



South Carolina Summit on Aging White Paper

Meeting Greater Elder Needs with Fewer Resources in South Carolina

November 3, 2004

Esther M. Forti, Ph.D., R.N.
Member, South Carolina Center for Gerontology Policy Board
Director, South Carolina Geriatric Education Center
Associate Professor, College of Health Professions,
Medical University of South Carolina

Cheryl Dye, Ph.D., CHES
Chair, South Carolina Center for Gerontology Policy Board
Associate Professor, Department of Public Health Sciences,
Clemson University

Geri Adler, Ph.D. M.S.W.
Director, South Carolina Center for Gerontology
Associate Professor, College of Social Work,
University of South Carolina

Published: April 2005



Sponsors

SC Alliance 2020

**SC Leadership in Public Service
Program**

SC Geriatric Education Center

**Medical University of South Carolina's
Center on Aging**

SC Area Health Education Consortium

SOUTH CAROLINA SUMMIT ON
aging

ACKNOWLEDGEMENTS

The authors acknowledge the support and assistance of the following persons who helped make the Summit on aging a success:

Transcription of the Summit proceedings: Mary Ann Moore, Ph.D.

Editorial review: Jennie Ariail, Ph.D.

Audio visual set-up and maintenance: Kesha Wall, M.S.W.

Registration and CE credits: Debbi Lewis, M.A., R.R.T.

University of South Carolina's students for assistance with the breakout sessions:

Scarlett Benjamin

Lacey Brother

Nicole M. Cavanagh

Stacey H. Craps

Beverly Dill

Jennifer L. Summers

Note: The morning session was videotaped for distribution. To request a copy of the videotape, contact: Geraldine Washington at the South Carolina Center for Gerontology, University of South Carolina, Columbia, SC, 29208, Telephone (803)777-4221 or email Geraldinew@gwm.sc.edu

Copies of the Summit White Paper are also available in hard copy by contacting Geraldine Washington or accessing it on the web at <http://www.cosw.sc.edu/research/gerontology> or <http://muscd.edu/scgec>

Table of Contents

	Page
Executive Summary.....	1
Summit on Aging Agenda.....	2
Speaker Biographical Information.....	3
Introduction/Rationale.....	4
Profile of South Carolina’s Mature Adults.....	5
Mature Adult Issues and Possible Actions.....	6
Summit on Aging: Overview and Welcome.....	7
Summit on Aging: Keynote Address – Aging Successfully.....	22
Summit on Aging: Panel Discussions.....	23
Summit on Aging: Breakout Sessions.....	34
Policy Recommendations.....	49
References.....	52

Executive Summary

One hundred fifty professionals across South Carolina attended the inaugural Summit on Aging held November 3, 2004 in Columbia, South Carolina. The Summit provided the opportunity for stakeholders from various agencies and organizations to identify issues, form collaborations to address a critical problem in South Carolina -- the growing numbers and needs of older adults with inadequate resources to meet those needs, and make policy recommendations.

Many older South Carolinians, especially those in rural areas, continue to experience compromised conditions, particularly in health and economic security. Solutions for reducing these disparities require collaboration among aging organizations and programs that leverage each stakeholder's limited resources. The Summit consisting of a panel of experts on aging and breakout sessions provided the synergy and creative problem-solving critical in meeting the needs of our state's oldest citizens.

The following policy recommendations were developed from the break-out session discussions:

Workforce Issues

- Offer tuition incentives and monetary enticements for high school graduates and undergraduates students to choose careers in aging.
- Eliminate issues of liability that may discourage people from volunteering.
- Be proactive in evaluating the consequences and developing strategies for the retirement of a large number of state employees in the near future.
- Mandate educational institutions to alter their curriculum to provide courses in geriatrics and gerontology.
- Mandate a specific number of credits in geriatrics for health and social services professionals as a condition for license renewal.
- Facilitate continuing education training in geriatrics and gerontology for health care professionals.
- Recruit, train, and retain more mental health providers.

Balancing Long-Term Care Expenditures

- Create government-sponsored programs to promote and support homecare for the elderly.
- Support policy research to examine policy options to address the long waiting period for obtaining long-term care services in South Carolina.
- Allow spouses, legal guardians, or parents of a minor child to participate as state providers in the policy change for family caregivers initiated November 1, 2004.

- Replicate and adapt Programs of All-inclusive Care for the Elderly (PACE) in South Carolina's rural areas to enable senior citizens to live as independently as possible and keeping them in their own homes and communities.
- Provide tax credits for long-term care insurance to South Carolinians.

Health Promotion

- Promote aging in place through health promotion and improved access to health and social services in rural communities.
- Empower older adults to manage their health through health promotion education about exercise, nutrition, and chronic disease management.
- Develop intergenerational programs that foster cultural appreciation for all age groups.
- Promote service-learning projects for high school and college students to increase a spirit of volunteerism and sensitivity to the elderly.
- Increase use of state-funded public service announcements about aging issues.

Rural Health and Health Disparities

- Promote interagency collaboration and service coordination such as the one-stop centers within and among rural communities.
- Provide quality of care for all older adults regardless of minority status, with special attention to differences among race in presentation and treatment of disease.
- Mandate cultural competence training for all those who provide health and social services to older minorities.
- Develop and administer strategies such as a core of volunteers in rural areas to provide transportation for elders.
- Promote and utilize churches in rural areas to assist with health and social services needs and health promotion.
- Develop and maintain databases on older minority populations.

Geriatrics Best Practices

- Promote policy on the federal and state levels to reimburse geriatric case managers and geriatric community health workers.
- Pressure insurance companies to pay for preventive health care so as not to wait for the onset of more serious and costly disease processes.
- Partner with universities to use Long-Term Care and Continuing Care Retirement Community facilities to train health professionals during internships and clinical experiences.
- Collaborate with Dental Societies to offer low--cost dental care for seniors.
- Bring faith-based community to the table for senior service discussions.

Hospice and End-of-Life Care

- Require a Pain Management curriculum requirement for all medical and health professions schools.
- Require Hospice rotation for all medical students and primary care resident physicians.
- Require geriatric fellowships to have segments on pain management and end-of-life care, including hospice rotation.
- Advocate for the South Carolina Medical Licensing Board, a re-licensing requirement for Continuing Medical Education (CME) hours related to pain management and palliative and end-of-life care for practicing physicians.
- Require annual in-service training on pain management, palliative and hospice care for all nursing and supportive staff in long-term care facilities.

Health Services Research

- Identify sources of funding for research to better understand the problem of transportation to health care and social services for older persons in rural areas.
- Connect evidence-based research to the delivery of health care and social services, by supporting translational research at South Carolina's universities and colleges.
- Support health services research on how the coming generation of older South Carolinians differs from the current older population to anticipate needs for health care and social services in the coming decades with a focus on healthy aging, lifestyles, and public health.
- Support health services research to examine health services utilization and needs of diverse segments of South Carolina's aging population, including the well-old and the disabled, minority populations, rural residents, and affluent older persons.
- Support epidemiological research examining disease occurrence among diverse segments of South Carolina's aging population, including the well-old and the disabled, minority populations, rural residents, and affluent older persons.

SOUTH CAROLINA SUMMIT ON
aging

AGENDA

Meeting Greater Needs with Fewer Resources in South Carolina

November 3, 2004

Columbiana Hotel and Conference Center

Hosted by SC Center for Gerontology

Sponsored by SC Leadership in Public Service, SC Alliance 2020, SC Geriatric Education Center, MUSC Center on Aging, and SC AHEC

8:30 – 9:00 AM

Registration

9:00 – 9:15 AM

Summit Overview and Welcome

Gerri Adler, Ph.D., M.S.W., Director, South Carolina Center for Gerontology

Cheryl Dye, Ph.D., CHES, Chair, South Carolina Center for Gerontology Policy board

9:15 – 9:30 AM

Opening Remarks

The Honorable Andre Bauer, Lieutenant Governor, State of South Carolina

9:30 – 10:15 AM

Keynote Presentation

Introduction: Jerome Kurent, M.D., Medical University of South Carolina

John Morley, M.B., B.Ch., St. Louis University

10:15 – 10:30 AM

Break

10:30 AM – Noon

Panel Discussion

Where Are We Now and Where Do We Need To Be?

Panel Facilitator: R. Bradford Whitney, M.D., Spartanburg Regional Healthcare System

Panelists

Bruce E. Bondo, M.P.H., Director of Planning and Education Services, Lieutenant Governor's Office on Aging

Michael Byrd, Director of the Bureau of Chronic Disease and Health Promotion, South Carolina Department of Health & Environmental Control

Lotta Granholm-Bentley, PhD, D.D.S., Professor of Physiology and Neuroscience & Director of the Center on Aging, Medical University of South Carolina

Victor Hirth, MD, MHA, CMD, FACP, AGSF, Medical Director, Geriatric Services, Palmetto Health System

Thomas Lloyd, South Carolina Silver Haired Legislature, Speaker 2003-2005

Gardenia Ruff, M.S.W., Director of the Office of Minority Health, South Carolina Department of Health & Environmental Control

Erika Walker, M.B.A., M.S.Ed., Director of the Sage Institute

Noon – 1 PM

Lunch

1:05 – 3 PM

Breakout Sessions

How do we Collaborate to Meet Growing Needs?

Workforce Planning – Jennifer Solomon, Ph.D.

Balancing Long-Term Care Expenditures – Michael Byrd & Judy Baskins. R.N.

Health Promotion of Older Adults – Cheryl Dye, Ph.D., CHES

Geriatric Best Practices – Erika Walker, M.B.A., M.S.Ed.

Rural Health & Health Disparities – Gardenia Ruff, M.S.W. & Esther M. Forti, Ph.D., R.N.

Hospice & End-of-Life Care – Jerome Kurent, M.D., M.P.H. & Tamra West. B.S.

Health Services Research – Jim Laditka, Ph.D. & Barbara Tilley, Ph.D.

3 – 3:15 PM

Break

3:15 – 4:130 PM

Summary of Group Discussions & Wrap-UP

G. Paul Eleazer, M.D., FACP, AGSF, University of South Carolina School of Medicine

SPEAKER BIOGRAPHICAL INFORMATION

Keynote: John Morley, M.B., B.Ch.

Dr. Morley is a Dammert Professor of Gerontology and Director of the Division of Geriatric Medicine, St. Louis University Medical School, St. Louis, Missouri, and Director of the Geriatric Research, Education, and Clinical Center, St. Louis VA Medical Center. He is internationally known as a gerontological researcher, clinician, and educator. Dr. Morley has directed the clinical training programs in endocrinology and geriatrics and supervised research activities ranging from basic biomedical investigation to epidemiology and health services research. Dr. Morley is the editor of the *Journal of Gerontology: Medical Sciences*. Dr. Morley's honors and awards include the Ipsen Foundation of Longevity Award in 2001; the American Geriatrics Society's Lascher/Manning Award for Lifetime Achievement in Geriatrics in 2002; Fellowship in the Gerontological Society of America in 2003; and the Gerontological Society of America Joseph T. Freeman Award for his work in geriatric research and practice in 2004.

Panel Facilitator: R. Bradley Whitney, M.D.

Dr. Whitney graduated from the University of the South in Sewanee, Tennessee, and the Medical University of South Carolina. Following his family practice residency in Chicago, he completed a fellowship in geriatric medicine at the Oregon Health Sciences University. Dr. Whitney is board certified in family medicine/geriatrics and is a certified medical director for long-term care facilities. He has been providing medical care to seniors for more than 19 years. Currently, Dr. Whitney serves as both Director and Medical Director of Regional Senior Health, a division of Spartanburg Regional Healthcare System. In 2004, Dr. Whitney was awarded the American Geriatrics Society Clinician of the Year.

Closing Speaker: G. Paul Eleazer, M.D., FACP, AGSF

Dr. Eleazer is Professor of Medicine at the University of South Carolina School of Medicine and Director of the Division of Geriatrics, Department of Internal Medicine. He received his medical degree from the Medical University of South Carolina and completed his residency in internal medicine at the University of Kentucky. Dr. Eleazer holds a certification in geriatric medicine and is a Fellow of the American Geriatrics Society (AGS), Diplomate of the American Board of Internal Medicine, and Fellow in the American College of Physicians. Dr. Eleazer's honors and awards include membership in Phi Beta Kappa Honor Fraternity, Omicron Delta Kappa Honor Fraternity, the O'Neill Barrett Teaching Excellence Award in 1991, the Teaching Advancement Award from the University of South Carolina School of Medicine in 1998, 1999 and 2001, and has been listed by Woodward & White as one of the Best Physicians in America in 1997, 1999, and 2001.

South Carolina Summit on Aging

Introduction

One hundred fifty professionals across South Carolina attended the inaugural Summit on Aging held November 3, 2004 in Columbia, South Carolina. The Summit provided the opportunity for stakeholders from various agencies and organizations to identify issues, form collaborations to address a critical problem in South Carolina -- the growing numbers and needs of older adults with inadequate resources to meet those needs, and formulate policy recommendations.

Rationale

Many older South Carolinians, especially those in rural areas, continue to experience compromised conditions, particularly in health and economic security. Solutions for reducing these disparities require collaboration among aging organizations and programs that leverage each stakeholder's limited resources. The Summit on Aging provided a dynamic platform for researchers, educators, practitioners, caregivers, politicians, policymakers, and grassroots-community members to collaborate to enhance the well being of older adults in South Carolina. The Summit consisting of a panel of experts on aging and breakout sessions provided the synergy and creative problem-solving critical to meeting the needs of our state's oldest citizens.

The Summit was divided into four sessions:

Session 1: Opening Remarks by the Honorable Andre Bauer, Lieutenant Governor of South Carolina.

Session 2: Keynote Address presented by John Morley, M.B., B.Ch., a nationally recognized geriatrician from St. Louis University.

Session 3: Panel Discussion with experts representing state agencies, academe, health care, and community groups shared their perspectives on the current state of aging in South Carolina and made recommendations to support the health and well being of older South Carolinians.

Session 4: Breakout Discussions whereby participants met in small groups to discuss existing agency programs and projects and to develop strategies for collaboration across agencies. Policy recommendations were formed from the breakout group discussions.

Background

The US Census Bureau (2000) predicts the 65 and older population will increase from one in eight Americans today to one in six by 2020; the mature adult population will total 53.7 million, representing a 53.8% increase over the current 34.9 million older adult population. By 2050, statisticians predict that there will be approximately 19 million persons who are 85 and older. Additionally, when the first Baby Boomer turned 50 in 1996, this was the first time in history that the 50-plus age group outnumbered teens. Those 50 and older now claim one-quarter of the nation's population, their numbers having risen steadily with each decade. The nation - and our state - is growing older.

Improved longevity and improved health status has been a major accomplishment of the 20th century. Disease prevention messages continue to increase awareness of the need for good nutrition, exercise, weight control, and smoking cessation in contributing to increased years and a healthier, more active mature life. Medical research and breakthroughs are also contributing to a vigorous old age: angioplasty and bypass surgery are sustaining hearts and saving lives at a stunning rate. New pharmaceuticals are helping prevent costly hospital stays and keeping potentially deadly diseases in check.

However, the greatest fears in growing old center on health. In a 2002 study by the National Council on the Aging, the greatest fears of Americans with regards to growing old were memory loss, suffering physical pain, and the costs of long- term care. With the aging of Boomers and their market force, medical and health care will increasingly focus on those fears. Recent AARP surveys (2002, 2003) also reveal that older adults desire to “age in place” for as long as possible in their homes and communities (SC Mature Adults Count, 2003).

Profile of South Carolina’s Mature Adults

Socio-demographic characteristics

Mature adults as a group outpaced others with a 33% growth rate between 1990 and 2000. In 2000, South Carolina had 485,300 residents 65 and older, a number that has increased by 100,000 each decade from 1950 to 1990, and by 90,900 from 1990 to 2000. South Carolina is one of the fastest growing states for seniors in the nation;

SC Adults 65 years and older represent 12.1% of the population.

42.3% of residents 65 and older have less than a high school education.

75.6% are white as compared to 67.2 percent of the total population.

55.3% are women as compared to 51.4 percent of the total population.

Life expectancy for a 55-year-old woman is 82 years; 5.4 years longer than for a man.

Whites live an average three years longer than non-whites. The life expectancy differences between races and genders is expected to lessen in the next century, which should result in the composition of the mature adult population more closely resembling the general population.

According to the Behavioral Risk Factor Surveillance Study (BRFSS, 2000), 2.3% of the population 65 and over has no health insurance.

During 2001, private health insurance was the payment source for 60% of the state's 50-64 population receiving either inpatient or outpatient services. The majority of individuals 65 and over used Medicare (94%) as their payment source for such services.

Older women are particularly vulnerable to poverty. Many have never been employed, left employment to raise children, or worked in jobs where pensions were not provided. They are dependent on their spouse's pension or Social Security survivor benefits, but find out too late that they are not eligible for them.

In 2000, the median income for South Carolina residents 65 and over living alone was \$13,721 for women and \$19,330 for men. According to the 2000 Census, 34.6% of black women 65 and over in South Carolina live in poverty as compared to 11.8 % of their white counterparts primarily because of the reduced employment opportunities and wages available to them during their work years; 9.2% of whites 60 and over lived below the poverty level, while 30.8% of blacks were below poverty.

In SC, 30.2% of the 65 and older age group are edentulous (tooth loss) as compared to 24.4% nationally. Fifty-eight percent of rural elders have not seen a dentist in the past year. In rural areas, 37% are edentulous as compared to 27% of urban elders (SC Mature Adults Count, 2003).

Mature Adult Issues

Many of the following mature adult issues have identified in the Summit panel and break-out session discussions as well as from the South Carolina Mature Adults Count, 2003 and the South Carolina DHEC Healthy People Living in Health Communities 2004 publications.

Alzheimer's Disease and Related Dementias

As people age, the nation and the state of South Carolina will face the soaring costs of caring for persons with Alzheimer's Disease (AD) and other dementias (ADRD). It is

estimated that currently 4 million people in the United States may have Alzheimer's disease. The disease usually begins after age 65 and risk of AD goes up with age. About 3% of men and women ages 65-74 have AD and nearly half of those over age 85 could have the disease (American Association for Geriatric Psychiatry, 2004). According to the South Carolina Alzheimer Disease Registry (2004) and population estimates for 2002 data, about 8% of those 65 and older have ADRD with 31% of those over 85 years having ADRD. African Americans are at higher risk of ADRD than non-Hispanic whites with those between 65 and 84 being twice as likely to have ADRD.

Alzheimer's disease advances in stages, ranging from mild forgetfulness to severe dementia. The course of the disease and the rate of decline varies from person to person. The duration from onset of symptoms to death can be from 5 to 20 years. Currently, there is no effective treatment for AD that can halt the progression. However, some experimental drugs have shown promise in easing symptoms in some patients. Medications can help control behavioral symptoms, making patients more comfortable and easier to manage for caregivers. Still other research efforts focus on alternative care programs that provide relief to the caregiver and support for the patient (American Association for Geriatric Psychiatry, 2004).

In South Carolina, the Alzheimer's Resource Coordination Center (ARCC) was created through state legislation in April of 1994. The center is housed in the Lieutenant Governor's Office on Aging and was created to provide statewide coordination, service system development, information and referral, and caregiver support services to individuals with Alzheimer's disease and related disorders, their families and caregivers. The center maintains resource materials, such as training videos and resource books on Alzheimer's disease and related dementias, which are available for use by entities serving persons with Alzheimer's disease and/or their caregivers. To assist local communities in developing or strengthening programs or services to serve people with dementia and their caregivers, the ARCC awards seed grants to community organizations. In awarding grants, consideration is given to priority needs and criteria for selecting grant recipients. As a condition to receiving a grant, the community or other entity must provide matching funds or in-kind contributions equal to the amount of funds awarded in the grant (ARCC, 2004).

Diabetes and Hypertension

Diabetes is also a common problem for the elderly, especially African American women. It is the sixth leading cause of death in South Carolina. According the 2000 Behavioral Risk Factor Surveillance System BRFSS, 12.7% of those 55-64 and 15.5% of those 65 and older reported having been told by a doctor that they had diabetes. The rates are twice as high for African-Americans.

Hypertension (high blood pressure) is one of the leading risk factors for heart disease and a common cause of death among older persons. In South Carolina, 44.8% of people ages 55-64, and half of those ages 65 and over reported that they had been told that they had high blood pressure. This problem is most common in African-American

females. High cholesterol, which can contribute to hypertension, was reported in 40.4% of people 55–64, and 37.2% of those 65 and over (SC Mature Adults Count, 2003).

Medication Use

According to a 1990 Panel Study of Older South Carolinians, 63% ages 55–64, 75% of those 65–84, and 82% of those 85 and over used prescription drugs to maintain their health. In each of these age groups, the majority was using an average of one to three drugs. Multiple medications including their suitability and adverse drug reactions particularly impact the elderly. The elderly take 4 times as many prescriptions per capita as the younger population. Hospital admissions for adverse drug reactions among the elderly are almost six times the rate for the general population. One report showed that 28% of hospitalizations of the elderly were due to adverse drug reactions (17%) or non-compliance (11%). In addition to the high cost of medications, overuse and under-use can be problems (GAO, 1995). Many older adults take drugs that are not suitable for their illnesses or age. A 1996 study found that nearly 1 million older persons were prescribed one of 11 drugs deemed unsuitable for the elderly (SC Mature Adults Count, 2003).

Mental Health

Nearly 20 percent of those 55 years-and-older experience mental disorders that are not part of normal aging. Most common disorders, in order of prevalence, are anxiety, severe cognitive impairment, and mood disorders. Studies report, however, that mental disorders in older adults are underreported. The rate of suicide is highest among older adults compared to any other age group – and the suicide rate for persons 85 years and older is the highest of all – twice the overall national rate. Depression often co-occurs with other serious illnesses such as heart disease, stroke, diabetes, cancer, and Parkinson’s disease. Because many older adults face these illnesses as well as various social and economic difficulties, health care professionals may mistakenly conclude that depression is a normal consequence of these problems, an attitude often shared by patients themselves. These factors together contribute to the under-diagnosis and under-treatment of depressive disorders in older people (American Association for Geriatric Psychiatry, 2004).

Mental health problems are present in many of the elderly in South Carolina. A significant number of older residents responding to the 1990 Panel Study of Older South Carolinians survey expressed the following problems:

- 15% report frequent depression and/or stress
- 22% had difficulty falling asleep
- 8% felt afraid
- 9% felt like crying
- 22% had poor appetites
- 25% felt lonely and/or depressed (SC Mature Adults Count, 2003)

Arthritis

Arthritis and other rheumatic conditions are among the most common chronic conditions and the leading cause of disability in the United States. In South Carolina, 28% of adults have physician-diagnosed arthritis. The prevalence increases with age as nearly 60% of adults 65 years and older have arthritis (SC DHEC, 2004).

Falls in the Elderly

In the US, unintentional injuries are the eight leading cause of death among adults 65 years-and-older. Consequently, injuries are a major cause of disabilities and hospitalization, and post-hospital care. The risk of falling increases with age and is greater for women than for men. Two-thirds of those who experience a fall will fall again within six months. A decrease in bone density contributes to falls and resultant injuries. Failure to exercise regularly results in poor muscle tone, decreased strength, and loss of bone mass and flexibility. In addition, as people grow older, they may have difficulty with their balance. Also, about 9% of adults 65 years-and-older report having problems with their balance. Approximately one-third of all falls in the elderly involve environmental hazards in the home. For the 85 or older age group, falls are the leading cause of injury-related deaths (Colorado Cooperative Extension, 2004).

Elder Abuse

In South Carolina, the 1993 Omnibus Adult Protection Act provides for the protection of vulnerable adults over the age of 18 from abuse, neglect, and exploitation by others. Moreover, these vulnerable adults may also experience self-neglect when they become unable to meet their own basic needs. The Department of Social Services and the Long Term Care Ombudsman program are responsible for investigating complaints of abuse, neglect and exploitation. The loss of good health, financial stability, a support network of family and friends, and safe neighborhoods and environments can result in increased vulnerability for older Americans to become victims of crime, fire deaths, financial scams, neglect, abuse or exploitation (SC Mature Adults Count, 2003).

Oral Health

Oral health is very important because of the oral-systemic connection and dental visits and good oral hygiene are important activities in maintaining this balance. However, Medicare does not cover oral care and Medicaid does not cover oral care for older adults in South Carolina. There is also a shortage of dentists in South Carolina, especially in rural areas. Many of the current dentists are near retirement age. Suggestions to increase dental providers include expanding loan programs for dental students, requiring students who receive loans to practice in underserved areas, and changing state regulation of hygienists so that they can provide more services (Vargus, Yellowitz, & Hayes 2003; SC Mature Adults Count, 2003).

Health Behaviors

Some health problems that the elderly frequently experience may be improved by behaviors such as exercising and eating a healthy diet. Being overweight or obese is a

common problem for many South Carolinians that can cause a variety of health problems, such as heart disease, stroke, some kinds of cancer, and diabetes. According to the 2000 BRFSS, 39.7% of 55–64 year olds are overweight, as are 32.4% of those 65 and over. The rates for obesity are 28.7% and 36.9%, respectively. Nutrition is a related issue where there is room to improve. Though it is recommended that people eat a low-fat diet with at least five servings of fruits and vegetables daily; 70.5% of 55–64 year olds and 68.5% of persons 65 and over said they did not eat 5 or more servings of fruits and vegetables a day.

Physical activity is another necessary ingredient for maintaining optimum health. Only 39.7% of 55–64 age group and 36.4% of those 65 and older reported engaging in regular physical activity. Of these same age groups, 29.3% and 38.9%, respectively, reported engaging in no leisure time physical activity (SC Adults Mature Count, 2003).

Health Disparities

Eliminating health disparities is a national priority and is embraced by South Carolina. The health conditions that disproportionately affect South Carolinians are cancer, cardiovascular disease, diabetes, HIV-AIDS, and immunizations. Diabetes affects older Black women more than any other group. Black men are more than twice as likely to die of cardiovascular disease as White men. Black women have 50% more strokes than White women. Cultural competency training and resources need to be targeted to providers and the public to facilitate early diagnosis and appropriate care and treatment to eliminate health disparities. In addition, efforts need to be enhanced to recruit more minorities into the health care field (SC DHEC, 2004).

Access to Care

Older adults use health services more than younger adults; about 45% of visits by older adults are to primary care physicians. Having a physician or medical facility nearby to provide basic and appropriate levels of health care will become more critical as the older population increases. Transportation is also an important factor in access to services. With an unprecedented growth in the aging population coupled with a significant in-migration of 50,997 over the age of 50 into the state between 1997 and 2002, some areas face serious shortages of primary and other medical care. The need for trained healthcare providers in geriatrics and gerontology will rise. Those living in rural areas, especially low-income elderly, will be particularly negatively affected because of currently inadequate supportive services such as health care and transportation. Low Medicare and Medicaid reimbursement rates contribute to the problem as a significant number of mature adults seek a medical home (SC Mature Adults Count, 2003).

Health Care Workforce

Increased longevity of our population brings the need for trained health care professionals and frontline workers who know about the aging process, presentation of diseases and disabilities in old age, and age-appropriate treatments, care, and support services. Many health care and social services professionals are not adequately trained

to recognize the unique health care needs of older adults. Providers may make incorrect diagnoses and health problems are often overlooked or dismissed as normal conditions of aging. Problems such as memory loss or incontinence are sometimes considered expected side effects of aging.

Moreover, less than half of medical schools have geriatric programs, and less than half of nursing programs have full-time faculty certified in geriatric nursing. The Institute of Medicine, Association of American Medical Colleges and other healthcare organizations have called for an increase in training in geriatrics and gerontology in health professions schools and universities. The complex needs of older adults often require a team of health care providers with aging-related expertise to work cooperatively in a variety of settings to help older adults maintain health and independence. The financial benefits of care provided by health and social services professionals trained in geriatrics and gerontology are potentially large. Prompt intervention and appropriate testing can reduce costs from avoidable hospital and nursing home admissions (Public Policy and Aging Report, 2003).

Transportation

Transportation strongly affects older people's ability to access health services as well as their ability to attend social activities to minimize a sense of loneliness and isolation. There are numerous problems in providing transportation especially in rural areas because of distance and economies of scale. Innovative solutions to transportation need to be developed resulting in better services and quality of life for older adults.

In-Hospital and Nursing Home Services

The need for in-hospital services and nursing home care increases with age. In 2001, South Carolinians ages 50–64 used 773.9 days of inpatient hospital services per 1,000 population. At age 65 and over, the days increased to 2242.1 days per 1,000 state population. There were 18,820 licensed nursing home beds in 196 facilities in South Carolina in January 2003. The occupancy rate was 91.9 for nursing home beds in the state and 81.3% of available beds are filled by persons over 65 years of age (SC Mature Adults Count, 2003).

Home Health Services

Home health services provide health care to the homebound or those confined to their homes because of illness or injury. Home health services include skilled nursing care, occupational, speech and physical therapy, social and dietetic services, and personal care aides. About 20% of all patients over 65 in medical practices have functional impairments that require home care services (SC Mature Adults Count, 2003).

Community based services allow older residents to "age in place" by bringing needed services into the patient's home, enhancing their quality of life, and delaying or reducing the cost of nursing home care. The trend toward home and community-based care has created 11,000 places for eligible people while 3,612 are on waiting lists for these services (SC Mature Adults Count, 2003).

Caregiving

Caregiving is a significant issue for mature adults who are frequently the recipients and the providers of such assistance. In South Carolina, family caregivers have always provided most of the long-term care for older persons. Among non-institutionalized persons needing assistance with activities of daily living, 65% depend solely on family and friends, and another 30% supplement family care with services from paid providers.

According to the 2000 BRFSS, approximately one out of every five adults in South Carolina (18%) provides care or assistance to a friend or family member over 60 years of age who is elderly or has a long-term illness or disability. Adult family caregivers provide 339.6 million hours of caregiving per year at an estimated value of 2.77 billion dollars. Many caregivers suffer serious stress and burnout, and 56% are forced to retire early or quit working. Without family caregivers, 50% of recipients being cared for would go to a Medicaid nursing home. The Older Americans Act Amendment of 2000 (PL 106-501) established the National Family Caregiver Support Program. In South Carolina, the program offers five basic services for family caregivers: information about services, referral in locating services, respite care, individual counseling and support groups, and supplemental support for services (SC Mature Adults Count, 2003).

Aging in Place

Aging in place is associated with greater quality of life. Surveys show repeatedly that older adults prefer to stay in their familiar homes and communities (i.e. age in place) (AARP 2000, 2003). Despite their intentions, they often have to move due to a various problems including diminishing health status, housing quality issues, lack of social support or caregiving, and economic hardships.

Rural elderly in particular have a strong “attachment to place” but face some of the greatest challenges to staying at home as they age and become frail. Rural elderly have poorer health, higher poverty rates, fewer healthcare practitioners and health resources, and more difficulty getting to health services (Gamm et al. 2003; Gamm & Bell, 2001; Schur & Franco, 1999; Chalmers & Joseph, 1998). These differences mean that rural residents have different needs for health care delivery, transportation, recreation, and access to social services than urban residents (Economic Research Service, USDA, 2004).

Recommendations from the first International Conference on Rural Aging held in 2000 were included in the report entitled “A Plan of Action on Rural Aging in the 21st Century.” The four major points noted in the report include: (1) the need for more and better research on the local, national, and worldwide consequences of increasing aging populations in rural areas; (2) the need to establish strategies for preventing illness and unintentional injury and to establish a base of good health among rural elderly people; (3) the need to educate all health care professionals about the special aspects of aging in rural communities; and (4) the need to abolish inequities in access to health care services and other services essential to the maintenance of independent lives among the rural elderly. The Plan includes policy recommendations for training programs for family and community caregivers, health professionals and paraprofessionals which

stress: supporting self-health-care; maintaining mobility, independence and mental health; preventing disability; coping with disabilities; and creating barrier-free environments (Hermanova and Richardson, 2000).

Rural and Medically Underserved Areas

South Carolina is predominantly a rural state with approximately 30% of the population in South Carolina living in rural areas with 40% of these are African Americans. South Carolina has 46 counties, of which 42 are federally designated whole or partial Health Professions Shortage Areas; 44 are federally designated whole or partial Medically Underserved Areas (HRSA, 2005). Rural areas also have a larger proportion of African American residents and thus, the issue of racial disparities in health and healthcare are directly related to improving health in rural areas. Policymakers need to consider the impact of policy decisions on health care based on rural needs. Urban policies are often inappropriately applied to rural areas.

Affording rural and medically underserved residents with health and social services is a challenge, especially with the decline in state resources. The costs per capita associated with service delivery tend to be higher in rural areas because of the lower population density. Ensuring access to convenient and reliable transportation is difficult in remote rural communities. Encouraging economic development is problematic since rural areas often lack the infrastructure needed to attract businesses. Less development coupled with lower per capita incomes limit local tax revenues resulting in fewer resources. Small rural employers are less likely than urban employers to provide health insurance. Rural agency staff has difficulty identifying persons/families in need because of sociological and psychological deterrents to reliance on public assistance programs. In addition, rural communities have a limited supply of health care providers and few or no specialty practices (Friedman, 2003).

Possible Actions

The older population explosion is creating specific needs and challenges. South Carolina could consider the following actions and programs to meet these needs:

Develop Senior Friendly Communities

Elements in a senior friendly community could include:

- Transportation
- One-stop-shops
- New senior center configurations
- Integration of elderly and non-elderly communities
- Change in attitudes towards aging

Promote a Continuum of Care

The continuum of care describes the breadth of health care services in life stages from personal behavior to palliative care. Public policy should facilitate an individual's understanding and navigation of the continuum of care.

Based on criteria and values affirmed by the Institute of Medicine, five principles underpin the continuum of care:

- Health of the individual is paramount;
- Health is an individual's capacity to pursue aspirations and happiness; unfettered by disease or disability;
- All individuals must have comparable opportunities to obtain services needed to assure good health;
- Local resource capacities to deliver healthcare services must be considered;
- Public policy should facilitate an individual's understanding; and navigation of the continuum of care.

Continuum of care needs to address public policies designed to assure that older adults receive appropriate health care services, in a timely manner, and in a place that optimizes care effectiveness (RUPRI Center for Rural Health Policy Analysis, December 2003).

Adapt Programs of All-inclusive Care for the Elderly (PACE)

Since 1983, Programs of All-inclusive Care for the Elderly (PACE) have been serving frail senior citizens in ways that enable them to live as independently as possible, keeping them in their own homes and communities. It accomplished this goal by offering a comprehensive set of services including medical care, physical and occupational therapy, nutrition, transportation, respite care, and socialization that kept people happier and healthier. It also created a way to pay for this care using federal, state and private funds that can be pooled at the program level, allowing maximum flexibility, effectiveness, and even cost-savings. The beauty of the PACE approach and the success it has had in keeping hospitalizations and nursing home admittance to a minimum have prompted its replication around the country.

There are five core elements of PACE that, according to the Centers for Medicare and Medicaid Services (CMS), must be maintained:

- Serve the frail elderly - participants in PACE programs must be 55 or older and nursing - home eligible
- Provide a comprehensive set of services - participants must receive a coordinated and integrated range of preventive, acute and long - term care services
- Use an interdisciplinary team of service providers - participants' care must be provided and managed by a team of providers ranging from primary care physicians and nutritionists to physical and occupational therapists
- Accept capitated payment-PACE providers receive a capitated rate that pools payment from Medicare, Medicaid and private payers

Because rural areas have smaller populations of PACE eligible seniors and have fewer health care providers, and also cover larger geographic areas, maintaining these core elements in a rural PACE program presents challenges. The key will be to focus on achieving the goals of PACE and its core elements while allowing for flexibility in the means used to achieve those ends. One possibility is using alternatives to the urban PACE model. Such action could include the use of a mobile center outfitted with the necessary personnel and equipment to deliver services to the participant rather than bringing the participant to the services. Another alternative might be the creation of several "outreach" centers that would be closer to, and serve, a smaller number of participants. In the information age, distance need not prevent providers from consulting one another or even from providing care. The use of advanced telecommunications technology can allow the team to "meet" face-to-face via two-way, live video. It also can enable a provider to monitor patients, assess their conditions, diagnose problems, and even administer care—all at a distance. Many rural communities are using lay people to fill in some of the gaps in workforce in rural areas. Community health workers can be trained to assist older adults with needed care and resources. With PACE, care management emphasizes preventive care and maximizes care in a community setting—leading to better health outcomes, higher participant satisfaction and lower costs (National PACE Association, 2005).

SUMMIT ON AGING

Overview and Welcome

Gerri Adler, Ph.D., M.S.W., Director of the South Carolina Center for Gerontology

Cheryl Dye, Ph.D., CHES, Chair of the South Carolina Center for Gerontology Policy Board

Opening Remarks

Speaker: The Honorable André Bauer, Lieutenant Governor State of South Carolina

Meeting Growing Needs of Elders with Fewer Resources

I am happy to be attending this meeting to discuss the conference theme: Meeting Growing Needs of Elders with Fewer Resources. This is a tough budget year in South Carolina. It is a good year to share our knowledge of health care needs of the elderly with legislative decision makers to make beneficial changes for the elderly. My advice to you is to get involved this year.

South Carolina is the *Number One* state in the Southeast for numbers of seniors migrating into the state. This is quite a distinction. Recently, the Surgeon General of the U.S. visited my office to share information concerning health matters, particularly the scare about the lack of flu vaccine this year. The press made a big story of the shortage while, in truth, four million units of the flu vaccine were thrown away last year. Sharing information helps keep everyone aware of the health care issues and needs of the people of the state and nation.

Transportation and other issues facing the elderly need to be explored and answers generated to keep the people aware of the facts. Huge challenges are ahead for the state in dealing with the elderly. Leaders must achieve a vision for the state of South Carolina. Communities like Sun City in Bluffton are the coming norm for the rising aged population, especially the affluent seniors migrating into our state. Everyone should take a look at the needs of aging citizens of the state. Young adults need to start today preparing for their elder years by buying long term care insurance, eating healthy, cooking without fats, all to promote changes in lifestyles and to add to their quality of life. By teaching the young now, it will eventually cut down on the cost for seniors.

QUESTIONS AND ANSWERS

What issues should be addressed this year in the General Assembly?

I want to see senior care issues be a permanent part of the responsibilities of the Lieutenant Governor's Office. We are meeting with different groups to get their perspective on what the senior issues are, so we can be their voice next year in the General Assembly. I may need your help swinging votes in the State Senate on some senior issues, so this may be a good year to get involved. Call your favorite legislator, begin a relationship and tell him/her what you need and want. This is all part of an education process that we've got to go through to let these legislators know what is on our minds. I can remember that when I served in the House and the Senate I listened very intently to what my constituents told me. If it was important to them, then it was important to me. Let's work together to make this a banner year for the seniors of South Carolina. One thing we should do is to join with the 23 other states that have created tax incentives for people to buy long term care insurance.

Where can I find assistance for respite care? Are there any state programs available or studies taking place for SC seniors?

There is an information, referral and assistance specialist in each of the 10 Area Agency on Aging in our state. There is also a caregiver advocate in each of the 10 AAA offices. In addition, we are working to launch the first web-based Aging Disability Information Center in Aiken later this year that could be the prototype for our state in coming years. Helping seniors find information is one of our top priorities. If anyone needs assistance in locating telephone numbers for their AAA office, please call my office at (803) 734-2080 or call the Lieutenant Governor's Office on Aging toll-free line at 1-800-868-9095. The information is also available on our website at www.aging.sc.gov

Is there any method in place for SC seniors to obtain low cost medications from sources outside this country such as Canada? Iowa has a plan for their seniors that seems to work.

Our Lieutenant Governor's Office on Aging is concentrating its I-Care insurance counseling program on helping seniors sign up for the new Medicare discount cards, and later on we will be working to see that our seniors are educated about and enrolled in the new Medicare prescription program. We are also working through some medication management pilot projects to help seniors access the free drug programs that the major pharmaceutical manufacturers offer. We are watching to see what other states are coming up with, and we are also waiting some sign from the federal government that these plans result in cost savings, are legal, and guarantee the safety of the prescription products.

With a state cap on long term care beds, what can be done to gain greater access to the limited number of beds and increase the certificates of need?

Again, these type issues begin with opening lines of communication with your legislators and helping educate them on the fundamental aspects of this issue. The certificate of need process is outside the jurisdiction of the Lieutenant Governor's Office on Aging but I encourage you to join together to lobby for your causes. Educate your legislators and help expand their knowledge on your issues.

Is there anything in the way of senior dental plans?

Dental care is a health issue, and I know the federally supported Medicaid and Medicare programs do not fund adult dental care in any meaningful way. We have a fantastic dental school at the Medical University of South Carolina, and we need to work together to broadcast to our seniors information about preventative dentistry.

Have you any knowledge of the Oregon Plan?

No, but maybe we should look into it.

What legislation is available for the prevention of Senior Abuse?

Protection of our seniors is a high priority, and we are asking for five new long-term care ombudsmen next year. New ombudsmen are also a priority with the Silver Haired Legislature and AARP, and we all need to work together to deal very firmly with those who abuse, neglect or exploit our seniors. You need to talk to legislators in the Senate Finance Committee and the Ways and Means Committee about the issues you have raised in your comments about the Department of Social Services losing resources and that impact on the Adult Protective Services programs. From now until January 1, there is a lull in the legislative schedule, so it is a good time to send your legislators pre-filing legislative initiatives for consideration in the 2005 General Assembly. Contact my office at the following number: 803-734-2080. I will be happy to fax out the current listing of legislative initiatives. If you have any good ideas you want me to hear, give them to Nela Gibbons, Director of the Lieutenant Governor's Office on Aging. You can call her on the Lieutenant Governor's Office on Aging toll-free line at 1-800-868-9095.

SUMMIT ON AGING

Keynote Address

Keynote Speaker: John Edward Morley, M.B., B.Ch.

Introduction: Jerome Kurent, M.D., M.P.H.

Aging Successfully

Helping older people means we work together as a team. Too often, we do not know what else is happening in people's lives. People in various professions try to police the actions of seniors rather than trying to work with them in making critical decisions. We need to involve seniors in their own lives and help them make the decisions that affect them. We non-seniors do not know what it is really like to be a senior. We must learn to listen, listen, and listen.

There is an autonomy conflict between people of younger ages and seniors. The young want to protect seniors by not letting them make their own critical life- decisions. The young are quick to restrict seniors' actions in order to protect them from themselves. Seniors want to live an unrestricted life for as long as they possibly can. They should be allowed to do everything they want unless it is dangerous, like bungee jumping.

We are all going to die. When we die should not be an issue of lawsuits. We should stop focusing on who is to blame. Tort legislation and lawsuits against physicians do not help the living. We should be looking instead at how we can make life better for the elderly and I suggest we get rid of lawyers from the health care system.

Since the 1900's, there has been a significant rise in the numbers of people who are living longer lives. By 2050, we can expect to see the 65+ age group will be about 20 per cent of the population. The 85+ population is the fastest rising age group.

Comparison studies show that we are getting stronger. In 1995, people over the age of 70 out-performed their counterparts in 1984, on endurance tests of basic physical functions walking, climbing stairs, stooping and reaching up, plus one of nine other functions. Men live better lives than women but women live longer lives. Women look after men and that is what makes their lives better. America will never be the top health care model when compared with the rest of the developing world. The numbers of people who are considered old (65 and above) are growing as well as the population considered old, old (70+).

As we age, we slowly lose the things that make life attractive...our vision dims, hearing lessens, our thinking process slows, memory is lost, senses of smell and taste lessen causing anorexia, hypodipsia, loss of muscle mass and strength, dehydration, and osteoporosis. Aging successfully is finding the ways around all of the stumbling blocks and disabilities.

As the Baby Boomers reach their 50's, they begin to take on quite a different look than in their younger days and that look shows definite signs of aging. Look at some of the people who did not let age slow them down. Grandma Moses painted her last picture at the age of 103. Sarah Louise Delaney of the Delaney Sisters was the eldest published author, publishing her second book at 105.

Remember, most of your physicians won't reach your age

Looking at the life expectancy of older people by gender, you see that both men and women are living longer today, up to four to five years longer for both men and women, if healthy. People want to remain in their homes longer, if possible. The criteria for living at home alone usually include the activities of daily living such as transfer from bed to other sites, toileting, bathing, dressing, eating and continence.

We see a considerable rise in memory impairment in people over 85 and older and younger age groups. It almost doubles each age group. About 25% of people 85 and older have severe depressive symptoms.

The core of Geriatrics comes when the elderly begin to exhibit social problems due to decreased functional status. Depression is the number one cause of ailments in the elderly. We must keep older people moving, not tying them down. There is NEVER a reason to tie down an elderly person. Our charge is to show them how to do the things they once could do before the strokes and heart attacks.

The elderly must keep up activity. Weight loss is lethal and we should be adding resistance exercises. The elders exercise prescriptions should include: endurance, yoga, balance, resistance and posture. Studies show that weight loss leads to death. The elderly have to fight to keep the weight on. The major cause of weight loss is the overuse of prescribed medications. Drugs do not work the same on the elderly. Polypharmacy problems have led us to conclude that when you decrease the number of medications, you decrease the number of deaths and hospitalizations.

A widely used pneumonic is "Meals on Wheels" to describe the causes of weight loss:

- Medications
- Emotional (depression)
- Alcoholism, anorexia tardive, abuse (elder)
- Late life paranoia
- Swallowing problems
- Oral problems
- Nosocomial infections, no money (poverty)

Wandering/dementia
Hyperthyroidism, hypocalcaemia, hypoadrenalism
Enteric problems (malabsorption)
Eating problems (tremor)
Low salt, low cholesterol diet
Shopping and meal preparation problems, Stones (cholecystitis)

Physicians prescribe the most expensive drugs for the elderly and tend to avoid the generic brands that are less expensive. That is the way of Capitalism. Medications should be used effectively to stop pain before it comes on, not after. The elderly need both high touch and high tech. The age wave is upon us. We are living longer and remaining functional for a greater time.

The elderly have a need for high touch not just high tech.

In **Aging 2010**, it is projected that all hospitals will have a continuum of care for the elderly. It will have units for the diseases of the elderly such as delirium and Alzheimer's. Computers will be a dominant feature in helping provide care, Medical records will be open-ended including monitoring prescriptions. As far as medications, the use of drugs will be more for prevention and less to promote the pharmacy industry.

In **Aging 2025**, our homes will be more aging friendly. There will be a cure for cancer. Drugs will be more user friendly without the side effects. Stem cell research will find cures for the neurological disorders such as Alzheimer's, heart disease, and sarcopenia. We will become more bionic as humans. Replacement of worn out parts will be even more common than it is today.

SUMMIT ON AGING

Panel Discussion

Theme: How Can the Health and Well Being of South Carolina's Older Adults be Improved?

***Panel Facilitator:* R. Bradford Whitney, M.D., Medical Director of Regional Senior Health, a division of Spartanburg Regional Healthcare System**

Panel Participants:

Bruce E. Bondo, M.P.H., Director of Planning and Education Services, Lieutenant Governor's, Office on Aging

Michael Byrd, Director of the Bureau of Chronic Disease and Health Promotion, South Carolina Department of Health & Environmental Control

Lotta Granholm-Bentley, Ph.D., D.D.S., Professor of Physiology and Neuroscience & Director of the Center on Aging, Medical University of South Carolina

Victor Hirth, M.D., M.H.A., CMD, FACP, AGSF, Medical Director, Geriatric Services, Palmetto Health System

Thomas Lloyd, South Carolina Silver Haired Legislature, Speaker 2003-2005

Gardenia Ruff, M.S.W., Director of the Office of Minority Health, South Carolina Department of Health & Environmental Control

Erika Walker, M.B.A., M.S.Ed., Director of the Sage Institute

Panel members were asked to respond to the following four questions:

1. What can professionals, providers, and caregivers do to improve the health and well being of South Carolina's older adults and elderly?
2. What can older South Carolinians do to improve their own health and quality of life?
3. What should the State Government be doing to improve the health and well being of South Carolina's older adults?
4. How can all of us influence governmental policy?

R. Brad Whitney, M.D.

According to the U. S. Bureau of the Census, in a 2003 Report, there were only 4,193 adults over the age of 85 in 1953. By 2000, there were 50, 289, twelve times the number in 1950. By 2025, estimates are that the number of people over 85 will reach 98, 609, representing a 96% increase of mature adults in South Carolina from 2000. Most elderly are seen as having no value. They struggle to hold on to their autonomy.

The specific needs and challenges facing South Carolina are

- How to provide health care infrastructure (medically trained staff and facilities) to meet the needs of the aging population.
- How to pay for increased health care needs, especially prescription drugs and long-term care.
- How Medicaid, Medicare, and Social Security will be able to cope with the growth in numbers of eligible elders.
- How to make available affordable and safe housing.
- How to prevent this population from outliving its financial resources.
- How to provide for other “special needs,” such as caregivers, for an older population.

According to the Behavioral Risk Factor Surveillance Study (BRFSS), 2.3 percent of the population 65 and over has no health insurance at all. However, prevention measures to improve the health quality of older Americans do not have to cost much.

The top ten preferred health and leisure activities among older South Carolinians are

1. walking paths
2. shopping
3. gardening
4. boating
5. health club
6. swimming
7. fishing
8. golfing
9. bicycle riding
10. home computer

Family, private and government support to sustaining independent living include:

- Home delivered meals
- Transportation
- Medicare & Medicaid coverage
- Homemaker & home manager services
- Respite care for family caregivers

- Financial assistance
- Personal care assistance
- Home health services
- Home adaptations for special needs
- Adult day care

The keys to the quality of life for the elderly are

- Good health
- Financial stability
- Support network of family & friends
- Access to health care
- Safe neighborhoods & environments

All these combine to enhance the quality of life for older South Carolinians.

Bruce E. Bondo, M.P.H.

Why is the growth of the senior population so important? Let's look at national health care expenditures:

- Nursing Homes: 1980 – 2012, an expected to increase from \$17.7 billion to \$178 billion, or 906% (averaging 28% per year).
- Prescription drugs will increase from \$12 billion in 1980, to \$445.9 billion in 2012 (averaging 13.6% per year).
- Home Health Care: 1980 – 2012, an expected increase from \$2.4 billion to \$68.9 billion, or 2,771%, (averaging 87% per year).

For South Carolina, the trends are similar:

- Home and Community-based care has increased from \$494,768 in 1981, to \$93,602,218 in 2002, for an increase of 18,818%.
- Prescribed drugs have increased from \$11,487,235 in 1981, to \$111,857,254 in 2002, for an increase of 874%.
- Nursing facility services have increased from \$78,251,339 in 1981, to \$318,779,194 in 2002, for an increase of 307%.
- Overall, Medicaid expenditures for persons 65+ have increased from \$115,352,442 in 1981, to \$622,093,757 in 2002, for an increase of 440%.

The impact of Alzheimer's on South Carolina includes the following data:

- The growth of persons 75 and 85 and older has a dramatic impact on Alzheimer's disease & dementia.
- The lifetime cost to treat a person with Alzheimer's is \$174,000.
- We see a growth in the numbers of persons with Alzheimer's disease from 43,000 in 2000, in South Carolina to 125,190 in 2025.

- The cost to society (all sources) will increase from \$794,000,000 to \$7.7 billion in 2025.

The promotion of independence and choice for senior adults include:

- With increased longevity, more of today's 65 year-olds can plan on living to their eighties and beyond. However, it is likely that not all of these years will be active and independent. One in four older adults have some type of physical impairment and most suffer from one of more chronic conditions.
- The challenge that accompanies the increased longevity is how to ensure the quality of life that older adults want and expect and to find ways that individuals, families, insurers, and the government address the need for resource demands in the future.
- Such awareness is leading to exploration of how to re-direct more public and private funding to support health promotion activities, as well as how to create an environment that encourages greater personal responsibility and choice.

Governmental agencies cannot do it all and people cannot pay for all the costs. People must begin to plan ahead for their own health care needs during their elder years.

Michael Byrd

The four real challenges related to the future of long term care include:

- Paying for long-term care
- Building a viable and affordable community-based delivery system
- Investing in healthy aging
- Recharging the concept of family and value of seniors

My vision is that by 2025, the elderly will be running marathons and will not succumb to inevitable chronic diseases. This can be prevented through the following list of components of healthy aging:

- Avoiding disease & disability through medicine and behavior
- Maintaining high levels of functioning (the elderly have a much higher potential for this than was previously thought)
- Nurturing strong interpersonal relationships decreases the risk for cognitive, emotional and physical decline

The number of chronically disabled Americans aged 65+ has dropped from 8.7 million in 1989, to 6.4 in 1994. Studies show that the numbers of elderly in poor general health (65+) has risen significantly in South Carolina compared to the national average. We must learn to change the definition of family, and include the informal caregiver as a member of the family.

The important role of informal care shows that, of community-dwelling elders with chronic disabilities:

- 64.9% rely on informal care only
- 5.4% rely on formal care only
- 29.7% receive formal and informal care

By 2025, the elderly will be running marathons and will not succumb to inevitable chronic diseases. These can be prevented as long as the elderly observe these healthful behaviors. Stop all use of tobacco, diet, exercise, and stay in their naturally occurring living space.

Lotta Granholm-Bentley, Ph.D., D.D.S.

The Medical University of South Carolina's Center on Aging is a multidisciplinary research and education center that focuses on providing education to all health professionals and on enhancing research on healthy aging and age-related disease. The Center was funded in 1987, and over the last several years with new leadership, a business plan, an executive board, and a recruitment plan for faculty were developed. As a result of this, funding in the area of age-related health and disease at MUSC has increased from less than 3 million to over 20 million dollars per year from 1996 to 2004.

In 2002, the president of the Medical University of South Carolina, Dr. Ray Greenberg, made Healthy Aging one of the three focus areas of the University's Strategic Plan for the next 5 years, along with health disparities and childhood health.

The specific objectives for the Center on Aging regarding the health of older individuals in South Carolina are

1. Establish a nationally prominent **research program** in aging with emphasis on translational research.
2. Develop a comprehensive and coordinated system of **health care delivery** for older individuals.
3. Provide **health promotion, education, and outreach** in aging for students, health providers and the public.

The plan for aging at the Medical University of South Carolina is to provide education in gerontology and geriatrics to all colleges at all levels that will eventually result in a better health care for older individuals in our state. In addition, an ongoing plan is to partner with other aging centers and geriatric clinics to disseminate information and perform important research on healthy aging and age-related disease that will benefit individuals in South Carolina and nationally.

Healthy aging relies on the elderly to develop a healthy lifestyle early on that includes exercising, watching fat intake, avoiding obesity, hormone replacement therapies and ongoing access to care.

Specific health needs are

- Better exercise program in South Carolina schools (access to bike paths and walking areas for individuals of all ages).
- Better information about dietary habits starting with our schools.
- Governmental involvement (such as bingo and lottery money) in the development of exercise areas and bike paths in South Carolina.

Victor Hirth, M.D., M.H.A., FACP, AGSF

What can we all do to improve access for the elderly?

The professionals, providers and caregivers can

- Improve Access
- Increase training opportunities
- Improve community outreach to isolated seniors
- Create viable practice opportunities
- Improve community Health promotion

What can patients do?

- Eat Right
- Walk each day to keep the doctor away
- Lobby your representatives
- Be involved and engaged
- Be a cohesive lobbyist.

What do we want from state government?

- Less paperwork
- Hold “town hall” meeting and listen to seniors
- Coordinate services for seniors

What can we ALL do?

- Make noise!
- Get involved
- Demand better access/service/cost

Thomas Lloyd

The goals of the Silver-Haired Legislature are to

- Identify issues, concerns and possible solutions facing older South Carolinians
- Make recommendations to the Governor, General Assembly and various departments
- Participate in educational forums
- Carry out activities on a nonpartisan basis

The Silver-Haired Legislature is not a lobbying group but rather, it reads the resolutions sent to the legislators and the general assembly. It meets with legislators and has their ear by developing long-term relationships with them as individuals. It keeps legislators informed on the impact proposed legislation will have on the elderly of the state.

Currently, we have five resolutions before the legislature that needs attention:

1. Increase the number of Ombudsman programs in the state.
2. Demand criminal checks on providers.
3. Include funding to prevent abuse of the elderly.
4. Eliminate the food tax.
5. Decrease real estate taxes for the elderly.

Gardenia Ruff, M.S.W.

Racial and ethnic health disparities need to be eliminated

- Disparities still exist for a number of health conditions such as heart disease, cancer, stroke, diabetes and pneumonia.
- Disparities in access, healthcare and quality, health providers, and information contribute to racial and ethnic health disparities.
- Quality health care is needed for all cultural groups. Often, minorities cannot obtain the health care services they need due to lack of access. Access depends on three features: economic, physical and cultural.
- Health care providers need to be made aware of the different problems facing minorities in gaining access and receiving needed information through training and educational programs.
- In addition to affordability (economic) and availability (physical), emphasis should be placed on developing a culturally competent system of care at all levels.
- Cultural competence is a set of cultural behaviors and attitudes integrated into the practice methods of a system, agency or its professionals that enables them to work effectively in cross cultural situations. The cultural issues are not just about language, but rather, understanding and trusting how the health care system works.

- Changes will need to happen at the institutional, community and individual levels to make a difference in meeting the needs of minority seniors.
 - At the institutional level, a culturally competent health system needs policies to support equality in health care and enforcement of the policies. Programs must be put into place to teach staff to be aware of cultural policies. Services will provide equality for all economic levels of the aged.
 - At the community level, support for and development of partnerships and collaborative efforts is needed. We all must be advocates for policy and environmental changes to support prevention and healthy lifestyles.
 - At the individual level, practice of prevention in life style behaviors is needed. We all must become active members of the health care team. We must become informed health care consumers by giving and receiving information and following up with questions.
- Because minorities tend not to participate in clinical trials and often lack trust in the healthcare system, there is much we do not know.
- We need more data and research to understand the impact and effectiveness of various health interventions and programs relative to minorities.

Erika Walker, M.B.A., M.S.Ed.

The SAGE Institute has been in existence since 1998, focusing on senior services, research and education. It is supported by the Duke Endowment and overseen by the South Carolina Hospital Association. It is housed within the Spartanburg Regional Health Care System (Regional Senior Health.)

The Institute's mission is to improve senior services and senior quality of life by

- Building collaborations,
- Working with physicians and other providers of senior services,
- Maximizing efficient uses of resources by building networks of care,
- Eliminating "silos of care" providing team development using the case management model for Spartanburg, and replicating proven best practices so that no senior is left behind.

The Geriatric Best Practices Initiative (2002-2004):

Identified and shared senior service best practices,

- Conducted senior services needs assessment meetings across South Carolina.
- Developed a Senior Service Resource List by SC counties.

Additionally, the Institute established:

- Closer relationships with physicians,
- Systems to improved communications,
- Developed partnerships with the Lieutenant Governor's Office so that needed services could be provided without paperwork delays.

The Institute established The South Carolina Network and Implementation Initiative (2004-2005) that is

- Developing state-wide geriatric network teams,
- Replicating Senior Service Best Practices, and
- Enhancing Senior Service Resource List.

The continuing goals of the SAGE Institute are to get all involved in focusing on seniors as customers crossing all economic levels and all care needs.

The Institute's job is to collaborate to provide a continuum of care to eliminate senior service weaknesses and gaps.

Results from the 2003 Senior Service Focus Groups show that the number one challenge for seniors in South Carolina is *transportation* and the second, is *mental health*.

What Can We Do to Improve Health and Well-Being of SC Older Adults?

- Reduce weaknesses and gaps in senior services.
- Pool resources and build collaborations.
- Keep accurate and consistent outcomes measurements to gain more buy-in of benefits of having senior services.
- Think "outside of the box"...consider offering services to seniors who can pay for them and cost-shifting.
- Develop a Team of Senior Service Providers to educate legislature on *provider's* challenges.
- Educate caregivers on available support systems.
- Provide more in-home and overnight respite.
- Focus on prevention and wellness with program development and incentives.
- Encourage seniors to develop close relationship and communicate well with physicians.
- Encourage seniors to communicate with their families.
- Support the development and advancement of transportation systems.
- Support incentives for programs that help seniors remain at home longer.
- Support development of community case management systems.

SUMMIT ON AGING

BREAKOUT SESSIONS

How Do We Collaborate to Meet Growing Needs?

Summit participants were given the opportunity to share their ideas in breakout sessions. Facilitators of the sessions summarized the purpose of the panel discussion and offered clarification of where South Carolina is now in its ability to meet the health and well-being needs of older adults. The Facilitators then asked participants to share ideas on what needs to be done to better meet those needs and how collaboration can play a role in meeting the needs of older South Carolinians.

Break-Out Session Topics and Facilitators

Workforce Planning: Jennifer Solomon, Ph.D., Professor, Coordinator of Gerontology Programs, & Assistant Dean of the University College, Winthrop University

Balancing Long Term Care Expenditures: Michael Byrd, Director, Bureau of Chronic Disease Prevention and Health Promotion and Judy Baskins, R.N., B.S.N., Director of Geriatric Services, Palmetto Health Richland Hospital

Health Promotion of Older Adults: Cheryl Dye, Ph.D., CHES, Associate Professor, Clemson University & Chair, South Carolina Center for Gerontology Policy Board

Rural Health and Health Disparities: Gardenia Ruff, M.S.W., Director, Office of Minority Health, Department of Health & Environmental Control & Esther M. Forti, Ph.D., RN, Director, South Carolina Geriatric Education Center, & Associate Director for Education & Outreach, Center on Aging, Medical University of South Carolina

Geriatrics Best Practices: Erika Walker, M.B.A., M.S.Ed., Director, Sage Institute

Hospice and End-of Life Care: Jerome E. Kurent, M.D., M.P.H., Associate Professor of Medicine, Neurology and Psychiatry and Tamra West, B.S., Director of Programs, The Carolinas Center for Hospice and End of Life Care

Health Services Research: James Laditka, D.A., Ph.D., Research Assistant Professor, Department of Epidemiology and Biostatistics, Arnold School of Public Health, University of South Carolina and Barbara Tilley, Ph.D., Professor and Chair, Department of Biostatistics, Bioinformatics, and Epidemiology, College of Medicine, Medical University of South Carolina

SUMMARY OF KEY POINTS

WORKFORCE PLANNING

Facilitator: Jennifer Solomon, Ph.D.

In order to plan for the work force needs of the State of South Carolina, the following suggestions and insights were proposed:

- Two primary workforce planning issues to address the population of South Carolina older adults are (1) providing training for professionals and other qualified personnel to meet the needs of older persons for health care, services, and products and (2) filling vacancies as potentially large numbers of state government employees retire in the near future.
- We need to value older adults and recognize their continuing importance to our communities as well as our families.
- Consumer directives may be one mechanism for producing the initiatives needed to meet the future service needs of older adults and their families.
- Creativity is also required to find solutions to the multitude of growing problems.
- Finding quality care providers to work in LTC facilities is a particular challenge and will continue to be a problem because of the low pay.
- The policy changes in South Carolina state laws, as of November 1, 2004, allow family caregivers to enroll as a state provider paid at \$10.08/hr. However, it does not allow spouses, legal guardians, or parents of a minor child to participate in this program.
 - Since caregiving is typically the responsibility and burden of women within a family, this policy change could be a potential reward for them.
 - Federal guidelines require that each enrollee must become a Medicaid provider with all of the qualifications necessary for any other Medicaid provider.
- Safeguards need to be established by the state in order to prevent the development of a two-tiered system of health care for the elderly based on ability to pay.

Possible New Workforce Sources:

Return to more faith-based initiatives, such as Parish nursing.

- Encourage volunteer work in senior service facilities by offering high school or college credit.
- Consider early retirees as resources for part-time work in senior service facilities, paying them a modest amount for their time and services.
- Eliminate issues of liability that may discourage people from volunteering in LTC settings.
- Create government-sponsored programs to promote and support homecare for the elderly.

- Provide skill training for the unemployed who want jobs serving older adults.
- Offer tuition incentives and monetary enticements for high school graduates and undergraduates students desiring careers working with older adults.
- Provide workshops and other training and support to prevent burnout among nurses.
- Encourage other professional colleges and universities in the state to model the Medical University of South Carolina by offering accelerated BA/BS programs in specialty areas such as geriatrics, in order to serve South Carolina's senior population growth.
- Provide state and federally funded grants for institutions offering intergenerational programming.
- Encourage higher education institutions to offer more classes and degrees targeted toward senior care and other aging related issues and professions.
- Identify the number and types of positions to be vacated by retirees with state jobs in the near future and make plans for the consequences in terms of current fiscal decisions and future hiring needs.

BALANCING LONG TERM CARE EXPENDITURES

Facilitators: Michael Byrd and Judy Baskins, R.N., B.S.N.

Promote the Concept of Aging in Place in South Carolina

The term "aging in place" means living where you have lived for many years, or living in a non-healthcare environment, and using products, services and conveniences to allow or enable you to not have to move as circumstances change. More recently "Aging in Place" is a term used in marketing by those in the rapidly evolving senior housing industry. Continuing Care Retirement Communities (CCRCs) by definition offer the chance to age in place, but first an older person must move to these kinds of communities to "start aging". Multi-level campuses market "Independent Living, Assisted Living and perhaps Alzheimer's care and Skilled Nursing" in one location, and claim to offer the opportunity to "age in place," but again you must move there first. In many cases you may move from one wing of the campus to another to receive increased services.

"Aging in place", should mean "to remain in one's current setting **without** first relocating." Reverse mortgages, long term care insurance, and informal and formal home and community-based services are other strategies that are pertinent to "aging in place."

Support the Development of Naturally Occurring Retirement Communities across South Carolina

In a community or neighborhood where residents remain for years, and age as neighbors, a Naturally Occurring Retirement Community (NORC) develops. A NORC may refer to a specific apartment building, or a street of old single-family homes.

Residents would have to be in their home or apartment for many years for this to evolve into a senior community. It is possible to band together and develop, or seek help to develop, access to services for those needing assistance, to retain the highest quality of life as they age within a NORC.

Adapt the Program of All-Inclusive Care for the Elderly (PACE) into other settings across South Carolina including rural sites.

The Program of All-inclusive Care for the Elderly (PACE), a Medicare/Medicaid capitation program, has been generating considerable excitement and presents new possibilities for the health care community. Providing older individuals and their families with more long-term health care choices is a key component to a successful care delivery system. Given today's competitive environment, non-profit health systems and long-term care providers must understand and provide a continuum of programs to serve the elderly, including community-based programs. Understanding how a successful PACE program keeps patients out of hospitals and nursing homes will also enable providers to serve their communities and succeed at the same time.

Balance State Long Term Care Spending in South Carolina

State Medicaid Agencies allot one-third of their Medicaid budgets for long-term care services. In 2002, 70 percent of these expenditures were for institutional services rather than for services in the homes and communities of individuals with chronic disabilities. In recent years, Center for Medicare and Medicaid Services (CMS) has endeavored to correct this imbalance by providing states with tools and resources to balance their service offerings between community and institutional options.

It has long been recognized that the Medicaid program is structurally designed so individuals are more likely to have an institutional option available than a community-based option. In its early years, Medicaid only provided coverage of institutional services. Moreover, many persons with long-term care needs could only become eligible for Medicaid benefits if they entered an institution.

State successes have included many common elements:

- **Access to the System:** States with balanced systems offer equal access to institutional and community services.
- **Financing of Programs and Services:** Many states changed their long-term care budgetary practices to enable funds to follow people as they choose community supports. Some states allow funds allocated to one program to transfer to another as the individual moves within the system. Others have created a single long-term care budget instead of separating budgets between facility and community services. Generally, state legislatures have established these budgetary changes. A legislative mandate can set the expectation that state decision-makers are responsible for improving the balance between institutional and community services, allow for consistent policies across state agencies, and ensure the vision of a balanced system will remain intact through administrative changes.

- **Service Sufficiency and Provider Capacity:** Offering a variety of service options provides flexibility to meet the variety of individual needs. In addition to funding more services, supports and items, many states have actively worked to build provider capacity to provide new or underutilized services. Several states expanded their service options beyond traditional medically oriented, agency-based services to include self-directed service models and social models for services.
- **Quality Assurance and Improvement:** In addition to offering individuals an authentic choice among services, the long-term support system must provide quality services that meet the needs of individuals with chronic conditions. CMS is striving to develop the resources that will enable states to design or enhance their quality systems. These resources include assistance in implementing person-centered planning, obtaining participant feedback, and ensuring stakeholder involvement.

Expand the Use of the Chronic Care Model

The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are

- Community
- Health system
- Self-management support
- Delivery-system design
- Decision support
- Clinical information systems

Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.

HEALTH PROMOTION OF OLDER ADULTS

Facilitator: Cheryl Dye, Ph.D., CHES

This list provides suggestions and web site contacts for programs and classes offered to promote various aspects of health care in older adults in South Carolina:

- Red Cross Caregiver Training – Alzheimer’s Courses
 - Alzheimer’s Association Palmetto Chapter
 - www.scpalmettoalz.org
- Low Country Senior Network
 - Marsha Clayman

- www.lowcountrysn.com
- Upstate Senior Network – Prime of Life Festival
 - Senior Action
- Richland County Sheriff's Department
 - Project Hope www.rcsd.net/projhope.htm
 - E-mail: phope@rcsd.net
- South Carolina Area Health Education Consortium (SC AHEC)
 - Continued education for health provider workforce and lay health workers
 - www.scahec.net
- Hospital Case Managers
- Parish Nurse Networks
 - Church van transportation network
- Life Line Program
 - Personal Emergency Response
- Charleston Area Senior Center Services
 - Senior Companion Program
- Seniors Helping Seniors
 - Conference on Aging

Possible Action Steps

- Focus on prevention
- Organize produce donations (fruits & vegetables) from grocery stores
- Improve transportation options for rural areas
- Replicate Roper-St. Francis – Life Quest
 - Exercise programs
- Investigate what should be done to promote “Aging in Place”
- Replicate Wesley Commons - Greenwood
 - Fitness classes – Aqua yoga
- Replicate Programs for All Inclusive Care for the Elderly (PACE) as a mechanism to age in place
- Replicate Home Bound – mobile county library
 - Provide books, video, etc.
 - Mobil meals
- Expand and replicate Elder Support Line in Charleston
 - Mental health & protective service
- Expand and replicate SC DHEC and Clemson University physical activity initiatives
 - SC DHEC Exercise program for people with Arthritis and fall prevention program
 - Clemson University physical activity program for low-literacy, elderly audiences
- Optimize use of Video Communication laboratories
 - Medical University of South Carolina, University of South Carolina and, Clemson University
 - Charleston

- Fullerton Foundation
- Involve High School and University students such as Presidential Scholars
 - Community Interventions and service learning
- Continue Conferences & Meetings among aging stakeholders
- Utilize Email list serves such as one created for health promotion
- Increase use of state-funded Public Service Announcements (PSAs)
 - General public
 - Access to aging services
 - Education about aging programs
- Promote use of South Carolina Access
 - Data base of aging services
- Increase awareness of health disparities
- Educate Legislators about aging issues
 - Look at other states
 - Medicaid Reimbursement
 - Resources
 - Where are we
 - Putting dollars in appropriate areas
- Provide for long-term care tax credits
- Reimbursed case management
- Communities should develop ways to coordinate volunteer groups such as retired law enforcement officers, retirees from health and social service professions, and other groups of volunteers who want to serve their community to assist the elderly.
- Develop intergenerational programs that foster cultural appreciation for all age groups.
- Home Health Care Agencies should coordinate their efforts with other groups such as hospital case managers and Meals on Wheels to maximize benefit of home visits and avoid duplication or lack of service.

RURAL HEALTH AND HEALTH DISPARITIES

Facilitators: Gardenia Ruff, M.S.W. and Esther M. Forti, Ph.D., R.N.

In review of the panel presentation, the facilitators made the following points as openers for discussion:

At first glance, South Carolina appears to provide thorough coverage of resources. However, under closer scrutiny, this is not so. The Older Americans Act has brought very little monies into the state from the federal government, leaving local resources to fill the gaps for its seniors.

South Carolina has

- The 2nd fastest growing population of elderly in the nation with a fragmentation of services to offer them.
- We need to look closely at where the health care gaps are and how the elderly can better gain access to services.
- Waiting lists are HUGE for services that are present.
- The distribution of lottery money divides into 20% into education and 58% for prizes.
- The state needs to look at making more money available by redistributing existing lottery money to provide for the health care needs of the state's elderly.

The following areas of need were mentioned:

- Low-income elderly access to health care.
- Rural health programs available for the elderly that might serve as models to be replicated, such as The Winnsboro Project.
- Immunizations for the elderly in rural areas.
- Support systems for health care services for the elderly in long-term care settings.
- Medicaid/Medicare services for the rural elderly.
 - Medications
 - Other health care needs
- Follow up on investigations of abuse in nursing homes.
- Current listing of statewide resources readily accessible for the rural elderly.
- Transportation services available within each county for the rural elderly to access health care.
- Health education programs such as Diabetes and Hypertension.
- Access to funding programs at the federal, state and local levels that are renewable.
- Health care programs that provide access to consumer advocates on aging issues.
- Nutrition Education Program through the Cooperative Extension that are beneficial to the elderly.
- Adult Protective Services for the elderly.
- Volunteer Programs in rural areas that assist caregivers in handling patients with Dementia/Alzheimer's.

Cultural Issues that need to be addressed to reach the rural and medically underserved elderly:

- Providers must use health care terms and language that are understandable to the elderly and minority ethnic groups.
- Most minority and ethnic groups have some lack of trust for doctors.

State resources and how they can help:

- Office on Aging:
 - Locating services for elderly or needy
 - Locating contacts with regard to finding home care services
- Churches:
 - Good mediums for disseminating information and referral contacts, especially in rural areas.
 - Some churches provide calendars with health information along with their church bulletins.

Suggested mechanisms to increase state resources:

- Allocate a portion of the State Lottery funds to cover health care for the elderly.
- Designate part of the Cancer Budget to be used exclusively for the elderly with cancer.
- Require colleges and universities to volunteer students to do more community outreach and service learning.
- Inform the Lieutenant Governor's Office of disparities and any helpful suggestions.
- Talk to members of the state legislature on a regular basis and develop a rapport about elderly issues.
- Contact the newspapers with human-interest stories on elderly needs.
- Appeal to community health systems to provide services to low-income elderly.
- Pressure insurance companies to pay for preventative procedures and not wait for the onset of more costly disease process.
- Provide patient advocates to aid elderly understand the process of dealing with health care insurance companies.
- Become familiar with the many cultural influences dominant in South Carolina.
- Provide a program of rewards or tax credits for family caregivers.
- Allow long-term care providers to use tax credits or rewards for medical reimbursement as is currently allowed in 23 states.
- Help families finance long-term care; not penalize the caregiver as currently happens with the loss of job, income and medical coverage.
- Reevaluate the Social Security classifications of what is considered disabled.
- Develop and maintain an organization of volunteers, such as various church groups, to provide transportation for the elderly.
- Increase cooperation and collaboration among state agencies to centralize transportation services and provide administration of these services.

GERIATRIC BEST PRACTICES

Facilitator: Erika Walker, M.B.A., M.S. Ed.

Ideas to collaborate to meet the needs of senior adults collected by this breakout group are

- Use more college interns or high school students to provide services for the senior adult population.
- Partner with universities to use LTC facilities and Continuing Care Retirement Community facilities to train health care professionals including physicians, nurses, dentists, social workers, psychologists, pharmacists, dental hygienists, and physician assistants for internships and clinical practice.
- Offer training for program coordinators and volunteer supervisors to include development/improvement of Senior Programs.
- Collaborate with Dental Societies to offer low--cost dental care for seniors.
- Provide education to seniors & providers on existing resources available in the community.
- Collaborate with community pharmacists. (An additional resource: needymeds.com & SILVERxCARD)
- Work with your state legislature or lawyers' organization to reduce litigation.
- Persuade the State Legislature to pass legislation requiring all physicians to accept a greater percentage of Medicare patients.
- Coordinate elderly service agencies such as assisted living facilities and hospice to build in more socialization and spiritual support for residents, including chaplain visits.
- Provide Transportation Programs similar to the Independent Transportation Network - Transportation Model
 - Supported by subsidizing tax services
 - Coordinated and maximized transportation resources to fill empty seats
 - "Riding with Faith" – Hampton County churches reimbursed volunteers for mileage
- Bring faith-based community to the table for senior service discussions.
- Provide better organized advocacy programs.
- Get a better picture of what is happening in other states.
- Have a monthly meeting of a state-wide coalition of all state groups.

HOSPICE AND END-OF-LIFE CARE

Facilitators: Jerry Kurent, M.D., M.P.H. and Tamra West, B.S.

Key Points for Hospice and End of Life Care Breakout Session

New Generation of Pain Management

- Pain can be adequately managed in 90-95% of patients.
- Pain is the number one reason patients visit health providers.
- There is a moral and ethical responsibility to treat pain.
- Fifty million Americans endure serious chronic pain (lasting more than 6 months) annually.
- Only 1 in 4 patients with chronic pain received adequate treatment (Chronic Pain in America, 1999).
- The SUPPORT study involving more than 9000 patients (JAMA, 1995) found that more than 50% of hospitalized dying patients suffered from poorly treated or untreated pain during the last 3 days of life.
- Elderly patients often bear the brunt of poorly treated and untreated pain.
- Elderly patients often have reduced expectations for pain relief. They have been frequently told, "What do you expect, you are getting old."
- Nationwide data indicate that 25%-40% of nursing home residents experience untreated or poorly treated pain.
- Nursing home residents at greatest risk for poorly treated pain are older than 85 years, cognitively impaired, or from minority backgrounds.
- Numerous barriers exist in the treatment of pain, including fear of addiction and inadequate knowledge concerning state-of-the-art and science of pain management.
- Many physicians are not familiar with The World Health Organization Analgesic Ladder and other authoritative sources for pain management.
- Only 5% of U.S. medical schools have a required pain management curriculum.
- There is an urgent need for professional education in pain assessment and pain management.

The National Pain Care Policy Act of 2003 will increase awareness of pain as a significant public health problem; establish a National Center for Pain and Palliative Care Research; provide funding for pain care education and training programs for health professionals.

Hospice and End of Life Care: How do we collaborate to meet growing needs?

- Recognize that as our society ages, end of life care will become more of a reality for a larger group of individuals. End of life and palliative care is a public health issue.
- With the myriad of health care choices and options available, advance planning for health care choices and desires will become even more important.

- Interest in end of life care issues such as hospice, palliative care, advance care planning and grief and loss is increasing as boomers age.
- Quality palliative and end of life care must be recognized as a critical and necessary component of the broader health care continuum.
- All health care professionals must promote and embrace this concept as part of their individual and collective responsibility to provide quality health care.
- Individuals and systems must identify potential barriers including access, public awareness and professional competency in end of life and palliative care.
- Advance health care planning must be promoted throughout the adult life span and in every venue of health care services and the community.
- Patients with non-cancer terminal diagnoses represent a steadily increasing proportion of patients served by hospice.
- A primary goal of hospice is to maximize quality of life at the end-of-life, with focus on pain and symptom management.
- The hospice *care unit* includes the patient and family caregivers.
- Late referral of terminally ill patients to hospice by physicians is a barrier to providing optimal care at the end-of-life.
- The Hospice Medicare benefit provides bereavement support for surviving family members for up to one year after death of the hospice patient.

Discussion:

- Hospice programs provide services needed by both the patient and those who care for them.
- Churches, synagogues, etc. can work with the secular community to offer needed services.
- The scope of services provided by hospice programs assists patients and families with physical, social, emotional and spiritual needs.
- Hospice programs promote access to services for those with no identified caregiver.
- Medicare, Medicaid and most private insurers reimburse hospice care.
- Professional education and public awareness efforts are necessary to insure services are requested.
- Hospice has unique attributes including the provision of a respite component, the requirement for the use of community volunteers and the requirement to provide services regardless of the availability of a pay source.
- Future development in hospice and end of life care include the development of additional hospice facilities in SC, collaborations with hospitals and other providers and the development of palliative care programs.
- The hospice team consists of well-trained, compassionate professionals.
- Hospice care provided to residents of nursing homes is increasing in SC.
- Patients suffer when health care professionals are ineffective in treating pain and symptoms. Fear of addiction to narcotics continues to be a concern with patients and some health care professionals.
- Pain, comfort and maintenance of dignity are primary end of life care concerns. Many patients, especially the elderly, have lower expectations for pain control, will often deny pain or will not request medications as needed.

- There continue to be barriers to using hospice care.
- Hospice care is the gold standard in end of life care.
- All hospice care is palliative care but not all palliative care is hospice.
- Only 5% of physicians in the US have had concentrated coursework in pain management for the dying.
- South Carolina ranks well in the availability of hospice and palliative care services.
- The Five Wishes document could help improve advance health care planning and the support for individual patient choice in South Carolina. What can be done to have it approved in South Carolina? It can currently serve as a guide to conversations and decisions and end of life care.

HEALTH SERVICES RESEARCH

Facilitators: James Laditka, D.A., Ph.D. and Barbara Tilley, Ph.D.

Research Topics of Interests:

- Transportation
- Prevention
- Health Promotion
- End of Life Care
- Socialization
- Resources
- Interventions
- Care-Case Management
- Funding

Health services research and where we want to be

- Need to increase limited resources for research by identifying national as well as local sources of funding. Continue use of Health Services Research to identify problems and solutions, and approaches to providing people with resources to address problems.
- Health Services Research hopes to identify the best approaches to achieve the best outcomes.
- Tax benefits – health services research should assess cost and benefit implications.
- Aging processes differ in the well and the unwell; this difference in process should be considered.

Suggested programs that could be the focus of Health Services Research

General topics:

- Health choices:
 - Information on how people make healthy choices;

- Reeducation of elderly people to promote healthy aging;
- The role of the media and our culture;
- The conflict with the care of the elderly;
- Innovative approaches for state and business community to pool resources
- Nursing Home Residents
 - What populations going into nursing homes and why;
 - Health and cost impact of one year waiting list on Medicaid beds;
 - Follow-up studies of people in nursing homes who transition out.
- People Aging in Place
 - Resources people need to keep an aging person in their home.

Research on Rural Issues:

- Transportation and the problems created for the elderly in rural settings, without it (e.g., isolation and deteriorating mental and physical health)
- Resources to improve the socialization of the rural elderly
- Approaches to funding programs for an All Inclusive Care for the Elderly (PACE) – demonstration project and program evaluation
- Approaches to de-institutionalizing day care
- The quality of life of the rural elderly

Other considerations:

- In developing programs and their evaluation we need to consider what the client wants is not always what we want
 - Look not at our perception, but their perception
 - We need to go to the client to address their needs
- Look at other organizations, such as the church and other community organizations to see how they address the needs of the elderly
- We need to consider education of family members on generational needs: the current elderly population's needs differ from the next generation's needs
- Address the basic needs of the elderly as relate to
 - Tax benefits for seniors
 - Dementia & driving
 - Rural Health Research
 - Exercise Science
 - Applied research
 - Accessing resources
 - Collaborative efforts among research institutions

WRAP-UP SESSION

Facilitator: G. Paul Eleazer, M.D., FACP, AGSF

To begin, always keep the end goal in mind

- Teach the health care workforce to communicate more effectively about health issues and care with patients and families.
- Teach the young to value and understand the needs of Older Adults.
- Provide the steps that keep Older People healthy.
- Avoid the overuse of medications.
- Be creative in taking care of problems that occur with older people.
- Train the young to take care of older adults, and to be a part of their lives.
- Make in-home services more accessible for older people.
- Oversee nursing homes to maintain mandated level of competency.
- Allow older adults to work as long as they want and are able.
- Provide state and federal programs to enrich and prolong the lives of the older adults.

POLICY RECOMMENDATIONS

WORKFORCE

- Offer tuition incentives and monetary enticements for high school graduates and undergraduates students to choose careers in aging.
- Eliminate issues of liability that may discourage people from volunteering.
- Be proactive in evaluating the consequences and developing strategies for the retirement of a large number of state employees in the near future.
- Mandate educational institutions to alter their curriculum to provide courses in geriatrics and gerontology.
- Mandate a specific number of credits in geriatrics for health and social services professionals as a condition for license renewal.
- Facilitate continuing education training in geriatrics and gerontology for health care professionals.
- Recruit, train, and retain more mental health providers.

BALANCING LONG-TERM CARE EXPENDITURES

- Create government-sponsored programs to promote and support homecare for the elderly.
- Support policy research to examine policy options to address the long waiting period for obtaining long-term care services in South Carolina.
- Allow spouses, legal guardians, or parents of a minor child to participate as state providers in the policy change for family caregivers initiated November 1, 2004.
- Replicate and adapt Programs of All-inclusive Care for the Elderly (PACE) in South Carolina's rural areas to enable senior citizens to live as independently as possible and keeping them in their own homes and communities.
- Provide tax credits for long-term care insurance to South Carolinians.

HEALTH PROMOTION

- Promote aging in place through health promotion and improved access to health and social services in rural communities.
- Empower older adults to manage their health through health promotion education about exercise, nutrition, and chronic disease management.
- Develop intergenerational programs that foster cultural appreciation for all age groups.
- Promote service-learning projects for high school and college students to increase a spirit of volunteerism and sensitivity to the elderly.
- Increase use of state-funded public service announcements about aging issues.

RURAL HEALTH AND HEALTH DISPARITIES

- Promote interagency collaboration and service coordination such as the one-stop centers within and among rural communities.
- Provide quality of care for all older adults regardless of minority status, with special attention to differences among race in presentation and treatment of disease.
- Mandate cultural competence training for all those who provide health and social services to older minorities.
- Develop and administer strategies such as a core of volunteers in rural areas to provide transportation for elders.
- Promote and utilize churches in rural areas to assist with health and social services needs and health promotion.
- Develop and maintain databases on older minority populations.

GERIATRICS BEST PRACTICES

- Promote policy on the federal and state levels to reimburse geriatric case managers and geriatric community health workers.
- Pressure insurance companies to pay for preventive health care so as not to wait for the onset of more serious and costly disease processes.
- Partner with universities to use Long-Term Care and Continuing Care Retirement Community facilities to train health professionals during internships and clinical experiences.

- Collaborate with Dental Societies to offer low--cost dental care for seniors.
- Bring faith-based community to the table for senior service discussions

HOSPICE AND END-OF-LIFE CARE

- Require a Pain Management curriculum requirement for all medical and health professions schools.
- Require Hospice rotation for all medical students and primary care resident physicians.
- Require geriatric fellowships to have segments on pain management and end-of-life care, including hospice rotation.
- Advocate for the South Carolina Medical Licensing Board, a re-licensing requirement for Continuing Medical Education (CME) hours related to pain management and palliative and end-of-life care for practicing physicians.
- Require annual in-service training on pain management, palliative and hospice care for all nursing and supportive staff in long-term care facilities.

HEALTH SERVICES RESEARCH

- Identify sources of funding for research to better understand the problem of transportation to health care and social services for older persons in rural areas.
- Connect evidence-based research to the delivery of health care and social services, by supporting translational research at South Carolina's universities and colleges.
- Support health services research on how the coming generation of older South Carolinians differs from the current older population to anticipate needs for health care and social services in the coming decades with a focus on healthy aging, lifestyles, and public health.
- Support health services research to examine health services utilization and needs of diverse segments of South Carolina's aging population, including the well-old and the disabled, minority populations, rural residents, and affluent older persons.
- Support epidemiological research examining disease occurrence among diverse segments of South Carolina's aging population, including the well-old and the disabled, minority populations, rural residents, and affluent older persons.

REFERENCES

- Alzheimer's Disease Resource Coordinating Center. Retrieved January 25, 2005, from <http://www.dhhs.state.sc.us>
- American Association for Geriatric Psychiatry. *Geriatrics and mental health: The facts*. Retrieved January 21, 2005, from http://www.aagpgpa.org/prof/facts_mh.asp
- American Association of Retired Persons (2000). *Fixing to stay*. Washington, D.C.: American Association of Retired Persons.
- American Association of Retired Persons (2003). *Fixing to stay*. Washington, D.C.: American Association of Retired Persons.
- Behavioral Risk Factor Surveillance System (BRFSS) (2000). Retrieved January 22, 2005, from http://www.cdc.gov/nchs/data/hp2000/hdspr/scr_docs.pdf
- Bureau of Health Professions. *Health professions shortage areas*. Retrieved January 24, 2005, from <http://bhpr.hrsa.gov/shortage>
- Chalmers, A., & Joseph, A. (1998). Rural change and the elderly in rural places: Commentaries from New Zealand. *Journal of Rural Studies*, 14, 155-165.
- Friedman, P. (2003, March). Meeting the challenges of social service delivery in rural areas. Retrieved October 22, 2003, from <http://financeprojectinfo.org/rural/rural.asp>
- Gamm, L. & Bell, S. (2001). Identifying rural health priorities within Healthy People 2010: A report on the results of the Rural Healthy People 2010 survey 1. Dallas, TX: National Rural Health Association Conference.
- Gamm, L.D., Hutchison, L.L., Dabney, B.J., & Dorsey, A.M., eds. (2003). Rural Healthy People 2010: A companion document to Healthy People 2010, Vol 1. College Station, Texas: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.
- General Accounting Office (1995). Prescription drugs and the elderly. GAO Report Number HEHS-95-152.
- Hermanova, H.M. & Richardson, S.K. (2000). *Conclusions and recommendations for policies on rural aging in the first decades of the 21st century*. Endorsed by a Plenary Session of the International Conference on Rural Aging. June 11, 2000. Charleston, WV.

- Mature Adults Count: A Profile of South Carolina's Older Population (2003). Retrieved January 20, 2005, from <http://www.scmatureadults.org>
- Mueller, K., & MacKinney, A.C. (2003, December). *Care across the continuum: Access to health care services in rural America*. RUPRI Center for Rural Health Policy Analysis. Working Policy Paper P2003-10.
- National PACE Association. Program of All Inclusive Care for Elderly (PACE). Retrieved January 20, 2005, from <http://www.NPAonline.org>
- O'Neill, G., & Barry, P. (2003). Training physicians in geriatric care: Responding to critical need. *Public Policy and Aging Report*, 13, (2), 17-21.
- Schur, S.J. & Franco, C.L. (1999). Access to health care. In T.C. Ricketts (Ed.), *Rural Health in the United States* (pp. 25-37). New York, NY: Oxford University Press.
- South Carolina Alzheimer's Disease Registry Annual Report (2004). The Norman J. Arnold School of Public Health. University of South Carolina. Columbia, SC. Retrieved January 25, 2005, from <http://www.sph.sc.edu/osa/osamain.asp>
- South Carolina Caregiver Advocate Program. Retrieved January 25, 2005, from <http://www.dhhs.state.sc.us/InsideDHHS/Bureaus/BureauofSeniorServices/default.htm>
- South Carolina DHEC. (2004). Annual report. Columbia, SC.
- South Carolina Diabetes Prevention and Control, Bureau of Chronic Disease and Health Promotion. Retrieved January 29, 2005, from <http://www.scdhec.gov/hs/comhlth/diabetes/index.asp>
- Tremblay, K., & Barber, C. (2004). *Preventing falls in the elderly*. Colorado Cooperative Extension. Retrieved January 21, 2005, from <http://www.ext.colostate.edu/pubs/consumer/10242.html>
- USDA Economic Research Service (2004, September). The economics of food, farming, natural resources and rural America. *Rural America at a glance*. Retrieved September 24, 2004, from <http://www.ers.usda.gov>
- Vargus, C., Yellowicz, J., & Hayes, K. (2003). Oral health status of older rural adults in the United States. *Journal of the Dental Association*, 134, 479-486.