, and 6th in grandparents responsible for raising grandchildren under 18 years old (2008, ACS). Population projections show that by the year 2030—when the youngest baby boomers are age 66—one of every four North Carolinians will be 60 or older. Between 2010 and 2030, our population age 60 and older will nearly double from 1.2 million to 2.1 million.

By 2030, 71 of North Carolina's counties are projected to have more people over age 60 than under age 17.

This population growth has important implications for every segment of society. There has never been a more important time to address the opportunities and challenges of an aging population to assure that North Carolina remains a leading livable and senior-friendly state.

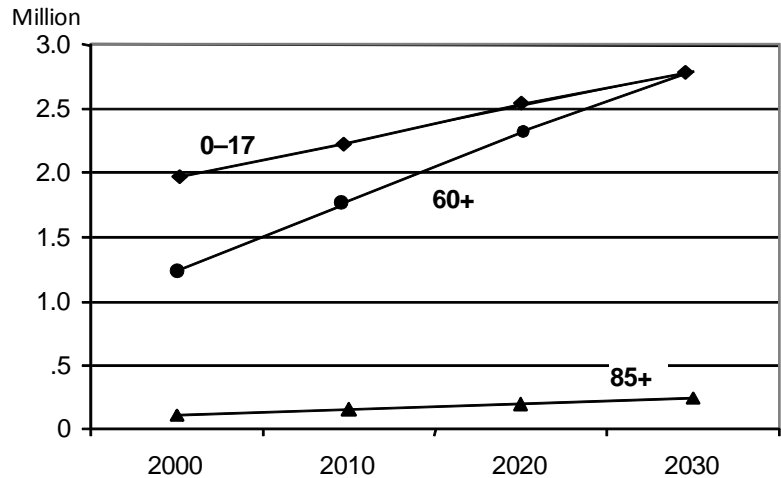
Planning for the Conference

To prepare for the conference, there were several initiatives to gather information at the community level.

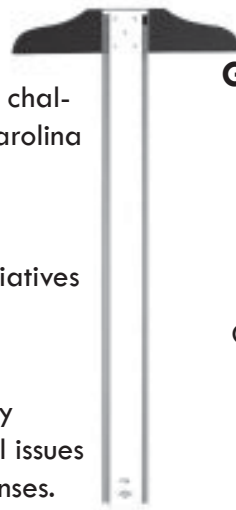
Governor's Aging Policy Roundtables

This past spring a series of six Governor's Aging Policy Roundtables were hosted regionally to identify critical issues that require effective policy and programmatic responses. These roundtables were offered through a collaborative effort of the Office of the Governor and her Advisory Council on Aging, the NC Division of Aging and Adult Services, the University of North Carolina (UNC) Institute on Aging, and the North Carolina Association of Area Agencies on Aging. More than 600 participants included older adults, aging boomers,

Growth of Various Segments of North Carolina's Population, 2000 to 2030



Source: State Data Center



Governor's Aging Policy Roundtables

Access and Choice in Services and Supports

Asheville, May 10, 2010

Economics of Aging

Greensboro, April 28, 2010

Health and Aging

Greenville, April 22, 2010

Homes and Neighborhoods

Charlotte, May 25, 2010

Lifelong Engagement and Contributions

Boone, May 19, 2010

Safe Communities

Wilmington, June 2, 2010

caregivers, advocates, government officials, faith-based leaders, representatives from local businesses and organizations, educators, and researchers—among others. Those who were unable to participate in person could provide their input online. Each of the six roundtables focused on a major area that mirrors those of the conference.

All the issues identified at the roundtables were subsequently shared with the participants, and white papers were written by content experts based on these issues for use in the policy sessions at the Governor's Conference. In addition, the Department of Health and Human Services shared the results of the roundtables with more than 120 key informants and invited them to give their views on what actions North Carolina should take. They were reminded of the serious economic and budget situation we face and the importance of identifying priorities and creative approaches to maximize the effect of available resources. Using a web-based survey, this diverse group of content experts and opinion leaders have given their ideas about existing policies and programs, immediate and longer-term actions that could make a positive difference without requiring new resources, and wise investments for the future of aging in the state that would require additional resources. Results of this survey will be shared during the conference's policy sessions.

State Aging Readiness Assessment Survey

For the first time in North Carolina's history, the state is undertaking a serious examination of its readiness to meet the opportunities and challenges of an aging population. Through Executive Order 54, Governor Perdue called upon her cabinet agencies to participate in this assessment and also encouraged other state agencies to do the same, including those under the authority of The Board of Governors of the UNC System, the State Board of

Community Colleges, the State Board of Education, and the Council of State. The Governor instructed the Division of Aging and Adult Services and her Policy Office to work with the UNC Institute on Aging and her Advisory Council on Aging to carry out the assessment. Nearly all state agencies have designated an Aging Liaison to assist with the assessment, which is focused on such topics as the aging of the workforce; implications for policies, planning, and resources; use of adaptive and smart technologies; modifications of the built environment; work with the private sector, local governments, and seniors themselves; and best practices. Preliminary results of the state assessment, which will be reported at the conference, were used in shaping the policy sessions. Governor Perdue is also encouraging completion of a local assessment, to be undertaken following the state-level assessment.

At the Conference

Information gathered from the policy roundtables, the state agency readiness assessment survey, and the content experts' survey will be shared at the policy and plenary sessions to aid participants in recommending strategies to guide future state policy and programs. The recommendations of the conference participants will help *draft the plan* for building a more livable and senior-friendly North Carolina. This is a starting point—the work of conferees will form the basis of the *State Aging Plan* for 2011–2015. More importantly, it will lay the groundwork for day-to-day efforts to meet the challenges of our aging population and also realize the many benefits of a mature society. We must all share a commitment to what Governor Perdue set as our overarching goal: *Building a Livable and Senior-Friendly North Carolina for Living Wise and Aging Well*.

TOP THREE ISSUES FROM THE POLICY ROUNDTABLES

(Examples of comments or concerns are shown for each issue.)

Access and Choice in Services and Supports

Asheville, May 10, 2010

- ◆ **Inadequate funding to support aging-in-place**
Need for community-based services, in-home services, and family caregiver supports
- ◆ **Lack of awareness and understanding among people about their choices in care and about possibilities for aging-in-place**
Difficulties in navigating a complex and fragmented system, inadequate information and assistance
- ◆ **Lack of transportation**
Rural areas, eligibility, inflexible options, affordability, inadequate linkage between housing and transportation

Economics of Aging

Greensboro, April 28, 2010

- ◆ **Inadequate responses to a wide range of workforce issues**
Skills training and job options for older workers, succession planning, job flexibility and supports for working caregivers, incentives for entrepreneurs and small businesses responding to the aging population, shortage of health care workers
- ◆ **Concerns about health care provision and cost**
Paying for medications, health care cost/fraud/abuse, lack of primary care doctors for Medicare patients, end-of-life issues, support for aging-in-place, fragmentation of services
- ◆ **Insufficient opportunities for education and engagement**
Opportunities for older adults to start businesses, education of employers on value of older workers, training at community colleges, financial and life/retirement planning, volunteerism

Health and Aging

Greenville, April 22, 2010

- ◆ **Need to strengthen link between health care and community service providers**
Integrating aging and medical services, enhancing communications, developing holistic approach, expanding support and resources for family caregivers
- ◆ **Shortage of trained health and allied health professionals who support an interdisciplinary approach**
Geriatricians, nurse practitioners, physical and occupational therapists, mental health clinicians, social workers
- ◆ **Lack of support for prevention**
Immunizations, screenings, evidence-based health promotion, wellness education, nutrition

Homes and Neighborhoods

Charlotte, May 25, 2010

- ◆ **Accessibility of housing**
Universal design, affordable and accessible housing, wheelchair access, care of home and property, zoning codes
- ◆ **Inadequate options for transportation and mobility**
Availability and accessibility of transit, lack of routes in rural areas, road design and signage, driver and pedestrian safety, funding, need for greater public and private collaboration
- ◆ **Inadequate personal education and preparedness (planning before a crisis)**
Awareness of continuum of options and services, education about and preparation for, consumer counseling, redesigning homes before a crisis, education of builders on universal design

Lifelong Engagement and Contributions

Boone, May 19, 2010

- ◆ **Lack of funding**
Support for lifelong learning and engagement, including programs for engagement, financial aid for continuing education, inadequate infrastructure for volunteerism
- ◆ **Fragmentation among agencies**
Lack of a cohesive network, confusion about how to connect with system, duplication of effort, missed opportunities and inefficiencies
- ◆ **Need for new terminology and approaches to volunteering**
Changing nature of the volunteers as boomers grow older

Safe Communities

Wilmington, June 2, 2010

- ◆ **Insufficient training and support for family caregivers**
Importance of respite care, including caregivers of persons with dementia and grandparents raising grandchildren, stress relief, access to resources
- ◆ **Growing concerns about abuse, neglect, and exploitation**
Identification and reporting of self-neglect, need to train and use public service employees as first line of defense for adult protective service reporting, address resistance to reporting
- ◆ **Lack of affordable housing and need to support proven services**
Value of services connected to affordable housing to support community living, lack of in-home support services and affordable home health care, reward for accountability

2 ACCESS AND CHOICE IN SERVICES AND SUPPORTS

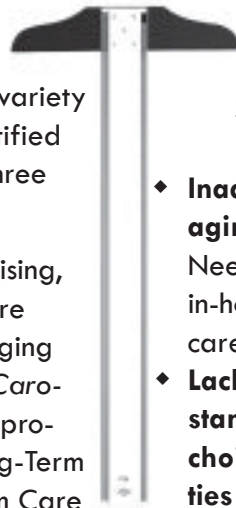
Participants at the regional roundtable on access and choice discussed the many facets of providing assistance to older adults and their family caregivers in a variety of settings and circumstances. While participants identified many barriers to access and choice, they agreed on three primary areas of concern, noted at the right.

Their principal concerns should not be especially surprising, because they are often heard in local meetings and are noted in the plans and reports of Area Agencies on Aging and others. The *2001 Long Term Care Plan for North Carolina*, prepared by an Institute of Medicine Task Force, produced recommendations related to “Entry into the Long-Term System” and the “Availability and Need for Long-Term Care Services.” This work, and that of others, has led North Carolina to pursue and secure several federal grants to help design and transform the disjointed system of care into one that is more accessible and understandable, not only for older adults, but for adults of all ages with disabilities, so that they and their families can exercise more choices about living arrangements and services and supports. While there has been progress—highlighted below—clearly there is more to do.

Concerns about Funding

Concerns about funding ranged from the general (“lack of funding” and “cutbacks in funding for home and community care”) to the more specific (e.g., support for “money follows the person services,” “not enough funding for home repairs”). Special concerns focused on the difficulties of people who are not impoverished enough to qualify for Medicaid services and cannot afford to pay for services themselves. The so-called “near-poor” especially struggle with access and choice, and they represent a sizable portion of seniors. Nearly 20% of those ages 65 to 74 live on incomes between 100% and 200% of the poverty level—that is, between \$10,830 and \$21,660 for an individual and \$14,570 and \$29,140 for a couple. For people age 75 and older, the rate is 30%.

In 1992, with the predicament of people in this middle ground in mind, the NC General Assembly established the Home and Community Care Block Grant (HCCBG), with counties asked to develop a funding plan for their allocation among 18 possible services (e.g., home-delivered meals, in-home aide, adult day services). In state fiscal year (SFY) 2009–10, HCCBG funding totaled about \$57.7 million, with 52% (about \$29.8 million)



Access and Choice in Services and Supports

Asheville, May 10, 2010

- ◆ **Inadequate funding to support aging in place**
Need for community-based services, in-home services, and family caregiver supports
- ◆ **Lack of awareness and understanding among people about their choices in care and about possibilities for aging in place**
Difficulties in navigating a complex and fragmented system, inadequate information and assistance
- ◆ **Lack of transportation**
Rural areas, eligibility, inflexible options, affordability, inadequate linkage between housing and transportation

being state money. From 2000 to 2010, there was a net increase of \$4.5 million in state appropriations for HCCBG (average growth of 1.77% per year), but there was no change in SFY 2010–11.

HCCBG services target the socially and economically needy. For example, the average home-delivered meals recipient is 80 years old, female, reporting income below poverty, and is at high risk of malnutrition. As of April 2010, an estimated 12,600 seniors were waiting for home and community services through HCCBG providers, with the largest wait lists for in-home aide and home-delivered meals. About 80% of Information and Assistance (I&A) providers reported increased requests for I&A, while nearly half (49%) said that community resources to which clients could be re-

ferred had decreased. More than half of HCCBG providers with additional funding through United Way (61%), corporate donations (57%), and private donations (54%) reported reductions or elimination of these funds.

In its 2010 Session, the General Assembly reduced Medicaid's In-Home Personal Care Services (PCS) funding by nearly \$51 million (recurring) and reformed the program to provide care to those persons at greatest risk of needing institutional care—that is, those who require extensive assistance with 2 or more activities of daily living (ADLs; eating, bathing, using the toilet, moving from bed to chair, dressing). These and other changes are prompting a reexamination of a model that the Division of Aging and Adult Services (DAAS) produced in 2005, to help communities evaluate how they support their residents and keep them thriving. The dimensions of this model are shown below. For many of the state's communities, the first issue is whether the service is provided there at all, and closely related is the question of whether there is a sufficient supply of that service to meet the demand.

Six Dimensions of Community Evaluation of Access to Services

1. Existence
2. Adequacy
3. Ease of accessibility
4. Efficiency/duplication
5. Equity
6. Effectiveness/quality

Based on the planning materials developed in 2005 by the NC Division of Aging and Adult Services, <http://www.ncdhhs.gov/aging/localplanning.htm#A>

Lack of Awareness about Choices and Possibilities

Awareness of options for assistance was another area of concern. Participants focused not only on older adults and their families—"So much out there; confusing to know where to go unless someone helps you; a lot of different agencies, duplication of services"—but also on educating health care and human services providers about the types of support available. The key to accessing services and supports is information: If people do not know what possible assistance there is to meet their needs and interests or where or whom to ask about such assistance, the most comprehensive array of services and supports is inaccessible.

In addition, participants identified a fragmented system of care marked by poor communication and turfism, although two people expressed hope for intergenerational partnering and a holistic, interdisciplinary care network. Because caregivers provide the bulk of care for adults with disabilities, participants also identified support for them, through education (especially about caring for people who have dementia), incentives to continue providing care, help for those providing long-distance care, and respite.

Transportation

Not surprisingly, concerns about transportation were high on participants' lists. Transportation issues were identified in nearly all, if not all, of the roundtables. It was likely an issue in this roundtable because the availability of suitable transportation greatly influences access to other services and supports.

Other Issues

As one would expect, roundtable participants identified many additional issues and ideas. Participants discussed a broad array of inadequacies in health and human services, from "lack of preventive care," to access to mental health, dental services, and foot care, to difficulties in affording hearing aids and other technology that supports independent living. Some emphasized the absence or paucity of certain services in rural areas or particular counties. A related concern of participants—important but not limited to rural areas—pertains to the inadequacy of the workforce that serves older adults—from physicians, case managers, and dental and other specialty medical services to direct care workers in home and long-term care settings.

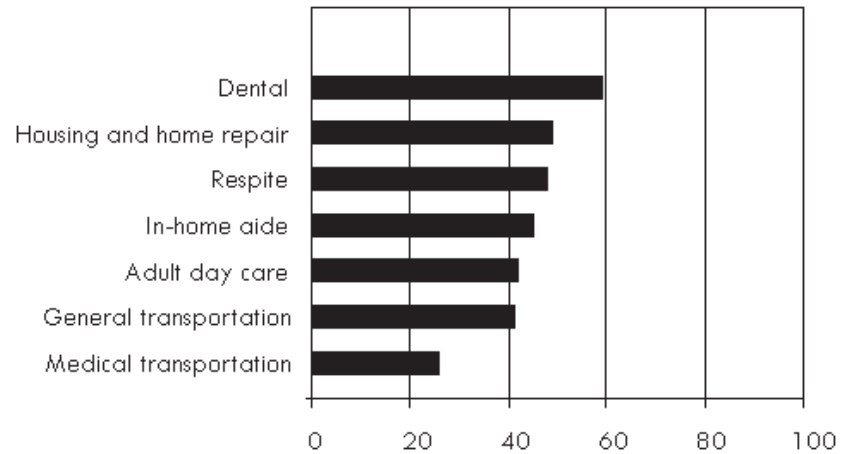
These reports from participants closely mirror some of what the Division of Aging and Adult Services (DAAS) and UNC CARES learned in its February 2010 survey of 671 service providers and administrators in North Carolina's aging service network. Based on a 37% response rate, DAAS was able to gauge some of the most serious service access issues.

Access to dental care was rated by North Carolina's aging services network as the most widespread problem from among 16 services included in the survey. Difficulty accessing dental services was said to be quite prevalent for those on Medicaid—64% of respondents—and especially for those whose incomes were too high for Medicaid, but who could not afford to pay privately (93%). Respondents' other concerns included that dentists do not provide services at home or in facilities to people who are too frail to travel to a dental practice, that few dentists accept Medicaid, and that there is no transportation to dentists in other counties.

At the roundtable, some raised concerns about the availability of services and supports for residents of assisted living and in other settings. This was not a focus of the survey mentioned above. A few participants also mentioned issues surrounding the colocation of older and younger populations in adult care homes as a consequence of inadequate services and supports and limited choices.

Participants also expressed interest and support for the person-centered movement that can expand choices and control for consumers. Everyone seeks to have a balance in their lives between what is "important to" them (that is,

Access to Service Rated as "A Serious Problem" or "One of the Most Serious Problems," North Carolina, March 2010



Of the 16 services respondents were asked to rate, these were deemed serious or one of the most serious problems by at least 20% of respondents.

choices based on personal values) and what is "important for" them (that is, issues of safety and health). When an individual needs to access services and supports, what is important for them often takes priority over what is important to them. Where the services are extensive and somewhat intrusive, what is important to people can be lost. From the perspective of public policy, not enough service, the wrong service, or a service not provided in a way that the individual can use can be as wasteful of public funds as too much service. Identifying individuals' goals and preferences and finding the right fit with available supports not only helps people thrive, regardless of their care setting or arrangement, but stewards limited resources, whether public, private, or individual.

Person-centered principles can be used to meet the needs of various population groups, including older and younger adults who need support. Plans and services developed with people who need relatively little support will differ from plans and services for people who require around-the-clock assistance. Attention not just to needs identified by the provider (health, safety, etc.) but to the preferences and values of the person (challenge, pleasure, choice, etc.) improve the services and the quality of life of those using them. Taking the person-centered notion further, self-directed support enables people who need assistance to move away from formal mechanisms of delivery where services, agencies, and professionals retain control, to a

situation where they can retain more control over their lives and make real choices about the nature and level of support they choose to access from a wide range of networks, options, and opportunities.

North Carolina's Current Initiatives to Improve Access and Choice Better Information

If information is the key to improved access, the "Community Resource Connections" project, designed to provide a "no wrong door" approach to serving adults of all ages who have disabilities, is the state's premier effort. Piloted through a federal grant in 2 counties in 2006, this program extends to 30 counties either operating or developing programs, with plans to reach the entire state. By sharing a common database of resources and clients' information, the goal is to connect people with community support in one stop and prevent their having to tell their stories to multiple providers.

NCcareLINK (www.nccarelink.gov) is the state's developing online searchable inventory of services. In the "Neighborhoods" section at the left of the page is a link to services specifically for older adults that may be searched by county, city, zip code, and address.

There are 2-1-1 services in about half of the counties, funded by local United Way agencies, to connect people by telephone to information about community services. To learn more, visit www.nc211.org.

Additionally, in North Carolina there are 162 senior centers, located in all counties but Gates, Henderson, and Hoke.

Besides providing opportunities for lifelong learning and community engagement, they also function as sources of information and access to services, either at the centers themselves or through referral to other local providers.

Although Medicaid and Medicare provide some security for medical care to people over age 65 or who have disabilities, understanding how to use the system can be difficult. For people whose income is just over the limit for Medicaid, affording the premiums, deductibles, and copayments associated with Medicare may be difficult. North Carolina's State Health Insurance Information Program (SHIIP) is available in all counties to provide free counseling and assistance. Additionally, SHIIP has a federal mandate to identify people who qualify for additional financial help with premiums and out-of-pocket expenses and help them enroll for this assistance, as well as for assistance in paying for medications. SHIIP volunteers are located in all counties, in senior centers, departments on aging, or cooperative extension offices.

Improved Choice and Person-centered Planning

As Ken Burgess points out in a recent article in the *NC Medical Journal*, the rising cohort of boomers have been "presented with more options in all phases of life than any prior generation. . . . So, we should assume they'll arrive at the doors of the state's long-term care facilities armed with this experience of choice and fully expecting, and likely demanding, that this will continue" (p. 164). This may be especially true as they witness their parents' experiences and struggles through their later years.

The federal Centers for Medicaid and Medicare Services have funded initiatives to bring person-centered care both to older adults and to younger adults in the Mental Health, Developmental Disabilities, and Substance Abuse Services system through training of care providers. NC's Office of Long Term Services and Supports has piloted training and organizational development in person-centered services to people in nursing facilities, as well as in adult day care settings. There are two new projects in development to teach person-centered practice to personnel in Community Resource Connections, as well as to hospital discharge planners, to make services more person-centered from first contact with the system to planning difficult transitions among care settings.

People who have choices about what care they receive and how it is provided to them will make more efficient use of those services, because the services support having lives that are meaningful day to day. Regardless of setting—in the community or in an institution—having one’s preferences heard and honored can make the difference between hope and despair.

Programs to Prevent or Delay Care in an Institution

North Carolina has two programs, “Community Alternatives for Disabled Adults” and “Special Assistance In-Home,” that provide support for care at home for people who would qualify for care in a nursing home or assisted living facility, respectively. The first program provides nursing and social work services and support for family caregivers, while the second provides a small monthly cash benefit, case management, and counseling on how to use the money to purchase services that allow people to stay at home. Both programs are available to people whose income qualifies them for Medicaid; the first is a Medicaid waiver program available in all 100 counties, while the second is a state-county partnership available in 91 counties. In both cases, though, the availability of funding limits the number of people who can participate.

Adult day care and day health care services often extend the time people can live with family caregivers by providing a place where people who need supervision or minimal health care can participate in activities during the work day. There are 103 programs in 53 counties.

North Carolina has an exemplary Family Caregiver Support Program, with a specialist in each Area Agency on Aging region. This federally supported program acknowledges that families are the real long-term care system in this country, providing 80 percent or more of the assistance to adults who need support. The goal of this program is to offer counseling about community-based services, assistance in contacting providers, training on caregiving issues, and, to a limited extent, respite for caregivers.

Helping People Return to the Community

“Money Follows the Person” is a federal demonstration project being implemented by the Division of Medical Assistance to help some people who are institutionalized move back into the community. Reorganizing Medicaid services to enable money

to follow people out of institutions is a very complex process that involves shifting state policies, rules, and regulations; adjusting Medicaid funding streams; and supporting communities so that adults with disabilities can receive services at home. North Carolina was awarded the Money Follows the Person Demonstration Grant in May 2007, and the funding will continue until September 2020, by which time it is hoped that the structures will be in place to support those who are eligible to receive services in a nursing home or institution to receive those same services in their homes and communities.

Staff members at the Center for Aging Research and Educational Services (CARES), School of Social Work, The University of North Carolina at Chapel Hill

3 ECONOMICS OF AGING

The economy plays a large part in shaping the lives of older North Carolinians, and the aging population substantially affects the economy in many ways. Much attention is drawn to workforce issues such as retooling the skills of older workers, as well as planning for the retirement of baby boomers, but it is also intertwined with health and health care, challenges to and opportunities for the business community, and perhaps most discussed, the economic security of older adults who risk outliving their resources as they enjoy more years of life. These were among the many topics considered by participants of the regional roundtable on the Economics of Aging. Although this list does not do justice to the roundtable's rich discussion, participants identified three broad themes that encompass many of the discrete issues they identified, and these are shown at the right. These themes are discussed here, but they, in turn, might fit into the four critical issues identified by the North Carolina Center for Public Policy Research: the financial well-being of older adults, workforce challenges, state budget challenges, and the geographical location of older adults.

Economics originally meant "management of the household," and we may consider the economics of aging first from the perspective of individuals and then how that figures in the economics of the state as a whole. Financial security in later years depends on many factors, some of which are under the control of individuals, some of which are not.

Differences within the Aging Population

Diversity of gender, income, race and ethnicity, education and experiences, marital and parental status, health, geographic location, and personal resources are among the variables that provide the context in which people age. The economic divide that exists among today's older population will certainly continue within the generations to follow. The North Carolina Center for Public Policy Research has noted that while today's baby boomers "should reach older age having earned more money and built more wealth . . . this overall prosperity clouds important differences in the distribution of income and wealth, which likely will be much more unequal than has been true in the past" (North Carolina Insight, April 2010, www.nccppr.org).

It is well recognized that older women are generally more economically vulnerable. In North Carolina, about 12% of women age 65 and older live in poverty, compared to about



Economics of Aging

Greensboro, April 28, 2010

- ◆ **Inadequate responses to a wide range of workforce issues**

Skills training and job options for older workers, succession planning, job flexibility and supports for working caregivers, incentives for entrepreneurs and small businesses responding to the aging population, shortage of health care workers

- ◆ **Concerns about health care provision and cost**

Paying for medications, health care cost/fraud/abuse, lack of primary care doctors for Medicare patients, end-of-life issues, support for aging-in-place, fragmentation of services

- ◆ **Insufficient opportunities for education and engagement**

Opportunities for older adults to start businesses, education of employers on value of older workers, training at community colleges, financial and life/retirement planning, volunteerism

6% of men. Moreover, being unmarried (widowed, divorced, separated, or never-married) increases a woman's vulnerability to poverty (NC Study Commission on Aging, 2009). On the other hand, with the closing of male-dominated industries like construction and manufacturing, men are disproportionately represented among the long-term unemployed (lasting more than 6 months), reducing their potential resources for their later years.

The 2009–10 economic downturns hit older African Americans, Latinos, and adults with limited education especially

hard. In North Carolina, about one-fifth of elderly African Americans and Latinos live in poverty, compared to only about 7% of Whites, although the majority of older adults who are poor are also White, because they are the majority racial group. (NC Study Commission on Aging, 2009).

Financial and Retirement Planning

Only a privileged few born in the 1930s, 1940s, and 1950s were able to plan for life after retirement. In 1950, the average retirement age, as well as the average life expectancy, was 68 years, so many older workers did not have the opportunity to enjoy retirement. They remained employed, often in physically challenging jobs. Life expectancy has increased by ten years since 1950, and today's workers are retiring earlier, on average at age 62. Because many people are living longer, healthier lives, financial insecurity is a concern. Most Americans are not saving enough money for retirement, and there is a large discrepancy between what most workers *think* they will need and what they will *actually need*. The Employee Benefit Research Institute (EBRI, www.ebri.org) conducted a confidence survey regarding financial readiness for retirement and found that although 84% of workers are confident that they have enough money to cover basic expenses in retirement, and 75% percent believe they will be able to manage their money so as not to outlive their funds, fewer than one-third had actually tried to calculate how much they would need. The amount of money one can spend each year without running out of funds is far less than most people think. A "sustainable rate of withdrawal" from a nest egg is 3% to 4%

of the principal per year. This means that most Americans would need at least \$1 million to generate an annual income of \$40,000 during retirement.

Efforts to achieve financial security in retirement have historically focused on the "three-legged stool," that is, employer pensions; private retirement accounts (e.g., IRAs and 401(k) plans), savings and assets, and Social Security. In recent years, however, some of the legs of this stool have become a bit wobbly. In addition, dramatic inequalities nationally and in North Carolina shape the quality of life and life expectancy for older adults. The wealthiest seniors (with annual incomes of at least \$34,000) receive almost 80% of their income from earnings (38%), pensions (23%), and assets (17%), with only 20% derived from Social Security. For the poorest seniors (those with annual incomes of \$17,000 or less), 84% of that income comes from Social Security, 4% from public assistance, and only 3% from earnings.

Social Security does provide support, and without it an average person would need to save an additional \$225,000 toward retirement from salary or wages. However, although the highest possible monthly benefit from Social Security is currently \$2,346, in 2009 the average amount paid monthly to individuals was \$1,153, or less than \$14,000 a year, and to couples, \$22,000 (AARP, 2010), so Social Security alone does not replace work-based earnings for many people.

Pensions have become a less reliable support for a variety of reasons. Many workers and farmers in North Carolina's traditional industries—tobacco, textiles, apparel, furniture, and other wood products—have taken early retirement or lost their jobs to outsourcing, downsizing, changes in demand, or enhancements in technology. As they reach traditional retirement age, depending on their circumstance, they may have no pension and few savings and assets.

Even among those with pensions, there is anxiety. Fewer and fewer employers offer *defined-benefit* plans, which promise a specified monthly benefit. If employers offer a pension plan at all, more often it is *defined-contribution*, where employees contribute to the plan, sometimes with a matching amount from the employer (401(k) and 457(k) plans work this way). Defined-contribution plans in particular are subject to market risks, and in the past 15 months, workers in the US who invested in them have experienced a \$2 trillion loss.

For some, the stool must be strengthened by two additional legs—pursuit of earnings and public assistance. According to a 2009 AARP report, 68% of older workers said their retirement income is not enough to live on, 46% currently continue to work to avoid losing their home, and 24% remain in the workforce to be able to cover the cost of personal medical needs for themselves and/or their spouse. Continued employment is crucial for many older adults in the current economic climate, and North Carolinians are facing the same challenges as their peers elsewhere. The NC Employment Security Commission reports that among workers age 55+ there were 40,000 more unemployed in 2009 than in 2000. Among workers age 64 and older, North Carolina ranks twelfth highest nationally in unemployment and forty-third in employment participation (15.4%). However, the rates have not fallen further because many older workers have stayed in the labor force, and earnings for full-time workers age 65 and over have increased (NC Employment Security Commission, April 2010).

For many, loss of their job and pursuit of another can be traumatic. AARP-NC's Mature Workforce Speakers Bureau is helping make a difference—having reached more than 25,000 job seekers and educating employers about the value of older workers. One bright spot is the increasing entrepreneurialism of older adults themselves, discussed at greater length below.

One way to obtain or retain employment after the traditional retirement age is to enhance one's existing skills or acquire new marketable ones, often including technology, and this requires access to educational opportunities. The North Carolina 2010 Budget/Senate Bill 897, Section 8.4. (a) 11 provides for a tuition waiver at community colleges of up to six hours of credit instruction and one course of noncredit instruction per academic semester. These provisions are made for people age 65 and older, who are qualified as legal residents of North Carolina (AARP, 2010).

In addition to courses through the community colleges, there are several on-the-job training programs for older workers. The federal Senior Community Service Employment Program (SCSEP), administered here by the Division of Aging and Adult Services; Senior Service America, Inc.; the National Council on Aging; and the National Center and Caucus of Black Aged, provides paid work-training toward unsubsidized jobs to over 1,500 people with low income who are age 55 and older, unemployed, and have poor employment prospects.

Finally, there are public benefit programs that older adults can use to supplement their income, but often they are not aware of these benefits or decide not to apply for them. Here are just a few examples.

- ◆ There is federally funded support for energy assistance.
- ◆ More older adults qualify for food assistance (formerly food stamps) than apply.
- ◆ The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) authorized funds to reach out to seniors with too much income for Medicaid and inform them about drug assistance programs and “Medicare Savings Programs” that help with Medicare premiums and deductibles.

Many Americans are unprepared for the costs of long-term care services and supports that may be needed in later life. Only a small fraction of North Carolinians have invested in long-term care insurance, but North Carolina's establishment of the Long-Term Insurance Partnership Program may encourage more to do so.

Ageing and the State's Economy **The Ageing Workforce**

As the population is ageing, so is the workforce, and this is not only for older workers themselves but for the state's public and private employers. Although workforce and succession planning are vital to sustaining our future capacity, there are still many employers unprepared for the departure of ageing boomers. As the Conference Board wrote in 2009, “Every time someone retires, skills, knowledge, experience, and relationships walk out the door, which takes time and money to replace” (www.conference-board.org).

Duke Energy provides an example of a private sector company in North Carolina

that has identified the problem and taken steps to confront it. With over 18,000 employees and 4 million customers, it has identified *brain drain* as a critical issue: Almost half of its employees will be eligible to retire in two years, and 43% of its employees are skilled craft workers directly responsible for bringing customers the energy. The company has responded by having its managers assess the risk of *knowledge loss* for the organization, and it has also developed strategies to enhance “knowledge transfer techniques.”

Even in the current times, an increasing number of employers are realizing the value of creating ways to keep older workers engaged. Some are using flexible scheduling and varied job options; others are seeing the importance of offering eldercare assistance. Working caregivers often experience spillover—work demands affect their ability to provide care, and caregiving demands compete with work. Nationally and in North Carolina most caregivers are women in their late 40s, at the peak of their earning power and potential job advancement (see the studies of caregivers at www.metlife.com). Both business and caregivers can suffer, the former through lost productivity and the latter because they reduce the hours they work or stop altogether, which in turn affects their ability to prepare for their own retirement, through loss of earnings, savings, and benefits. SAS, in Cary, provides an example of how companies might respond. It provides assistance for eldercare—not only information and referral services to employees, but also one-on-one consultations, visits to care facilities, and help in navigating eldercare systems.

The Economics of Health Care

Individual preparation to pay for health care is one concern, but another also has far-reaching economic implications: the workforce needed to provide health and other types of supportive care. Health care is a growing economic engine, driven by increased demand for services as the population ages. This growth requires the recruitment and retention of direct care workers in acute care, hospitals, nursing homes, home and community care, and other settings. These are high-demand, high-stress jobs that typically pay low wages and offer limited opportunities for advancement, and employers of these direct care workers often have a 100% annual turnover rate. This workforce is over 30% African American and Latino, and 40% are single parents (Applebaum, Bernhardt, and Murnane, 2003; Morgan, Stein, Farrar, and Jason, 2010). To ensure an adequate supply of care providers, North Carolina has initiated and been recognized for its progressive efforts to address the situation, including its Better Jobs, Better Care initiative, designed to increase the competencies of the direct care workforce and improve their workplaces; the WIN A STEP UP program, offering continuing education for direct care workers and their supervisors; and North Carolina NOVA, a special state license that recognizes workplace excellence in long-term care settings.

Still another aspect of the economics of aging and health relates to the growing interest of employers and the government in stemming the cost of health care, especially pertaining to chronic conditions. North Carolina’s evidence-based chronic disease self-management program—*Living Healthy*—and its Roadmap for Healthy Aging (www.aging.unc.edu/roadmap/index.html) are examples of tools that can aid this effort. (See the section on Aging and Health for more information.)

Aging as Opportunity: The Business of Aging

The Baby Boom that followed World War II was a boom for businesses, marketers, and the economy. Public service announcements posted in the New York City subway stations during the 1950s advertised the innovative and ever-increasing business possibilities that expanding families brought to the American market. However, few, if any, public service announcements are publicizing the innovative and growing business possibilities that the surge of older adults can bring to the marketplace. The economic prospects available by tapping into the older consumer market have great potential for the American economy.

The aging of the workforce, retirement, pensions, and financial security, recruitment and retention of older workers, and the costs of caregiving and health care present challenges to the state and to society. However, the dynamics of expanding mature markets, product development and adaptation, and changes affecting how business can successfully respond to the needs of current and future older adults present considerable opportunities, as well, and these deserve consideration.

It is important to remember that there is no single “Senior Market” or “Baby Boom Market.” Some seniors are well off, others are struggling. Nonetheless, marketers present boomers as the fastest-growing consumer market in the United States. Currently they earn more than \$2 trillion annually, have annual discretionary spending of about \$750 billion, and have an appetite for new products and services (Business and Aging Task Force of the Association of Gerontology in Higher Education, 2010).

Termed *silver industries* by Neal Cutler (2004, p. 6), growing numbers of businesses and services are studying older adults and designing products and services for them, but as Kohlbacher points out, the most “successful and innovative silver products are those that are age-neutral with value to older adults but also attractive to younger customers—they focus on connecting and integrating different generations” (2008, p. 18).

The growth of silver industries has been an economic boom for Japan, a super-aging society where one out of four Japanese will be age 60 or older by 2015. Silver industry opportunities seek to meet older adults’ demands for products that promote independence and healthy lifestyles, sustain mobility, encourage technology, and are transgenerational. They range from low-cost investments, such as widened aisles, lowered shelves, and increased lighting in grocery stores that accommodate older customers to high-tech solutions such as robotics. The new technologies that support autonomy, provide physical care and leisure activities, and combat isolation are a burgeoning area for the economics of aging. (H. Murata, *The Business of Aging*, 2010)

Seniors themselves are increasingly becoming entrepreneurs—creating wealth by establishing, operating, and investing in business ventures. Characterized by self-employment and including both innovative and copycat businesses, this entrepreneurship makes no requirements as to hours spent in the business, percentage of ownership, or legal structure, and it makes no assumption about the size of the financial ambitions of the entrepreneur

(Rogoff, 2007; 2010). People become entrepreneurs out of desire or necessity, influenced by economic conditions; discrimination; pursuit of a dream; family and time constraints; interest in time-flexibility; building equity value; being one’s own boss; and pursuing political and social goals. Opportunities are especially available for older people who are motivated and have the means.

The future of good business practices, in which older adults have consumer choices and the services they need, is the responsibility of gerontologists and other professionals. Shifting the focus from youthful consumers to older consumers offers new promises for business. One initiative in North Carolina leads the way for others. The University of North Carolina in Greensboro (UNCG), under the leadership of Dr. Jan Wassel, has recognized the importance of understanding the need for businesses to be involved in the aging of our society. UNCG has developed an interdisciplinary program in gerontology focusing on the business of aging. Working closely with the Bryan School of Business and the North Carolina Center for Entrepreneurship, the program prepares students for academic and professional careers. Through courses and the “Aging is Good Business” summit, UNCG reaches out to the private and public sectors, working to build linkages between them and public policy.

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4 HEALTH AND AGING

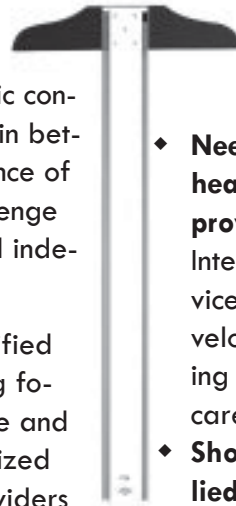
Sustaining good health and minimizing the effect of disease is imperative, given that the majority of people age 50 and older live with at least one chronic condition. While people age 50 and older report being in better health than earlier generations, the rising prevalence of chronic illness and functional limitation creates a challenge for those working to maximize health, well-being, and independence in later life.

It is not surprising, then, that the top three issues identified by participants at the roundtable on health and aging focused on various aspects of addressing the prevalence and effect of chronic conditions. First, participants emphasized the importance of strengthening the link between providers of health care and providers of community services. Second, participants called for measures to address the shortage of health and allied health professionals trained in geriatrics. Third, participants voiced strong support for prevention and promotion activities. It is also not surprising that the recent health care reform legislation addressed these same areas.

What follows here is background information for continuing the discussion of these three priorities, but in different order: understanding the causes of disability so as to prevent it; promoting better communication among providers of health care and community support service, because support for people with disabilities is not exclusively (or even primarily) a health care issue; and developing health care professionals trained in the care of older adults.

What causes chronic disease, disability, and death?

The burden of chronic disease and its resulting disability is heavy in North Carolina. Heart disease is the leading cause of death among older adults, both nationwide and in North Carolina, and in this state, it is followed by cancer, stroke, respiratory diseases, Alzheimer's disease, and diabetes. All of these can cause short or extended periods of disability, and all except Alzheimer's disease can be prevented to some extent through personal changes in behavior and mitigated by early diagnosis and care. Some 62% of North Carolinians ages 65 to 74 report having hypertension, and the rate increases to 66% among those 75 and older (BRFSS, 2009). Among people 65 to 74, 22% reported having diabetes and the same proportion said they had cardiovascular disease. At ages 75 and older, 19% report diabetes, and 30%, cardiovascular disease.



Health and Aging

Greenville, April 22, 2010

- ◆ **Need to strengthen link between health care and community service providers**
Integrating aging and medical services, enhancing communications, developing holistic approach, expanding support and resources for family caregivers
- ◆ **Shortage of trained health and allied health professionals who support an interdisciplinary approach**
Geriatricians, nurse practitioners, physical and occupational therapists, mental health clinicians, social workers
- ◆ **Lack of support for prevention**
Immunizations, screenings, evidence-based health promotion, wellness education, nutrition

As mentioned previously, the diseases that most often cause chronic disability and death are frequently correlated with behavioral risk factors—lifestyle choices that increase an individual's risk of disease and have a major effect on the health and well-being of the population as a whole. Major risk factors among older adults are physical inactivity, smoking, poor diet/nutrition, poor adherence to taking prescribed medications, and poor self-management of chronic disease.

Although long-term behavioral risk factors are principal contributors to disability and death, short-term conditions also play a part. In 1997, 2,457 deaths in North Carolina were attributed to influenza and pneumonia, both of which can be prevented by inoculation. Significantly, over 88% of those deaths were people age 65 and older.

Health Disparities and Health Care Disparities

Considerable differences exist in health and well-being among North Carolinians. These differences in health are called health disparities and are a major public health concern. Health disparities are “differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups” (NIH Workgroup on Health Disparities). Population groups that experience health disparities include minority groups, people living in rural areas, those with lower socioeconomic status (often related to less education), and older adults. For example, African Americans and other racial minorities are at substantially higher risk for heart disease, stroke, and diabetes than Whites and are more likely to die from these diseases and at earlier ages.

In North Carolina, rural counties often have disproportionate numbers of older adults. While the proportion of older African Americans, the state’s largest ethnic minority population, is about 16% (about twice the national rate), in some counties toward the coast they are the majority or nearly so. African Americans ages 65 to 74 are about twice as likely to be in poverty as Whites, and the disparity is much higher for those over 75. Women are more likely to be poor in their later years than men. (NCDAAS, 2009) It is easy to see how conditions associated with poor health outcomes can be compounded.

North Carolinians not only experience health disparities, but also *health care* disparities. Health care disparities are

defined as “racial and ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of the intervention” (Institute of Medicine, 2003). Differences in care based on minority group membership are a significant concern. An example would be vaccination against pneumococcal infections and influenza among African Americans/Blacks and Hispanic/Latinos, which remains substantially below the rate for Whites (NC BRFSS, 2008).

Health Promotion

Several themes related to the need to promote health and wellness among North Carolinians emerged during the Health and Aging roundtable discussion. Participants acknowledged that a lifespan approach—including children, young adults, baby boomers, and older adults—is necessary for health promotion and prevention of chronic disease. In order to institute a culture of health and wellness throughout society, health promotion and wellness needs to be a high priority.

One important opportunity to affect the health of current and future older adults that can be strengthened is worksite wellness programs, especially those which address the needs of older workers. Consistent with the growth in the total older adult population, the number of workers over age 55 is expected to increase nationally from 19.2 million in 2002 to 31.8 million by 2015 (GAO Report, 2003). Older workers are known to use more health care services and incur health-related absenteeism (Rix, 2001). Given these projected increases, supporting health promotion among older workers could be vital.

Adoption and maintenance of evidence-based health promotion and disease prevention programs, which address a wide variety of behavioral risk factors, are one important component of promoting a culture of disease and disability prevention and health promotion. North Carolina is at the front of a national movement to embed evidence-based programming within larger systems and to develop sustainable approaches to managing programs across organizations. The state has had great success to date in the dissemination of these programs, but sustaining them depends on the aging service network’s continuing ability to coordinate and manage their delivery by developing strong regional partnerships, particularly with health care providers.

North Carolina currently offers several evidence-based programs for older adults through its diverse network of aging service providers across the state. These programs address chronic disease self-management (the *Living Healthy* program), diabetes self-management (*Living Healthy with Diabetes*), falls prevention (*A Matter of Balance*), and physical activity (*Fit and Strong!*), to name just four. About 4,000 older North Carolinians have participated in evidence-based programs in the past four years, and a considerable supply of master trainers and leaders has been developed. However, more work remains. North Carolina needs to increase access to these programs in rural areas, for the underserved, for frail and vulnerable older adults, and for the homebound, as well as to ensure the quality of the programs and that they are delivered exactly as they were designed. The NC Roadmap for Healthy Aging (described in greater detail below), an interactive website that provides information about available programs and services for providers and consumers, seeks to increase information and access to these programs.

Support for People Living with Chronic Disease and Disability

Promoting healthy lifestyles and preventing chronic disease are important steps toward a healthier older population, but the state also needs resources for those who are already living with health conditions that affect their functional ability and independence. Roundtable participants identified a number of issues that need particular attention: dental and hearing care, dementia and mental health care, falls prevention, and health literacy.

Both dental and hearing care contribute not only to the quality of life of older adults, but poor care for either can result in excess disease and disability. Individuals who experience poor **dental health** are at greater risk for deficits in other areas of health. Roundtable participants discussed the need to increase funding for dental care services and create more opportunities for access to care. Among North Carolinians, 18% of those age 65+ and 26% of those 75+ report having had all of their natural teeth removed, with higher rates among those with low incomes and minority group members (BRFSS, 2008). One-third of North Carolina's adults age 65+ and 37% of those 75+ had not visited a dentist in the previous year (BRFSS, 2008). An added concern voiced by participants was

dental health care for persons with special care needs (an example might be people with advanced dementia in institutional settings who might not be able to go to dentists in the community and whose ability to cooperate with care might be limited). Improving access to dental care may depend on increasing the supply of providers as well as financial support for these services.

Hearing loss is the third most common chronic condition among older adults. It contributes to social isolation as people withdraw from social events because of the difficulty in participating easily in communication. A recent report on the impact of hearing loss among North Carolinians states that while 95% of people with hearing loss might benefit from hearing aids, only 23% say they use them. Some of this is the result of their high cost, which is not covered by Medicare (although Medicaid does cover this expense). Roundtable participants also raised concerns about availability and access to affordable equipment that would ameliorate hearing loss. They also raised several additional concerns about the issues of living with hearing loss, including the need for education about hearing loss and how to live with it; ways to reduce social isolation experienced by those who have it; and improved access to programs, services, and equipment that might help them.

Dementia is a general term for a broader set of symptoms (e.g., memory loss, confusion, impaired judgment, etc.) that accompany certain diseases or physical conditions. While some dementing conditions can be reversed, others cannot, and they cause steady

decline until death. Alzheimer's disease is the best known and the most prevalent cause of dementia that currently cannot be prevented or reversed, representing more than half of all dementia cases. It is the fifth leading cause of death for adults over age 65 in the US. In North Carolina, over 170,000 older adults currently have Alzheimer's disease or other types of dementia, and by 2025, this number is projected to rise to over 210,000 (Alzheimer's Association, 2010, www.alz.org), as the large group of boomers reach the ages where they are at greatest risk of developing the disease. As that report also demonstrates, this is not an "equal opportunity" disease, because it disproportionately affects women and African Americans and Latinos of both sexes.

Much of the caregiving for people with Alzheimer's dementia is provided by family and friends, and according to the report cited above, replacing that unpaid care with paid would have cost \$4.7 billion in 2009 alone for North Carolina. One out of four dementia caregivers provides constant care—an average of 47 hours per week—often for several years on end. More than half of these caregivers feel as if they are "on call" 24 hours a day and find it necessary to reduce or end employment to fulfill the demands of caregiving. They often experience profound grief and feelings of anger, guilt, fear and isolation. Nearly half (43%) are clinically depressed, and these anxiety-inducing conditions often go untreated and unchecked because caregivers do not have the time or resources to manage them. The detrimental health effect of provid-

ing long-term care to a person with serious illness or disability has emerged as a critical public health issue. Roundtable participants called for access to programs and services for older adults with dementia and their caregivers such as Project C.A.R.E: "Caregiver Alternatives to Running on Empty." Project C.A.R.E., a nationally recognized best practice, uses a family consultant model to provide consumer-directed respite care and comprehensive support to families caring for a person with dementia at home. Currently available in only 23 NC counties, the goal is to expand this cost-effective program statewide.

The coming elder boom creates great challenges for the mental health system. Older adults with **mental disorders** are a heterogeneous population. Included in this group are people who have had severe and persistent mental illnesses such as bipolar disorder or schizophrenia for much of their lives, who are growing old, and who may have lost contact with family or never developed social support systems. Others include people who abuse alcohol and other substances, whether long-term or more recent. Others still may develop mental health conditions in response to aging, such as anxiety or depression. That said, only 20% to 25% of older adults with mental disorders receive services from mental health professionals. Many causes may contribute to the low use of mental health services: problems of access and supply, problems of affordability, lack of services in home and community settings, limited access to medications, ageism, and lack of cultural competence on the part of providers. For older adults themselves, there is fear of stigma and lack of knowledge about mental illness and the effectiveness of treatment. Roundtable participants remarked that mental health services in both community settings and institutions such as adult care homes and nursing homes are of uneven quality.

Falls are a major source of concern among older adults, families, and aging service providers. Incidence and severity of falls rise steadily in later years. About 35 to 40% of community-dwelling people age 65 and over fall annually. Problems with balance and gait dramatically increase the risk of falling, as do muscle weakness, history of falls, fear of falling, use of an assistive device (particularly an inappropriate assistive device), arthritis, impairment in activities of daily living, depres-

sion, cognitive impairment, and being over age 80. Nonetheless, preventing falls is one of the more straightforward ways to improve the health of the older population and will grow more important as the number of older adults increases. Falls prevention strategies include increasing physical activity to improve strength and balance, review of medications, regular vision checks, and home modifications or repairs to reduce risk (e.g., handrails, appropriate lighting, proper flooring).

There are several efforts under way in the state to reduce falls. The North Carolina Falls Prevention Coalition brings together researchers, planners, health care providers, housing specialists, aging services providers, and many others to work together toward reducing the state's number of falls and fall-related injuries (www.med.unc.edu/aging/ncfp/). *A Matter of Balance*, an evidence-based program for falls prevention, is being implemented across the state, with over 780 older adult participants to date.

Health literacy has been defined as the ability to read and comprehend prescription bottles, appointment slips, and other essential health-related materials to participate successfully in one's own health care. The first roadblock to health literacy is literacy at all: 44% of those over 65 are functionally illiterate, while the rate is 26% for people ages 55 to 64 and 16% for those 45 to 54. Health literacy also includes the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions, and older adults are not the only ones who struggle with it. Difficulties with health literacy can complicate already challenging health problems, and people with low health literacy may use emergency rooms and other expensive health services more often than people with higher health literacy skills (IOM, 2004).

Dewalt (2007) suggests that there are four categories of interventions to address low health literacy: (1) improve health literacy skills in the population, (2) improve written and multimedia communication, (3) improve patient-provider communication in health care visits, and (4) alter systems of care. These categories suggest a multitiered approach to addressing the problem of low health literacy: improving knowledge and training among health professionals, making changes in the ways in which care is provided, and educating consumers.

Access to Health-related Services and Programs

Second on roundtable participants' list of priorities was the availability of, and access to, programs and services. North Carolina is taking steps to strengthen this availability and access, and several recent initiatives are described at greater length in the second section on "Access and Choice." Three that have particular relevance to the issues raised at this forum are Community Care of North Carolina, (CCNC; www.communitycarenc.com), North Carolina CareLINK (NCcareLINK; www.nccarelink.gov), and the North Carolina Healthy Aging Roadmap (www.ncroadmap.org).

In July 1998, North Carolina established Community Care of North Carolina, based on a pilot Medicaid waiver program begun in 1991. Under CCNC, providers plan cooperatively to meet patients' needs and strengthen the community health care delivery infrastructure. Providers are expected to act as a *medical home* for participants—that is, to take responsibility for managing their care and providing preventive services, and for their patient population as a whole, establish ways to identify people with a high likelihood of developing health-related disabilities and to intervene early to forestall more expensive care. CCNC provides care to more than 870,000 Medicaid recipients in the state, making the program the largest single payer in North Carolina.

The "Services for Older Adults Neighborhood" of NCcareLINK is designed to help seniors, their families, and caregivers find the help they need. The website links users to a wide variety of

services including senior centers and community-based programs, adult day care, employment, family and caregiver support programs, health-related resources including prescription drug benefits, and housing and long-term care options. The interactive system allows users to search for resources statewide by county, city, zip code, or address.

The North Carolina Healthy Aging Roadmap is an online, interactive resource for promoting healthy aging in the state. Providers of programs and services maintain the content on the website regularly. Consumers—older adults, their families, and caregivers—can search by county for information about the aging population and for the programs and services that are available, including those that are evidence-based.

Education and Training of Health Professionals

First on the list of roundtable participants' concerns was having sufficient trained personnel. To provide the necessary supply of programs and services, support for the recruitment, education, and training of health professionals at all levels—physicians, nurses, therapists, and paraprofessionals with training in geriatrics—is critical, not only in North Carolina but across the country. North Carolina is projected to need over 40,000 additional direct care workers between 2006 and 2016, a 43% increase from current levels (Harmuth & Konrad, *NC Medical Journal*, 2010). Recruitment and retention of health professionals continue to be priorities, with a major effort particularly needed to reduce turnover among direct care workers. North Carolina's turnover rates among direct care providers is substantially higher than national levels (McConnell et al., *NC Medical Journal*, 2010). Two nationally recognized programs to address these issues were developed and tested here. The first, WIN A STEP UP (www.winastepup.org), has reached over 1,000 direct care workers and their supervisors in nearly 25% of North Carolina's nursing homes. This program has demonstrated improvements in skills, in-

creases in career commitment, and provided recognition to its participants. The second program is the North Carolina New Organizational Vision Award (NC NOVA), which provides special licensure for nursing homes, adult care homes, and home care agencies and is intended to improve direct care jobs, build effective workplace teams, boost staff morale across the organization, reduce turnover, and improve quality care and consumer satisfaction (www.ncnova.org).

Recruitment and retention of physicians and other health care providers to serve North Carolinians in both the urban and rural areas of the state are also crucial. North Carolina had 20.7 physicians to every 10,000 people in 2005 (slightly less than the national average), and the ratio has gotten smaller over time (Silberman et al., *NC Medical Journal*, 2007). Remembering that the number of practitioners located in an area does not necessarily mean that they have openings in their practice or that they accept Medicare, Medicaid, or other forms of reimbursement, it is important to note that there is wide variation across the state in the supply of providers, including some rural counties with none at all. (For the most recent statistics by provider type and county, consult the Sheps Center for Health Services Research's website, www.shepscenter.unc.edu/hp/).

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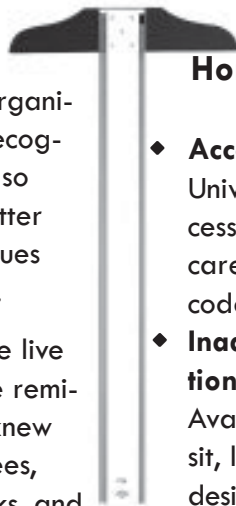
5 HOMES AND NEIGHBORHOODS

Because of North Carolina's changing demographics and its rapidly increasing older population, government officials, business leaders, educators, nonprofit organizations, advocates, and older adults themselves are recognizing the need to reevaluate where and how we live so that all individuals, regardless of age, can enjoy a better quality of life. Shown at the right are the top three issues identified by participants at the Charlotte roundtable.

Participants focused on the need to redesign where we live and how we move about within our communities. Some reminisced about neighborhoods of old, where everyone knew everyone else. Young families lived next door to retirees, with each looking after the other. There were sidewalks, and there were stores, schools, and places of worship within walking distance. Perhaps you could even walk to work. Many families relied on one car, with bicycles for the kids. Your doctor knew your name, and you knew your elected officials. Entertainment ranged from a neighborhood "kick the can" competition to a Saturday-night band concert in the center of town. Those living in rural areas also knew and looked after one another. Farms were small and family-owned. Small towns thrived and provided jobs and needed services, as well as a "neighborhood" connection for farm families.

Then came the building of suburbs after World War II, when people moved away from "downtown" and the rural areas, away from the stores and other places of business, away from family and friends, to two- and three-story homes with bigger lawns and longer driveways, the further out the better. Then two- and three-car families became the norm, so family members could travel to work, school events, and shopping.

Fast-forwarding to 2010, we find that many of the children who grew up in the suburbs moved out, leaving empty nesters and retirees often isolated in large two- and three-story homes, away from family and friends, away from stores, medical facilities, and places of worship, and away from opportunities to stay involved. Children living in rural areas also grew up, and many moved to the cities, leaving their parents in rural areas where the small towns had fewer and fewer businesses and other resources. Regardless of location—town, suburbs, rural area—people who do not drive are even more isolated because other transportation alternatives can be difficult to access or do not exist at all.



Homes and Neighborhoods

Charlotte, May 25, 2010

- ◆ **Accessibility of housing**
Universal design, affordable and accessible housing, wheelchair access, care of home and property, zoning codes
- ◆ **Inadequate options for transportation and mobility**
Availability and accessibility of transit, lack of routes in rural areas, road design and signage, driver and pedestrian safety, funding, need for greater public and private collaboration
- ◆ **Inadequate personal education and preparedness (planning before a crisis)**
Awareness of continuum of options and services, education about and preparation for aging, consumer counseling, redesigning homes before a crisis, education of builders on universal design

Participants at Charlotte's Homes and Neighborhoods roundtable were well aware of the need for change: change in how we plan our neighborhoods and our communities, change in the types of housing we build, change in how we access services, and change in how we educate and involve individuals in decision making. Participants noted that our overall goal should be the creation of communities that allow individuals to age in place and that the concept of aging in place should not be limited to remaining in one's own home but be expanded to include other housing and service options in one's own community—options that best suit the particular needs of the individual.

Accessible, Affordable Homes Universal Design

Included within this general topic, Charlotte participants noted that too few homes have incorporated the concept of universal design. Universal design was originally associated with adapting homes, products, and environments for persons with disabilities. Today, universal design proponents have expanded their vision, recognizing that what works for those with disabilities also works for the population at large, particularly older adults. Examples include at least one step-free entrance to the home, doorways and hallways wide enough to adequately accommodate a mobility device, accessible bedroom and bath on main level, doorknobs and faucets with lever handles, countertops and cabinets with heights that vary, and nonglare lighting. Universal design also applies to our environment as a whole and includes such things as curb cuts, larger print street signs, and adapted traffic lights.

The biggest challenge that designers and builders face in selling universal design to clients is shifting the popular perception that it only addresses the needs of older adults and people with disabilities. Builders instead hold that their public drives their products and unless universal design is requested, they choose not to evoke the negative perception that it sometimes prompts. Likewise, many clients refuse even to discuss universal design, wanting to avoid the thought of growing old and frail or developing mobility limitations. But as more developments and unified efforts to advance universal design emerge, many designers and builders are concentrating

on its positive aspects—open spaces, larger circulation areas, and easy to use equipment—to promote this principle for all ages. Such descriptive phrases as *lifespan design*, *inclusive design*, *barrier-free design*, and *visitability* may come and go, but universal design's emphasis on independence, safety, comfort, and convenience will maintain a following that will survive and benefit the generations to come. Some cities, both large and small, have recognized the importance of such basic design requirements and have passed local ordinances requiring that all new construction meet universal design standards to some degree. Examples include Bowling Brook, Illinois, and Atlanta, Georgia.

Affordable Housing

Even if housing becomes more accessible, affordability continues to be an issue that the state is attempting to address through North Carolina's three property tax relief programs.

1. *Elderly or Disabled Exclusion*: applicants who are 65 years and older or totally and permanently disabled and have a household income not to exceed \$27,100 can have excluded from their yearly taxation the first \$25,000 or 50%, whichever is greater, of assessed value for their primary permanent residence.
2. *Circuit Breaker Tax Deferment*: applicants who are 65 years and older or totally and permanently disabled whose previous year household income does not exceed \$40,650 will have their taxes limited to a percentage of the household income; those above the limitation will be deferred until a future date.
3. *Disabled Veteran*: honorably discharged service-connected disabled veterans or their unmarried surviving spouse may be eligible to have excluded from taxation the first \$45,000 of the assessed value of the permanent residence.

Affordable housing is also a primary goal of the North Carolina Housing Finance Agency. This agency not only helps developers create affordable rental housing but also provides special financing for income-qualified buyers, households needing home repair and renovations, and households at risk of foreclosure. (More detailed information about their services can be found on their web site, www.nchfa.com.)

Accessible Goods and Services

Having a home that is accessible and affordable are first requisites for aging in the community. Another that is equally im-

portant is accessibility to needed goods and services. Because of the cost of land, the cost of building of accessible homes that are convenient to commercial areas is often prohibitive. This has resulted in builders seeking land away from high-density areas so that homes can be more affordable. However, these same homes are also far from needed goods and services, often creating a variety of transportation problems and resulting in a “Catch 22” dilemma. One possible answer is to identify and strengthen naturally occurring retirement communities (NORCs). These are described as communities that were not originally designed for older adults nor intended to meet any particular health or social need but whose residents have aged in place and need a variety of support services to remain there. Since the 1990s, the national aging network has seen NORCs as “a singular opportunity to deliver targeted health and supportive services cost effectively.” In such concentrated areas of older adults, the availability of services can be increased, cooperatives promoting healthy living can be organized, the cost of some services can be shared by the residents, and a variety of community improvement projects, such as creating walking trails, can be initiated.

The Beacon Hill Village in the heart of Boston is one such example. Founded in 2001, older residents living in Beacon Hill who wanted to age in place worked together to organize a service delivery system that has allowed them to lead “safe, healthy and productive lives in their own homes.” Following the success of Beacon Hill Village, many communities across the country are attempting to replicate their experience. In response, Beacon Hill has published *The Village Concept: A Founders Manual*, which is available through their website, www.beaconhillvillage.org. Additionally, the private nonprofit group NCB Capital helped Beacon Hill Village and 38 other village-like communities access capital and expert technical assistance for low- and moderate-income communities. Their involvement has improved the quality of life in these communities by putting in place such additional features as affordable shared-equity homeownership, community health centers, and community-based long-term services and supports.

The “village” concept has gained some attention in North Carolina. In Chapel Hill, a popular retirement area, several focus groups met in early 2010 to discuss creating a village-like environment to provide a social network and improved ac-

cess to a variety of services through a newly created private nonprofit organization. Services would be financed by an annual subscription fee, contributions, and grants. Plans included hiring a minimum number of staff members and launching an extensive volunteer recruitment effort. The leaders of this initiative do not see the nonprofit organization competing with other well-established service providers but rather facilitating the assessment and referral process. Additionally, the group hopes that the building of such a natural village will be a multigenerational effort.

A second example in the Chapel Hill/Durham area is Falconbridge Village. This more established community has similar goals, including that of creating a multigenerational, neighborhood supportive service system along with social networks. Interestingly, one of their distinctive goals is to “encourage a more environmentally responsible life style.” More information about Falconbridge Village can be found on their website, www.falconbridgevillage.org.

Another village-like concept that is becoming more popular is a university- or college-based housing community. Such housing provides not only many of the same village services but also a formalized link to the college or university. Residents are able to take advantage of campus facilities such as libraries, as well as the many services a campus environment has to offer including classes, sporting and cultural events, and physical fitness programs.

Still another example is found in Asheville, where a group of residents have formed the Asheville Communities

Network, whose focus is to “educate, network, and support the growth of ‘intentional’ communities.” An *intentional community* is defined as a consciously created community whose purpose is that residents live cooperatively, “sharing a lifestyle that reflects core shared values.” More information can be found at www.ashevillecommunitiesnetwork.com.

Zoning

Zoning was also included within the discussion of housing alternatives. Participants believed that local zoning often has a negative effect not only on affordable and accessible housing but also on recreating “neighborhood friendly” communities. Mableton, Georgia, sees revision of its zoning as a way to rebuild itself and resurrect the concept of “neighborhood friendly” communities where people can again walk to needed goods and services. City planners are moving from zoning based on “function,” such as single family homes or retail, to “form-based zoning,” where the scale and character of the buildings relate to one another rather than the function of the building. The City of Mableton is also in the process of reconnecting its streets, constructing more sidewalks, and installing better street lighting and signage. Once these changes in the city’s infrastructure are completed, city planners hope to attract more diversified housing and efficient transportation. (Atlanta Regional Commission, a recipient of the Administration on Aging’s Community Innovations for Aging in Place grants, selected Mableton as the community in which to implement the grant.)

Repairing and Modifying Older Homes

Many homes in which older adults live have continued to deteriorate as their owners have aged and have had to make choices whether to buy medicine or pay utilities. Floors, ceilings and roofs have been neglected, and major damage has resulted. Insulation, heating and cooling equipment, and appliances have long since outlived their life expectancy. The Weatherization Program and the Heating Air Repair and Replacement Program have been instrumental in addressing some of these energy efficiency needs, as have the Community Development Block Grant (CDBG) program, the Single Family Rehab Program, and USDA rural development program for home repair.

Mobility and accessibility needs have also been supported by Urgent Repair, the Displacement Prevention Partnership and the Home and Community Care Block Grant (HCCBG) Housing and Home Improvement program, but eligibility requirements for these programs are tight and waiting lists are long. Some programs receive funding only once every two or three years, and the HCCBG home improvement service is available in only 31 counties. Many people wait far too long for repairs or accessibility modifications that could assist them in remaining independent and maintaining safe mobility at home, rather than in a more expensive congregate care setting.

In a survey conducted in spring 2010, HCCBG agencies reported serving in excess of 1,600 people in the first half of the state fiscal year (July 1 to December 31), but they also reported over 1,200 people on waiting or inquiry lists. The Housing and Home Improvement service was the only one of the 16 HCCBG services surveyed whose providers said that their money would be spent well before the end of the fiscal year, and they would need to suspend services. The Urgent Repair Program and the Displacement Prevention Partnership, among other publicly funded programs, also struggle to meet demand.

Much credit, however, is due to the many volunteers—faith-based and civic and professional groups that donate not only their time but also resources to make accessibility modifications and repairs to those needing assistance. Without them, many more households would lack basic health and safety measures.

Communities might investigate a new option that is gaining ground across the country: intergenerational “shared housing.”

These programs connect older homeowners who need assistance with ongoing maintenance or who feel isolated with young adults, often students, who need affordable housing. The older homeowner contributes living quarters, and the young adult contributes labor and, oftentimes, much-needed company.

Transportation

As noted above, the second major issue identified at the roundtable was “**inadequate options for transportation**,” an issue that surfaced in a number of roundtables around the state, notwithstanding the fact that public transportation and/or human service transportation services are offered to some extent in all 100 counties. Statistics show that one in five adults over 65 do not drive. Information from the National Household Travel Survey indicates that, compared to older drivers, older nondrivers make fewer trips to the doctor; fewer shopping trips and visits to restaurants; and fewer trips for social, family and religious activities. Social isolation and lack of access to services can affect an older person’s ability to age in the community. If family and friends cannot assure mobility options for older adults who give up their car keys, then public transportation often is the essential alternative.

Unfortunately, the demand for transportation services exceeds the ability of North Carolina’s extensive public and private transportation network to respond. Roundtable participants were well aware of this dilemma, citing the lack of public transit in many urban, suburban, and rural communities alike, as well as some issues of affordability and accessibility. Even though North Carolina adds substantial state funding to federal allocations through the NC Elderly and Disabled Transportation Assistance Program (EDTAP), the need for new strategies to expand transportation options appears to be a statewide dilemma.

In 2009 the NC General Assembly gave counties and transportation authorities another source of revenue to finance local transportation systems. Session Law 2009-527 (House Bill 148) authorized a local option sales tax for public transportation and the option to levy a local vehicle registration fee and county vehicle registration tax. Authorization for a local sales and use tax was given to Mecklenburg County more than a decade ago. In 2007 Mecklenburg voters reaffirmed their support for a one-half percent sales tax for additional transit options. The 2009 expansion to other jurisdictions reflects

rapid population growth and traffic congestion in the state’s Triangle and Triad areas. Wake, Durham, Orange, Forsyth, and Guilford are now authorized to put a one-half percent sales tax option before voters. Other counties were authorized to seek approval for a one-quarter percent sales tax in support of public transportation options.

The need for more customer-oriented transportation options was another theme that emerged in the policy roundtable discussions. One example is the need for *assisted transportation*, for example, assistance to customers beyond what public transit drivers are allowed to provide for boarding or leaving the vehicle. Volunteer transportation can sometimes address individual needs that cannot be accommodated otherwise. The Center for Volunteer Caregiving in Cary, the Faith in Action Care Program at the Shepherd Center of Greater Winston-Salem, and the Shepherd’s Wheels program at the Shepherd’s Center of Greensboro are examples of North Carolina programs that recruit volunteers to address unmet transportation needs in those communities.

Another concern voiced is that transportation services are not affordable if they are not sponsored by a human-service agency. One success story in our state is the Buncombe County Senior Pass Program, which gives seniors age 65 and older a monthly bus pass to ride the Asheville fixed route bus system at no cost and without advance reservations.

Another strategy gaining national attention is the idea of public transportation systems hiring “mobility managers” to

coordinate services to the benefit of consumers, and in some cases they offer travel training to seniors who are afraid of using public transportation. Chatham, Durham, Henderson, and Swain counties are examples of NC communities that have been funded in the past year to hire mobility managers.

For communities with limited public transportation, one strategy that seems to be gaining attention in many communities across the country is a transportation voucher system. Instead of public transportation systems or human service providers transporting older adults in vans to and from senior centers, medical facilities or other needed services, eligible older adults are given vouchers to purchase transportation services from other sources, such as taxis, friends or relatives. In this manner vouchers can increase the number of persons receiving transportation assistance in locations where other options are not available or are not suitable for an individual's needs.

For communities interested in promoting walking as a "mobility option," lessons could be learned from Henderson County and its *Walk Wise, Drive Smart* program, part of the county's Livable and Senior-Friendly Community Initiative. Using community input to identify needed improvements for walkability, this project has worked to create pedestrian-friendly environments in Hendersonville and surrounding areas. A number of NC counties are now addressing walkability in local planning efforts, and there is a growing awareness of the need to integrate concerns about the condition of walking paths, sidewalks and curb cuts, access to transit, and

other adaptations of the physical infrastructure to benefit the general public as well as older adults.

Although walkable communities and public transportation alternatives are key tools for maintaining mobility in later years, it is nevertheless true that driving or riding in cars is still the main way that most older adults get around. In many cases, homes are located in places where the only transportation option available is the automobile. Road design, signage, and driver and pedestrian safety were high on the list of concerns listed by roundtable participants, along with the need for greater public and private collaborations to address these concerns. Well-placed signage with larger lettering, clearer road markings, brighter stoplights, and dedicated left-turn lanes are all important strategies to keep older drivers on the road safely for as long as possible. The NC Department of Transportation (NC DOT) already has adopted some of the recommendations of the Federal Highway Administration to accommodate older drivers and pedestrians, but funding constraints prevent the implementation of certain remedial measures. However, in 2007, NC DOT adopted a new traffic safety design standard to increase the size and letter-height of new or replacement signage and allow for advance placement of signage at certain types of interchanges that have been identified as problematic.

For those older adults who continue to drive, the opportunity to participate in driver safety education and refresher courses is critical. Both AARP and AAA Carolinas offer classroom and online instruction for older drivers, emphasizing the importance of driver and pedestrian safety. In addition, AARP supports an initiative called "We Need to Talk," which provides practical tips and guidance to older adults and their families on when it is time to "retire from driving." The transition to non-driving status, often influenced by the perception of transportation alternatives, is a particularly difficult decision point for older adults and their families. Research tends to show that older drivers self-regulate by reducing the number of miles driven and avoiding areas with difficult traffic patterns. However, this is not always the case.

Older drivers with early cognitive impairments often are not capable of making good judgments about their ability to drive. For drivers with conditions that could compromise their ability to safely operate a vehicle, assessments beyond the

usual driver's license renewal tests may be needed in order to certify that they are medically fit to drive. For many years the NC Division of Motor Vehicles (NC DMV) has operated a successful Driver Medical Review Program that conducts these types of reviews. The medical review program accepts referrals from driver's license examiners, physicians, law enforcement, the court system, family members, and other sources, but the referral must be in writing and the process is not anonymous.

Far from being a program to get all older drivers "off the road," this program has a fair process based on the recommendations of health care professionals and the evaluation of individual circumstances. At the end of this evaluation process, drivers may have their driving privileges canceled, but sometimes their licenses instead are renewed with restrictions. Typical restrictions include daylight driving, no interstate driving, and driving no more than 45 m.p.h. In practice, the NC DMV has developed a model program that promotes highway safety while helping older drivers stay on the road with restrictions, when it is appropriate.

Older drivers and their families and friends will continue to be key players in the effort to maintain mobility options in our neighborhoods and communities, but programs and policies related to transportation alternatives, land use planning, road building, pedestrian walkways, and driver safety strategies must also be addressed.

Education about Preparation for Later Life

The third major issue identified at the roundtable was inadequate education and preparation for life changes. Included under this heading were concerns about the general public's understanding of what options and services are available for those wishing to stay in their own homes or communities. Unfortunately, education about ways to prepare for aging in place is not widely distributed, so many individuals and/or their family members make major decisions with limited information, often at times of crisis. Consumer counseling is scarce, and even where it is available, people rarely know how and where to access it. Roundtable participants thought there should be more education about consumer issues such as reverse mortgages, identity theft, and credit counseling.

Education for families and those providing products and services to older adults was also a concern. For example, neither

service providers nor the public may be aware of North Carolina's Assistive Technology Program (NCATP), a state-federal partnership to provide information on a variety of assistive devices that people can use to help carry out tasks of daily living. Home builders may not be aware of the many options within the categories of universal design. Fortunately, information for home builders is readily available through national organizations such as the Universal Design Alliance and The Easy Living Program. The Universal Design Alliance seeks to increase awareness and knowledge of universal design for all ages. The Easy Living Program, currently promoted in Tennessee, Kansas, Missouri, and Georgia, is the country's first certification program for "visitable" homes. It provides information on the basic criteria in everyday construction and remodeling and "seeks to encourage voluntary inclusion of key features which make a home cost-effective, accessible and convenient for every one without sacrificing style or adding substantial construction costs." The next step must then be to share information with home builders and the general public so that individuals can better prepare themselves for "aging in place," and builders can help to make it a reality.

Making the Whole Community More Livable for People of All Ages

Although participants at the roundtable focused on housing, transportation, and education, they also recognized the importance of expanding the concept of "livability" from homes and neighborhoods to the community at large, asking

the question “What other components are important in the building of livable communities, not only for older adults but for people of all ages?” AARP’s *Beyond 50.05* report (2005) described what often makes a community livable. It includes, but is not limited to, affordable and appropriate housing, a range of support services, and a variety of mobility options. Other organizations, both public and private, when rating retirement areas, consider cost of living, climate, housing options, educational opportunities, medical care and health promotion, recreation, dining and shopping, financial services, volunteer options, and spiritual opportunities. Going a step further, several states and cities have developed criteria by which to certify communities specifically as *retirement communities*. For example, the Tyler, Texas, Chamber of Commerce and its Economic Development Council led an initiative to evaluate the city’s infrastructure and to market resources available in the city that help to make it “Retirement Friendly.” They created a community profile that addresses areas such as transportation,

medical care, health and wellness, education, employment, government, real estate, taxes, recreation, and local attractions. Florida, Kansas, and Mississippi have initiated similar retirement city initiatives. In North Carolina, the Department of Commerce is currently developing a Certified Retirement Communities Program “for communities that are positioning for retiree attraction as an economic and community development strategy.”

Launching the *Building a Livable and Senior Friendly North Carolina* initiative is definitely an important first step in envisioning the future and preparing for the rapidly growing older population. Issues have been discussed, and barriers have been identified. Now is the time to seek solutions—solutions that involve both the public and private sectors working together to help improve the quality of life for generations to come.

Cheryl Schramm

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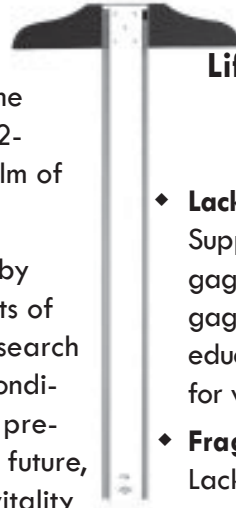
6 LIFELONG ENGAGEMENT AND CONTRIBUTIONS

One day recently, the *Durham Herald-Sun* featured a story about a 96-year-old woman who works out at a wellness center three times a week and—on the same day—the *New York Times* featured a story about a 92-year-old businessman who purchased and took the helm of *Newsweek* magazine.

Although we marvel at people who defy stereotypes by leading active lives past 85 or 90, the accomplishments of the very old are becoming less surprising. Scientific research now shows that a number of the problems, diseases, conditions, and circumstances associated with aging can be prevented, reversed, delayed, or compensated for. In the future, more people are likely to experience more years of vitality and will be able stay engaged and contribute to their communities into advanced ages. In a livable and senior-friendly environment, even people with chronic illnesses and other adversities will find fewer barriers to participation and may draw on such strengths as resilience, faith, social support, and positive attitudes to bolster motivation for purposeful living.

From a public policy standpoint, planners of a livable and senior-friendly state recognize that older adults thrive when they are an integral part of the fabric of their communities. According to the World Health Organization, engagement (participation in social, economic, cultural, spiritual, and civic affairs) is one of the three cornerstones of quality of life for older people, along with health and security. This theme is echoed in many reports on trends in aging, including a special policy forum on “Healthy Aging in North Carolina,” published in the September/October 2008 issue of the *North Carolina Medical Journal*.

In coming years, many people may forgo retirement and continue to work or start second careers. Some experts use a new paradigm to describe the possibilities of later life, substituting the term “refirement” to suggest that many people will find a new burst of inspiration and energy in a life filled with volunteering and other meaningful pursuits. Today’s seniors and boomers tend to be doers and share both a “busy ethic” and an interest in the common good. Many also have a zest for continued learning, creative self-expression, spiritual development, recreation, and commitment to friends and family. With experience, skills, knowledge, historical perspective, wisdom, connections, altruism, motivation, perseverance, and time, many older people have the passion and potential to serve as lead-



Lifelong Engagement and Contributions

Boone, May 19, 2010

- ◆ **Lack of funding**
Support for lifelong learning and engagement, including programs for engagement, financial aid for continuing education, inadequate infrastructure for volunteerism
- ◆ **Fragmentation among agencies**
Lack of a cohesive network, confusion about how to connect with system, duplication of effort, missed opportunities and inefficiencies
- ◆ **Need for new terminology and approaches to volunteering**
Changing nature of the volunteers as boomers grow older

ers, teachers, thinkers and visionaries, mentors, organizers, kinkeepers, neighbors, helpers, listeners, nurturers, advocates, voters, and more. Leading a life of purpose has been shown to enhance health and perceived well-being in later life, which, in turn, heightens the possibility that individuals will continue making contributions. Acknowledging these benefits to individuals and to society, policymakers and program developers must continue to create opportunities and remove barriers to lifelong engagement.

So, how should North Carolina stimulate and facilitate lifelong engagement to harvest the talents and energies of our elders and plan for those now in midlife? How can community institutions, public and private (e.g., senior and community centers, schools and colleges, libraries, environmental and political organizations, businesses and nonprofits, faith-based or-

ganizations) encourage and support seniors as engaged participants? How can we ensure access to meaningful roles and activities in all communities? How can we overcome misguided beliefs and other barriers that hold people back from finding satisfying activities?

Volunteerism and Civic Engagement

Two areas are at the heart of the national public policy dialogue on lifelong engagement and contributions of elders and boomers: (1) volunteerism and civic engagement and (2) lifelong learning. For each, there are key issues, promising practices, and emerging ideas important to program and policy development.

From barn-raising to fundraising, Americans have a long tradition of **volunteering** to help others. For many older adults, retirement means having more time to volunteer in their communities or to help friends, neighbors, and families. When asked why they volunteer, older adults often say they are motivated by the desire to help others and stay active. In fact, there is ample evidence of the physical and mental health benefits to volunteering, in addition to personal satisfaction. As for the impact on society, the National Governors Association reports that volunteerism by older Americans increases economic productivity, strengthens intergenerational relationships, and generates approximately \$162 billion annually for the US economy.

Studies estimate that nationally 23.5% of adults age 65 and older participate in formal volunteer activities, and that 45% of these older volunteers serve more than 100 hours per year. Recent data from the Corporation for National

and Community Service showed that in 2008, 22.7% of North Carolinians age 65+ performed volunteer activities for or through a formal organization. The rate would be higher if people were asked to report informal volunteering such as helping a neighbor with shopping, supplying wood for a family in which the breadwinner is out of work, or looking after a family member with Alzheimer's to give the primary caregiver some respite.

Although national volunteer programs such as the Foster Grandparent Program, RSVP, the Senior Companion program, and SCORE still draw interest from older adults, many civic and fraternal organizations known for their efforts in community service (e.g., the Kiwanis and the Elks) show declines as members age and boomers seek out organizations offering different types of opportunities and activities.

The profile of boomers with interests in volunteering is somewhat different from their parents' and elder siblings'. Over 29% of North Carolina boomers volunteered through a formal organization in 2008. However, boomers are less likely than their elders to want to volunteer for a formal organization, on a fixed schedule, and are less likely to want to be just another warm body doing a routine task. Boomers tend to approach volunteering entrepreneurially, that is, with a desire to gain and use unique knowledge and skills to solve problems and see their effect. One study reported: "Boomers need to understand the impact of their afternoon spent volunteering rather than receive a reward for the number of hours they've served."

This entrepreneurial bent may explain the trend in the last decade to get boomers involved in **civic engagement**. Although the terms volunteering and civic engagement are often used interchangeably, civic engagement usually refers to activities to enhance the quality of community life, often with regard to participation in the political process, community capacity-building, or community service.

National organizations such as Civic Ventures, the National Academy on an Aging Society, the National Council on Aging, and the American Society on Aging have launched large-scale projects and studies to determine direction for recruiting midlife and older adults into civic engagement and to building an infrastructure to make this engagement sustainable and productive. They have popularized the concept of "encore careers" (paid and unpaid) to address social and envi-

ronmental problems. They have created national media campaigns to interest boomers in community service, initiated public dialogue about the meaning and purpose of the later years, established visible and prestigious incentives and rewards for commitment and innovation such as The Purpose Prize, and completed demonstration projects to learn how older adult volunteers can be used in delivering services to families. Journals in the field of aging have published special issues or lead articles on civic engagement or volunteerism in later life. In May 2010, the US Administration on Aging issued a Request for Proposals for the development of a National Aging Civic Engagement Technical Center to increase the capacity of the aging network to use volunteers, and in July 2010 it disseminated a toolkit to guide agencies in creating an inviting environment for boomers to become involved in their communities.

In North Carolina, there are many ways in which seniors can make a difference. The North Carolina Commission on Volunteering and Community Service administers the AmeriCorps state service programs (sometimes called a domestic version of the Peace Corps, where volunteers offer assistance to immigrants, persons with disabilities, vulnerable youth, older adults, school children, persons seeking literacy skills, etc.) and the Citizen Corps, whose volunteers help communities with emergency preparedness. Seniors serve in advisory and advocacy roles, especially on behalf of the senior population, through the Governor's Advisory Council on Aging, the Senior Tar Heel Legislature, and the more than 35 organizations that make up the NC Coalition on Aging. Additionally, senior leaders serve on the advisory councils of the Area Agencies on Aging and other aging network agencies. The Senior Leadership Initiative of the UNC Institute on Aging provides training for seniors who aspire to become leaders to advocate on issues facing older adults. Thousands of North Carolina seniors participate as members of advocacy groups and engage in grassroots activities such as volunteering for political campaigns, working at polls, and transporting people with disabilities to vote.

Senior centers regularly use volunteers age 60 and older to provide a range of services at centers and in the community (e.g., delivering meals or being senior companions). North Carolina's nationally recognized program of senior center certification evaluates how centers plan for the use of volunteers, recruit and train them, and acknowledge their service in ways to keep them engaged. Many other senior programs such as North

Carolina Senior Games and the North Carolina Senior Health Insurance Information Program (SHIIP) rely heavily on middle-aged and senior volunteers to function effectively. Recently, AARP has initiated a large national program, Create The Good, which helps people find self-directed volunteer opportunities in local communities by easy online searches. Several recent reports from volunteer organizations highlight innovations such as online volunteering (also referred to as "e-volunteering") and "family volunteering" in which all members from a family (from children to grandparents) participate.

According to AARP's research, the primary reason people do not volunteer is that "no one has asked them! Nearly seven in 10 non-volunteers have never been asked." Other obstacles to building and maintaining successful volunteer programs for seniors and boomers are issues in the management and retention of a rapidly changing pool of potential volunteers. Studies show that about 30% of older adults drop out of volunteering after one year of service. People providing general labor and transportation have the shortest tenure, while those providing professional and management services stay the longest. Recruitment and retention of boomer volunteers may be even more challenging due to the number of options and incentives for pursuing paid employment or competing demands of caregiving.

Few reports and studies focus on civic engagement (using this terminology) for older adults with lifelong disabilities or acquired physical and/or cognitive challenges, although many community programs and care settings foster social engagement and cultural enrichment, as well as volunteerism among their members or

residents. A recent article in the *Journal of Gerontological Social Work* documented the shortage of civic engagement among nursing home residents and issued “a call for social work action” to “develop, implement, and evaluate interventions that increase civic engagement opportunities for this undervalued group.” In July 2010, the *International Journal of Volunteer Administration* published a special issue on engaging volunteers (of all ages) with disabilities, providing examples of inclusive volunteer programs and management strategies that may help guide the development of programs for seniors and boomers as well. With thoughtful planning, there is great potential for civic programming to be built into the culture of senior living communities and long-term care facilities. Some suggestions include engaging nursing home residents in assembling care packages for military families or making and selling crafts to support school fundraisers, as well as bringing residents together with other people in the community to achieve shared goals.

Lifelong Learning

In the last few decades, there has been a surge of interest among mature adults in continued learning. Some want to complete deferred degrees or obtain a new one; refresh or add skills for promotions or career changes; engage in volunteer or leisure activities; study for the pleasure of learning or mental stimulation; or have a place to share their intellectual interests, experience, and wisdom with others. With this demand, there has been a growth of opportunities and venues for adult learning.

Across the U.S., students from teens to centenarians co-matriculate in degree

and nondegree programs on university and community college campuses, broadening the perspectives of students from all age groups. Some of these institutions offer free or reduced tuition for seniors. North Carolina’s Community College System currently offers tuition waivers to legal residents age 65+ for up to 6 hours per semester of credit instruction and one course of noncredit instruction.

In their 2008 data book, the NC Community College System reported that North Carolinians age 65 and older constituted approximately 3.5% of community college students. According to the March 2010 issue of *NC Insight*, figures from 2008 showed that people age 64 and older constituted about .1% of students in the 16-campus UNC system. For the same time period, people ages 40 to 64 (largely boomers) made up approximately one-third of community college students and 3.4% of enrollees in the UNC system.

Many institutions in North Carolina offer special nondegree programs for mature adults through lifelong learning institutes or institutes for learning in retirement that offer noncredit short courses and study trips, workshops, speaker series, special events, interest groups/clubs, and intergenerational co-learning. A typical program functions as a learning community that includes peer leadership, peer teaching, and volunteer/civic involvement in the larger community or campus. As an example, in a column called “Regeneration,” *The Chronicle of Philanthropy* cited the NC Center for Creative Retirement at UNC-Asheville for its workshops and educational programs to encourage involvement of older people in their communities.

Libraries can play a vital role in supporting lifelong learners by linking them with materials, programs, and other community agencies. The North Carolina Lifelong Access Libraries Collaborative at the UNC Institute on Aging has been developed to help transform libraries into centers of lifelong learning and civic engagement for active older adults. Other institutions such as senior centers, recreation centers, Cooperative Extension centers, faith-based organizations, adult day care centers, retirement communities, and long-term care facilities also offer a wide array of informal learning opportunities, including increasingly popular programs on wellness, nutrition, physical activity, and self-care. National organizations such as Road Scholar (formerly Elderhostel), Chautauqua, and others offer educational vacations and travel opportunities.

Additionally, increasing numbers of older adults are taking advantage of learning opportunities available online. In North Carolina, credit courses are available through the UNC system at www.elearningnc.gov. Many national and North Carolina sites offer informal online learning opportunities such as educational games and brain fitness exercises. For those interested in “ideas worth spreading” in science and technology, business, the arts and global issues, short video presentations are available through the nonprofit organization known as TED (Technology, Entertainment and Design) at www.ted.org.

Experts predict that interest in and need for lifelong learning will continue to grow, but they also predict that there will be a need for increased diversity of course offerings and teaching methods to meet differing educational and literacy levels, functional abilities, economic constraints, technological savvy, and generational preferences, among other considerations.

Report from the Regional Policy Roundtable

At the roundtable in Boone, participants identified key issues of concern in the areas of lifelong engagement and the contributions of older adults and boomers. They agreed on the importance of maintaining and enhancing opportunities, although they differed somewhat as to priorities. Three issues emerged for the group as a whole: (1) the lack of funding to support lifelong learning and engagement, including programs for engagement, financial aid for continuing education, and an inadequate infrastructure for volunteerism; (2) fragmentation among agencies and lack of a cohesive network, resulting in duplication of effort, missed opportunities, and inefficiencies; and (3) the need for a new terminology and approaches for encouraging volunteering because boomers view it differently than older volunteers.

Lack of Funding

Participants agreed that more funding is needed to support efforts to engage elders and boomers in lifelong learning, volunteerism, and civic projects. They noted the effect that the recession is having on the community college and university systems. Increases in tuition and reduction in the number of courses of instruction across UNC system campuses, as well as new restrictions on tuition waivers for people age 65 and older at community colleges may limit access. One group pointed out that little if any financial aid is available for adults taking nondegree continuing education courses. Others

were concerned about the sustainability of lifelong learning and learning in retirement programs and informal offerings at senior centers and other community venues (e.g., libraries, senior centers without walls), owing to strained budgets at those institutions as well. One group also mentioned the need for peer-led apprenticeships or mentorships for continued learning. Several groups also noted the lack of funding to build and sustain programs to support volunteerism in local communities. Funding is needed for personnel to manage programs; transportation support for volunteers; and implementation of marketing, recruiting, training, resource development, and many other elements of running well-designed and managed programs.

Fragmentation among Agencies and Organizations

Participants represented a wide range of agencies, organizations, and individual interests. More than one group shared the perception that there is no cohesive network communicating or working together toward common goals of enhancing engagement of seniors and boomers. Participants saw the need for building broad-based collaborations in communities and pointed out that seniors and boomers must be recruited to play key roles in this effort and that seniors should be “empowered to drive the programs.” Participants urged greater connections among community colleges, businesses, and faith communities in the collaborative network.

Need for a New Vision of Volunteering

Several participants raised the issue of motivating people to become engaged in volunteering or other forms of engagement. Some suggested that older people are not interested in volunteering

because they prefer not to use their time this way, have low self-esteem and do not see what they can offer, are not aware of opportunities, or have preconceived negative notions of what volunteering involves. Many agreed that with the influx of boomers into the pool of potential volunteers, new strategies have to be developed for marketing an updated view of volunteerism, emphasizing such ideas as service, community, the value of experience and specialized skills, the health benefits of volunteering, and the chance to make a tangible impact. One group suggested focusing on volunteerism as an essential part of life. Additionally, roundtable participants encouraged planners of volunteer programs to think expansively about specific local needs that can be filled by volunteers (for example, in the Boone area, one path could be travel tourism) and to put systems in place for matching experience, skills, interests, and schedules with available opportunities.

Participants saw a need for “helping boomers transition from work to community engagement.” Suggestions included helping people begin or plan for volunteering while they are still working, including volunteerism as part of workplace culture and as part of preretirement education. Several participants reflected that both seniors and boomers would be more inclined to volunteer and be engaged if older adults in general were recognized as assets to the community. Participants provided several examples of ageist attitudes expressed by people of all ages and positions in the community, and how these attitudes interfered with access, participation, and partnerships. One suggestion was to use a

positive promotional campaign about senior volunteerism to bring boomers and elders to North Carolina.

Additional issues raised included barriers such as cultural differences within a community, differences between natives and newcomers, geographic and transportation challenges, health problems and disabilities, the lack of opportunities for engagement for frail and homebound adults, caregiving responsibilities, lack of respite care, and difficulty recruiting men to volunteer. Several groups offered suggestions that adults and boomers could become engaged in their communities through participation in healthful recreational activities such as Senior Games and walking programs.

Commentary

The concerns of the people attending the regional roundtable were very much in line with many recent reports and articles about the challenges of engaging seniors and boomers. Clearly, many states and local communities are dealing with funding issues across the board for education and all human services. There is growing interest in recruiting the oldest boomers as they make the transition from full-time work and seek meaningful activities.

At the roundtable discussion, despite the broad topic of lifelong engagement and contributions, there were more than a few spontaneous comments made about other kinds of enriching activities in which seniors and boomers do or could participate, such as the arts, recreation, religious and spiritual life, and caregiving. In every community, there are many avenues for making valued contributions to others (e.g., instrumental help, emotional support, humor, and inspiration). In fact, most people have meaningful exchanges as they interact with family members, friends, neighbors, and others they encounter in the course of a day or week, from hairdressers to cashiers, from clergy to online acquaintances.

Many older adults find meaning, purpose, and fellowship through engagement in religious or spiritual activities. In a 2010 study of AARP members age 45+, 27% reported being very involved in religious or spiritual activities and another 31% reported being somewhat involved. Although membership in faith-based organizations has declined somewhat in recent years, these organizations offer a major pathway to volunteering and connecting with others in the community, as well as lifelong learning and personal growth.

Older adults, like younger ones, find purpose and meaning in creative and recreational activities, brought forward over a lifetime or discovered along the way. Creativity can also be seen as “an essential element of self-directed lifelong learning.” Creative pursuits such as painting, sculpture, crafts, dance, music, theater, writing, guided autobiography, and storytelling give people the opportunity to look within, express themselves, and in many cases, contribute to the enjoyment of others and receive praise and thanks from others. There is a substantial research literature which shows the value to individuals of creative activity in terms of physical health, mental health, and social functioning outcomes. There is also much evidence that creative potential is available to people even if they have lost some physical, sensory, and mental functions. Programs such as those offered by the National Center for Creative Aging, the North Carolina Center for Creative Aging, NC Silver Arts, senior centers, recreation centers, art centers, and senior living and long-term care facilities, as well as other venues discussed above, can have a tremendous effect on individuals, groups, and communities. Some programs such as one at the Shepherd’s Center in Forsyth County combine creative activities with intergenerational outreach—with older adult volunteers offering reading and storytelling, creative arts, music, rhythm and movement, and games to preschoolers.

Of great importance to both seniors and boomers are commitments to family, including extended family, in sickness and in health. For many in midlife and beyond, family priorities come first, as a given, and significantly influence the choices made about participating in other forms of engagement. Often midlife and older adults relish their roles as husbands and wives, parents of an adult child, grandparents or great-grandparents, siblings, and in-laws, and appreciate the gift of time, especially postretirement, to spend with loved ones. Some stay engaged and connected, for example, by hosting family meals, serving as the family historian or reunion planner, giving financial help to younger family members, or crafting an ethical will to leave a legacy of values for generations to come. In many families, being a caregiver for spouses or parents with chronic conditions may totally preclude involvement in any other sustained commitments and yet offer its own deeply personal rewards. Some midlife and older adults find themselves raising or providing a heavy schedule of child care for their grandchildren and struggle to navigate the system to find needed resources. Federal, state, and regional programs as-

sociated with the National Family Caregiver Support program as well as other partner agencies provide services to help caregivers stay engaged in family care without neglecting self-care.

Now and in the near future, seniors and boomers are facing a new kind of old age and making choices for lifestyles without a clear sense of what they are capable of doing and what options are available for living purposefully and meaningfully in later life. Carrying around stereotypes and fears of aging, images of our “possible selves” may be limited and self-protective, sometimes pushing us toward disengagement rather than engagement. With the emerging public conversations about lifelong learning and civic engagement and the upgrading of the volunteer role, we may raise our expectations and reach to take on challenging and potentially more satisfying roles in our later years. At the same time, we may raise our community’s expectations too high and marginalize those people who must or choose to reject the new path. Education for and about aging may help clarify our attitudes, beliefs, choices and decisions. Clearly, the planners of a livable and senior-friendly North Carolina have much to think about and act on in terms of supporting lifelong engagement and realizing the potential contributions of our aging population.

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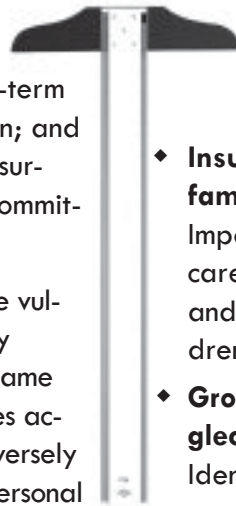
7 SAFE COMMUNITIES

An essential part of North Carolina's efforts to promote safe communities must involve protecting the rights of vulnerable elders, including residents of long-term care facilities; victims of abuse, neglect, or exploitation; and those needing legal aid and assistance in obtaining insurance and public benefits. Safe communities are also committed to emergency preparedness for major disasters.

There are several reasons why older adults may be more vulnerable: isolation from support systems or stress on family caregivers that can heighten the potential for abuse, to name just two. The physical changes and illnesses that sometimes accompany advanced age, combined with ageism, can adversely influence older adults' sense of self-determination and personal power, increasing their vulnerability and risk for mistreatment.

These are many of the issues and challenges that were identified and discussed at the Safe Communities roundtable. Topics ranged from those focusing on the individual—falls prevention, driver safety, domestic violence, and caregiver support, for example—to organizational-level concerns such as safety in long-term care to community-level matters such as affordable housing, expanded transportation options, and public awareness of the needs of and resources for seniors, and on to broader safety-related issues such as disaster preparedness. The top three issues identified by the Wilmington group appear at the right.

When considering these key issues in state and national contexts, we should perhaps allow that a few other issues may be equally important and pressing. For example, the 2007 North Carolina Aging Services Plan identifies driver safety and domestic violence as emerging safety and security issues, neither of which were identified in Wilmington, yet both of which remain important in considering elder safety. Nationally, the Elder Justice Act, passed earlier this year, sets forth a number of initiatives that may inform priorities for our state. Finally, although the economy has slowed, the population of older adults in North Carolina continues to grow rapidly. It is more important than ever to identify the most effective and efficient strategies for building safe communities for North Carolina's older adults. Here is a brief examination of three of the major issues identified by roundtable participants. We identify best practices and questions for attendees at the Governor's Conference to consider, and conclude with recommendations for legislative and community action.



Safe Communities

Wilmington, June 2, 2010

- ◆ **Insufficient training and support for family caregivers**

Importance of respite care, including caregivers of persons with dementia and grandparents raising grandchildren, stress relief, access to resources

- ◆ **Growing concerns about abuse, neglect, and exploitation**

Identification and reporting of self-neglect, need to train and use public service employees as first line of defense for adult protective service reporting, address resistance to reporting

- ◆ **Lack of affordable housing and need to support proven services**

Value of services connected to affordable housing to support community living, lack of in-home support services and affordable home health care, reward for accountability

Fraud, Scams, and Financial Exploitation

With North Carolina's growing aging population, an increasing number of seniors risk being targeted by unethical telemarketers, home repair scams, sweepstakes fraud, and other deceptive practices. Elder fraud or the fraudulent financial exploitation of older adults is not a new phenomenon. What is new is the increasing sophistication and international scope of fraudulent operations and the widening role of the Internet and other forms of advanced technology as a means of perpetrating new and often hard-to-detect schemes. On a national scale, consumers lose over \$40

billion a year to telemarketing fraud, which is just one of many types of scams older adults face. According to the Federal Trade Commission, North Carolina consumers lodged 14,846 fraud complaints in 2007, and 23,128 in 2008. In 2008, 85% of these complainants reported an actual total loss of \$25,473,738. In addition, North Carolina consumers lodged 6,069 identify theft complaints in 2007, and 7,069 in 2008. These numbers are likely to increase as scammers obtain greater access to advanced technologies for reaching potential victims.

Perpetrators of the financial exploitation of older adults range from complete strangers to trusted family members, caregivers, and advisors. Motives range from intentional theft to withholding services or medical care to conserve the older person's financial estate. Different types of fraud and financial exploitation tend to strike different populations of older adults. For example, baby boomers are generally accustomed to taking high financial risk, making frequent use of computers, and using cell phones—all of which can aid telemarketers in gaining access to them in future years. Victims of lottery scams are more likely to be older unmarried or widowed women who live alone and who tend to be less educated. On the other hand, the victims of investment fraud tend to be more highly educated men who are married and have slightly higher income levels. There also has recently been a rise in health care fraud, as scammers take advantage of confusion over Medicare Part D. Finally, there is a growing concern for people affected by Alzheimer's disease and other dementias. These people are particularly vulnerable because they often lack the ability to make sound decisions, especially when pressured to decide quickly.

Training for family caregivers in how to identify attempts at exploitation is among the top three priorities roundtable participants identified, but some of the issues they gave lower priority included education and public awareness about mail fraud, sweepstakes lotteries, prescription drug abuse and selling, and prostitution aimed at older men in exchange for drugs.

North Carolina's programs to assist in preventing and addressing fraud, scams, and financial exploitation include:

- ◆ The NC Senior Consumer Fraud Task Force distributes regular fraud alerts.

- ◆ Project S.A.F.E. is an initiative of the NC Division of Aging and Adult Services and the NC Justice Academy to better prepare law enforcement personnel to investigate criminal allegations on behalf of residents of long-term care facilities.
- ◆ The Senior Medicare Patrol, led by the NC Department of Insurance, uses older volunteers to detect, prevent and report health care errors, fraud, and abuse
- ◆ People who have been exploited once are more likely to be exploited again, so the Victims Assistance Program, operated through the NC Division of Aging and Adult Services and the NC Attorney General's Office, helps people avoid being exploited again.
- ◆ AARP sponsors volunteers for a Fraud Fighters program.
- ◆ Scam Jams and Shred-a-Thons are sponsored by Area Agencies on Aging and others.
- ◆ Finally, county departments of social services, which are responsible by law for evaluating all allegations of elder abuse, neglect, and exploitation, play a key role in keeping older adults and younger adults with disabilities safe.

Still, the NC Public Policy Research Center recognized that North Carolina has more to do. The Center included the following recommendations in its 2010 report "The Art of Aging: Our Elders, Our State":

1. Give the NC Attorney General authority to initiate prosecutions for fraud against older people. North Carolina is one of only five states

whose Attorney General has no authority to initiate local prosecutions (others are Arkansas, Connecticut, Texas, and West Virginia).

2. Clarify and strengthen the language of N.C. General Statute Chapter 108A, the Protection of the Abused, Neglected, or Exploited Disabled Adult Act to include vulnerable adults instead of limiting it to adults with disabilities.
3. Expand North Carolina's current data collection system to require reporting on the statewide incidence and prevalence of mistreatment of older adults.
4. Establish a study commission to examine how the NC Commissioner of Banks, the financial management industry, and law enforcement agencies can partner to prevent fraud against the older people. The study commission should assess whether training for bank employees can help them recognize, report, and reduce the incidence of fraud.

In an earlier report, the NC Public Policy Research Center also made the following recommendations:

1. Enact meaningful legislation that will provide government oversight and consumer protection against telemarketing fraud.
2. Require all telemarketing businesses and their agents that operate in the state to be registered. If North Carolina allows any exemptions to the registration requirement, the entity must still be subject to the state's telemarketing and consumer fraud laws.

3. All telemarketers must be bonded, so they can compensate consumers they defraud.

Disaster Preparedness

Regardless of age, too many North Carolinians are ill-prepared for any kind of major disaster. We have the illusion that we can gather needed supplies and items at a moment's notice, but most of us suffer from ignorance about what it really takes to survive a major interruption in our regular lives. For older adults, the issues may be even more complex. When planning for a disaster, we must guard against categorizing the diverse and growing older population into one large group. Different subpopulations may well have different needs and obstacles. For instance, seniors who belong to minority groups may have a historical distrust of government, and the response to Hurricane Katrina in 2005 may have reinforced this point of view. People living in poverty may be too stressed by managing day to day to prepare. Homeless seniors, including some veterans, continue to be a growing issue in North Carolina, and accounting for people with no fixed residence in a disaster is challenging. Another lesson from Hurricane Katrina showed clearly the vulnerability of residents of long-term care facilities. The challenges of these various groups can be aggravated by the differences that exist in local emergency planning guidelines among the 100 County Emergency Management Departments.

In September 2008 North Carolina's Disability and Elderly Emergency Management (DEEM) Taskforce released 16 recommendations to strengthen emergency preparedness and response for people with disabilities and older adults. This multiagency initiative sponsored community forums and based its final report on the work of a large taskforce. Recommendations are posted at www.nccrimecontrol.org/div/em/Documents/DEEM_Report_of_Recommendations.pdf.

Older adults who live in rural areas and people with disabilities, regardless of location, are at disproportionate risk during disasters. Many North Carolinians face economic and transportation challenges daily. People of all ages who have disabilities and depend on assistance to manage their lives face significant barriers in preparing for and responding to disaster.

Local emergency response units and the agencies providing services to older adults and people with disabilities must be better connected. Both groups must build a closer network in order to best meet the needs of the community, so that each group understands the other's mission and responsibilities.

Emergency shelters for the general population are not equipped to assist individuals with specialized needs. Shelters for special medical needs, which provides medical support to people of all ages (including children) and their caregivers, are opened on a county-by-county basis. However, neither general nor medical shelters may be prepared to work with people who are deaf/hard of hearing, blind, or both. People with barriers to communication often do not need the support of a medical needs shelter, but they do need access to communication resources in shelters and at home to receive important emergency information. Participants also identified the need for communication strategies—closed-captioned weather alerts, for example—before disaster strikes. At most of the roundtables, transportation was cited as a critical need, and during an emergency it rises to particular prominence, particularly for people who live in rural areas.

Finally, participants at the roundtable recognized the lack of disaster plans in long-term care facilities, the importance of special needs registries, and other community and individual plans, including planning for sheltering pets.

Adult Protective Services

North Carolina's Adult Protective Services (APS) Program, as authorized by N.C.G.S. 108A, gives county departments of social services responsibility for receiving and evaluating reports of abuse, neglect, and exploitation of vulnerable adults. APS social workers help identify, remedy, and prevent elder mistreatment. Research has consistently shown that the risk increases with age, and the number of reports increases as the number of older adults in our state grows. In fact, adults age

60 and over make up of nearly 70% of those receiving Adult Protective Services in North Carolina. Our state's APS program must be prepared to respond to the needs of a growing population of vulnerable and older adults.

According to a 2009 survey that included 77 of 100 county Departments of Social Services (DSSs), there are demonstrated increases in reports received and evaluated over the last few years. (See the table.) Not only have reports increased in general, but two-thirds (67%) of county DSSs are seeing an increase in first-time APS reports. Nearly half (49%) of DSSs report increased referrals from their Adult Medicaid and Special Assistance areas, more than a third are from their Energy Assistance Program (34%) and their units serving children and families (38%). To add to the challenge, two-thirds of DSSs are experiencing reduced funding for their own essential services for APS cases.

The most common forms of mistreatment reported involve self- and caregiver neglect. Financial exploitation of vulnerable and older adults is among the fastest growing crimes in the nation. Perpetrators of caregiver neglect and financial exploitation are generally family members, professional caregivers, close friends or others in a position of trust, with the most frequently named perpetrator of these acts being an adult child. Research suggests that there are far more actual instances of abuse, neglect, and exploitation of vulnerable and older adults than are actually reported.

Abuse, neglect, and exploitation of vulnerable and older adults is not a new phenomenon. We have long recognized

Adult Protective Services in North Carolina, 2007–2010

	State Fiscal Year			
	2007	2008	2009	2010
Reports Received	14,177	15,337	17,073	18,378
Reports Evaluated	6,786	8,117	9,252	9,588

Note that only reports meeting the requirements of the state statute are evaluated.

its existence but have failed to give it national importance consistent with comparable programs dealing with child protective services and violence against women. North Carolina passed one of the earliest versions of state law to protect vulnerable adults, but after more than 35 years, there is a need to make statutory reforms and fund investments to keep pace with current and future service demands.

There is some encouraging news in the landmark health care reform act, signed by President Obama in March 2010, which included some elder justice provisions. Elder justice in this context means assuring adequate public-private infrastructure and resources to prevent, detect, treat, understand, intervene in, and, where appropriate, prosecute elder abuse, neglect, and exploitation. From an individual perspective, elder justice is the right of every older person to be free of abuse, neglect, and exploitation. The Elder Justice Act promotes both aspects. The nonpartisan Elder Justice Coalition called these provisions, “The most comprehensive federal legislation ever to combat elder abuse, neglect and exploitation.” Still, while the provisions authorize federal resources to support state and community efforts to address elder abuse through APS and the Long Term Care Ombudsman Program, no funds have been appropriated.

Participants at the roundtable recognized the important role of APS in several areas. First, by identifying the need for training and support for family caregivers as a priority issue, the group indirectly identified the important role of APS in safe communities, because many cases of elder abuse and neglect stem from unaddressed caregiver stress. In

addition, the group identified the need for training and education for public service employees and the general public regarding abuse and neglect and how APS works (so they can effectively report). Increased funding for APS was noted, and although it does not directly mention APS, the priority issue “increase funding and accountability of funding for services that keep older adults safe” certainly must include the services provided by APS.

The National Center on Elder Abuse’s Promising Practices Clearinghouse lists program models and information resources around the country related to elder abuse, prevention, intervention, and public education. Three model programs are identified for North Carolina: First is an agency that treats domestic violence and sexual assault and that offers direct services to older adults. Second, the NC Division on Aging and Adult Services Long-term Care Ombudsman program has developed *Strategic Alliances for Elders in Long Term Care* (S.A.F.E. in LTC), a curriculum and workshop for law enforcement investigators and detectives titled “Investigating Crimes in Long Term Care Facilities—Voiceless Victims.” Third, the University of North Carolina (UNC) Hospitals Beacon Child and Family Program provides comprehensive, coordinated care to patients, families, and employees experiencing a variety of family violence.

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